MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

IN-PERSON MEETING OF THE DUAL ELIGIBLE BENEFICIARIES WORKGROUP

NOVEMBER 15, 2011

NATIONAL QUALITY FORUM

NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

Dual Eligible Beneficiaries Workgroup: In-Person Meeting #3
November 15, 2011

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

Please use the following information to access the conference call line:

Dial-in Number for Public Audience: (888) 455-2296, Confirmation Code 7114975

AGENDA

Meeting Objectives:
- Discuss central themes from the Interim Report to HHS and input from external stakeholders
- Understand potential short-term and long-term approaches to measurement for the dual eligible beneficiary population
- Examine candidate measures in five high-leverage opportunity areas and document gaps
- Understand MAP progress on pre-rulemaking activities and the workgroup's role in providing input

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

9:15 am **Review Interim Report Themes and Responses**
Sarah Lash, Program Director, Strategic Partnerships, NQF
- Interim Report themes
- Input received during public comment period
- Input received from HHS
- Workgroup discussion and questions

10:00 am **Design of Potential Measurement Initiatives**
Cheryl Powell, Medicare-Medicaid Coordination Office, CMS
- Long-Term Opportunities: Potential New Initiative
  - Intended purpose, goal, level(s) of analysis
  - Structure and capabilities of the data
- Short-Term Opportunities: Existing Federal Programs
- Workgroup discussion and questions
- Opportunity for public comment

10:45 am **Break**

11:00 am **MAP Measure Selection Criteria**

Connie Hwang, Vice President, Measure Applications Partnership, NQF

- Evolution of MAP measure selection criteria
- Workgroup discussion and questions

11:30 am **Selecting Candidate Measures in High-Leverage Opportunity Areas**
Small Group Activity

- Quality of Life
- Care Coordination
- Screening and Assessment
- Mental Health and Substance Use
- Structural Measures

Noon **Working Lunch, Small Group Activity Continues**

1:30 pm **Report Out from Small Groups**
Alice Lind and Workgroup Members

- Selected and second-tier measures in each area
- Measures for potential modification
- Measure gaps revealed
- Workgroup discussion and questions

3:00 pm **Break**

3:15 pm **Identifying “Duals-Sensitive” Measures**
Nicole Williams McElveen, Senior Project Manager, Performance Measures, NQF
Elisa Munthali, Senior Project Manager, Performance Measures, NQF
Heidi Bossley, Vice President, Performance Measures, NQF

- Experience of “disparities-sensitive” measures
- Measure characteristics or topics for “duals-sensitive” measures
- Workgroup discussion and questions

4:15 pm **Pre-Rulemaking Activities**
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF

- Review core sets and Coordinating Committee guidance
- Introduce survey exercise
- Workgroup discussion and questions
- Opportunity for public comment

5:00 pm **Summation and Next Steps**
Alice Lind

5:15 pm **Adjourn**

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup
In-Person Meeting

November 15, 2011

NATIONAL
QUALITY FORUM

Welcome and
Review of Meeting Objectives

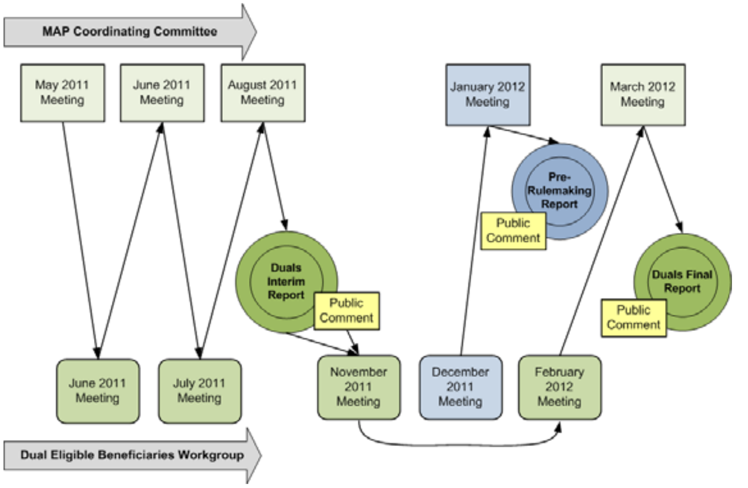
Introductions

Dual Eligible Beneficiaries Workgroup Charge

To advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact
- Identify a core set of current measures that address the identified quality issues and apply to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes)
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings

Flow of Information to Inform Reports



MAP Coordinating Committee

May 2011 Meeting

June 2011 Meeting

August 2011 Meeting

January 2012 Meeting

March 2012 Meeting

Pre-Rulemaking Report

Public Comment

Duals Interim Report

Public Comment

Duals Final Report

Public Comment

June 2011 Meeting

July 2011 Meeting

November 2011 Meeting

December 2011 Meeting

February 2012 Meeting

Dual Eligible Beneficiaries Workgroup

Analytic Strategy

Establish vision for improved quality of care and strategic approach to performance measurement

Align with broader initiatives and guiding frameworks

Prioritize high-leverage improvement opportunities for dual eligible population

Consider data source and HIT implications

Identify measures currently in use and map them to high-leverage opportunities

Refine core measure set, identify gaps, and propose modifications or new measure concepts

Meeting Objectives

Discuss central themes from the Interim Report to HHS and input from external stakeholders

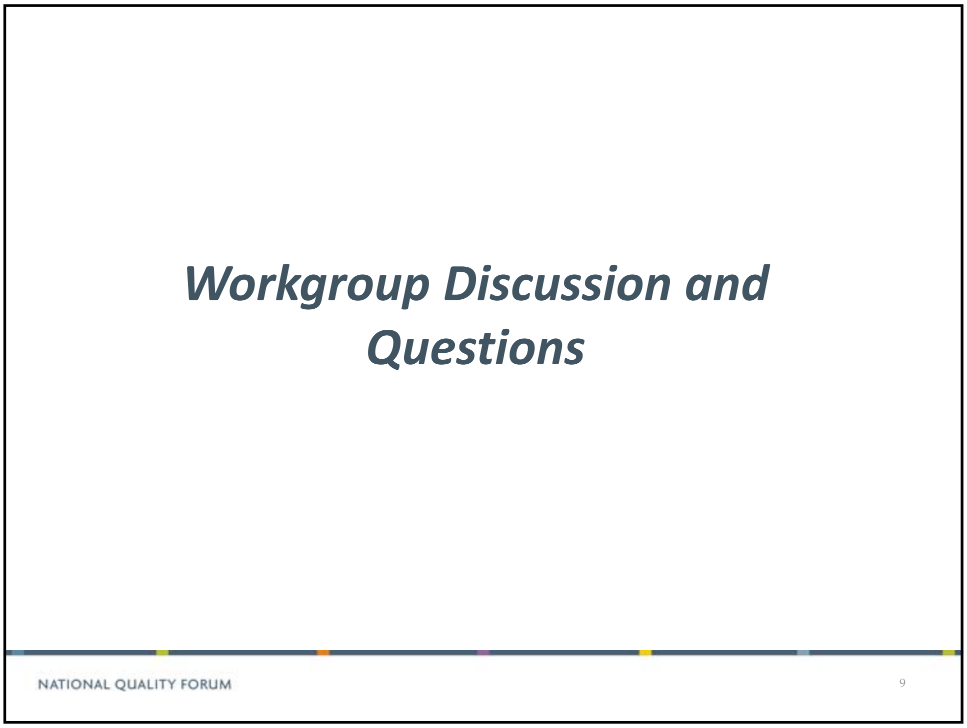
Understand potential short-term and long-term approaches to measurement for the dual eligible beneficiary population

Examine candidate measures in five high-leverage opportunity areas and document gaps

Understand MAP progress on pre-rulemaking activities and the workgroup’s role in providing input

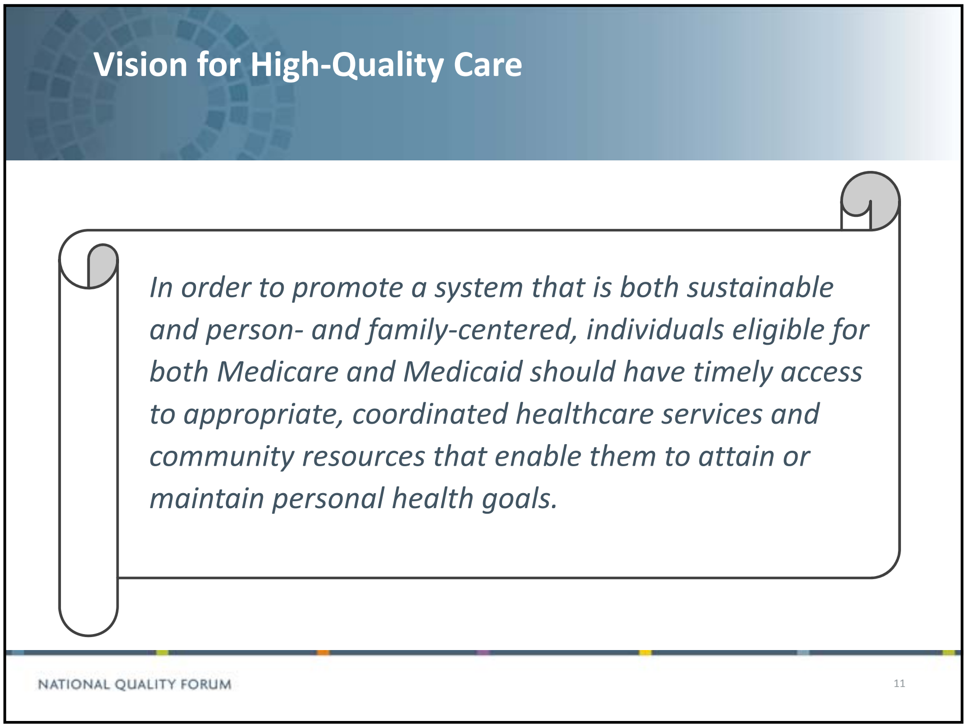
Agenda

9:00	Welcome and Review of Meeting Objectives
9:15	Review Interim Report Themes and Responses
10:00	Design of Potential Measurement Initiatives
11:00	MAP Measure Selection Criteria
11:30	Selecting Candidate Measures in High-Leverage Opportunity Areas
1:30	Report Out from Small Groups
3:15	Identifying “Duals-Sensitive” measures
4:15	Pre-Rulemaking Activities
5:00	Summation and Next Steps
5:15	Adjourn



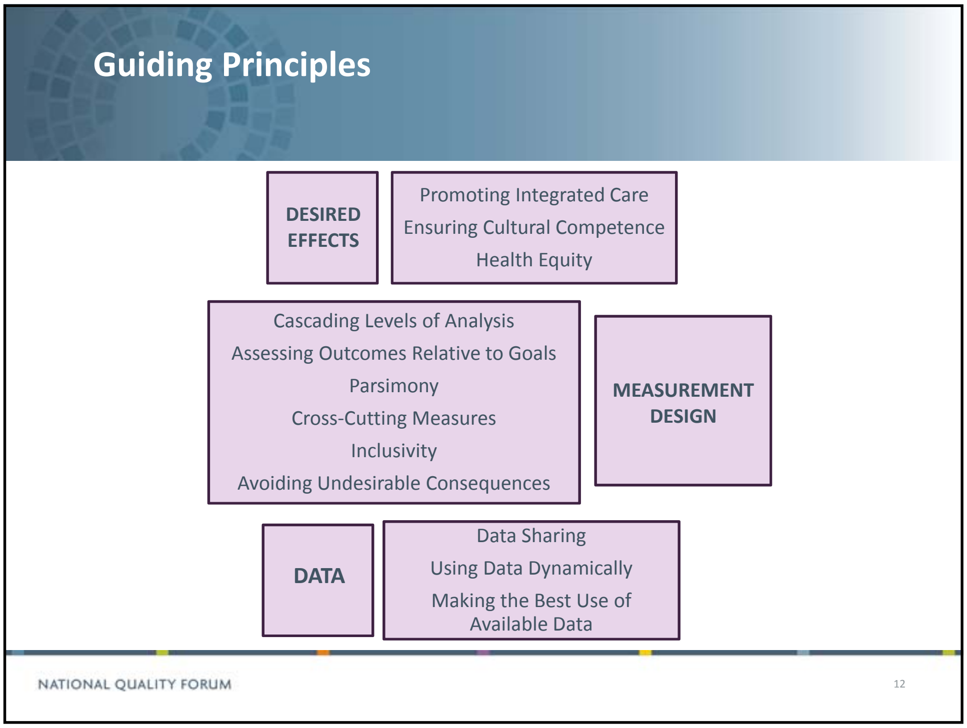
Workgroup Discussion and Questions

Interim Report Themes and Responses



Vision for High-Quality Care

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



Guiding Principles

DESIRED EFFECTS

- Promoting Integrated Care
- Ensuring Cultural Competence
- Health Equity

MEASUREMENT DESIGN

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

DATA

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

High-Need Subgroups and Affordability

- Some population sub-groups have particularly intense service needs; targeting their care for improvement may yield large gains
- Sub-populations may require specialized performance measures in addition to a common core
- Commenters suggested defining the parameters of the behavioral health sub-population
- Emphasis on improving value and affordability of care, reinforced need to capture information about total cost of care and resource use

High-Leverage Opportunities and Illustrative Measures

Quality of Life	Improvement in Ambulation/Locomotion Change in Daily Activity Function as Measured by the AM-PAC
Care Coordination	3-Item Care Transition Measure Advance Care Plan
Screening and Assessment	Screening for Fall Risk Tobacco Use Assessment and Tobacco Cessation Intervention
Mental Health and Substance Use	Depression Remission at Six Months Follow-Up After Hospitalization for Mental Illness
Structural Measures	SNP Structure and Process Measure #6: Coordination of Medicare and Medicaid Coverage Medical Home System Survey

Illustrative Measures and Gaps

- Comments on mix of measure types:
  - Supported focus on outcomes and patient experience
  - Concern structural measures are a minimum standard and not sufficient to ensure high quality
  - Agreed measures should move beyond documenting a process to ensure appropriate follow-up is performed
  - Conflicting views regarding validity and value of patient-reported data
- Additional gaps: health status, medical home

Data Sources

- Data remains a fundamental challenge
- Fragmentation of the system makes measurement difficult; existence of multiple reporting programs, each with different goals and measures, exacerbates the problem
- Use existing data as much as possible to minimize reporting burden
- Data elements should be aligned across providers throughout the continuum of care and a standardized vocabulary should be used to support interoperability and data exchange
- Confidentiality laws and regulatory issues associated with mental health and substance use are significant barriers to both care coordination and measurement

Themes from Public Comment

- Accountability
- Affordability
- Mental Health
- Measures and Design
- Data and Alignment

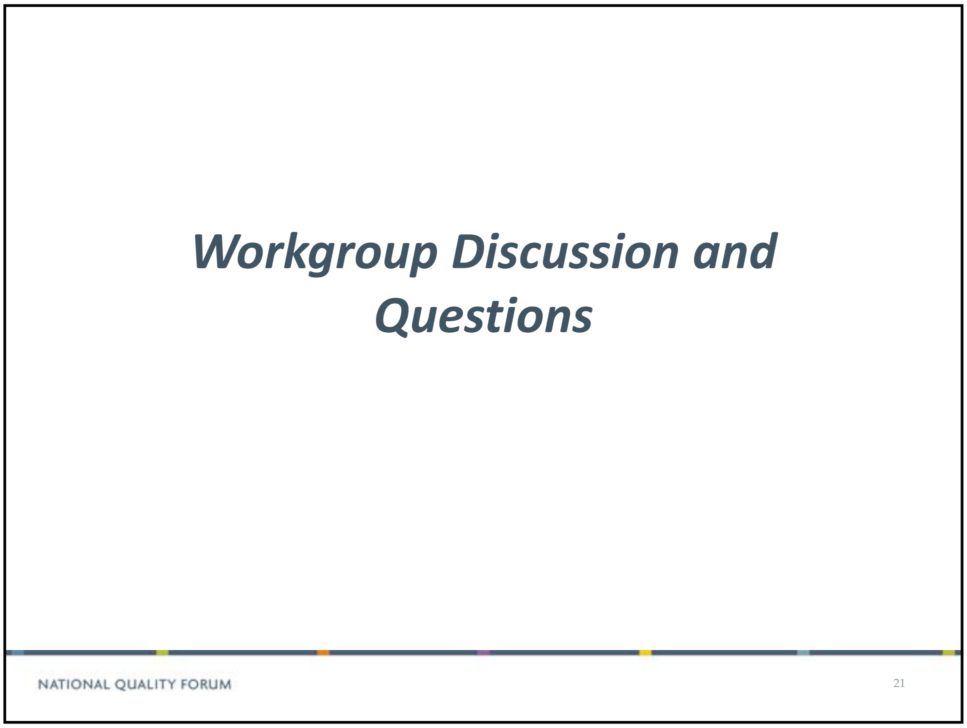
Input from HHS

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

Workgroup Discussion and Questions

How would the workgroup like to respond to the input received?

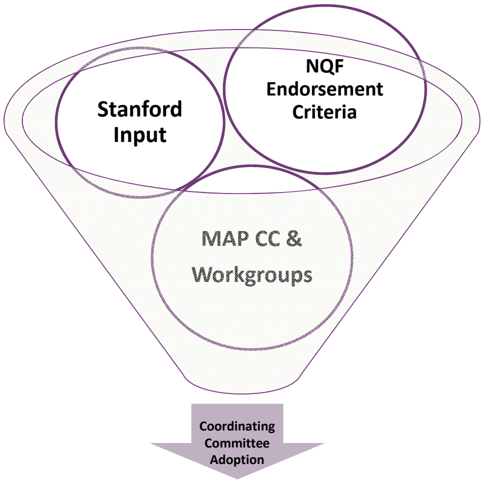
Design of Potential Measurement Initiatives



Workgroup Discussion and Questions

Opportunity for Public Comment

MAP Measure Selection Criteria



Measure Selection Criteria

Meeting/Activities	Output
May Coordinating Committee	Measure Selection Principles
June Coordinating Committee	Measure Selection Criteria "Strawperson"
July • Clinician Workgroup • Dual Eligible Beneficiaries Workgroup	Feedback on Measure Selection Criteria "Strawperson"
August • Coordinating Committee • Public Comment via MAP Clinician Report	Draft Measure Selection Criteria
September/October • Hospital Workgroup Survey Exercise and Meeting • PAC/LTC Workgroup • Public Comment	Draft Measure Selection Criteria Refinement
November 1-2 Coordinating Committee	Finalize Measure Selection Criteria

Input for Criteria Development

- National Quality Strategy provides solid foundation for measurement goals described by MAP committees (e.g., patient-centered, care coordination, and resource use/cost)
- Many MAP committee inputs overlap with NQF endorsement criteria (e.g., importance to measure and report, usability, and feasibility)
- Emphasis on patient-focused episodes of care across settings and time as one way to address “systemness”
- Representation of measure types relevant to the program (e.g., process, outcomes, patient experience, and cost)
- Assessment of measure set suitability for specific programs, including extent to which a set covers the accountable entities

Feedback Received During Public Comment

- Parsimony: minimum number of measures and the least burdensome
- Avoidance of adverse unintended consequences
- Consideration of disparities
- Clarification on definitions (e.g., “adequate,” “episode of care”)
- Explore alternative rating systems to allow for more nuanced assessment
  - Binary versus scaled response options
- Clarification on how criteria will be used to consider individual measures as well as measure sets

Resulting Changes

Modification	Rationale
Consideration of individual measures as well as measure sets	- Criteria assesses measure set alignment with intended use and reflection of “quality” health and healthcare - Consideration of endorsement status and potential unintended consequences for individual measures
Alternative Rating System to a modified scaled-response	- Help raters define more clearly whether a given criterion was met
Creation of an interpretive guide	- Provides guidance on how to apply MAP Measure Selection Criteria - Includes definitions of terms - Discusses how ratings and rationale can be conveyed when applying criteria - Includes considerations for individual measures

Final Measure Selection Criteria

1) Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review
Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences

2) Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities
Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

- Subcriterion 2.1 - Safer care
- Subcriterion 2.2 - Effective care coordination
- Subcriterion 2.3 - Preventing and treating leading causes of mortality and morbidity
- Subcriterion 2.4 - Person- and family-centered care
- Subcriterion 2.5 - Supporting better health in communities
- Subcriterion 2.6 - Making care more affordable

Final Measure Selection Criteria

3) Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)
Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s).

4) Program measure set promotes alignment with specific program attributes, as well as alignment across programs
Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

- Subcriterion 4.1 - Program measure set is applicable to the program's intended care setting(s)
- Subcriterion 4.2 - Program measure set is applicable to the program's intended level(s) of analysis
- Subcriterion 4.3 - Program measure set is applicable to the program's population(s)

Final Measure Selection Criteria

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

- Subcriterion 5.1 - Outcome measures are adequately represented in the program measure set
- Subcriterion 5.2 - Process measures are adequately represented in the program measure set
- Subcriterion 5.3 - Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
- Subcriterion 5.4 - Cost/resource use/appropriateness measures are adequately represented in the program measure set
- Subcriterion 5.5 - Structural measures and measures of access are represented in the program measure set when appropriate

6) Program measure set enables measurement across the person-centered episode of care
Demonstrated by assessment of the person's trajectory across providers, settings, and time.

- Subcriterion 6.1 - Measures within the program measure set are applicable across relevant providers
- Subcriterion 6.2 - Measures within the program measure set are applicable across relevant settings
- Subcriterion 6.3 - Program measure set adequately measures patient care across time

Final Measure Selection Criteria

7) Program measure set includes considerations for healthcare disparities

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

- Subcriterion 7.1 - Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
- Subcriterion 7.2 - Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8) Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

- Subcriterion 8.1 - Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)
- Subcriterion 8.2 - Program measure set can be used across multiple programs (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

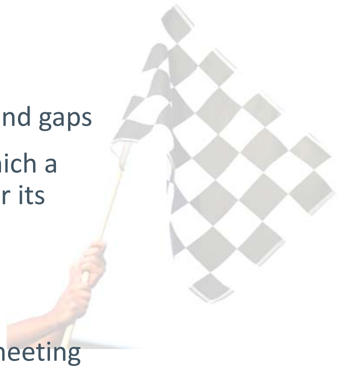
Workgroup Discussion and Questions

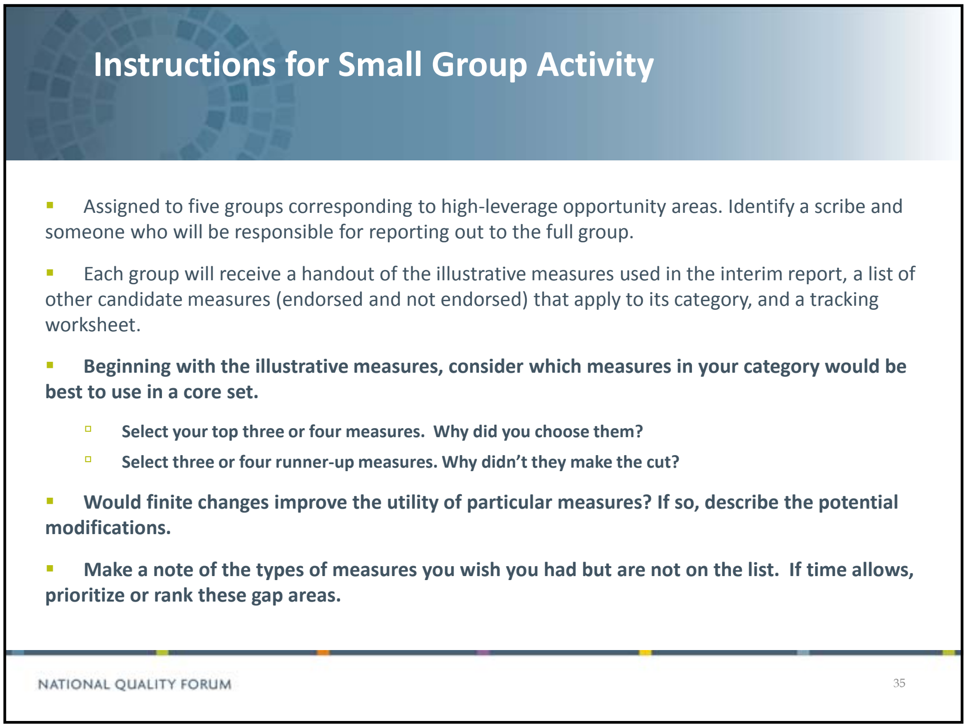
Small Group Activity:

Selecting Candidate Measures in High-Leverage Opportunity Areas

Purpose of Small Group Activity

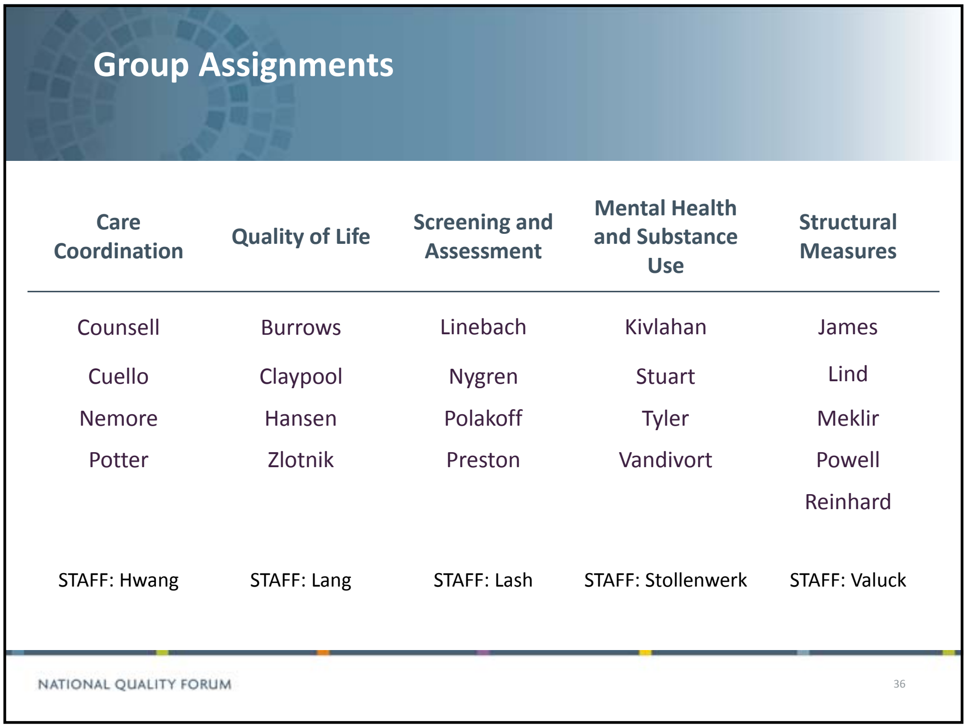
- Divide and conquer a large universe of potential measures
- Propose candidate measures to form the foundation of a core set
- Begin to draw out potential modifications and gaps
  - Modifications: changes to the way in which a measure is specified that would not alter its intent
  - Gaps: includes endorsement gaps and development gaps
- Outputs will enable detailed work at final meeting





Instructions for Small Group Activity

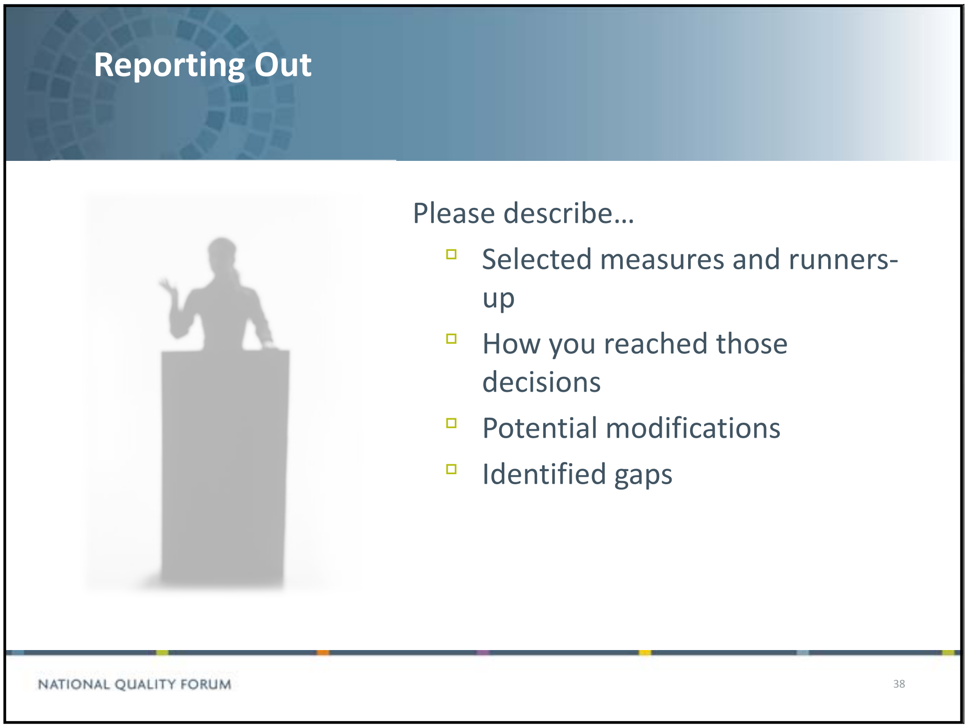
- Assigned to five groups corresponding to high-leverage opportunity areas. Identify a scribe and someone who will be responsible for reporting out to the full group.
- Each group will receive a handout of the illustrative measures used in the interim report, a list of other candidate measures (endorsed and not endorsed) that apply to its category, and a tracking worksheet.
- **Beginning with the illustrative measures, consider which measures in your category would be best to use in a core set.**
  - **Select your top three or four measures. Why did you choose them?**
  - **Select three or four runner-up measures. Why didn't they make the cut?**
- **Would finite changes improve the utility of particular measures? If so, describe the potential modifications.**
- **Make a note of the types of measures you wish you had but are not on the list. If time allows, prioritize or rank these gap areas.**



Group Assignments

Care Coordination	Quality of Life	Screening and Assessment	Mental Health and Substance Use	Structural Measures
Counsell	Burrows	Linebach	Kivlahan	James
Cuello	Claypool	Nygren	Stuart	Lind
Nemore	Hansen	Polakoff	Tyler	Meklir
Potter	Zlotnik	Preston	Vandivort	Powell
				Reinhard
STAFF: Hwang	STAFF: Lang	STAFF: Lash	STAFF: Stollenwerk	STAFF: Valuck

Report Out from Small Group Activity



Reporting Out

Please describe…

- Selected measures and runners-up
- How you reached those decisions
- Potential modifications
- Identified gaps

Identifying "Duals-Sensitive" Measures

Quality and Disparities Measurement

- **Improving Healthcare Quality for Minority Patients: Workshop Summary (2001)**
  - ✓ Explored measurement and reporting strategies to improve healthcare quality for minority patients
  - ✓ Identified 10 specific recommendations to engage all stakeholders in reducing disparities through measurement and reporting
- **Disparities-Sensitive Measures for Ambulatory Care (2006)**
  - ✓ Endorsed 35 "disparity-sensitive" measures at the clinician-level of measurement
  - ✓ Endorsed 14 AHRQ Prevention Quality Indicators (PQIs) suitable for the community-level quality improvement
- **Cultural Competency Framework and Preferred Practices (2009)**
  - ✓ Endorsed comprehensive framework for measuring and reporting quality of culturally competent care
  - ✓ Endorsed 45 preferred practices for measuring and reporting cultural competency

Primary Criteria: Disparity-Sensitive Criteria

- **Prevalence**
  - Is this disease or condition among the most prevalent in the disparity population?
- **Impact of the condition**
  - Does the condition have a relatively high impact on the health of disparity population—e.g., mortality, QOL, stigma?
- **Impact of the quality process**
  - What proportion of the target population are likely to benefit from broader implementation of the targeted quality process?
- **Quality gap**
  - How large is the gap in quality between the disparity population and the benchmark populations?

Secondary Criteria: Disparity-Sensitive Measures

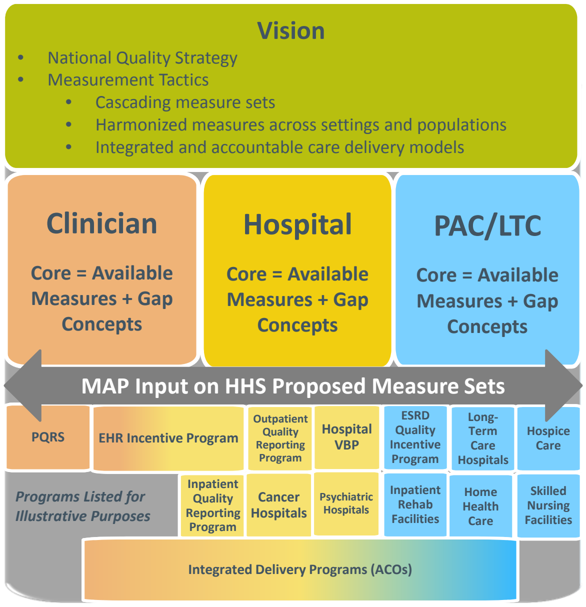
- **Ease and feasibility of improving the quality process**
  - Any evidence that care can be improved for healthcare disparity populations, whether an intervention exists to reduce the disparity, and that gaps between different groups can be closed.
- **Low health literacy**
  - Any evidence that low literacy negatively affects health outcomes for that specific measure’s leverage point.
- **Unintended or Adverse Consequences**
  - Example: measures that might penalize safety net providers based on factors that are beyond their control

Discussion of Measure Characteristics or Topics

- What factors can be used to identify "Duals-sensitive" measures?
  - Guiding principles from disparities work?
  - Measures that apply to a highly prevalent condition?
  - Measures that apply in a particular setting of care?
  - Measures that apply to one of the five high-leverage areas?
  - Others?
- Is stratification by dual eligible status possible?
- Is stratification by dual eligible status advisable?

Workgroup Discussion and Questions

MAP's Annual Input to HHS: Pre-Rulemaking Activities



Vision

- National Quality Strategy
- Measurement Tactics
  - Cascading measure sets
  - Harmonized measures across settings and populations
  - Integrated and accountable care delivery models

Clinician

Core = Available Measures + Gap Concepts

Hospital

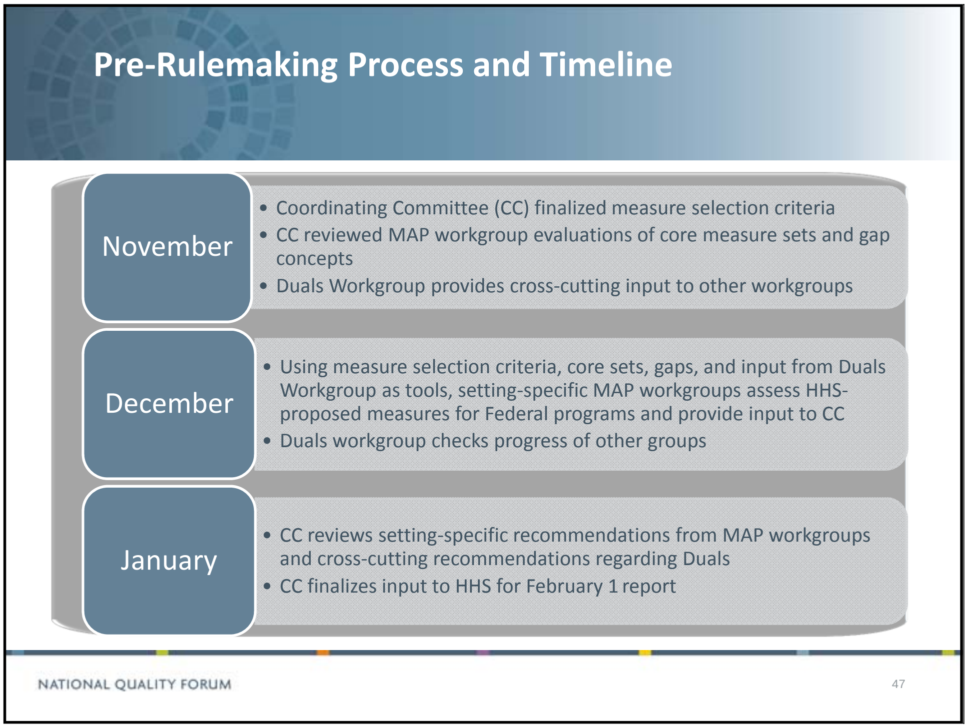
Core = Available Measures + Gap Concepts

PAC/LTC

Core = Available Measures + Gap Concepts

MAP Input on HHS Proposed Measure Sets

Programs Listed for Illustrative Purposes

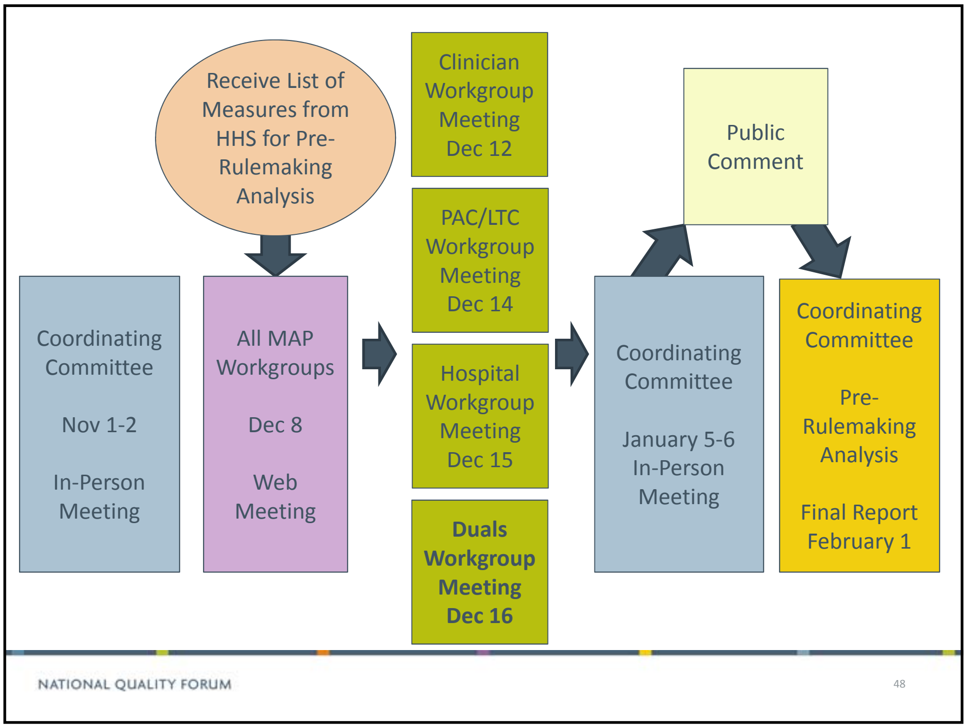


Pre-Rulemaking Process and Timeline

November
- Coordinating Committee (CC) finalized measure selection criteria
- CC reviewed MAP workgroup evaluations of core measure sets and gap concepts
- Duals Workgroup provides cross-cutting input to other workgroups

December
- Using measure selection criteria, core sets, gaps, and input from Duals Workgroup as tools, setting-specific MAP workgroups assess HHS-proposed measures for Federal programs and provide input to CC
- Duals workgroup checks progress of other groups

January
- CC reviews setting-specific recommendations from MAP workgroups and cross-cutting recommendations regarding Duals
- CC finalizes input to HHS for February 1 report



Receive List of Measures from HHS for Pre-Rulemaking Analysis

Coordinating Committee

Nov 1-2

In-Person Meeting

All MAP Workgroups

Dec 8

Web Meeting

Clinician Workgroup Meeting Dec 12

PAC/LTC Workgroup Meeting Dec 14

Hospital Workgroup Meeting Dec 15

Duals Workgroup Meeting Dec 16

Coordinating Committee

January 5-6 In-Person Meeting

Public Comment

Coordinating Committee

Pre-Rulemaking Analysis

Final Report February 1

Proposed Core Sets

- Beginning with measures already used in Federal reporting programs the Hospital, Clinician, and PAC/LTC Workgroups undertook a series of exercises to propose an initial core set of measures for each setting of care
- Core sets serve as a target and a tool to evaluate lists of measures selected by HHS
- Gaps in desired measures are noted so HHS and MAP can attempt to fill them through pre-rulemaking input and measure development
- **Take 10 minutes to familiarize yourself with the proposed core sets for pre-rulemaking…**

Discussion Questions

- In considering how a set relates to the care needs of dual eligible beneficiaries, should any of the measure selection criteria be emphasized?
- What types of measures would make the sets more responsive to the needs of dual eligible beneficiaries?
  - Hospital
  - Clinician
  - PAC/LTC
- Could any aspects of the core sets have potentially harmful unintended consequences?

Post-Meeting Survey

- Online survey tool distributed to workgroup members later this week
- Two-fold purpose:
  - Validate workgroup’s working core measure set for evaluating care of dual eligible beneficiaries
  - Further input on setting-specific core sets for pre-rulemaking
- Due back **Monday, November 28**

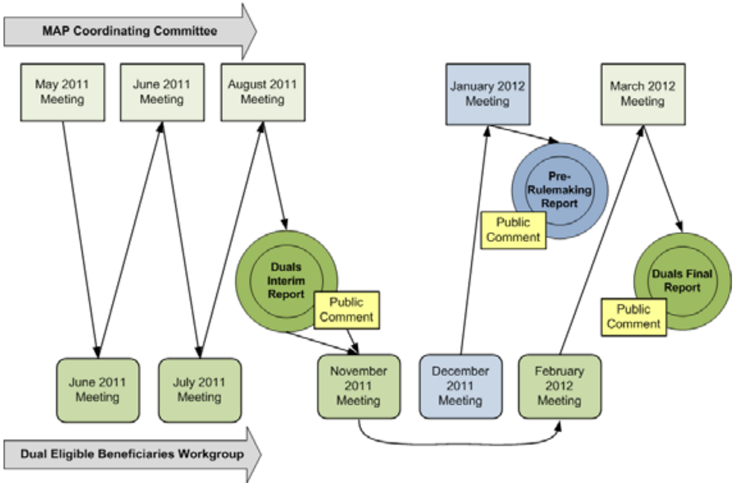
Workgroup Discussion and Questions

Opportunity for Public Comment

Summation and Next Steps

Meeting Themes

Flow of Information to Inform Reports



MAP Coordinating Committee

May 2011 Meeting

June 2011 Meeting

August 2011 Meeting

January 2012 Meeting

March 2012 Meeting

Pre-Rulemaking Report

Public Comment

Duals Interim Report

Public Comment

Duals Final Report

Public Comment

June 2011 Meeting

July 2011 Meeting

November 2011 Meeting

December 2011 Meeting

February 2012 Meeting

Dual Eligible Beneficiaries Workgroup

Future Meetings

All MAP Workgroups
Web Meeting
December 8, 2011, from 1:00-3:00 pm Eastern

Dual Eligible Beneficiaries Workgroup
Web Meeting
December 16, 2011, from 1:00-3:00 pm Eastern

Dual Eligible Beneficiaries Workgroup
Web Meeting
January 27, 2012, from 1:00-3:00 pm Eastern

Dual Eligible Beneficiaries Workgroup
In-Person Meeting
February 21-22, 2012, in Washington, DC

Measure Applications Partnership

Comments on the Interim Report to HHS: "Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries"

NQF Response to Comments Received:

The National Quality Forum thanks all who responded with comments on the Interim Report. Multiple commenters highlighted the importance of improving the affordability of care, the need to correctly assign accountability for quality, and promoting alignment with the National Quality Strategy, across Medicare and Medicaid, and between current reporting programs. MAP members also emphasized these points in their deliberations. Input from NQF members and the public will be given careful consideration in the second phase of the MAP Dual Eligible Beneficiaries Workgroup's effort. In particular, MAP will continue to focus on the design of a potential measurement program, candidate measures, measure gaps, and data sources. A final report on the subject of identifying appropriate performance measures for use in the complex and heterogeneous population of dual eligible beneficiaries is due to HHS on June 1, 2012.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	America's Health Insurance Plans	Carmella Bocchino	We applaud the effort by the Measures Application Partnership (MAP) to bring together experts from many disciplines in the development of this strategic framework for dual eligible performance measures. Overall, this is an important initiative that has the potential to improve health outcomes while also reducing the rate of healthcare spending among the dual eligibles, a population that includes some of the highest utilizers of healthcare resources and drives much of the current public sector healthcare costs. AHIP supports the interim report of the MAP to Performance Measurement for Dual Eligible Beneficiaries to better facilitate achievement of the three-part aim for this population. For this initiative to be successful effective engagement of providers and patients is critical. This can be achieved through a number of interventions including patient engagement, appropriate provider incentives and value-based benefit design.
General Comments on the Interim Report	National Association of Children's Hospitals and Related Institutions	Ellen Schwalenstocker	Even though the population is described in detail in Appendix D, it might be helpful to include a little more description of dual eligible beneficiaries at a high level on page 4 just to set more context for the report. Of course, I really like the discussion of inclusivity (especially all age groups) on page 6. The Care Coordination measure comments note that the measure is not age-restricted. As far as I know, the measure has only been tested in adult populations although the description on the NQF site suggests it could probably be applied to pediatric settings. Similarly the Tobacco use assessment and intervention measure pair comments say the measures are not limited by age, but I believe they are restricted to >18 year olds.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals ("FAH") is pleased to have the opportunity to comment on the Measure Applications Partnership report, Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries: Interim Report to HHS. The FAH appreciates the report's clarity identifying the many challenges in a comprehensive measurement and care coordination initiative for the dual eligible population. We suggest that the concepts included in the third paragraph on page 20 also be discussed in the earlier Measurement Design section. The existence of multiple quality reporting programs and the diverse goals of these programs with large numbers of reporting measures exacerbates the challenges of alignment across programs, and increases the challenges in developing a focus on limited number of realistic evidence-based measures that can be leveraged from other programs for use in the dual eligible measurement initiative. The FAH suggests mentioning this overall concept early in the paper and reiterating it in the Program Alignment section would strengthen the paper. We also appreciate the report's recognition that the new comprehensive measure strategy will need to balance immediate, short-term, and long-term steps, and the recognition of the significant challenges of Data Sources. Further, we strongly support the report's statement that providers should not be held accountable for "macro-level elements that are beyond their sphere of influence and for which there is no Medicare or Medicaid benefit."
General Comments on the Interim Report	Georgetown University Law Center	Rachel Nelson	Presumably because it's a draft produced on a tight timeline, there seems to be an edit artifact on Page 5: the NQS aim cited seems less an "example" of what the MAP has espoused than a statement of the aim with which the group's philosophical significant other is consistent.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	SNP Alliance (NHPG)	Richard Bringewatt	The SNP Alliance applauds NQF's dual effort. 1. We support accountability within context of parsimony. 2. We applaud system orientation. Current measures too focused on pieces. 3. Aligning program regulations and performance measurements is critical. 4. Judge all measures within context of the endgame. For consumers: a. Simplify access , b. Improve their experience, c. Improve health and wellbeing; For governments: a. Bend cost curve, b. Reduce administrative costs, c. Achieve better results; For specialized MC: a. Eliminate duplication and conflicts, b. Eliminate impediments to specialization, c. Empower plans to transform care 5. Align all M/M for HEDIS, HOS, CHAPS, QIPs, PIPs, CCIPs, etc. Require validation of the proxy for HOS and CAHPS. 6. Resolve self-report problems for mentally ill, cognitively impaired, and frail elders. 7. Modify STARS to support what's MOST important for duals, particularly for high-risk. 8. Stratify or risk-adjust findings to target populations. 9. Move to outcome methods ASAP. Consider hospitalization, emergency room visits, long-stay NH days, adverse drug events and consumer satisfaction as starting point. 10. Make distinction between care integration, e.g. care management, care transitions, etc. and program integration, e.g. eligibility determination, member communication, grievance and appeals, etc. but focus on both. 11. Make stronger distinction between Over 65 and Under 65. 12. Assure measures will be population focused. 13. Consider three-step process: 1) Eliminate duplication and conflicts, 2) identify core set of existing measures, 3) only add new measures after completing steps 1 and 2. 14. Empower practitioners to make quality care decisions rather than become skilled documentation and compliance specialists. 15. Be wary of unintended consequences.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	State of Minnesota	Pam Parker	I read the section on alignment (pages 19-21) and thought it was doing a nice job of making the points I expressed concern to you about. However I would like to see something added in the fourth paragraph where you list all of the measures that need to be rationalized. You do mention “setting specific” measures, which I assume would mean nursing homes for example, but I think it would be worth mentioning CMS requirements for home and community based waiver services specifically. I would call that out because CMS expectations of States have been growing around measures for this portion of the population and service set (and thus are being passed on to their managed long term care programs and integrated SNP programs as well. So as the SNP expectations have grown as well, we as a State are having a harder time finding “room” for addressing increasing CMS expectations on HCBS. In addition, one of the confusions about those measures that has come up over the years, is the scope creep of expectations. In a desire to look at the comprehensive person centered needs of members, patients, clients or whatever group is being focused on, we are forgetting about who controls what. For example, at one point CMS was considering using a measure that related to how well medications were managed for people getting home and community based services in their homes. However, this is not something Medicaid controls for dual eligibles. Medicare pays for most drugs and primary care for duals, so States lack the normal tools (including data!) for managing accountability for how people are accessing and using prescription drugs. It would be fine, if in our integrated programs we are held responsible for all of this, but if we are unable to have integrated options for some groups, we cannot take responsibility for Medicare requirements. So in the absence of perfect integration, at the same time that we need to rationalize the total measures that are being applied from many different regulatory structures and funding sources to achieve an overarching and efficient framework for a comprehensive set of measures, we also need to consider the scope of accountability of the various entities providing or responsible for care and/or financing to make sure we are holding the right part of the system accountable. This may mean parsing out some of the new comprehensive total package of measures in a new way, thereby avoiding duplication, but not necessarily having each entity collect or be evaluated by the total set unless they are an entity that holds responsibility for all of the care provided. So for example, where there is a fully integrated program, it should be held accountable for all measures including medication management and behavioral health and home and community based services, but where for some reason some of this is in a different payer or provider group or carved out entity , that subset of measures needs to go with the entity responsible. Has there been much discussion around this and does this make sense to you or is there another way to think about this.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	WellPoint	Lisa Latts	This is an honest and practical attempt to measure the process and results of a badly broken and dysfunctional relationship. The challenge is to document present state and ongoing improvement towards goals and vision. Disparate data sources and fragmented care structure make this very difficult. Integrated care systems will likely demonstrate much better scores while unlinked fragments will demonstrate uncoordinated, expensive, worse outcomes. It might be useful to organize the measurements around systems of care so that if we aren't comparing apples and oranges, we can at least compare round fruit... We are concerned that we will monitor reporting capability rather than actual competence of care (recognizing that if it isn't documented, it wasn't done) – but members in fragmented care settings (as the report documents) have significant complexity in measurement. The other issue is, do we report (and reward) systems that already function well or do we focus reporting (and reward) on systems that show improvement. Do we create a scenario where health plans "perform to the test" or do we create measurements that document improvement year over year. We would favor the latter. If we don't measure, we won't manage. But we need to be certain that measurements reflect the complexity of the system(s) and the differences in the system. The logical conclusion of all of this effort will be that a coordinated, integrated care system works far better than the alternative and it will compel the management of all dual eligible persons beyond the current SNP initiatives.
Strategic Approach (Vision and Guiding Principles)	America's Health Insurance Plans	Carmella Bocchino	We support the set of guiding principles described in the report and offer the following additional principles for consideration by the MAP: 1) Align strategy with the three-part aim articulated in the National Quality Strategy 2) Align performance measurement efforts across all HHS programs and also specifically among CMS, state Medicaid, and accreditation programs to ensure consistency across programs, minimize burden on stakeholders, and promote achievement of the three-part aim. 3) Graduate performance measurement to focus on evidence-based health outcomes versus the current predominance of process and program measures including ensuring a focus on measures that have been NQF-endorsed, field tested and validated. 4) Recognize that measurement for the purposes of accountability need to be balanced with the need for promoting innovation in program design and implementation that can improve quality for this population 5) Minimize administrative burden for providers, health plans, and other relevant stakeholders in the performance measurement enterprise through maximizing the use of existing data sources and its conversion to actionable information. 6) Prioritize measures that have high-impact and support improvement. 7) Acknowledge challenge of accounting for risk in the high-risk, high-disease burden dual eligible population and find approaches to address this issue.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategic Approach (Vision and Guiding Principles)	Consumer-Purchaser Disclosure Project	Christine Chen	Vision Statement: We recommend that MAP modify the title of the vision statement to read: "Vision for High-Quality AND High-Value Care" (page 4). Currently, the title only reflects quality (page 4). Better value is critical to achieving sustainability, a key pillar of the vision statement. This recommendation is also in line with the statement that "the vision aspires to high-value care . . ." (page 5). Guiding Principles: **Desired effects**: The MAP identified "promoting integrated care," "ensuring cultural competence," and "health equity" as desired effects. We encourage MAP to add "improving outcomes and affordability of care" to the list. At the end of the day, changes in how providers and others care for dual eligible beneficiaries should result in better health. Given the fiscal challenges that Medicare and Medicaid facing, advancing affordability is critical. **Measurement design**: This section highlights, "the measurement approach should evaluate person-level outcomes relative to the goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measure related to the individual's or family's assessment of the care and supports received." We applaud the MAP's recognition that care should meet patients' (and their families') expectations, with a focus on outcomes. Measure design is impacted by the level at which measures are captured (e.g., individual physician, practice, hospital, ACO). Shared accountability should therefore be a part of this discussion (although shared accountability is briefly mentioned in a few places in the document, it is never defined). Whenever feasible, there should be a focus on individual clinicians, particularly where variation in performance is most evident, and not just higher levels of aggregation. Promoting individual accountability, together with shared accountability, will generate the greatest improvements in care. Shared accountability means holding all components of a system (or all members of a team) accountable, not just the system or team itself. Focusing on individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement opportunities that are masked by higher levels of aggregation.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategic Approach (Vision and Guiding Principles)	Georgetown University Law Center	Rachel Nelson	In one individual’s opinion: measurement design should use stratification and risk adjustment to avoid exacerbating access problems while still assuring providers are appropriately accountable for furnishing quality care to even the most clinically complex, vulnerable and socioeconomically disadvantaged patients. (Use of strategic process measures may be needed to be sure strategy doesn’t weigh so heavily toward access that it sets the accountability bar too low for services providers furnish to duals.) Using Data Dynamically; in this context, draft phrasing does not convey to those who don’t follow MAP closely just what MAP means by “data exchange platform.” Suggest rephrasing to something that is a more immediate and unambiguous reference to the QDM and associated formats/standards for specific purposes of exchange (e.g. eMeasures Format, whatever emerges as the exchange standard for transition of care). The shortest way to avoid the unintended implications would be to use “strategy” in place of “platform.” (A more pedantic solution it might be to spell out right here, up front, what you mean by “platform” -- or at least what I understand you to mean by platform, based on the Quality Measurement Enterprise slide with its explanatory boxes and Dr. Valuck's accompanying explanations to the various workgroups.) Use of, not mere alignment with, nationally adopted vocabulary standards for interoperability and exchange of data is essential. Such use of standards adopted by the Secretary could, in the multi-setting exchange model, accommodate various data stewards continuing to store and use data in local vocabulary so long as it was translated into the common national vocabulary standards at some point along its way to the next data steward. (There may be more than one happy medium between [all standard, all the time, everywhere] and [translated by central hub], depending what “central hub” is used to convey.) Is “portable EHR” a creative way to reference methods of accessing EHRs from places other than the physician office or hospital that maintains the EHR? Web and mobile interfaces to EHRs and PHRs that can exchange data with certified EHRs in standard vocabularies and using standard protocols seem to be what is described here.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategic Approach (Vision and Guiding Principles)	SNP Alliance (NHPG)	Richard Bringewatt	1. There should be more clarity about the endgame. If you don't know where you're going, any pathway can get you there. If you look at measurement, a number of the existing measures may not be the most important for advancing care for duals, particularly for high-risk/high-need persons. We made some suggestions above. 2. We strongly support principles focused on: a. Promoting integrated care, the ability to drive integrated, collaborative, and coordinated care. b. Health equity, important to measure dual eligible beneficiaries in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access. Important to also address differences in beneficiary needs. c. Assessing outcomes related to goals. We support the intent of this goal but we believe the goals of "person level" outcomes and parsimonious approach that uses the fewest number of measures may be in conflict. May be best to focus on structure for this to occur. Implementation of a person-specific measurement approach is probably too detailed for federal oversight. d. Parsimony design. To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. e. Avoiding Undesirable Consequences (MD): We think risk stratification and case mix adjustment will be critical for proper review of findings for plans specializing in care of certain populations. f. Use Data Dynamically (Data): Dynamic data exchanges is critical to effective care management, care transition, etc.
High-Need Subgroups	Consumer-Purchaser Disclosure Project	Christine Chen	Link to Affordability of Care: The report provides important information about the cost of care for dual eligible beneficiaries. CPDP strongly agrees that "any discussion of the quality of duals' care is inextricable from discussion of its affordability." We are therefore surprised that the earlier sections on measurement strategy do not reinforce that need to capture cost and resource use. While measuring total cost may be challenging because of fragmented data sources (as the report details), it doesn't mean that we shouldn't begin measuring this important facet of care immediately.

Comment Category	Commenter Organization	Commenter Name	Comment
High-Need Subgroups	Molina Healthcare, Inc.	Berenice Nunez	Molina Healthcare has over 30 years of experience serving patients who have traditionally faced barriers to obtaining quality healthcare; primarily individuals covered by government sponsored health insurance programs. We serve over 23,000 dual eligible members, making Molina Healthcare the eighth largest Special Needs Plans (SNP) in the nation. Molina Healthcare believes that measurement of the quality of care provided for dual eligible populations should focus on outcomes not process measures. The majority of the “illustrative measures” reviewed in the MAP report were structure and process measures and several only applied to limited segments of the population. Molina does not believe that structure and process measures such as those reviewed in the report are necessarily linked to quality outcomes. Subjective, self-reported quality measures are particularly problematic in the dual population due to the high prevalence of cognitive, behavioral health and substance abuse disorders. HOS and CAHPS measures currently in place already use such measures. Several of the “illustrative measures” in the MAP report contained self-reported data. Molina would like to see less emphasis on the current HOS and CAHPS measures for dual eligible populations as well as avoiding adding any future quality measures utilizing self-reported data.
High-Need Subgroups	Renal Physicians Association	Amy Beckrich (on behalf of Robert Blaser)	The Renal Physicians Association (RPA) strongly supports the explicit inclusion of ESRD dual eligible beneficiaries as a high-need subgroup.

Measure Applications Partnership
Comments on the Interim Report to HHS: "Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries"

Comment Category	Commenter Organization	Commenter Name	Comment
High-Need Subgroups	SNP Alliance (NHPG)	Richard Bringewatt	1. We like the schemata for identifying risk levels but implementation may be too complicated. Consider using a limited set of high-need subgroups, e.g., frail elderly, adults with physical, mental or developmental disabilities, and persons with complex chronic conditions, such as AIDS, or a set of co-morbid conditions such as diabetes, CHF, and COPD. This could also encourage targeting key subgroups. 2. We need to get a better handle on the total cost of care, even though it's difficult. However, we have many questions about the unintended consequences of using encounter data for payment and performance evaluation before full analysis. 3. Things like access to primary care and team-based care, are important, but just having access and care teams doesn't always equal quality. The "evidence-base" for some measures are also still pretty thin to be mandated or applied to broadly. 4. Give more emphasis to using rapid-transformation/multi-variant analysis and continuous quality improvement. Consider collecting information on a set of utilization measures, such as hospitalization rates, ER visits, long-stay nursing home admits (over 90 days), and medication management; stratify or risk adjustment to account for population differences; and rigorously study specific interventions associated with positive outcomes. Also, consider costs of inadequate end of life care and how individual preferences for "person centered" care impact costs. 5. A major deterrent to specialized managed care is broad application of generic measures that are either inappropriate for a given population or they are not the best indicators for the subgroups being targeted.
High-Need Subgroups	[not supplied]	Richard Smith	Is all Mental Health now addressed within Dual Eligibility? More attention is needed for this underdeveloped vulnerable and costly care?

Comment Category	Commenter Organization	Commenter Name	Comment
High-Leverage Opportunities, Illustrative Measures, Gaps	America's Health Insurance Plans	Carmella Bocchino	We concur with the high leverage areas and offer additional comments: 1) Quality of Life— Functional status assessments are important indicators and there is need for alignment and consistency among assessments, across different settings including long-term care. 2) Care Coordination and Mental Health and Substance Abuse — These are important focus areas, but confidentiality rules regarding mental health and substance abuse may limit the ability to achieve full benefits from coordination and other programs. 3) Screening and Assessment—Prevention and usual screening should be age appropriate, condition specific, and tailored to patient, with special focus on frailty, cognitive impairment, and mental health and substance abuse. Measures such as reductions in emergency room (ER) visits or preventive screenings (e.g. mammography screening) can be used to ensure that patients are receiving appropriate care in an ambulatory setting and can serve as proxies for monitoring behavior modification in an SNP that frequently is sicker and uses ERs rather than seeking preventative care. Benchmarks should be utilized with the recommendation of developing quality measure benchmarks specific to the unique characteristics and healthcare challenges of the dual eligible population. Current benchmarks for existing quality measures (HEDIS, HOS, CAHPS, and other Star Ratings components) are generated from the entire Medicare population and do not reflect the dual eligible population. This makes it difficult to identify the impact of the challenged of dual eligible beneficiaries on quality measures as well as measure quality of care progress within the dual eligible population. The lack of population specific benchmarks also penalizes health plans and providers that focus on providing care for this important and vulnerable group of beneficiaries. Developing and scoring against dual eligible specific benchmarks would make existing and future quality measures more meaningful to beneficiaries and providers.

Comment Category	Commenter Organization	Commenter Name	Comment
			Comments on illustrative measures: 1) Some of the "illustrative measures" appear to require additional chart review beyond those already required for HEDIS, which is an expensive and burdensome requirement. 2) For the care coordination measure, MAP should consider using Plan of Care goals. 3) While we support the metrics related to ADLs and function, we recommend coordination of care between medical and behavioral health services is a key area in the success of goal achievement. Therefore, we recommend expanding mental health metrics to include members with Dementia and Alzheimer's Disease. 4) We recommend developing specific metrics to measure impact of The Medical Home (Health Home). 5) The provider's role is one that is critical to achieving desired outcomes. Specifically, for the Falls Assessment metric, we do not agree with the statement that, "the Measure does not push the provider to change the care plan based on results of the assessment, only to document that one was performed". Therefore, we recommend using language aimed at engaging the provider to react to a positive screen with follow up (PT/OT evaluation, assistive device, med review, etc.). 6) On page 14, last box in grid 'Mental Health and Substance Use Measure', we ask for clarification on whether the mental health issue is strictly a primary diagnosis or if it also includes secondary diagnosis, or dual diagnosis.
High-Leverage Opportunities, Illustrative Measures, Gaps	Consumer-Purchaser Disclosure Project	Christine Chen	**Quality of life**: We strongly support the MAP's emphasis on quality of life and that "measures in this care domain should focus on outcomes." We also appreciate the MAP underscoring the importance of capturing functional status over time and from the patient's perspective. **Care coordination**: We suggest adding readmissions and outcomes into the mix of proposed measure areas (i.e., medication management, access to an inter-professional care team, advance care planning, and palliative care). They can be helpful indicators of whether care was effectively coordinated. **Screening and Assessment**: We agree that appropriate screening and assessment are important. The document notes that "after screening and assessment is complete, the results should be incorporated into an individual's plan of care." While this is helpful, the results should also be reported. This is line with the MAP's commitment to "tracking 'delta measures' of change in outcomes of interest" (page 6). For example, Minnesota Community Measurement's measure of depression remission actually reports whether remission occurred. **Mental Health and Substance Use**: We are pleased to see that this section underscores the importance of having measures of outcomes and patient experience.

Comment Category	Commenter Organization	Commenter Name	Comment
			Structural measures: There are some structural measures such as those related to care coordination which may help advance organization of care in doctors' offices, medical care groups and hospitals to better support patient-centered care. However, they are often thought of as minimum standards—necessary qualifications, but not sufficient to ensure or foster improvements in the quality of care. A recent Hearth Affairs article found that "measuring structural characteristics and care processes in primary care practices and patient-centered medical homes is not necessarily associated with higher quality of care."1 Structural measures also provide little information on how well the capacities and resources are being used for their intended purposes. We ask the MAP recognize these challenges and to exercise caution in selecting structural measures. **Measure development gaps**: We agree with many of the identified measure development gaps and encourage the MAP to add measures of health status.
High-Leverage Opportunities, Illustrative Measures, Gaps	Molina Healthcare, Inc.	Berenice Nunez	Molina Healthcare recommends that actual health outcomes measures reflect the quality of care being provided to this population. Hospital admission rates-avoiding unnecessary hospitalizations reflects good access to primary care as well as the effectiveness of outpatient care plans and care coordination activities Emergency department visit rates-lowering ER visits shows good access to primary care, effectiveness of outpatient care plans and care coordination activities Hospital readmission rates-avoiding hospital readmissions shows the effectiveness of care transitions, outpatient care plans and care coordination activities Hospital admissions from LTC facilities- avoiding preventable hospital admissions from Long Term Care facilities demonstrates the effectiveness of care transitions and care coordination activities HEDIS preventive service screening and outcomes measures-well established measures of preventive care being provided to dual eligible beneficiaries and care outcomes achieved, reflects access to care and that care providers are following evidence based care guidelines Molina Healthcare strongly recommends developing quality measure benchmarks specific to the unique characteristics and healthcare challenges of the dual eligible population. Wherever possible, Molina Healthcare recommends using measures that are already reported as data analysis measures.

Comment Category	Commenter Organization	Commenter Name	Comment
High-Leverage Opportunities, Illustrative Measures, Gaps	SNP Alliance (NHPG)	Richard Bringewatt	1. We like the five domains listed for driving positive change. 2. Quality of Life: We encourage research on measuring illness and/or disability trajectories. Analyze cost trajectories associated with certain conditions. Provide incentives to prevent, delay or minimize disease and disability progression…for bending the cumulative cost curve…delaying nursing home admissions, or other indicators re: disease and disabling prevention. 3. Care Coordination: Give more emphasis to: high-risk screening, addressing co-morbid illnesses, managing illnesses within the context of disability, family caregiver support, use of principal care managers; safe and effective care transitions; integrating mental, behavioral and physical health; self-care empowerment; care management linkage with provider care planning; standardized assessments and care plans across settings; use of extended care pathways; and ensuring care continuity among related providers. 4. Assessment and Screening: Consider screening and triage for persons at-risk of death, hospitalization, nursing home admissions, functional decline, and cumulative costs with ongoing assessment and care planning for targeted high-risk groups. Consider inappropriate preventive screening. (VA study). 5. Mental Health and Substance Abuse: Mental health carve outs can make difficult accurate assessment, tracking service use and interventions, etc. Confidentiality issues also important. Strengthen relationship to health management. Be clear about primary and secondary diagnoses, as well as co-morbid relationships. 6. Structural Measures: Measuring structural issues re: disconnects between Medicare and Medicaid, among related care providers, and use of system management methods are key. Consider SNP Alliance Gold Standards Framework.
Data Sources	America's Health Insurance Plans	Carmella Bocchino	There are specific challenges with the data available for performance measurement of the dual eligible population. These challenges include: 1) Lack of integrated data sources across Medicare and Medicaid. The approach presented in the report to integrate disparate data sources can help with calculation of measures but may lead to lack of measure validity and reliability as the data are not captured in a standardized manner across these sources. 2) Attention should be given to the use of reliable data sources for measurement. While patient surveys can serve as additional sources of data, results from these surveys may not always be reliable given the mental health, cognitive and behavioral problems associated with this population. 3) The frequency of the data collection can also impact the ability to measure quality in a valid and reliable manner as individuals' frequently cycle on and off Medicaid. While dual eligibles cycle less quickly that TANF recipients, they are often dually eligible at the end of life and the length of their stay on a given program can be limited. The frequency with which the data are collected will impact the credibility of the data and needs to be factored into the quality measurement program.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Sources	Consumer-Purchaser Disclosure Project	Christine Chen	**Data Sharing**: This section should include a reference on the need to share data with patients and their families, not just with providers. Patients need timely data to better manage their health. **Using Data Dynamically**: This section only identifies the usefulness of data for quality improvement. It should also address the importance of having data for supporting consumer-decision making and accountability. The document importantly highlights the importance of tracking longitudinal data, in particular outcomes. **Making the Best Use of Available Data**: We appreciate that the report includes administrative claims data and registries. We suggest that the report add patient-reported data. Patients are often in the best position to evaluate the effectiveness of the health services they receive.
Data Sources	SNP Alliance (NHPG)	Richard Bringewatt	1. Aligning data elements and overall management structures for Medicare and Medicaid and among providers across the continuum is central…if not a prerequisite…to advancing a truly integrated program. This is particularly important for high-risk/high-need populations that represent the majority of dual expenditures and who experience the majority of complications from the current system. 2. EHRs are important, but many do not fully encompass all provider elements or include an aligned set of Medicare and Medicaid requirements. It is important for federal and state governments to invest in transformation of EHR systems, working with states and the federal government, as well as the spectrum of primary, acute and long-term care providers and related professional and consumer organizations so that at some point record systems are not simply computerized but truly integrated, with the spectrum of data elements responsive to doing what is necessary for all parties involved to manage care around person-centered, system-oriented care plans. We propose developing standard EHR elements. 3. The starting point is obviously getting Medicare and Medicaid to align…sharing data between states and the fed…and retooling the composition of BOTH to embrace more of a person-centered, system-oriented approach to program management, with primary regard for the multi-dimensional, interdependent, disabling, personal and ongoing care needs of high-risk/high-need subgroups. 4. We are concerned about combining measures with different definition, e.g., ADLs. ADLs measures are important but standardization is critical for meaningful alignment. 5. We caution NQF in introducing new measures that are not broadly used in the industry. Claims data is a reliable source.

Comment Category	Commenter Organization	Commenter Name	Comment
Program Alignment	Consumer-Purchaser Disclosure Project	Christine Chen	We agree with the need for greater alignment in performance measurement across Medicare and Medicaid programs, but the desire for alignment should be balanced with the need for impactful measures of care. The MAP recommends that: "The core measurement approach should leverage other programs' required measures whenever possible and expand to specialized measures for key segment s of the dual eligible population. Adding the complexity of many new measures will likely not drive as much improvement as focusing on the specific identified opportunities to improve quality and affordability." But to facilitate rapid improvements in care and judicious use of public funds, it is extremely important that the Medicare and Medicaid measures that MAP selects are high value and not low value for the sake of alignment.
Program Alignment	SNP Alliance (NHPG)	Richard Bringewatt	1. We cannot over emphasize the importance of "alignment across programs and a concerted focus on a limited number of realistic evidence-based measures as vital to reducing the burden of reporting". While some elements of our current system should be retained, the level of confusion, complexity, and financial commitment involved actually detracts from a plan's ability to provide the right care, at the right time, in the right place. Alignment and parsimony can actually increase, not decrease, quality and accountability. We are committed to both. 2. We support use of evidence-based measures, but we caution doing what is measurable rather than what is meaningful. In most cases, there is not sufficient evidence to mandate a certain care approach. Therefore, while we support moving toward "uniform performance measurement' we caution simple adoption of measures that may be common without reassessing their value proposition. 3. We suggest starting with a comprehensive review of ALL reporting requirements for Medicare and Medicaid. Then, identify ALL places where existing measures are either defined differently or have different or parallel reporting processes. Once the confusion and disconnects are resolved, identify a core set of measures that are MOST important for advancing the OVERALL GOALS of INTEGRATION, with special regard for serving HIGH-RISK/HIGH-NEED beneficiaries. Then, hone in on those measures that are most important for defined subsets, e.g., frail elders, adults with serious and persistent mental illness, AIDS, etc. and establish a limited set of reporting requirements, with a single process, that is responsive to all duals as well as defined subgroups. 4. We believe coordination of alignment through the CMS Dual Office is critical.

MAP “Working” Measure Selection Criteria

1. **Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review**

   Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

   Response option: Strongly Agree / Agree / Disagree / Strongly Disagree
      Measures within the program measure set are NQF endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

   <u>Additional Implementation Consideration</u>: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. **Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities**

   Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	*Safer care*
Subcriterion 2.2	*Effective care coordination*
Subcriterion 2.3	*Preventing and treating leading causes of mortality and morbidity*
Subcriterion 2.4	*Person- and family-centered care*
Subcriterion 2.5	*Supporting better health in communities*
Subcriterion 2.6	*Making care more affordable*

   Response option for each subcriterion:
   Strongly Agree / Agree / Disagree / Strongly Disagree:
      NQS priority is adequately addressed in the program measure set

3. **Program measure set adequately addresses high-impact conditions relevant to the program’s intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)**

   Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program’s intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option:
Strongly Agree / Agree / Disagree / Strongly Disagree:
Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	*Program* measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	*Program* measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	*Program* measure set is applicable to the program's population(s)

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

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

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care [1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion:

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[1] National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC: NQF; 2010.

Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	*Program* measure set adequately measures patient care across time

7. Program measure set includes considerations for healthcare disparities[2]

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

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1	Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
Subcriterion 7.2	Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1	*Program* measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)
Subcriterion 8.2	*Program* measure set can be used across multiple programs (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

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[2] NQF, *Healthcare Disparities Measurement,* Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities:

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

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma

7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger’s, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP “Working” Measure Selection Criteria Interpretive Guide

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of Strongly Agree, Agree, Disagree, Strongly Disagree is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best that reflects ‘quality’ health and healthcare. The term “measure set” can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a “program measure set,” a “core measure set” for a setting, or a “condition measure set.” The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

<u>For criterion 1 – NQF endorsement:</u>

The optimal option is for all measures in the program measure set to be NQF endorsed. The endorsement process evaluates individual measures against four main criteria:

1) ‘Importance to measure and report” - how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;

2) ‘Scientific acceptability of the measurement properties’ - evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.

3) ‘Usability’- the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.

4) ‘Feasibility’ - the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

<u>To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:</u>

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow

- time-sensitive legislative/regulatory mandate for the measure(s)

Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

For criterion 2 – Program measure set addresses the National Quality Strategy priorities:

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

For criterion 3 – Program measure set addresses high-impact conditions:

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and child health conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

For criterion 4 – Program measure set promotes alignment with specific program attributes, as well as alignment across programs

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- Care settings include: Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.

- Level of analysis includes: Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.

- Populations include: Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

<u>For criterion 5 – Program measure set includes an appropriate mix of measure types:</u>

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1) Outcome measures – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]

2) Process measures – Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures– Defined as patients' perspective on their care.[5]

3) Cost/resource use/appropriateness measures–
    a. Cost measures – Total cost of care.
    b. Resource use measures - Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[6]

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[1] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

[2] Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

[3] Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

4 National Quality Forum. (2011). Consensus development process. Retrieved from http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx

[5] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

[6] National Quality Forum. (2011). National voluntary consensus standards for cost and resource use (cycle 1): a consensus report. (draft report for commenting). Retrieved from http://www.qualityforum.org/projects/efficiency_resource_use_2.aspx?section=PublicandMemberComment-Non-ConditionSpecificCVDiabetes2011-08-302011-09-28

c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]

4) Structure measures– Reflect the conditions in which providers care for patients. [8]This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organizations, methods of peer review, and methods of reimbursement).[9] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

For criterion 6 – Program measure set enables measurement across the person-centered episode of care:

The optimal option is for the program measure set to approach measurement in such a way as to capture a person's natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

For criterion 7 – Program measure set includes considerations for healthcare disparities:

Program measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[10]

Subcriterion 7.1 seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).

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[7] National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

[8] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

[9] Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

[10] Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

Subcriterion 7.2 seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

For criterion 8 – Program measure set promotes parsimony:

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entitles, while also measuring the patient's health and healthcare comprehensively.

Subcriterion 8.1 can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entitles.

Subcriterion 8.2 can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.)

MAP Dual Eligible Beneficiaries Workgroup
Worksheet for Small Group Exercise – November 15 Meeting

First Tier Candidate Measures			
Rank	**NQF #**	**Topic**	**Rationale**
1			
2			
3			
4			

Second Tier Runner-Up Measures			
Rank	**NQF #**	**Topic**	**Rationale**
5			
6			
7			
8			

MAP Dual Eligible Beneficiaries Workgroup
Worksheet for Small Group Exercise – November 15 Meeting

Measure	Potential Shortcoming	Potential Modification

Measure Gaps

1)

2)

3)

4)

5)

6)

Quality of Life Measure

Improvement in Ambulation/Locomotion

Measure Description: 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.

Numerator Statement: Number 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.

Improvement in Ambulation/Locomotion is coded as follows:

- 1 (YES) IF: 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.
- 0 (NO) IF: The value recorded for the OASIS item M0702 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care.

OASIS C item: (M0702) Ambulation/Locomotion: Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).

1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings.

2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

3 - Able to walk only with the supervision or assistance of another person at all times.

4 - Chairfast, unable to ambulate but is able to wheel self independently.

5 - Chairfast, unable to ambulate and is unable to wheel self.

6 - Bedfast, unable to ambulate or be up in a chair.

Denominator Statement: All home health episodes except those where either of the following conditions applies: (1) The value recorded for the OASIS item M0702 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. OR (2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

Exclusions: All home health episodes except those where: (1) The value recorded for the OASIS item M0672 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. OR (2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home. Please note also generic exclusions under Q6, Denominator Exclusions.

Measure Steward: CMS

NQF-Endorsed Measure?	Yes, #0167
National Quality Strategy Priority	Effective prevention and treatment
Disparity-Sensitive Measure?	No

Quality of Life Measure

Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Outcome
Data Source(s)	Patient Reported
Care Setting(s)	Home Health
Level(s) of Analysis	Facility

Change in Daily Activity Function as Measured by the AM-PAC

Measure Description: The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified that consists of functional tasks that cover the following areas: feeding, meal preparation, hygiene, grooming, and dressing.

Numerator Statement: The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Daily Activity (i.e., ADL and IADL) functioning. We recommend that the target threshold is based on the percentage of patients who exceed one or more Minimal Detectable Change (MDC) thresholds. The percentage threshold is derived from a normative database used for benchmarking. MDC is considered the minimal amount of change that is not likely to be due to measurement error. It is one of the more common change indices, which can be used to identify reliable changes in an outcome like Daily Activity function adjusting for the amount of measurement error inherent in the measurement. MDC can be reported at different confidence levels (see Haley & Fragala, 2006).

Denominator Statement: All patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or alternatively, based on CPT codes relevant to treatment goals focused on Daily Activity function.

Exclusions: Those patients who did not have one or more mobility function goals for the episode of care.

Measure Steward: CREcare

NQF-Endorsed Measure?	Yes, #0430
National Quality Strategy Priority	Effective prevention and treatment
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Outcome
Data Source(s)	Electronic Health Records
Care Setting(s)	Ambulatory Care, Home Health, Hospital, PAC/LTC Facility
Level(s) of Analysis	Facility, Clinician

Care Coordination Measure

3-Item Care Transition Measure (CTM-3)

Measure Description: Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.

Numerator Statement: The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows:

- Strongly Disagree = 1
- Disagree = 2
- Agree = 3
- Strongly Agree = 4

Next, the scores can be aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100.

Time Window = recommended within 30 days of event

Denominator Statement: n/a

Exclusions: The CTM has application to all hospitalized adults. Testing has not included children, but the measure may have potential application to this population as well. Persons with cognitive impairment have been included in prior testing, provided they are able to identify a willing and able proxy. The CTM has been tested in English- and Spanish-speaking (using an available Spanish version of the CTM) populations.

Measure Steward: University of Colorado Health Sciences Center

NQF-Endorsed Measure?	Yes, #0228
National Quality Strategy Priority	Effective Care Coordination
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Patient Experience of Care
Data Source(s)	Patient Reported
Care Setting(s)	Hospital
Level(s) of Analysis	Facility

Care Coordination Measure

Advance Care Plan

Measure Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Denominator Statement: All patients aged 65 years and older

Exclusions: None

Measure Steward: NCQA

NQF-Endorsed Measure?	Yes, #0326
National Quality Strategy Priority	Effective Care Coordination
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Process
Data Source(s)	Administrative Claims
Care Setting(s)	Ambulatory Care
Level(s) of Analysis	Individual Clinician

Mental Health and Substance Use Measure

Depression Remission at Six Months

Measure Description: Adult patients aged 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at six months defined as a PHQ-9 score less than 5.

Numerator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.

Denominator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

Measure Steward: Minnesota Community Measurement

NQF-Endorsed Measure?	Yes, #0711
National Quality Strategy Priority	Promoting effective prevention and treatment
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	No
Proposed Medicaid Adult Core Measure?	No
Measure Type	Outcome
Data Source(s)	Paper Records, Electronic Health Records, Other Electronic Clinical Data
Care Setting(s)	Ambulatory Care, Behavioral Health
Level(s) of Analysis	Individual Clinician

Mental Health and Substance Use Measure

Follow-up After Hospitalization for Mental Illness

Measure Description: 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.

Numerator Statement: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

Time Window: Date of discharge through 30 days after discharge

Denominator Statement: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year.

Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclusions: Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer for codes to identify nonacute care.

Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Measure Steward: NCQA

NQF-Endorsed Measure?	Yes, #0576
National Quality Strategy Priority	Promoting effective communication and coordination of care
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	Yes
Measure Type	Process
Data Source(s)	Administrative Claims, Electronic Health Records
Care Setting(s)	Ambulatory Care, Behavioral Health/psychiatric unit, Other
Level(s) of Analysis	Can be measured at all levels

Screening and Assessment Measure

Screening for Fall Risk

Measure Description: Percentage of patients aged 65 years and older who were screened for fall risk (two or more falls in the past year or any fall with injury in the past year) at least once within 12 months

Numerator Statement: Patients who were screened for future fall* risk** at last once within 12 months

*A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

**Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year.

Denominator Statement: All patients aged 65 years and older

Exclusions: Patients who have documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory) are considered exceptions to this measure.

Measure Steward: NCQA

NQF-Endorsed Measure?	Yes, #0101
National Quality Strategy Priority	Making care safer, Best practices for healthy living
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Process
Data Source(s)	Administrative Claims
Care Setting(s)	Ambulatory Care
Level(s) of Analysis	Individual Clinician

Screening and Assessment Measure

Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

Measure Description: 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

Numerator Statement: Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco

**Cessation counseling intervention includes brief counseling (3 minutes or less) and/or pharmacotherapy

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

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)

Measure Steward: AMA-PCPI

NQF-Endorsed Measure?	Yes, #0028
National Quality Strategy Priority	Best practices for healthy living
Disparity-Sensitive Measure?	Yes
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Process
Data Source(s)	Administrative Claims
Care Setting(s)	Ambulatory Care
Level(s) of Analysis	Individual Clinician

Structural Measure

Medical Home System Survey

Measure Description: Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with:

- a. Improved access and communication
- b. Care management using evidence-based guidelines
- c. Patient tracking and registry functions
- d. Support for patient self-management
- e. Test and referral tracking
- f. Practice performance and improvement functions

Standard 1: Access and Communication [9 pt total]
A. Has written standards for patient access and patient communication [4 pt]
B. Uses data to show it meets its standards for patient access and communication [5pt]

Standard 2: Patient Tracking and Registry Functions [21 pt total]
A. Uses data system for basic patient information (mostly non-clinical data) [2 pt]
B. Has clinical data system with clinical data in searchable data fields [3 pt]
C. Uses the clinical data system [3 pt]
D. Used paper or electronic-based charting tools to organize clinical information [6 pt]
E. Uses data to identify important diagnoses and conditions in practice [4 pt]
F. Generates lists of patients and reminds patients and clinicians of services needed (population management) [3 pt]

Standard 3: Care Management [20 pt total]
A. Adopts and implements evidence-based guidelines for three conditions [3 pt]
B. Generates reminders about preventive services for clinicians [4 pt]
C. Uses non-physician staff to manage patient care [3 pt]
D. Conducts care management, including care plans, assessing progress, addressing barriers [5 pt]
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities [5 pt]

Standard 4: Patient Self-Management Support [6 pt total]
A. Assesses language preference and other communication barriers [2 pt]
B. Actively supports patient self-management [4 pt]

Standard 5: Electronic Prescribing [8 pt total]
A. Uses electronic system to write prescriptions [3 pt]
B. Has electronic prescription writer with safety checks [3 pt]
C. Has electronic prescription writer with cost checks [2 pt]

Standard 6: Test Tracking [13 pt total]
A. Tracks tests and identifies abnormal results systematically [7 pt]
B. Uses electronic systems to order and retrieve tests and flag duplicate tests [6 pt]

Standard 7: Referral Tracking [4 pt total]
A. Tracks referrals using paper-based or electronic system [4 pt]

Standard 8: Performance Reporting & Improvement [15 pt total]
A. Measures clinical and/or service performance by physician or across the practice [3 pt]

Structural Measure

B. Survey of patients' care experience [3 pt]
C. Reports performance across the practice or by physician [3 pt]
D. Sets goals and takes action to improve performance [3 pt]
E. Produces reports using standardized measures [2 pt]
F. Transmits reports with standardized measures electronically to external entities [1 pt]

Standard 9: Advanced Electronic Communications [4 pt total]
A. Availability of Interactive Website [1 pt]
B. Electronic Patient Identification [2 pt]
C. Electronic Care Management Support [1 pt]

Exclusions: None

Measure Steward: NCQA

NQF-Endorsed Measure?	Yes, #0494
National Quality Strategy Priority	Effective Care Coordination
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Structure
Data Source(s)	Provider
Care Setting(s)	Ambulatory Care
Level(s) of Analysis	Facility/Agency, Group

Structural Measure

SNP Structure and Process Measure #6: Coordination of Medicare and Medicaid Coverage

Measure Description: The organization coordinates Medicare and Medicaid benefits and services for members.

Element A: Administrative coordination for dual-eligible benefit packages
Element B: Relationship with state Medicaid agency for dual-eligible benefit packages
Element C: Administrative coordination for chronic condition and institutional benefit packages
Element D: Service coordination

Also see attached specifications.

Measure Steward: NCQA

NQF-Endorsed Measure?	No
National Quality Strategy Priority	Effective Care Coordination
Disparity-Sensitive Measure?	No
Measure Applicable Across Multiple Conditions?	Yes
Proposed Medicaid Adult Core Measure?	No
Measure Type	Structure/Process
Data Source(s)	Health Plan
Care Setting(s)	n/a
Level(s) of Analysis	Health Plan

SNP 6: Coordination of Medicare and Medicaid Coverage

The organization coordinates Medicare and Medicaid benefits and services for members.

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.

Element A: Administrative Coordination for Dual-Eligible Benefit Packages

The organization coordinates Medicare and Medicaid benefits by:

1. **Giving prospective members information about benefits they are eligible to receive from both programs**
2. **Using a process to identify changes in members' Medicaid eligibility**
3. **Informing members about maintaining their Medicaid eligibility**
4. **Providing information to members about benefits they are eligible to receive from both programs**
5. **Giving members access to staff who can advise them on using both Medicare and Medicaid**
6. **Coordinating adjudication of Medicare and Medicaid claims for which the organization is contractually responsible**
7. **Giving members clear explanations of benefits and of any communications they receive regarding claims or cost sharing from Medicare, Medicaid or providers**
8. **Giving members clear explanations of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 8 factors	The organization meets 7 factors	The organization meets 6 factors	The organization meets 5 factors	The organization meets 0-4 factors

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation **Administrative functions**

This element addresses the administrative functions involved in providing Medicare and Medicaid benefits for dual-eligible SNP members (i.e., marketing, eligibility, beneficiary information, claims processing, cost sharing, claims adjudication, grievances and appeals).

Objectives of coordinating administration

Though the desired goal for coordination is that dual-eligible members receive through their SNP a single program that combines Medicare and Medicaid benefits transparently, achieving complete integration of the two programs involves decisions beyond the organization's control. At this time, regulations of CMS and some state Medicaid agencies may put this goal beyond the organization's control; therefore, this element requires the organization to coordinate administrative functions for Medicare and Medicaid benefits and to provide dual-eligible members with comprehensive information on both sets of benefits.

Prospective members

The organization provides marketing materials specifically designed for dual-eligible members, combining information about Medicare and Medicaid benefits. The organization may provide members and prospective members with written materials or contact them in person or by telephone. If the organization contacts members by telephone, NCQA reviews the written scripts or outlines used.

Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members' specific benefit plans, including cost sharing, if any.

Medicaid eligibility

The organization receives information on changes in Medicaid eligibility, which may come from monthly reports on all Medicaid-eligible members or from another source. Changes to Medicaid eligibility involve gaining and losing Medicaid eligibility, and the organization monitors both kinds of change. The organization may help members or refer them to state personnel to maintain Medicaid eligibility. It provides assistance, as appropriate, including during the Medicaid reapplication process, for members who have lost eligibility.

Coordinated information

Descriptions of member benefits include Medicare and Medicaid benefits and cover the details of each member's specific benefit package, including cost sharing. Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members' specific benefit plans. The organization must provide contact information for someone within the organization whom the member can call, as an alternative to written documents.

Staff who can advise on Medicare and Medicaid

The organization has staff who can respond to questions about Medicare benefits, including questions about any level of cost sharing, and can either respond or refer members to the appropriate state personnel for Medicaid questions~~, including the level of cost sharing, if any~~. A member or responsible party can speak with a designated organization representative who knows the Medicare benefits, knows state resources for Medicaid information, knows the organization's network and can guide the member or responsible party in understanding and using benefits.

Coordinating adjudication of claims and explanation of benefits and grievance and appeal procedures

The organization adjudicates all Medicare claims and Medicaid claims for services it administers under a contract with the state Medicaid agency. For other Medicaid services, the organization helps members understand the state's adjudication of claims submitted by providers. If the organization does not have a contract to administer Medicaid-paid services, it nevertheless maintains the capability to help members understand the benefits they are entitled to, their cost sharing and their rights. Cost sharing and grievance and appeal procedures can be confusing for members, especially the frail and disabled. Where Medicare and Medicaid each pay part of the same claims, the organization makes the results from both programs easily understood for members. This includes helping members understand their appeal rights, upon request.

Exceptions

This element is NA for Chronic condition and Institutional benefit packages.

Documentation

To demonstrate performance on this element, the organization must provide documented processes and may also provide reports or materials as examples of carrying out the processes.

Examples

~~The organization may provide any one of the three kinds of data sources for each factor. The following are examples; there may be other kinds of documentation:~~

Documented process

- Job descriptions for staff who help members with coordination of both sets of benefits
- Procedures used to determine changes in members' Medicaid eligibility

Materials

- Sample marketing materials provided to prospective members
- Sample benefit summaries provided to members
- Instructions on where to reapply for Medicaid, which are sent to members or to responsible parties
- Job descriptions for staff who help members with eligibility, benefits and claims for both Medicare and Medicaid
- Scripts or guidelines for staff who help members with eligibility, benefits and claims for both Medicare and Medicaid

Reports

- Format or shell of reports on Medicaid eligibility used by the organization

Element B: Relationship With State Medicaid Agency for Dual-Eligible Benefit Packages

The organization maintains a documented relationship with the state Medicaid agency to foster coordinated care, by having or working toward a contract or agreement for administering any part of the Medicaid benefit package.

Scoring

100%	80%	50%	20%	0%
The organization either has or is working toward an agreement with state Medicaid agency	No scoring option	No scoring option	No scoring option	The organization does not have and is not working toward an agreement

Data source Reports, Materials, Documented process

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation The status of the organization's coordination with the state Medicaid agency may be:

- Established and operating under an agreement, which may take the form of a memorandum of agreement (MOA), a memorandum of understanding (MOU) or a contract
- In the process of development, which the organization may document with a letter or proposal sent to the state, showing an ongoing effort to establish a relationship with the state. Whatever the type of documentation, it should be dated within the ~~previous~~ 12 months prior to the start of the look-back period.

This element assesses whether plans are progressing toward establishing contracts with the state Medicaid agency, as required by MIPPA beginning in 2010.

Coordination with the state should encompass administration of some part of Medicaid benefits.

Note: The interim final rule for the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) has the following requirements:

- Effective January 1, 2010, MA organizations offering new dual-eligible SNPs must have a contract with the state Medicaid agency
- MA organizations offering existing dual-eligible SNPs may continue to operate without a contract through 2010 as long as they meet other statutory requirements

Exceptions

The element is NA if the organization is in a state that does not enter into agreements with SNPs or if the state agency refuses to enter into an agreement with the organization. To document the state's refusal or inability to enter into agreements, the organization must provide a letter from the state or legislation or regulations that indicate the state currently cannot enter into agreements, or proposed legislation documenting that the state is progressing towards agreements.

This element is NA for Chronic condition and Institutional benefit packages.

Examples

~~The organization may provide one document from any of the three kinds of data sources, such as the following.~~

Documented process

- Contracts or agreements with the state Medicaid agency covering administration or benefits
- Procedures for administering Medicaid benefits, where the procedures reflect an ongoing process

Reports

- Written notification of a scheduled meeting with the state to discuss contracting within the past 12 months
- Written notice from the state acknowledging receipt of, or action on, the organization's proposal for contracting to administer Medicaid benefits within the past 12 months

Materials

- Instructional materials from the state Medicaid agency on how to administer benefits

Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages

The organization coordinates Medicare and Medicaid benefits for chronic and institutional SNP members by:

1. **Using a process to identify any changes in members' Medicaid eligibility**
2. **Informing members about maintaining Medicaid eligibility**
3. **Giving information to members about benefits they are eligible to receive for both Medicare and Medicaid**
4. **Giving members access to staff who can advise them on use of both Medicare and Medicaid.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation **Objectives of coordinating administration**

There are many dual-eligible members in chronic condition and institutional SNPs. For these members, the organization coordinates benefits from Medicaid and Medicare, similar to dual-eligible SNPs.

The organization has documented processes for administrative coordination across Medicare and Medicaid benefits. Though the goal is for dual-eligible members to have a single program that combines Medicare and Medicaid benefits transparently, achieving complete integration of the two programs depends on decisions beyond the organization’s control. At this time, regulations of CMS and some state Medicaid agencies may be beyond the organization’s control; therefore, this element requires the organization to coordinate administrative functions for Medicare and Medicaid benefits and to provide dual-eligible members with comprehensive information on both sets of benefits.

Methods for coordinating administration

The organization may accomplish coordination by carrying out the functions itself or by arranging for affiliated providers to carry them out. For example, the institutions may be the entities that perform all of these functions for institutionalized members, rather than the organization. Processes may reflect the fact that, for institutionalized members, Medicaid status is not likely to change and does not require frequent updating.

Medicaid eligibility

The organization receives information on changes in Medicaid eligibility, which may come from monthly reports on all Medicaid-eligible members or from another source. Changes to Medicaid eligibility involve gaining and losing Medicaid eligibility, and the organization monitors both kinds of change. The organization may help members or refer them to state personnel to maintain Medicaid eligibility. It provides assistance, as appropriate, including during the Medicaid reapplication process, for members who have lost eligibility.

Coordinated information

Descriptions of member benefits include Medicare and Medicaid benefits and cover the details of each member’s specific benefit package, including cost sharing. Where there are conflicting requirements for Medicare and Medicaid information and the requirements do not allow the organization to integrate materials, the organization provides both sets of information. Materials must cover the details of members’ specific benefit plans. The organization must provide contact information for someone within the organization whom the member can call, as an alternative to written documents.

Staff who can advise on Medicare and Medicaid

The organization has staff who can respond to questions about Medicare benefits and can either respond or refer members to the appropriate state personnel for Medicaid questions, including the level of cost sharing, if any. A member or responsible party can speak with a designated organization representative who knows the Medicare benefits, knows state resources for Medicaid information, knows the organization’s network and can guide the member or responsible party in understanding and using benefits.

Exception

This element is NA for Dual-eligible benefit packages and Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. The organization must provide documentation demonstrating this.

Documentation

To demonstrate performance on this element, the organization must provide documented processes and may also provide reports or materials as examples of carrying out the processes.

Examples

~~The organization may provide any of the three kinds of data sources, such as the following.~~

Documented process

- Job descriptions for staff who assist members with coordination of both sets of benefits
- Procedures used to verify changes in members’ Medicaid eligibility

Materials

- Sample benefit summaries provided to members
- Instructions sent to members or to responsible parties that explain where to reapply for Medicaid
- Job descriptions for staff who help members with eligibility and benefits information for Medicare and Medicaid
- Scripts or guidelines for staff who help members with eligibility and benefits information for both Medicare and Medicaid

Reports

- File layouts for reports on Medicaid-eligible members or for members losing or gaining Medicaid eligibility

Element D: Service Coordination

The organization coordinates delivery of services covered by Medicare and Medicaid through the following:

1. **Helping members access network providers that participate in both the Medicare and Medicaid programs or providers that accept Medicaid patients**
2. **Educating providers about coordinating Medicare and Medicaid benefits for which members are eligible and about members' special needs**
3. **Educating members about both kinds of benefits for which they are eligible**
4. **Helping members obtain services funded by either program when assistance is needed**
5. **Assessing adequacy of the network for providing member access at least semiannually.**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets no factors

Data source Documented process, Materials, Reports

Scope of review SNP benefit package

Look-back period *For Initial Surveys:* NCQA looks for evidence of completion of the required activities during the 3 months prior to the survey date.

Explanation

Objective of coordinating services

The organization facilitates coordination of services covered by Medicare and Medicaid. The goal is that services are specific to member needs and are provided seamlessly, whether they are reimbursed by Medicare or Medicaid.

Methods of coordinating services

The organization is responsible for maintaining an adequate network and for educating network practitioners and providers about their role in coordinating services. For the other functions in this element, the organization may coordinate services in different ways. It may carry out the functions itself, or it may arrange for affiliated providers to perform them. For example, with institutionalized members, the facilities may be the entities that educate members about benefits and arrange for services, rather than the organization.

For some benefit packages of all types, the organization's staff practitioners may order needed services and the affiliated providers may arrange for the services by carrying out the orders. Many SNPs assign to network practitioners the responsibility for arranging services funded under either program.

Providing access

To avoid creating financial barriers for dual-eligible members, the organization may work with providers in a variety of ways, depending on members' Medicaid benefits. Medicare benefits are fairly standard throughout the country; Medicaid benefits vary by state and by type of eligibility; and organizations' agreements with state Medicaid agencies vary. Therefore, to meet the intent of factor 1, the organization should include providers in its network and publish a directory for members, so that:

- All members have access to providers that accept Medicare for services paid only by Medicare
- Dual-eligible members have access to providers who accept Medicaid for services paid only by Medicaid
- For services that are reimbursed by both Medicare and Medicaid for dual-eligible members, such as physicians' services for which Medicaid pays the Medicare copayment, the organization requires that physicians in the network do one of the following:
  - Accept both Medicare and Medicaid payment and do not bill patients more than any co-payment required by the state, ***or***
  - If only accepting Medicare, do not balance-bill dual-eligible members for copayments paid by Medicaid.
- For institutional benefit packages, the provider directory may be designed for use by the member's responsible party or by institution staff.

Educating providers and members

When members need services, the organization alerts them and their providers to the full range of benefits and services for which they are eligible, including their responsibility for cost-sharing, if any, and their right to reimbursement by both programs. The organization may do this for members by providing materials or by counseling members by telephone or in person.

The organization may educate providers about members and their benefits using briefing materials, interactive Web information or personal contact. Whatever the mode of education, the organization briefs providers on any allowable copayments for SNP members and on the special need to coordinate services for dual-eligible SNP members. The organization informs providers who is responsible (the provider or the organization) for coordinating services covered by both Medicare and Medicaid.

Arranging for services

The organization may arrange services by contracting with providers, by working directly with facilities, by referring members to non-contracted providers, by assisting members in scheduling services or by directly providing the services.

Assessing adequacy of the network

Dual-eligible members of any SNP may not gain access to care when providers do not accept their Medicaid coverage. To assess whether dual-eligible members have access to care, the organization regularly monitors indicators of access, and adds providers to serve its membership across kinds of coverage, geography, cultural and linguistic needs and health needs, as needed.

Exception

This element is NA for Chronic and Institutional benefit packages with fewer than 5 percent dual-eligible members. The organization must provide documentation demonstrating this.

Documentation

To demonstrate performance on this element, the organization must provide (1) documented processes and (2) reports or materials as examples of carrying out the processes.

Examples

~~The organization may provide any of the three kinds of data sources, such as the following.~~

Documented process

- Policies and procedures for arranging services for members
- For organizations that rely upon affiliated providers, policies and procedures, or sample briefing materials for institutions or other provider organizations that show the functions for which the provider organization is responsible, rather than the organization.

Materials

- The provider directory, procedures or briefing materials that show the organization's rules for providers treating members
- Sample provider manuals, recruitment material, briefing materials or fax blasts
- Sample benefit summaries.

Reports

- Reports on access indicators, such as percentage of in-network and out-of-network use; rate of ED use compared to norms for the area; or member surveys of satisfaction with access.

NATIONAL QUALITY FORUM

HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS

Disparities-sensitive Measures Screening Protocol

The Steering Committee suggested that the entire NQF portfolio of measures be reviewed and a subset of disparities-sensitive measures identified for their further review. Based on the Committee's discussion at the meeting and the paper by Massachusetts General Hospital, the following draft protocol is proposed:

1. **First-tier of the Disparities-sensitive Criteria**
   The disparities-sensitive selection criteria (prevalence, impact of condition, impact of the quality process, quality gap, and ease and feasibility of improving the quality process) will serve as a starting point with emphasis placed on prevalence, quality gap and impact to identify measures.
   a. Prevalence - how prevalent the condition is among the minority population? The following conditions are identified by the Office of Minority Health as large contributors of health disparities. The NQF portfolio will first be reviewed for performance measures related to the following conditions: **Cancer, Diabetes, Heart Disease (including Hypertension), HIV/AIDS, Immunizations, Infant Mortality, and Stroke, Tobacco use, Oral care.** These measures will be given 3 points. Measures that fall in **cross-cutting areas** (e.g., patient safety, care coordination, functional status, palliative care, pain management or *any* child health/peds) also will be scored 3 points. Measures that fall into the top 20 of NQF's **"Top 20" priorities,** see table 1 (amended to include substance abuse, Obesity, and ESRD) will be scored 2 points. All other measures will be scored 1 point.
   b. Quality gap – how large the gap in quality *of care* between the disparity population and the group with the highest quality for that measure. Measure submission/evaluation forms will be reviewed and the gap information for that measure will be recorded. In many cases, information may not be available if the measure has not been recently evaluated as part of NQF's endorsement maintenance process and the Steering Committee will be asked to provide expert opinion. Literature review by staff can also supplement the information provided on submission forms. After NQF staff assesses the range and nature of gap information available, we will consult with the Steering Committee as to appropriate demarcation of (relatively) large, medium, small gaps and score appropriately based on this schema. (i.e., the gap information will be assessed and distribution shown by percentages, 50%, 30%, etc. – then each group will be assigned a scoring number).
   c. Impact – the influence a condition or topic has financially, publically, and on the community at large. Performance measures addressing the National Quality Strategy priority areas or goals will be given a score of 1 point each (see

attachment 1 – *Summary of NPP's Proposed Goals and Measure Concepts*) AND/OR a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality) 1 point for any one of these factors.

2. **Second Tier of the Disparities-sensitive selection Criteria**
   Following this initial review, an additional filter will be applied to those measures where performance data is not stratified by race/ethnicity or when a known disparity does not exist. The measures will be reviewed using the following criteria:
   a. Care with a High Degree of Discretion - Many of the disparities described depends on a certain degree of discretion on the part of the clinician. The less there is a standard protocol that must be followed, the easier it is for a clinician to offer a procedure differently based on the patient's socio-demographic characteristics (whether or not this is consciously factored into the decision). NQF staff can review the measure submission forms and identify those measures that specifically cite a clinical guideline as part of the evidence, scoring those that do as having 2 points and those without as 0.
   b. Communication-Sensitive Services - Disparities are more likely to occur when there are challenges to communication across language and cultures. As an indicator of communication-sensitive services, performance measures will be tagged for the Committee's review as disparities-sensitive when they match one of the following NQF-endorsed framework domains; scoring those that do as having 2 points and those that do not as 0.
      i. Cultural Competency Framework Domain: Patient-Provider Communication and the corresponding sub-domains and/or preferred practices.
      ii. Care Coordination Framework Domain: Communication and the corresponding sub-domains and/or preferred practices
   c. Social Determinant-Dependent Measures - Disparities often are seen in areas that relate to behavioral aspects of health, including patient self-management (e.g., diet, exercise, and medication adherence for diabetes or congestive heart failure management). As an indicator of social determinant-dependent measures, performance measures should be matched to social or behavioral aspects of health. Measures in the NQF portfolio that are within the direct "control sphere" of either healthcare delivery or public health will be given a score of 3 points; measures that address behavioral aspects of health will be given a score of 2 points; measures that address environmental aspects will be given 1 point and measures that meet other social determinant indicators will be given a score of 0.

3. **Tagging of All Measures as Screening Proceeds**

All measures will be tagged as belonging to a specific category as outlined in the commissioned paper:

a. Practitioner Performance
b. Consumer Surveys that measure patient experience
c. Hospital, Ambulatory care, home health nursing home
d. Ambulatory care sensitive conditions and management
e. Cultural Competency
f. Patient-Centered

All measures will be further identified as system-based or provider-based, then cross-cutting or the potential to influence multiple measures. In addition, the measure type (structure, process, and outcome) will be indicated.

Table 1. Prioritized List of 20 High-Impact Medicare Conditions

Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke / Transient Ischemic Attack
6. Alzheimer's
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/ Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis / Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

NATIONAL QUALITY FORUM

HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS

Recommendations for Healthcare Disparities Measurement

Data Collection

Recommendation: Directly reported race/ethnicity and language (self-identified) is the preferred method for data collection. Efforts should be taken to solidify and support the infrastructure for race, ethnicity, and language proficiency data collection from patients/members within all healthcare settings. There is clear guidance from IOM/NQF/HRET that should be followed for self-reports (the gold standard). Where not feasible in the short term, indirect estimation can be put into place immediately.

Identifying Disparities Measures and Indicators

(See Disparities-sensitive Measures Screening Protocol)

Methodological Approaches and Concepts for Disparities Measurement

Reference Point: The reference point serves as the specific value against which a disparity is measured. Recommendation – the reference point should always be the historically advantaged group, not the largest or best performing in an area/on a measure.

Absolute versus Relative Disparities and Favorable versus Adverse Measures: The absolute and relative changes in disparities can reveal different conclusions about whether gaps are actually closing and often can lead to different interpretations when making these comparisons. Recommendation – both absolute and relative statistics should be calculated, and if they lead to conflicting conclusions, then both statistics should be presented, allowing readers to reach their own conclusion**.** In addition trends should be calculated and specific rates provided along with a narrative for explanation.

Paired Comparisons versus Summary Statistics: Recommendation – pairwise comparisons using the historically advantaged group as the reference point should be checked to see if a positive finding from the summary statistic reflects superior care received by the disadvantaged group—and if so, then the context of that result and relevant policy goals must be explicitly considered.

Normative Judgments About Disparity Measures: Recommendation – normative judgments and inherent biases should be minimized, and, when used in reported measures, they should be mentioned and referenced appropriately. In addition, further evaluation of the measure and reference point for which the normative judgment is based should be explained.

Risk Adjustment and Stratification: Recommendation – stratification by race/ethnicity and primary language should be performed when there are sufficient data to do so and that risk adjustment may be appropriate when performance is highly dependent on community factors beyond a provider's control. (Existing NQF policy is that risk models should not include race/ethnicity adjusters, which may mask disparities in quality of care.)

Interaction Effects: Recommendation – when clear differences in quality exist by racial/ethnic sub-strata, further stratification of results serves to highlight areas of the greatest potential for intervention. Additional variables to consider for stratification include income, age, highest level of education, acculturation, and urban/rural effects and language, to further elucidate areas for intervention. An interaction effect should be acknowledged, but reported only if it is large enough to make a difference on the disparity.

Sample Size Consideration: Recommendation of options to consider –

1. The racial/ethnic categories can be "rolled up" into broader categories containing more than one group. Commonly, researchers will use the OMB categories, or some combination, or even minority and majority.
2. Use a summary statistic such as the BGV, which considers all of the racial/ethnic groups simultaneously. However these should not be used blindly
3. Use composite quality measures. Composite measures provide a global comparison of the quality of care by combining across indicators to produce a "composite" or "aggregate" score. Composite scores can be generated using much smaller sample sizes than those required for single indicators.
4. Over-sample minority patients, including race, ethnicity, and language as well as other sub-groups
5. Combine data from two or more years.

Consideration of Socioeconomic and Other Demographic Variables: Recommendation – performance reports stratified by race/ethnicity should not be risk adjusted by socioeconomic status or other contributory factors, and instead should be further stratified if the data permit. While stratification is a better option for pulling out differences in the underlying racial/ethnic population, there should be some sensitivity to over adjusting for disparities within a population.

NQF's Approach for Measuring Disparities Prospectively

Recommendations regarding NQF's approach for addressing disparities measurement both in the current form and prospectively; (1) entire NQF portfolio of measures be reviewed and a subset of disparities-sensitive measures identified; (2) Consider process and outcome measures separately or look at system-based and provider-based measures first and then identify the cross-cutting measures; and (3) all measures should be stratified by race/ ethnicity and language and consider prioritizing measures for implementation and uptake by various institutions.

Recommended changes to the measure submission form – (1) advising measure developers more specifically about including disparities within the submission form; (2) aggregating the currently dispersed disparities sections within each evaluation criterion to a new, separate section toward the beginning of the form; and (3) considering disparities as a threshold criterion for NQF endorsement.

Massachusetts
General Hospital

Harvard
Medical School

Commissioned Paper: Healthcare Disparities Measurement

July 19, 2011

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This work was sponsored by the National Quality Forum

THE DISPARITIES
SOLUTIONS CENTER
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Tables and Figures

EXECUTIVE SUMMARY

The purpose of this report is to: (1) provide guidance to a National Quality Forum (NQF) Steering Committee charged with the selection and evaluation of disparity-sensitive quality measures, (2) describe methodological issues with disparities measurement, and (3) identify cross-cutting measurement gaps in disparities.

1. Background: Disparities and Quality Measurement

The Institute of Medicine (IOM) reports *Crossing the Quality Chasm* and *Unequal Treatment* highlight the critical nexus between improving quality and eliminating racial and ethnic disparities in healthcare. Racial and ethnic minorities and people with limited English proficiency (LEP) often receive lower quality of care. The ability of hospitals, health plans, and other healthcare organizations to identify and address disparities hinges on effective collection of patient demographic data that captures race, ethnicity, language, and income. This information, however, is often not collected by providers and, when collected, is rarely analyzed to examine disparities in quality of care. We note here that some analysts differentiate between "health disparities" and "healthcare disparities." The former usually refers to differences in health status or health outcomes, which may be difficult to attribute to individual providers. In this report we focus on disparities in *healthcare*, defined by the IOM as "racial and ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention."[1]

2. Data Collection: Building the Foundation

The Office of Management and Budget's (OMB) basic racial/ethnic categories (i.e., White, Black, Asian, American Indian/Alaskan Native, Native Hawaiian/Other Pacific Islander),should be supplemented by additional questions that identify subgroups within each group to capture better the unique experiences of smaller populations within each major category (e.g., the category "Asian" encompasses people of Japanese, Indian, Laotian, etc., origin). Additionally, people should be able to identify as multiracial, a group that should not be considered homogenous but rather should be divided into subgroups based on the component identities.

To assess language proficiency and preference, we endorse the approach proposed by the IOM's Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement (the "IOM Subcommittee") in conjunction with the Committee on Future Directions for the National Healthcare Quality and Disparities Report, which recommends using two types of questions to assess both proficiency and preferred language for medical encounters—"Spoken English language proficiency" and "Spoken language preferred for healthcare." Because of the great degree of variability in the languages spoken in different parts of the country, local and regional providers are best positioned to develop a response list relevant to their area.

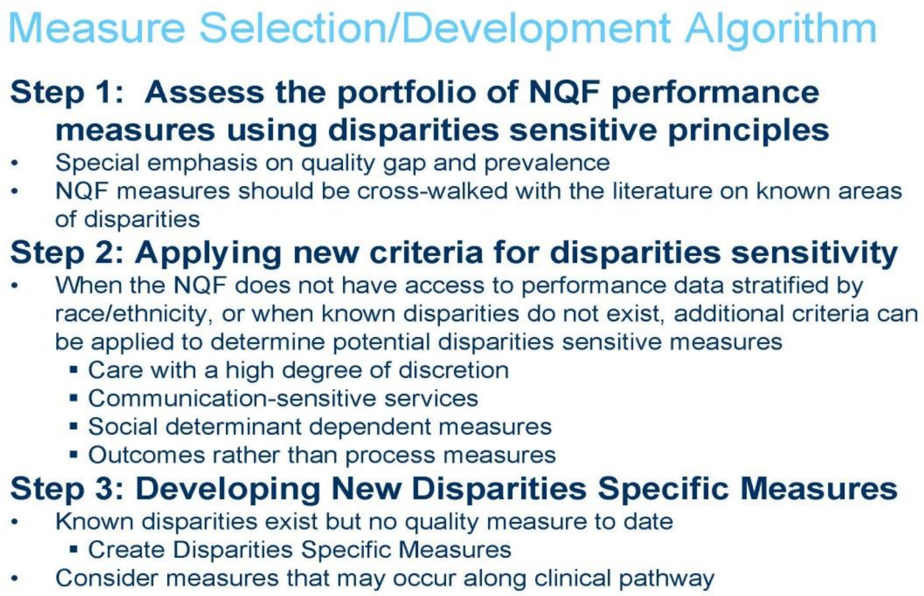
Information on race, ethnicity, and language should be obtained by self-report. However, these data are not widely available. In particular, although they are uniquely positioned to track disparities in ambulatory care, insurance plans have limited ability to obtain self-identified race and ethnicity due to minimal contact with enrollees, limits by some states that prohibit insurers from requesting such information from applicants, enrollee reluctance to disclose, and member turnover. When self-report data are not available, estimations using a combination of geo-coding and surname analysis should be used.

> **Recommendation: Directly reported race/ethnicity and language (self-identified) is the preferred method for data collection. Efforts should be taken to solidify and support the infrastructure for race, ethnicity, and language proficiency data collection from patients/members within all healthcare settings. There is clear guidance from IOM/NQF/HRET that should be followed for self-reports (the gold standard). Where not feasible in the short term, indirect estimation can be put into place immediately.**

In considering the future collection of information on race, ethnicity, and language, several considerations should be taken into account. First, as legislation increasingly requires the reporting of this information, it will be more widely available; and as the use of electronic health records continues to spread, obtaining and sharing this information among different levels of the health system may make measuring disparities more efficient. However, during this time of transition, there also is the possibility that because of their generally more limited access to resources, providers who care for large numbers of minority and LEP patients will lag behind providers of less diverse populations in their ability to collect this information and analyze health outcomes and quality measures by it.

3. Disparities Measures and Indicators: What to Measure?

NQF has previously developed a set of criteria to determine whether a quality measure would qualify as “disparities sensitive.” Disparities-sensitive measures are those that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (race/ethnicity, language, etc.). The NQF portfolio of endorsed standards and measures includes more than 700 performance measures of quality of care for both ambulatory and institution-based settings, including disease-specific measures and cross-cutting measures that apply across disease areas. None of these measures was designed specifically with the idea of detecting disparities in care by race/ethnicity or language. However, as a broad assessment of quality of care, it is reasonable to assume that some of these measures would be more sensitive to disparities in care than others. We envision identifying current and potential disparities-sensitive measures as a three--step process (below).



Measure Selection/Development Algorithm

Step 1: Assess the portfolio of NQF performance measures using disparities sensitive principles

- Special emphasis on quality gap and prevalence
- NQF measures should be cross-walked with the literature on known areas of disparities

Step 2: Applying new criteria for disparities sensitivity

- When the NQF does not have access to performance data stratified by race/ethnicity, or when known disparities do not exist, additional criteria can be applied to determine potential disparities sensitive measures
  - Care with a high degree of discretion
  - Communication-sensitive services
  - Social determinant dependent measures
  - Outcomes rather than process measures

Step 3: Developing New Disparities Specific Measures

- Known disparities exist but no quality measure to date
  - Create Disparities Specific Measures
- Consider measures that may occur along clinical pathway

4. Methodological Approaches to Disparities Measurement: How to Measure/Monitor?

In addition to the choice of race/ethnicity measures to use, how data are analyzed and reported can impact the identification and perception of disparities. We discuss several issues around the mathematical analysis of disparities in healthcare. These issues include a selection of reference point, sample size considerations, reporting relative versus absolute differences in care, and adjusting results by demographic case mix versus stratifying results by demographic characteristics, among others.

Whether to report relative or absolute differences in care or favorable or unfavorable events should be determined in the context of the measure, but neither approach is universally superior for each outcome of interest. Summary statistics may be used when groups are arbitrarily defined or when sample size of one group is very small, but should otherwise generally be avoided in favor of paired comparisons because of the many non-transparent characteristics of the statistic. To circumvent this, we recommend a few strategies, including combining smaller groups into broader categories, (i.e., using the OMB categories instead of measures of greater granularity) and using composite quality measures. In addition, when used for quality improvement and not necessarily for high-stakes reporting, it may be valuable to providers to analyze even small samples for disparities in case it suggests practice patterns that, while not statistically significant, are opportunities for improvement. We also weigh the pros and cons of risk adjustment versus stratification by race/ethnicity, and LEP, and recommend that the ultimate use of the measurement be used to guide selection of one approach over the other. We recommend that stratified models of race/ethnicity should not be adjusted for socioeconomic status (SES) However, payment systems also should consider risk adjusting payments to providers, while holding them accountable for equitable performance.

Recommendations:

Whereas some organizations consider any differences in quality to be evidence of a disparity, in this report we believe that for purposes of achieving equity in healthcare that is fair and just, the choice of the reference group should always be the historically advantaged group.

The choice of a disparity measure can lead to different interpretations when making comparisons over time or among providers. Therefore, both absolute and relative statistics should be calculated, and if they lead to conflicting conclusions, both should be presented, allowing the readers to make their own interpretation.

Public reporting of disparities should calculate statistics using both favorable and adverse events. If the results are notably different, both statistics should be reported, allowing the reader to judge the importance by taking the context of the report into consideration.

Because most summary measures of disparities lack "directionality," great care must be taken before using them to track disparities. Paired comparisons using the historically advantaged group as the reference point should be checked to see if a positive finding from the summary statistic reflects superior care received by the disadvantaged group. If so, the context of the report and relevant policy goals need to be explicitly considered.

When clear differences in quality exist by racial/ethnic substrata, further stratification of results will serve to highlight areas of the greatest potential for intervention.

Stratification by race/ethnicity and primary language should be performed when there are sufficient data to do so. Risk adjustment may be appropriate when performance is highly dependent on community factors beyond a provider's control.

Performance reports stratified by race/ethnicity should not be risk adjusted by SES or other contributory factors, and instead could optionally be stratified by SES if the data permit.

5. Priorities and Options for Quality Improvement and Public Reporting of Healthcare Disparities

Disparities measurement should achieve generally the same aims as overall quality measurement, that is, to monitor progress, inform consumers and purchasers, stimulate competition, and stimulate innovation. Short case studies of government initiatives, organizations, and institutions that have begun to collect, analyze, and report disparities on quality measures illustrate the incipient progress that is attainable and provide valuable lessons. Massachusetts in particular has been at the forefront of disparities measurement and reduction, experiencing both progress and setbacks. As discussed above, health plans face several barriers to collecting demographic information. Very large plans may not have the resources to invest in collecting these data given the limited contact they have with their large number of enrollees, although smaller plans may have the ability to do so. A few hospitals have begun to construct "dashboards" or disparities reports that display disparities in outcomes for a few standardized measures, and to use these to develop targeted interventions to reduce disparities.

At the same time, challenges exist in program design due to the potential for unintended consequences, such as the following: 1) minority patients tend to have poorer outcomes than majority patients; 2) hospitals with high numbers of minority patients could be disadvantaged in high-stakes incentive programs; 3) "teaching to the test" may result in the inappropriate provision of services to patients; 4) "color–blind" quality improvement programs could fail to reduce disparities if minority patients do not benefit from them to the same degree as majority patients; and 5) reducing the disparity in situations in which differences can be traced by inappropriate overuse by the majority population would not improve the overall quality of care.

Disparities measurement is undoubtedly an area that will grow in the coming years. To date, regulating bodies and federal and state legislative efforts are fostering the collection of race, ethnicity, and language proficiency data as a precursor to measurement efforts that will allow us to monitor quality and equity of care across the nation and perhaps design programs to encourage their reduction. To avoid unintended consequences, a number of design features should be considered as either alternatives to, or more likely, supplements to be used in combination with, standard components. Among these are:

- Using payment for improvement (versus payment to achieve quality benchmarks or thresholds). The Centers for Medicare & Medicaid Services (CMS) Value-Based Payment program, for example, uses a mix of achievement (median), benchmark (90th percentile) and improvement thresholds.

- Paying for performance based on lower racial/ethnic disparities (versus paying for higher-quality performance applied generally to all patients).

- Conducting special studies that monitor for potential unintended consequences, such as increased difficulty accessing care or adverse financial impacts on safety net providers.

- Paying for performance focused on improving quality of care for minority populations.

- Exception reporting (as used in the United Kingdom).

- Quality improvement efforts targeting safety net providers and high-minority providers (and directing supplemental resources to those providers including the sharing of best practices).

- Assessing structural characteristics of providers until more evidence-based process and outcome measures are developed.

- One option that has not appeared in the literature to our knowledge is the idea of risk adjusting ***payments to providers*** rather than risk adjusting performance measures. Such an approach recognizes the greater resource needs of providers to reach populations with multiple social disadvantages. Once these resources are available, it may then be more reasonable to hold all providers to the same quality performance standards applied to everyone without risk adjustment.

The development of a standardized and comprehensive set of disparities-sensitive measures that are used across the healthcare continuum is essential in enabling meaningful comparison of equality among providers, institutions, health plans, and regions. While these are being developed, existing measures should be stratified using modifications of the Office of Management and Budget (OMB) categories and examined for disparities in care. As we move forward, what level disparities are measured on and how this information will be used and reported remains to be determined.

1. Background: Disparities and Quality Measurement

The Institute of Medicine (IOM) reports *Crossing the Quality Chasm* and *Unequal Treatment* highlight the critical nexus between improving quality and eliminating racial and ethnic disparities in healthcare.[1, 3] *Unequal Treatment* found that even with the same insurance and socioeconomic status—and when comorbidities, stage of presentation, and other confounders are controlled for—racial and ethnic minorities often receive a lower quality of healthcare than do their white counterparts. In sum, racial and ethnic disparities in healthcare may be characterized as poorer-quality care for minorities that are not due to access-related factors, patient preferences, or clinical needs or appropriateness of the intervention.[1] Disparities populations include Blacks/African-Americans, Hispanics/Latinos, Asian/Pacific Islanders, Native Americans/Alaska Natives, and persons with Limited English Proficiency (LEP).[2]

Crossing the Quality Chasm suggests that to truly achieve quality care, healthcare systems must, among other things, be equitable. Equity is achieved by providing care that is free from disparities and does not vary by personal characteristics such as race, ethnicity, gender, geographic location, and socioeconomic status. Over the past few years, there has been an increased focus on improving quality, eliminating disparities, and achieving equity. These efforts have intensified as research has shown that racial and ethnic disparities in healthcare, and their root causes, have an impact on quality, safety, cost, patient experience, and risk management. For example:

- Patients with LEP and racial/ethnic minorities are more likely than their English-speaking white counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[4-6]

- Communication problems are the most frequent cause of serious adverse events (as recorded in the Joint Commission database) and arise due to language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.[5]

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[1] Some analysts differentiate between "health disparities" and "healthcare disparities." The former usually refers to differences in health status or health outcomes, which may be difficult to attribute to individual providers. Disparities in *healthcare* are defined by the IOM as "racial and ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention."[1]

[2] For the purpose of this work, we are focusing on disparities measures that compare racial, ethnic, and linguistic minorities with the majority population. Although we acknowledge that there are other vulnerable groups that should be considered "disparities populations"—such as women, the disabled, and lesbian/gay/bisexual/transgender (LGBT) individuals, among others—we are concentrating our efforts on the aforementioned groups because (1) the evidence on racial/ethnic disparities is substantial and has garnered national attention and (2) efforts to develop measures for these other vulnerable populations are still in the developmental phase. By no means does our focus diminish the importance of disparities in these other groups, and we hope this work can serve as the foundation for future advancements for all vulnerable populations

- In the presence of communication difficulties with patients (i.e., due to language barriers or cultural barriers) healthcare providers may tend to order expensive tests (such as CT Scans) for conditions that could have been diagnosed through basic history taking.[7]

- Patients with LEP have longer hospital stays for some common medical and surgical conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement) than their white counterparts.

- Minorities are more likely to be readmitted for certain chronic conditions,[8-10] such as congestive heart failure.[11] Moving forward, this issue might take on greater financial importance given that CMS will likely limit or refuse reimbursement for Medicare patients with congestive heart failure who are readmitted within 30 days of discharge.[12, 13]

- Minorities, even when controlling for insurance status, may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than their white counterparts.

- There are multiple liability exposures that arise when there is a demonstrated failure to address the root causes for disparities. These include patients' misunderstanding of their medical condition, treatment plan, or discharge instructions (including how to identify complications and when to follow up); ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures; and poor or inadequate informed consent.

The ability of hospitals, health plans, and other healthcare organizations to identify and address racial and ethnic disparities hinges on their capacity to collect information about their patients' race, ethnicity, and language proficiency. This essential step was recommended in *Unequal Treatment*, as well as in the 2004 National Research Council report *Eliminating Health Disparities: Measurement and Data Needs*.[14, 15] Collecting race and ethnicity data alone is not enough to address disparities, however. Once such data are collected, healthcare organizations should routinely and regularly analyze and review them internally to monitor for disparities. This would allow them to identify variations in quality of care by race, ethnicity, and language proficiency and develop interventions to address them. For example, health plans and hospitals could determine whether patients of different racial and ethnic backgrounds were receiving the recommended testing and treatment for particular clinical conditions and develop quality improvement interventions to address any disparities or variations in care, if found.

To date, there have been several studies that have attempted to measure variations in quality by race and ethnicity,[8-11, 16, 17] and some that have even tried to address disparities through quality improvement strategies such as provider education and detailing.[18] However, a 2006 survey of 500 hospitals nationwide found that while 78.4 percent collected patient race information, 50 percent collected data on patient ethnicity, and 50 percent collected data on primary language,[19] fewer than one in five of the hospitals that collected race/ethnicity and language information routinely used it to assess disparities in quality of care, healthcare outcomes, or patient satisfaction.

The National Quality Forum (NQF) has taken the lead on the important issue of disparities measurement, building on its previous work, including the development of the *National Voluntary Standards for Ambulatory Care–Measuring Healthcare Disparities*,[20] and the consensus report on *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*.[15, 21] Ultimately, the development of a set of standardized disparities measures will be a major contribution to monitoring for—and achieving—equity in healthcare.

2. Data Collection: Building the Foundation

2.a. Categories, Methods, and Modes of Data Collection

A significant amount of research has been conducted on, and efforts devoted to, how to collect race, ethnicity, and language data from patients.[22] This work is critical, as it serves as the foundation for any disparities measurement efforts.

Usually, the first challenge organizations face when seeking to collect race/ethnicity data is determining what questions to ask and which racial, ethnic, and linguistic categories to use. In 2008, IOM convened the Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement in conjunction with the Committee on Future Directions for the National Healthcare Quality and Disparities Reports and produced a report that is the most complete and often-cited source on this topic. [23] This report made several key observations and recommendations that are worth noting:

2.a.i. Race/Ethnicity Categories

- The concepts of race and ethnicity are defined socially and culturally and, in the case of federal data collection, by legislative and political necessity.[24]

- OMB has developed a minimum set of standardized categories for reporting on race and Hispanic ethnicity by federal agencies and recipients of federal funds.[25-27] The five OMB race categories are: Black or African American, White, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. The only ethnicity choice is one of “yes” or “no” to Hispanic/Latino ethnicity. NQF [20] has endorsed these categories, at minimum. Additionally, NQF has endorsed the use of the Hospital Research & Education Trust (HRET) Toolkit as the preferred method for asking patients about race/ethnicity. Of note, at the time of endorsement, the HRET Toolkit recommended the use of OMB categories with a modification to include multiracial. Since the NQF endorsement, the Toolkit has been updated to endorse the approach of collecting granular ethnicity as recommended by IOM (see Figure 1).

2.a.ii. Language Categories

- OMB has not established a list of language categories. The preferred option is local choice informed by data on the languages spoken most frequently in the service area by persons with LEP.

- IOM concluded that spoken language can best be assessed by asking two types of questions: one aimed at determining whether an individual speaks English less than very well, and a second aimed at identifying the individual's preferred spoken language during a healthcare encounter (see Figure 1). However, IOM does not recommend suggest specific language for these two types of questions.

- When the individual is a child, the language need of the parent/guardian must be determined. Similarly, if an adult has a guardian/conservator, that individual's language need must be assessed.

- A single list of languages does not suit all areas given that the top non-English languages vary greatly from area to area. The aim is to have data on each individual's specific language need; but when an entity designs its collection instruments, whether paper or electronic, it may, because of space considerations, have to use a limited number of response categories. Therefore, such a response list should always include an "Other, please specify: __" option.

2.a.iii. Ethnic Granularity and Multiracial Categories and Other Key Issues

One limitation with the OMB minimum race and ethnicity set is that using too few categories can frustrate respondents who do not self-identify with those groups. It also can mask disparities by aggregating heterogeneous subpopulations with different cultures, behaviors, and risk factors.

> "For example, the group of individuals who identify as Asian varies tremendously, including individuals from Japan, India, Laos, and other countries with vastly differing cultures and experiences in the United States. Similarly, the Latino category includes many different ethnic groups that have been found to have very different experiences with health care utilization, such as Puerto Ricans, Mexicans, and Central Americans."[28, 29]

OMB encourages the collection of more detailed data provided they can be aggregated back to the minimum categories.[30] IOM recommended a separate question to collect data on granular ethnicity—defined as "a person's ethnic origin or descent, 'roots,' or heritage, or the place of birth of the person or the person's parents or ancestors…"[23]—in addition to OMB race and Hispanic ethnicity categories.

In addition, according to the US Census Bureau, the number of Americans identifying as multiracial increased by approximately one-third between the 2000 and 2010, making them one of the fastest-growing racial or ethnic groups during this interval. In the 2010 census, just more than 9 million people, or 2.9 percent of all respondents, identified with two or more races (see Figure 2). Among those who reported two or more races in the most recent census, more than 90 percent identified with two races. Predominant among those reporting two or more races were those identifying as white and another racial group (see

Figure 3). In particular, those identifying as white and black, some other race, Asian, or American Indian and Alaska Native collectively comprised more than two-thirds of those who reported multiple races. Among Hispanics, a relatively high proportion of those reporting multiple races identified as some other race in combination with another category.[31]

The Subcommittee suggested adding "Some other race" to the OMB list.[23] Finally, the Subcommittee recommended reporting specific multiple-race combinations to enable reporting detailed breakdowns rather than just "multiracial," as used by the Toolkit. Essentially, the emerging philosophy is that patients should be allowed to choose as many categories as they want, and in additional should be allowed to write in a response if they do not see a category that fits them.

This approach is not without its own limitations. Including too many racial and ethnic categories in a data collection tool can strain the data collection system and can make it difficult for workers at the registration site to locate a particular racial or ethnic group. More categories also mean that some groups will have few members, making it unlikely that the data reported will be statistically reliable.

Another minor issue is frequency of collection. While a change in race or ethnicity is highly unusual, race/ethnicity categories do in fact change. Thus, the Subcommittee recommended reconfirming race and ethnicity data every five years.[28, 29, 32]

2.a.iv. Data Collection Methods and Training

The primary modes of collecting information on race, ethnicity, and language are self-report, observation, and indirect estimation. Surveys typically use questionnaire items for self-report. In the past, patient intake procedures used observation but are moving in the direction of allowing the patient to self-identify. Medical records often rely on observation. Self-reported race/ethnicity is considered the gold standard because it reflects the individual's self-judgment and the population with which he or she identifies, and thus is endorsed by national experts from IOM and OMB.

- Eliciting accurate and reliable race, Hispanic ethnicity, and granular ethnicity data depends on the ways in which the questions are asked, the instructions provided to respondents (e.g., “Select one or more”), and the format of the questions (i.e., OMB one-question versus two-question format). This latter issue is especially relevant to how Hispanic populations self-identify. Pilot projects and further study are necessary to confirm the best ways to collect accurate data that are useful for healthcare quality improvement.

- Each of the entities involved in the nation’s healthcare system has some capability for the collection of race, ethnicity, and language data. However, some are better positioned than others to collect these data through self-report, generally the agreed-upon best way to define a person’s racial and ethnic identity.

- Training of staff, upgrades to health information technology (health IT) systems, and communication with patients and enrollees are potential avenues for improved data collection and building of trust. This is essential because in practice, the uniform implementation of the population definitions is as challenging as the initial population definition specification.

- In IOM’s proposed framework, optional categories are offered (e.g., declined, unavailable, unknown, self-reported, observer-reported); these are not for patient response but for tracking the portion of the patient population for which an entity has been able to collect data or the nature of the data collection.

2.b. Interim Methods for Race/Ethnicity Data when Direct Self-Reports are not Feasible

2.b.i. Challenges Faced by Health Plans

Because individuals receive most of their healthcare in the ambulatory setting, the greatest potential at this time for tracking healthcare disparities lies with health plans.[3] The ability to take a population-centered approach, in which enrollment in health plans clearly defines a group, will become increasingly important in our reformed health system. In fact, a survey conducted by America’s Health Insurance Plans (AHIP) found that health plan executives reported at least five reasons for collecting race/ethnicity data: 1) to identify enrollees at risk for certain medical conditions; 2) to support linguistically and culturally appropriate communications; 3) to structure quality improvement efforts in order to reduce disparities; 4) to assess variation in quality measures; and 5) to develop targeted disease management or similar

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[3] Most U.S. hospitals collect data on patients’ race or ethnic group, but few record this information systematically. Furthermore, the value of this data is limited since in the course of any given year only a small fraction of people are hospitalized. Many more people visit doctors, but very few physician practices collect race and ethnic data routinely. The reality is that most healthcare is provided in the ambulatory setting, and health insurers and payers, including Medicare, Medicaid, and commercial health plans, are the largest source of information.

programs.[33] However, health plans face sizeable barriers to obtaining self-reported race/ethnicity data:

1. Health plans have only sporadic direct contact with enrollees, principally at the time of enrollment. Since most individuals enroll in plans through their place of employment, employers provide one avenue for collecting race, ethnicity, and language need data. It is possible in principle for individuals to self-identify during open enrollment, but employers rarely use opportunity and are not required to do so.

2. Health plan enrollees may be reluctant to provide their race or ethnic background.[34]

3. Some states prohibit insurers from requesting such information from applicants at the time of enrollment to prevent the possibility of being denied access to insurance or certain services, a practice sometimes referred to as “redlining.”[23]

4. Even if they decide to collect the race/ethnicity data themselves, data-collection costs are high due to the costs of contacting patients.

5. Member turnover means that health plans need to update their files constantly.

Despite these obstacles, some health plans have actively begun to collect race/ethnicity from their members. This is attempted in a variety of ways, including by member self-identification through enrollment forms, incoming and outgoing customer service calls, disease/care/case management, health risk appraisals and health needs assessments, member surveys via providers or hospitals, Web portals, and interactive voice response surveying.[35]

However, even plans that have tried to collect race data after enrollment have had limited success. For example, after a decade of making direct reporting of race/ethnicity a priority, Aetna has collected these data for more than 60 million encounters and yet have self-reported data for only one-third of active members.[36] Among states, Massachusetts is one of only a few in the country to require self-reported race/ethnicity by health plans; but due to pressure from stakeholders, the state set a floor that requires reporting on only 5 percent of membership by 2012.[37] Thus, the majority of race/ethnicity fields in the submitted claims are empty.

2.b.ii. Indirect Estimation Methods

As an interim strategy, until a healthcare data infrastructure exists for routinely collecting and reporting race/ethnicity data, IOM recommends imputing information on race or ethnic background through indirect estimation.[23] The most common method uses geo-coded data from the U.S. Census to characterize people on the basis of their address or ZIP code as living in a high-, medium-, or low-minority area.

A second approach uses each person’s surname, along with Census information on the self-identification of people with that name. The U.S. Census Bureau created a new surname list based on data from the 2000 census that was far more detailed compared with prior lists.[38] The new list compared surnames shared by 100 or more individuals with self-reported race and ethnicity data. The enhanced list covers 151,671 people, or 89.8 percent of persons listed in the census. For each name, the lists provide the frequency of occurrence in *each* of six categories: (1) Hispanic, (2) White, (3) Black, (4) Asian and Pacific Islander, (5) American Indian/Alaska Native, and (6) Multiracial. Thus for each such name, one can calculate the probability of being in that self-reported category. Surnames are especially useful for identifying Hispanics and Asians, whereas "geocoding" is most useful for identifying blacks.

Combining geocoding and surnames can substantially increase imputation's accuracy. For example, someone named Smith living in an area with a high proportion of blacks is more likely to be black than someone named Smith living in a largely white community. The newer indirect methods do not assign a single race or ethnic background to any individual, instead estimating probabilities for each race or ethnic category.[39] The probabilities can then be "rolled up" to estimate racial distributions in populations or combined with utilization data to examine disparities in care. Used in this way, imputed data can reveal aggregate disparities with remarkable accuracy, achieving an average accuracy of 93 percent by the common "area under the ROC curve" (AUC) measure in a validation using nearly 2 million commercially insured beneficiaries.[39] RAND researchers compared indirect estimation with self-reports and were able to match within a percentage point or two the demographic characteristics of a population and measurements of healthcare disparities (see Table 1 and Table 2).[40]

Table 1. Comparing Population Estimates Using Self-Report vs RAND Indirect Estimation in Health Plan of 2 Million

	Hispanic	Asian	Black	White/Other
Self-Report	8.9	5.0	8.0	78.1
RAND	10.0	4.5	9.1	76.4

Source: Elliott, et al., 2008.[41]

Table 2. Comparing Disparities from Self-Report vs RAND Indirect Method in a Health Plan of 2 Million

(~30k Diabetics)	Racial Disparity (White vs Black)	
	Direct Method	Indirect Method
B-Blocker	22.7	23.1
HgbA1c	14.5	14.5
Lipids	21.6	21.3
Eye Exam	7.6	7.4

Source: Fremont, et al., 2005.[40]

The indirect method of race/ethnicity estimation is not without its critics. For example, its reliance on housing segregation to maximize its predictive power makes some potential users uncomfortable and, of course, makes it less useful in highly integrated communities. Further, it lacks precision for American Indians and Alaska natives and multiracial groups, and, as currently implemented, it is unable to distinguish sub-ethnic groups such as Haitians among the black population or Vietnamese among Asians. Thus, it might not be useful for organizations serving increasingly diverse populations. Finally, the method is best applied in the aggregate and never should be used to make clinical decisions for individuals.

Despite these reservations, experts now suggest that until self-reported data on race/ethnicity become feasible on a broad scale, implementing indirect estimation methods by insurance plans would provide an unprecedented opportunity to populate vast quantities of health-claims records with racial and ethnic information.[42]

Recommendation: Directly reported race/ethnicity and language (self-identified) is the preferred method for data collection. Efforts should be taken to solidify and support the infrastructure for race, ethnicity, and language proficiency data collection from patients/members within all healthcare settings. There is clear guidance from IOM/NQF/HRET that should be followed for self-reports (the gold standard). Where not feasible in the short term, indirect estimation can be put into place immediately.

2.c. Looking Toward the Future

The capacity for disparities measurement hinges on the effective collection of patient race, ethnicity, and language data. Aside from public health bodies that collect vital statistics, the data providing the ability to link health data to patients’ race, ethnicity, or linguistic proficiency for measurement purposes are collected haphazardly and are not routinely available.

There are, however, several key considerations for the future that are relevant to these efforts:

- Looking ahead, information infrastructure may enable integrated data exchange so that all entities will not need to collect all data. For now, however, all health and healthcare entities have roles to play in collecting these data directly from individuals.

- Some electronic data collection systems may evolve and be more sophisticated, allowing the use of keystroke recognition to accommodate hundreds races/ethnicities and languages.

- The American Recovery and Reinvestment Act of 2009’s (ARRA) goal of having a national electronic health record (EHR) for each individual by 2014 that incorporates collection of data on the person’s race, ethnicity, and primary language, will foster efforts of data collection and disparities measurement.

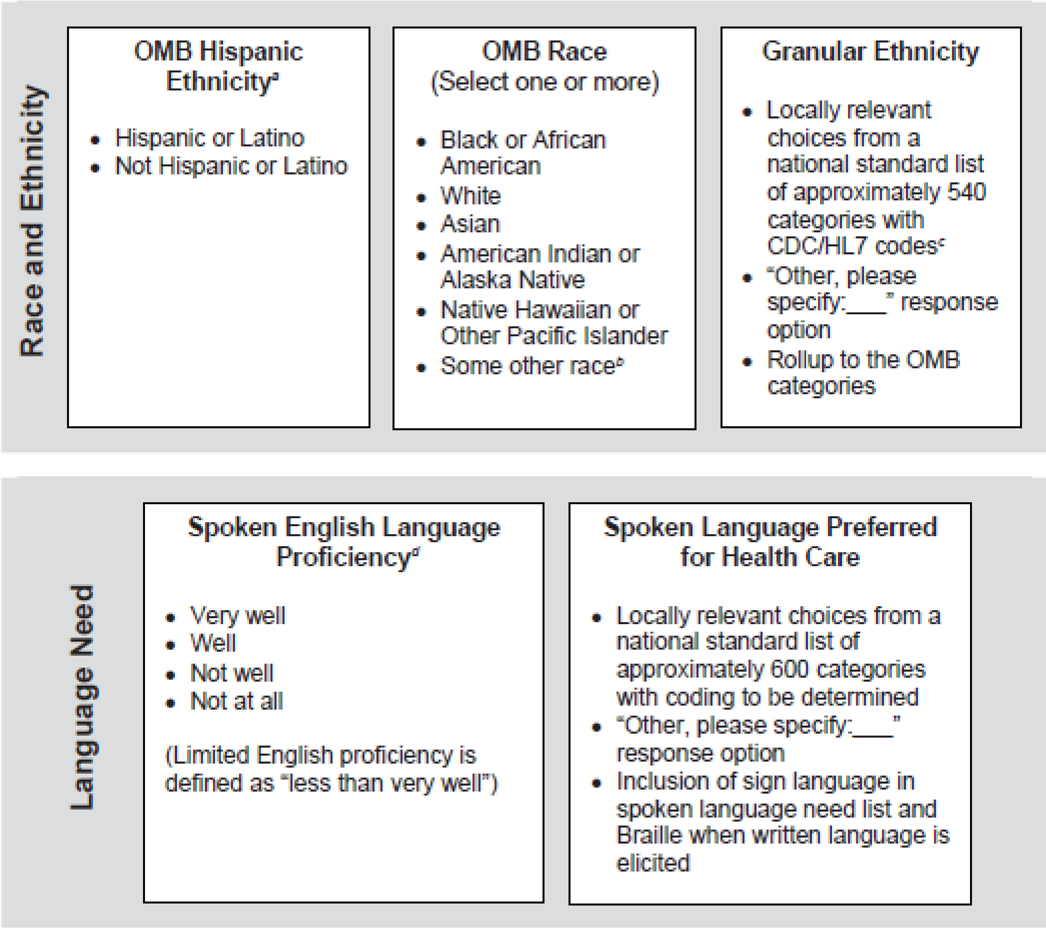
- To be eligible for meaningful use incentives related to EHRs, the Health Information Technology for Economic and Clinical Health Act (HITECH) requires physicians to record race or ethnic background for at least half their patients.

- The Patient Protection and Affordable Care Act (PPACA) includes provisions requiring race and ethnicity to be collected for selected federal programs including population surveys, Medicaid, and the Children's Health Insurance Program.

- Differential adoption and slow diffusion of health IT may lead to a "digital divide" that could impact disparities data collection, measurement, and reduction. For example, providers who cared for uninsured and Medicaid black and Hispanic patients had 12 percent to 36 percent lower odds of using electronic health records than privately insured non-Hispanic white patients.[43] In addition, federally qualified health centers with high rates of uninsured patients had 47 percent lower odds of EHR adoption.[44] Hospitals that disproportionately care for the poor (defined by a hospital's Medicare disproportionate-share hospital [DSH] index) have slightly lower rates of adoption of either basic or comprehensive EHR compared to low-DSH-index hospitals.[45]

In summary, race, ethnicity, and language proficiency, data collection serves as the foundation for disparities measurement, and the field is rapidly evolving. Key lessons from the field as well as legislative efforts should facilitate advances in this area.

Figure 1. IOM Recommended Categories



Race and Ethnicity

OMB Hispanic Ethnicity[a]

- Hispanic or Latino
- Not Hispanic or Latino

OMB Race (Select one or more)

- Black or African American
- White
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Some other race[b]

Granular Ethnicity

- Locally relevant choices from a national standard list of approximately 540 categories with CDC/HL7 codes[c]
- "Other, please specify:___" response option
- Rollup to the OMB categories

Language Need

Spoken English Language Proficiency[d]

- Very well
- Well
- Not well
- Not at all

(Limited English proficiency is defined as "less than very well")

Spoken Language Preferred for Health Care

- Locally relevant choices from a national standard list of approximately 600 categories with coding to be determined
- "Other, please specify:___" response option
- Inclusion of sign language in spoken language need list and Braille when written language is elicited

FIGURE S-1 Recommended variables for standardized collection of race, ethnicity, and language need.

NOTE: Additional categories for HIT tracking might include whether respondents have not yet responded (unavailable), refuse to answer (declined), or do not know (unknown), as well as whether responses are self-reported or observer-reported.

[a] The preferred order of questioning is Hispanic ethnicity first, followed by race, as OMB recommends, and then granular ethnicity.

[b] The U.S. Census Bureau received OMB permission to add "Some other race" to the standard OMB categories in Census 2000 and subsequent Census collections.

[c] Additional codes will be needed for categories added to the CDC/HL7 list.

[d] Need is determined on the basis of two questions, with asking about proficiency first. Limited English proficiency is defined for health care purposes as speaking English less than very well.

SOURCES: CDC, 2000; Office of Management and Budget, 1997b; Shin and Bruno, 2003; U.S. Census Bureau, 2002.

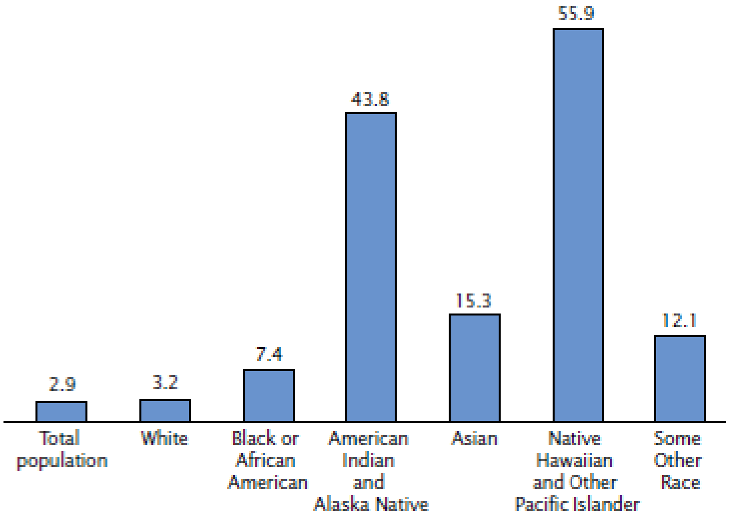
© IOM, 2009.

Figure 2. Persons Reporting Multiple Races

Figure 2.

Percentage of Major Race Groups Reporting Multiple Races: 2010

(For more information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/pl94-171.pdf*)



Note: Specified race group refers to the alone or in-combination population.
Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

Figure 3. Distribution of Multiple Races

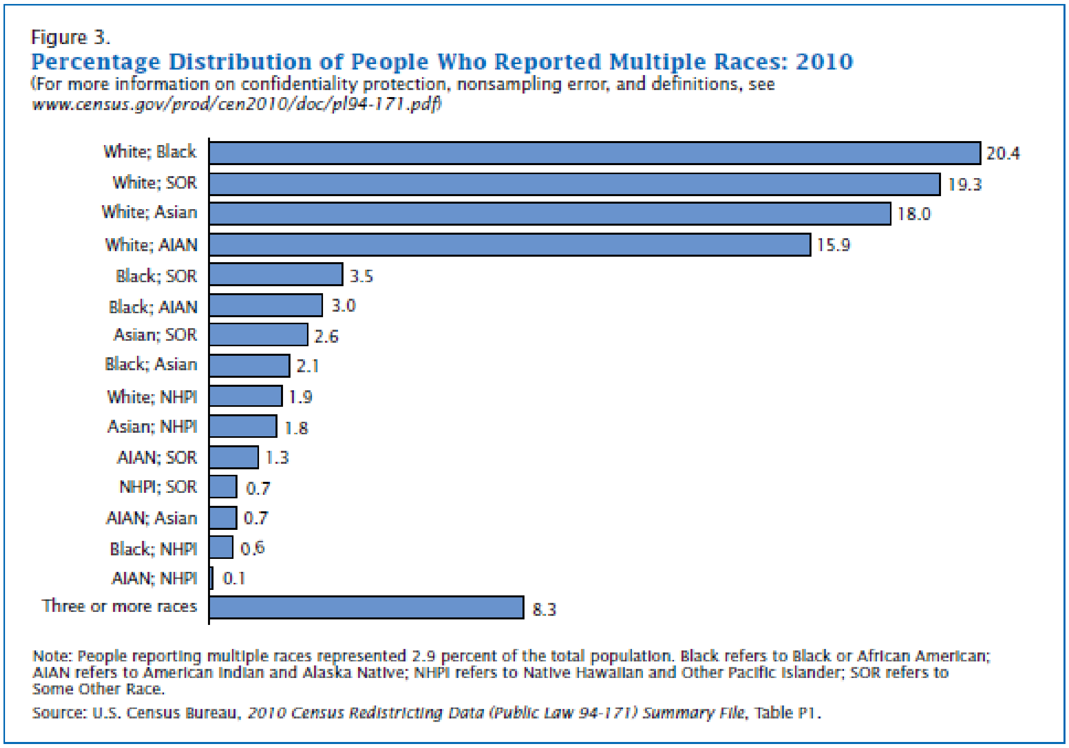


Figure 3.
Percentage Distribution of People Who Reported Multiple Races: 2010
(For more information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/pl94-171.pdf*)

Note: People reporting multiple races represented 2.9 percent of the total population. Black refers to Black or African American; AIAN refers to American Indian and Alaska Native; NHPI refers to Native Hawaiian and Other Pacific Islander; SOR refers to Some Other Race.

Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

3. Disparities Measures and Indicators: What to Measure?

NQF has previously developed a set of criteria to determine whether a quality measure would qualify as "disparities sensitive." Disparities-sensitive measures are those that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (race/ethnicity, language, etc.). In this chapter we will review existing NQF criteria for disparities sensitivity and provide some additional perspective on them. We also will recommend a new set of criteria and ways of categorizing measures with respect to disparities sensitivity. We present a system for categorizing and characterizing the mechanisms behind selected disparities-sensitive measures and end by discussing possible approaches to the creation of developmental (new) measures for disparities when the need exists. The algorithm for this process can be found in Figure 5.

3.a. Criteria for Disparities-Sensitive Measure Selection Among the NQF Portfolio of Endorsed Standards and Measures

The NQF portfolio of endorsed standards and measures includes more than 700 performance measures of quality of care for both ambulatory and institution-based settings, including disease specific measures and cross-cutting measures that apply across disease areas.[4] None of these measures was designed specifically with the idea of detecting disparities in care by race/ethnicity or language. However, as a broad assessment of quality of care, it is reasonable to assume that some of these measures would be more sensitive to disparities in care than others. We envision identifying current and potential disparities sensitive measures as a three-step process, which we now describe.

3.a.i. Step 1: Assess the Portfolio of NQF Performance Measures Using Disparities-Sensitive Principles, with Special Emphasis on Quality Gap and Prevalence

Step 1a: All existing performance measures should be evaluated against the guiding principles established by the NQF Steering Committee and TAP that produced the report on consensus standards in 2008.[20] The guiding principles are:

1. Prevalence—How prevalent is the condition among minority populations?
2. Impact of the Condition—What is the impact of the condition on the health of the disparity population?
3. Impact of the Quality Process—How strong is the evidence linking improvement in the measure to improved outcomes in the disparity population?
4. Quality Gap—How large is the gap in quality between the disparity population and the group with the highest quality for that measure?
5. Ease and Feasibility of Improving the Quality Process (Actionable)—Is the measure actionable among the disparity population?

In reviewing these principles, however, two of the five listed above are particularly useful for distinguishing measures as disparities sensitive: Quality Gap and Prevalence. The other principles are less precisely evaluated, and it is not well known whether evidence is available to apply these principles specifically to minority populations.

The most important of these two is Quality Gap. This criterion essentially means that if there is evidence showing a difference in the quality of care by race/ethnicity or language, it should be considered disparities sensitive. The other criterion that we consider particularly relevant is Prevalence. To achieve NQF endorsement, it is assumed that a measure should demonstrate sufficient prevalence to merit consideration. There are no instances of rare diseases or conditions that relate to the approximately 700 NQF-endorsed measures. However, prevalence also is an important criterion for disparities sensitivity because measures for diseases that are more prevalent in minority communities—such as end-stage renal disease, diabetes, and congestive heart failure—may allow for the detection of disparities even when no data demonstrating disparities currently exist.

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[4] NQF measures are all evaluated with a set of standard criteria before being listed (http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/Measure_Evaluation_Criteria.aspx). The criteria described in this report refer to those that might be applied to select disparities-sensitive measures.

Step 1-b: We recommend that all of the NQF measures should be compared with the literature on known areas of disparities, beginning with AHRQ's National Healthcare Disparities and Quality Report, the Institute of Medicine's *Unequal Treatment Report*,[1] and then a new review of the disparities literature since the publication of *Unequal Treatment*. All NQF measures that can be matched (at least partially if not identically) to disparities that have been documented in at least one of the sources mentioned should be considered as candidates for disparities sensitive measures. Appendix I contains an example of a table of some measures that are compared with AHRQ's National Healthcare Disparities and Quality Report. In addition, these measures can be categorized further according to the described scheme at the end of this chapter.

3.a.ii. Step 2: Apply New Criteria for Disparities Sensitivity

It seems fairly clear that the best criterion to use to determine whether a quality measure is disparities sensitive is the existence of known disparities using the same or a similar measure. When the NQF does not have access to performance data stratified by race/ethnicity, or when known disparities do not exist, a set of additional criteria can be applied to determine potential disparities sensitive measures. [1] These include the following:

- **Care with a High Degree of Discretion:** Many of the disparities described depend on a certain degree of discretion on the part of the clinician.[47] The less there is a standard protocol that must be followed, the easier it is for a clinician to offer a procedure differently based on the patient's socio-demographic characteristics (whether or not this is consciously factored into the decision). This tends to impact the utilization of high-cost procedures, referral for specialty care, newly emerging technologies, and other "high-end" aspects of care. However, there are other areas where discretion is important. For example, pain is very subjective, and the decision to prescribe medications to control a patient's pain is full of nuance and subtle cues that could be related to stereotype—race/ethnicity, socioeconomic status, language, etc.

- **Communication-Sensitive Services:** When receiving care depends to a great extent on providers and patients communicating well, disparities are likely to occur given the challenges to communication across cultures. For example, studies have shown that many of the core hospitals quality measures (such as aspirin at arrival and discharge or oxygenation assessment) reveal very similar performance between minority and majority populations, partly due to the fact that performance on these measures is generally high. On the other hand, measures that required communication with patients (such as receipt of smoking cessation counseling or discharge instructions) where language or cultural barriers may come into play exhibited larger and statistically significant disparities.[48, 49]

- **Social Determinant-Dependent Measures:** Disparities often are seen in areas that depend to a large extent on patient self-management (e.g., diet, exercise, and medication adherence for diabetes or congestive heart failure management). Social determinants, such as low socioeconomic status, education level, and environment, can present barriers to health-related changes in lifestyle, which are challenging for all patients, but especially for those who are disproportionately affected by these challenges—which we know minorities are.

- **Outcomes Rather than Process Measures:** Many process measures are relatively straightforward and less likely to be influenced by subjective factors or patient factors that can lead to disparities. For example, prescribing beta-blocker after a myocardial infarction has now achieved very high rates of success in most organizations and rarely shows disparities. This is largely because processes are standardized and patients do not hold particular beliefs or concerns about standard medications such as these. However, in a situation such as the provision of flu shots, although standard processes may be put in place, patient preferences based on beliefs or concerns about this particular intervention may make this a disparities-sensitive measure (insomuch as minority patients have specific concerns about some interventions or medications over others).

These four areas overlap significantly. For example, readmission rates depend to a large extent on both communication and lifestyle changes, as do diabetes outcomes measures. We recommend that all the current measures as well as newly proposed measures be reviewed in the context of these four disparities-sensitive criteria. While no one of these automatically qualifies a measure for disparities sensitivity, they all can provide some rough guidance when solid data on disparities do not yet exist.

3.b. Categories and Characteristics of Disparities-Sensitive Measures

In reviewing the NQF-endorsed standards for sensitivity to disparities, we identified six different types of disparities-sensitive measures. These are described below, and examples are provided. Our recommendation is that a full set of NQF-endorsed measures should be analyzed according to this system of categorization, not as a way of determining disparities sensitivity, but rather, as a way of understanding the range of measures used to identify disparities.

After assigning a measure to a category, each measure should be further assessed according the following characteristics: 1) whether it is condition specific (CS) or cross-cutting (CC); 2) whether the mechanisms of the disparities are provider-based, patient-based, system-based, or related to health insurance; and 3) whether it is a measure of structure, process, or outcome (based on Donabedian's classification system).[2] Appendix II contains an additional sample table of NQF Endorsed Measures for Sensitivity to Disparities catalogued using the above three characteristics. Each measure is numbered according to the official NQF-Endorsed Standard listing (www.qualityforum.org/Measures_list.aspx).

3.b.i. Practitioner Performance Measures

These are the measures that assess practitioners' performance and their adherence to prescribed screenings and healthcare that is consistent with national evidence-based clinical standards. Areas of performance that are assessed include screening, treatment, and follow-up. Generally, practitioner performance measures are condition specific. The following are examples of such disparities-sensitive measures and their characteristics (see Table 3):

Table 3. Practitioner Performance Measure

NQF Number	Name	Type of Measure—Condition Specific (CS) or Cross-Cutting (CC)	Root of Potential Disparity—Provider (PB), Patient (PtB), Systemic, or Health Insurance	Donabedian Category—Structural (S), Process (P), Outcome (O)
1	Asthma Assessment	CS	PB	P
2	Appropriate testing for Children with Pharyngitis	CS	PB	P
3	Bipolar Dis: DM Assessment	CS	PB or PtB	P
4	Alcohol, Drug Treatment (Initiation, Engagement)	CS	PB or PtB	P
12	HIV Prenatal Screening	CS	PB or PtB or Systemic	O
61	BP Measurement	CS	PB or PtB or Systemic or Insurance	O
Other examples of this type of measure are: #14 – 112, #568, 569, #579-587, #593 – 637, #650 – 659.				

3.b.ii. Consumer Surveys that Measure the Patient Experience

Consumer surveys are disparity-sensitive tools. Generally, consumer surveys are cross-cutting and provide a type of outcome measure, according to Donabedian's classification. Within the consumer surveys, those question that deal with communication are the most likely to be disparities sensitive. The following are examples within the universe of NQF-endorsed measures (see Table 4):

Table 4. Consumer Surveys that Measure the Patient Experience

NQF Number	Name	Type of Measure	Root of Potential	Donabedian Category—

		Condition—Specific (CS) or Cross-Cutting (CC)	Disparity—Provider (PB), Patient (PtB), Systemic, or Health Insurance	Structural (S), Process (P), Outcome (O)
5	CAHPS (B): Clinician/Group Surveys (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	CS	PB or PtB or Systemic	O
6	CAHPS (C): CAHPS Health Plan Survey v 4.0—Adult Questionnaire	CS	PB or PtB or Systemic	O
8	Experience of Care and Health Outcomes (ECHO) Survey (Behavioral Health, Managed Care Versions)	CS	PB or PtB or Systemic	O
9	CAHPS (D): Health Plan Survey v 3.0 Children with Chronic Conditions Supplement	CS	PB or PtB or Systemic	O
10	YAHCS: Young Adult Health Care Survey	CS	PB or PtB or Systemic	O
11	PHDS: Promoting Healthy Development Survey	CS	PB or PtB or Systemic	O
Other examples include: #166, #258, #517, #691 – 693, #726.				

3.b.iii. Hospital, Ambulatory Care Center, Home Health Nursing Home Performance Measures

These types of measures assess the performance of a particular health facility. Generally, quality standards are fairly even within systems of care, and disparities are not detected. Some institutions could be poorly performing, or they could be High-Performing Hospitals, as measured by CMS, or Patient-Centered Medical Homes, as designated by National Committee for Quality Assurance (NCQA). The level and quality of care within such facilities may compare favorably or unfavorably with their peers; however, disparities within the institution disparities may be less evident.

Some examples are below (Table 5):

Table 5. Hospital, Ambulatory Care Center, Home Health Nurse Home Performance Measures

NQF Number	Name	Type of Measure—Condition Specific (CS) or	Root of Potential Disparity—Provider (PB), Patient (PtB),	Donabedian Category—Structural (S), Process (P), Outcome (O)

		Cross-Cutting (CC)	Systemic, or Health Insurance	
119	Risk-Adjusted Mortality for CABG	CS	PB or PtB or Systemic	O
124	Annual Procedure Volume for CABG, Valve or Combined Surgeries	CS	PB or PtB or Systemic	O
130	Deep Sternal Wounds	CS	PB or PtB or Systemic	O
Other examples of this type of measure include: #286 – 304, #318 – 324, #334 – 376, #450 – 487, #495 – 497 (ED Performance), #530 – 532 (AHRQ Composite Measures), #640 – 649, #694 – 709.				

3.b.iv. Measures of Ambulatory Care Sensitive Conditions and Management

Community level data that can point to population-based disparities are available. Fourteen AHRQ Prevention Quality Indicators (PQIs) were included as part of the NQF Ambulatory Care Disparities report. The AHRQ PQIs measure potentially avoidable hospitalizations for ambulatory care-sensitive conditions. The indicators rely on hospital discharge data and are intended to reflect issues of access to high-quality ambulatory care (see Table 6).[20]

Table 6. Measures of Ambulatory Care-Sensitive Conditions Management

NQF Number	Name	Type of Measure—Condition Specific (CS) or Cross-Cutting (CC)	Root of Potential Disparity—Provider (PB), Patient (PtB), Systemic, or Health Insurance	Donabedian Category—Structural (S), Process (P), Outcome (O)
272	Diabetes, short-term complications (PQI 1)	CS	PB or PtB or Systemic	O
638	Uncontrolled Diabetes Admission Rate (PQI 14)	CS	PB or PtB or Systemic	O

3.b.v. Measures Associated with Cultural Competency

A number of the NQF-endorsed measures may be associated with issues of culture, language, and health literacy. Examples of these include the Home Health measures #175 – 181; assessment of post-stroke communication capabilities #445 – 449.

All measures that deal with patient readmissions are disparities sensitive because of the crucial importance of patient communication in transitions of care. This is noted in measure #506

(30-day pneumonia readmission) and #505 (30-day MI readmission), as well as #541-547 (Medication management).

Measures of Depression assessment (#518, 710-712) and patient education (#519, 520, 136—Detailed heart failure discharge instructions) are also disparities sensitive and related to cultural competency (see Table 7).

Table 7. Measures Associated with Cultural Competency

NQF Number	Name	Type of Measure—Condition Specific (CS) or Cross-Cutting (CC)	Root of Potential Disparity—Provider (PB), Patient (PtB), Systemic, or Health Insurance	Donabedian Category—Structural (S), Process (P), Outcome (O)
176	Improvement in Management of Oral Medications	CS	PB or PtB or Systemic	O
445	Functional Communication Measure: Spoken Language Comprehension	CS	PB or PtB or Systemic	O
506	Thirty-Day All-Cause Risk Standardized Readmission Rate Following Pneumonia Hospitalization	CS	PB or PtB or Systemic	O
542	Adherence to Chronic Medication	CS	PB or PtB, Systemic or Insurance	O
518	Depression Assessment Conducted	CS	PB or PtB or Systemic	PM
520	Drug Education on All Medications Provided to Patient/Caregiver During Episode	CS	PB or PtB or Systemic	O
Home health measures #175 – 181; assessment of post stroke communication capabilities #445 – 449, #506 (30 day pneumonia readmission) and #505 (30 day MI readmission) as well as #541-547 (Medication Management); measure of depression assessment (#518, #710 - 712) and patient education (#519, 520, 136).				

3.b.vi. Patient-Centered Measures

Generally, patient-centered measures are cross-cutting. They may be structural, process, or outcome measures according to the Donabedian classification. The field of patient-reported outcomes measures is growing rapidly and is likely to be a major opportunity for disparities measurement in the future. Examples of patient-centered measures are below (see Table 8):

Table 8. Patient-Centered Measures

NQF Number	Name	Type of Measure—Condition Specific (CS) or Cross-Cutting (CC)	Root of Potential Disparity—Provider (PB), Patient (PtB), Systemic, or Health Insurance	Donabedian Category—Structural (S), Process (P), Outcome (O)
717	Children School Days Missed	CS	PtB, Sytemic, Insurance	O
718	Children Obtaining Referrals	CC	PtB, Systemic, Insurance	O
719	Children Get Effective Care Coordination	CC	PB, PtB, Systemic, Insurance	O
720	Children Live in Safe Communities	CC	Structural	O
721	Safe School	CC	Structural	O

3.c. Step 3: Developing New Disparities Specific Measures

While NQF measures, HEDIS measures, and hospital core measures provide a solid foundation for measuring disparities in quality broadly speaking, they may miss out on important phenomena. In general, quality measures are not developed specifically with the idea of identifying disparities. The disparities literature includes hundreds of studies documenting disparities in screening measures, surgical procedure utilization, diabetes outcomes, transplantation, pain management, and many other areas by race, ethnicity, and other sociodemographic characteristics.[1] Most do not appear as NQF measures (or other standard quality measures) and were not intended to be quality measures. The disparities literature is wide-ranging, but some of the most important disparities are in specific disease areas or procedures where sample sizes within organizations are relatively small, such as renal transplantation rates. These would not typically be used as a measure of quality, yet we know that African Americans are less likely to receive renal transplants while waiting longer on dialysis than their white counterparts. In this section we describe two approaches to identifying potential new disparities-sensitive quality measures: 1) disparities-specific measures that draw upon known or suspected disparities from the academic literature but for which no current performance measures exist, and 2) consideration of additional measures along the clinical pathway.

3.c.i. Disparities-Specific Measures

The term *disparities-specific measures* distinguish these as new measures that are created specifically as indicators of the existence of disparities in particular areas of care where research has shown disparities to exist. These are distinguished from *disparities-sensitive* measures, a term that includes any current quality measure in which disparities have already been identified. Disparities-specific measures would thus play the role of making healthcare organizations aware of disparities that may exist even though they may not be apparent when using standard quality indicators. These measures can be developed based on a review of the disparities literature, cross-walking this with the existing NQF measures to ensure that no current measure exists, and developing a new disparities-specific measure. For example, there is a abundant literature that demonstrates disparities in pain management for long bong fractures in the emergency department (minorities receiving significantly less pain medication for the same exact fracture as their white counterparts).[53] Currently, there is no off-the-shelf measure that allows organizations to determine if there are differences in pain management by race/ethnicity in patients who present to the emergency department with long bong fracture. As such, Massachusetts General Hospital went about developing a new disparities-specific measure to measure and monitor pain management routinely by race/ethnicity. This would be considered a disparities-specific measure. Other areas where disparities specific measures might be developed include cardiac catheterization rates,[51,52] amputation rates for peripheral vascular disease, referral for renal transplantation, and stage at initial diagnosis of prostate cancer.[54, 55]

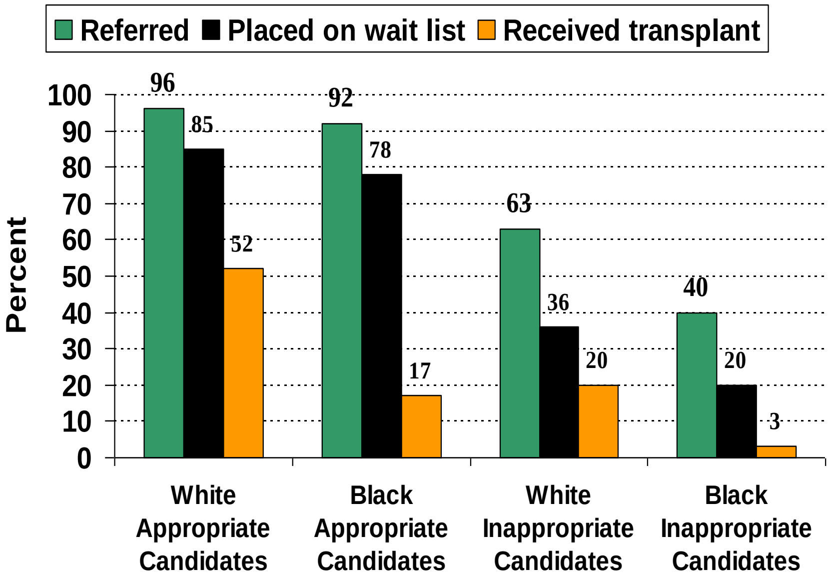
3.c.ii. Disparities that may Occur Along the Clinical Pathway

Another option for identifying new disparities-sensitive measures is to search for processes or services that occur at various points along the clinical pathway. Optimal outcomes often depend on a series of interventions, each of which may pose barriers to disadvantaged patients. Measuring performance at only one point may miss important sources of disparities. A case in point is renal transplantation, which is particularly exasperating because disparities have been known for more than 20 years. The endpoint—a new kidney—is essentially a zero-sum game because kidneys are a limited and scarce resource. Obtaining a kidney transplant requires attaining a number of services, including initial referral to a specialist, clinical work-up, referral to the wait list, registration, matching the criteria, understanding and adhering to procedures around the offer and acceptance, and the transplantation itself. Although the problem of latent racism may exist (minorities in the past were seen as inferior candidates compared with whites[56]) in fact, differences in rates can be identified at many key steps along the clinical pathway (see Figure 4).[57]

A related concern is the possibility that focusing on disparities in utilization may inadequately describe the appropriateness of that utilization. "Differences" in procedure rates, for example, may reflect one or more of the following phenomena: 1) differences in clinical appropriateness (presenting condition); 2) underuse (defined as lower use, even when clinically appropriate or necessary); or, 3) overuse (defined as more frequent use, even when the risks outweigh the benefits). Research on access to cardiac surgery demonstrates that all three phenomena may be involved in explaining differences in use rates—higher rates of clinical appropriateness among whites, greater underuse among blacks, and greater likelihood of revascularization among whites when it is not clinically appropriate.[52, 58]

The implication of these studies for quality measurement is that improving access at only one or two points along the way is unlikely to eliminate the disparities in "things that matter." For example, for renal transplantation, disparities in receipt of a transplant can occur because of failure to refer to a transplant nephrologist, failure to place the patient on the renal transplant list, or failure to receive the transplant. We recommend that disparities measures represent a complete and comprehensive view of care, not just one point along the clinical pathway.

Figure 4. Access to Renal Transplantation



Epstein AM, et al. Racial disparities in access to renal transplantation: Clinically appropriate or due to underuse or overuse, *NEJM* 2000;343:1537-44.

Source: Epstein, et al., 2000.[57]

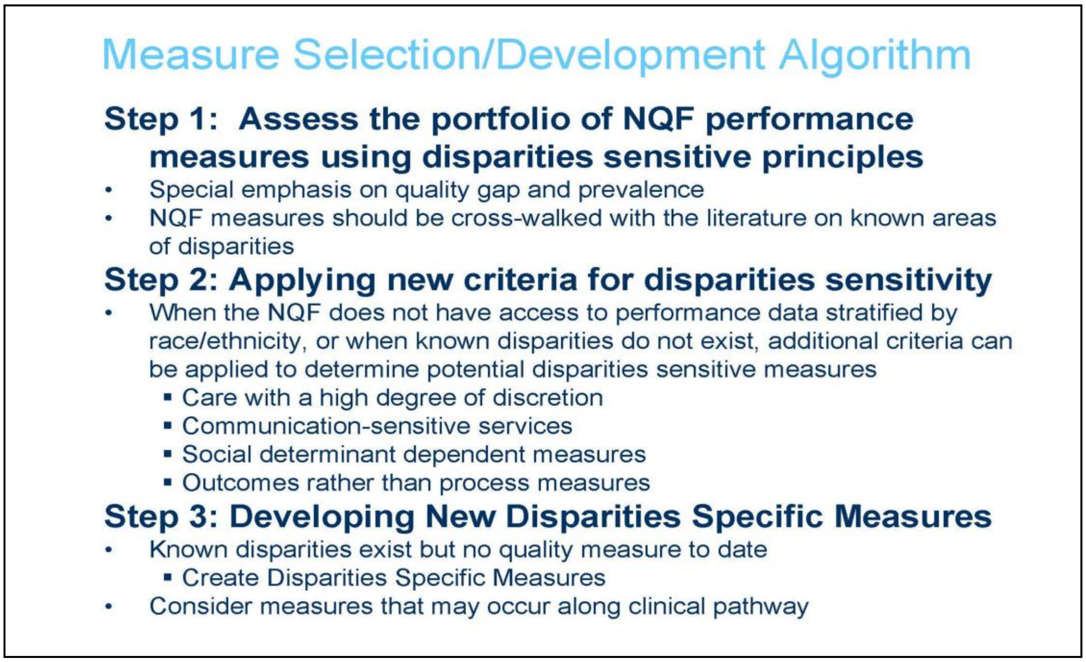
Rates adjusted for age, region, primary cause of renal failure, education, income, overall health status, patients' preferences, distance to nearest transplantation facility

3.c.iii. Summary and Recommendations

In summary, the peer-reviewed literature may contain the seeds of new disparities-specific measure development. In 2006 a study published in the *New England Journal of Medicine* examined 439 quality indicators for 30 chronic and acute conditions and for disease prevention among randomly selected patients from 12 communities around the United States.[50] The goal was to determine where disparities by race/ethnicity existed and the magnitude of these disparities compared to overall levels of quality when benchmarked against national standards. The findings were surprising because the variation in quality-of-care scores according to this set of indicators was very small across racial/ethnic groups compared to the gaps between observed and desired quality across all groups. Initially, it was difficult to reconcile this with the abundant literature on disparities. However, when the authors confined their quality measures to those that had known disparities in the literature, they confirmed that disparities existed in their data as well. Disparities-specific measures might emerge from services that reflect provider biases against certain groups (conscious or unconscious), poor communication across cultures, mistrust, language barriers, and ineffective systems of care, among other factors.

Finally, our recommendation also includes tracking the progress of the National Priorities Partnership (NPP) and NQF's Measure Applications Partnership (MAP) because any effort in disparities measurement should be synchronized with their work whenever possible. Priorities that NPP has targeted for improvement are proven ways to eliminate harm, waste, and disparities, including action in the areas of payment, public reporting, quality improvement, and consumer engagement. MAP will provide direction and direct input to HHS on preliminarily identified performance measures available for benchmarking and improvement purposes, and will advise on measures needed for specific care settings, care providers, and patient populations. These priorities and goals provide opportunities for immediate action and measurement and include measures such as preventable re-admission and equitable access to care, which can be included in disparities-sensitive measures.

Figure 5. Measure Selection/Development Algorithm



Measure Selection/Development Algorithm

Step 1: Assess the portfolio of NQF performance measures using disparities sensitive principles

- Special emphasis on quality gap and prevalence
- NQF measures should be cross-walked with the literature on known areas of disparities

Step 2: Applying new criteria for disparities sensitivity

- When the NQF does not have access to performance data stratified by race/ethnicity, or when known disparities do not exist, additional criteria can be applied to determine potential disparities sensitive measures
  - Care with a high degree of discretion
  - Communication-sensitive services
  - Social determinant dependent measures
  - Outcomes rather than process measures

Step 3: Developing New Disparities Specific Measures

- Known disparities exist but no quality measure to date
  - Create Disparities Specific Measures
- Consider measures that may occur along clinical pathway

4. Methodological Approaches to Disparities Measurement: How to Measure and Monitor

4.a. Overview

The goal of eliminating health disparities can be achieved only if indicators of interest are monitored and disparities recorded. Progress toward reducing disparities means that indicators are measured over time. This section will provide an in-depth discussion of methodological approaches to disparities measurement, including statistical and technical considerations of disparities measurement, highlighting strengths and weaknesses of the different approaches.

Measuring disparities is essentially an exercise in arithmetic, usually comparing indicators of health status or quality of care (performance) among two or more groups of interest. Indicators are usually measured in terms of rates, percents, proportions, or means for each group in a "domain." A domain is defined as "a set of groups defined in terms of a specific characteristic of persons in a population."[60] For example, the race domain according to OMB consists of Black or African American, White, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. Disparities become evident when quantitative measures of health or measures of health quality (rates, percents, etc.) differ among groups in a domain. However, what may seem straightforward in fact has a number of pitfalls. In the calculation of disparities there are several considerations that must be addressed. These issues are discussed below.

4.b. Reference Points

A *reference point* is "the specific value of a rate, percent, proportion, mean, or other quantitative measure relative to which a disparity is measured."[60] Disparities frequently are measured among groups in a domain.[5] From a purely statistical point of view, any one of the groups in a domain could be chosen as a reference point. For example, the largest group might be selected because its rate is usually the most stable. Thus if in some localities a "minority-majority" exists, the minority population would be the reference group. Alternatively, one might select the group with the best rate or highest-quality performance because this represents a realistic attainment. In addition, choosing the group with the best performance ensures that all of the differences with the other groups will be positive and have ratios greater than 1.

A disadvantage of using the largest group or the best-performing group is that the reference point may change over time. Furthermore, using a method that ignores a priori evidence of social disadvantage could lead to policies that redirect resources toward more privileged populations.[61] In this white paper we follow the argument proffered by Braveman,

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[5] Disparities also can be measured from a reference point that is not a group characteristic. For example, one could compare each group against the unweighted mean of all the groups in the domain, or to a benchmark or goals. The goal (e.g., from Healthy People reports) has intuitive appeal because it implies that all groups could improve. However, in this paper we have chosen to concentrate on differences between groups.

who defines disparities as "…potentially avoidable differences in health (or in health risks that policy can influence) between groups of people who are more and less advantaged socially."[61] Therefore,

> **Recommendation: In this report, we believe that for purposes of achieving equity in healthcare that is fair and just, the chosen reference group should always be the historically advantaged group.**

4.c. Absolute versus Relative Disparities, and Favorable versus Adverse Measures

While calculations of disparities can be straightforward, comparisons of disparities among entities or over time can be sensitive to the calculations chosen. The simplest measure of disparity is the absolute or simple difference, that is, the arithmetic difference between two rates, expressed in the same units as the rates themselves:

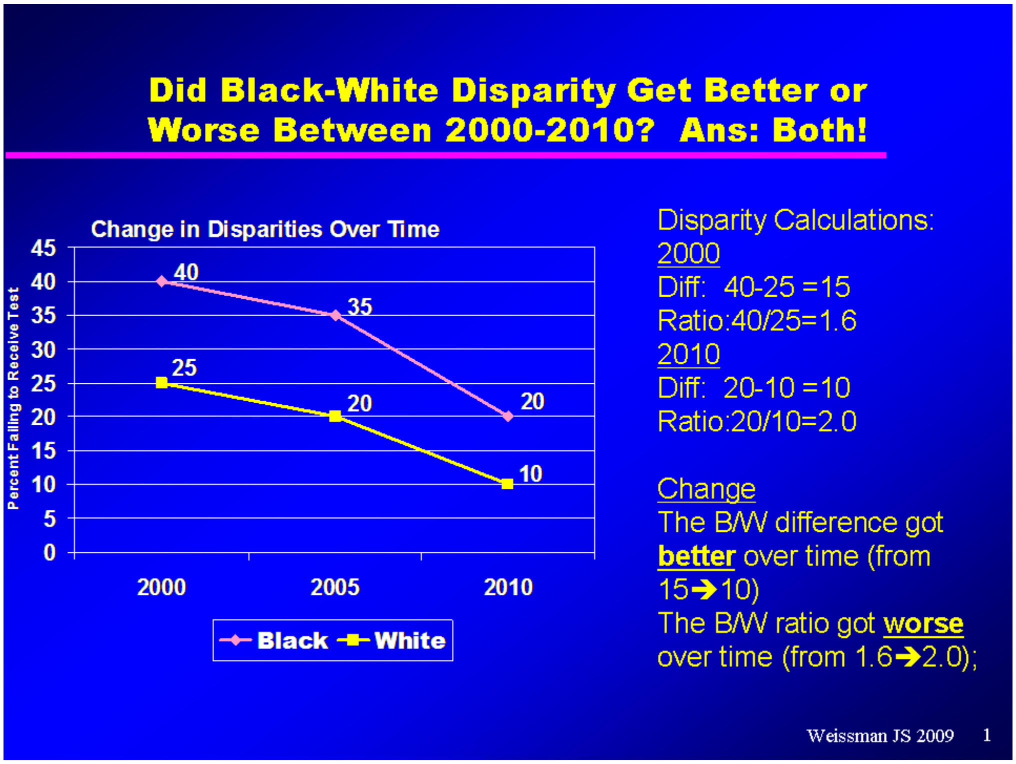
Simple difference = rate of reference group – rate of group of interest

Another straightforward approach is to calculate the relative measure of disparity, usually expressed as the simple difference from the reference point (or group) as a percentage of the reference point:

$$\text{Relative disparity} = \frac{\text{(rate of interest–reference point rate)}}{\text{reference point rate}} \times 100$$

For any given domain, the "direction" of the disparity will always be the same whether one chooses absolute or relative measures. In other words, if the absolute difference is greater than zero, then the relative difference will always be greater than one (1). Many analysts focus on the relative rate because it has an intuitive connection with the idea of equality.[62] However, making comparisons across time or geography or institutions can result in different interpretations, partly because a change in disparities is a "difference in differences" problem. A simple example illustrates this. In Figure 6 the percentage of blacks and whites failing to receive the indicated test decreases over time from 40 to 20, and 25 to 10, respectively. The absolute disparity improved (decreasing from 15 to 10), while the relative worsened (increasing from 1.6 to 2.0).

Figure 6. Percentage of Blacks and Whites Failing to Receive Test



Did Black-White Disparity Get Better or Worse Between 2000-2010? Ans: Both!

Disparity Calculations:
2000
Diff: 40-25 =15
Ratio:40/25=1.6
2010
Diff: 20-10 =10
Ratio:20/10=2.0

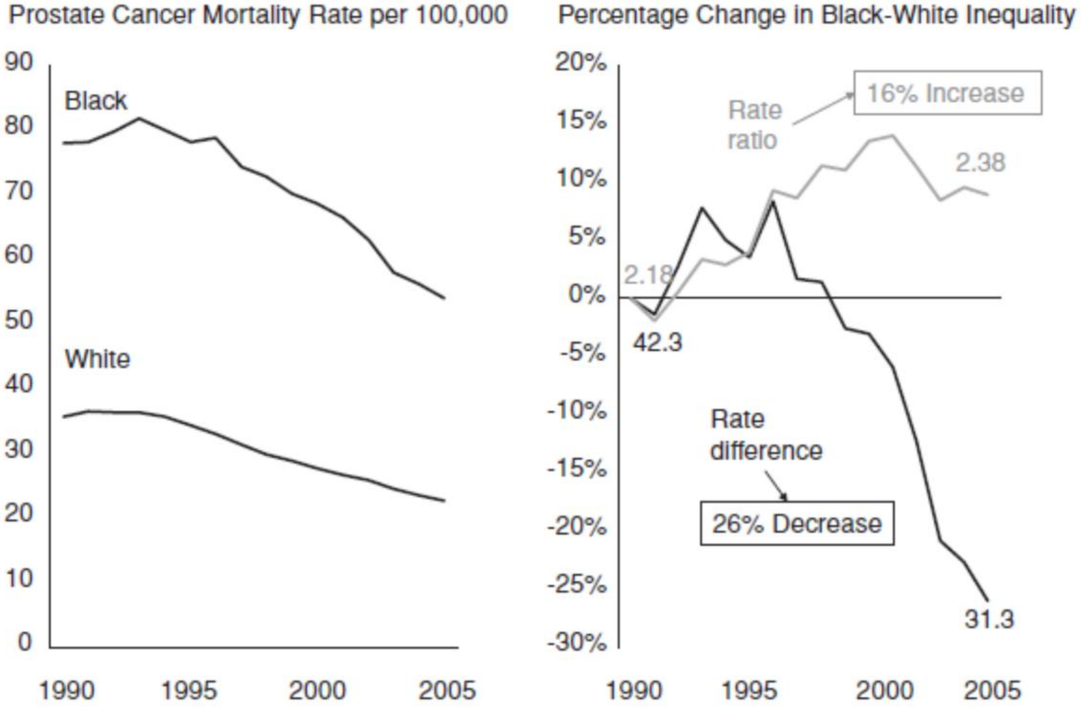
Change
The B/W difference got **better** over time (from 15➔10)
The B/W ratio got **worse** over time (from 1.6➔2.0);

Weissman JS 2009 1

Harper, et al., provide another example (see Figure 7).[62] In this case, the relative disparity in prostate cancer mortality between whites and blacks increased, while the absolute disparity, or rate difference, declined. This occurred because blacks had worse health at the beginning, and the rate of improvement for blacks was smaller than for whites. However, the authors note that the rate for blacks declined by 24 deaths per 100,000 while the rate for whites decreased by 13 deaths per 100,000; so on an absolute basis, blacks made more progress. In a widely cited paper by Werner, et al., [63] using the highly inflammatory title, “Racial profiling: the unintended consequences of coronary artery bypass graft report cards,” the authors claimed that “The release of CABG report cards in New York was associated with a widening of the disparity in CABG use between white versus black and Hispanic patients.” However, a close inspection of the data shows that the rate more than tripled for blacks (rising from 0.9 to 3.0) while only doubling for whites.

Recommendation: The choice of a disparity measure can lead to different interpretations when making comparisons over time or among providers. Therefore, both absolute and relative statistics should be calculated; and if they lead to conflicting conclusions, both should be presented, allowing readers to make their own interpretation.

Figure 7. Trends in Prostrate Cancer among Black and White Males and Percentage Change in Black-White Ratio and Rate Difference



Note: The rate ratio is calculated as the black mortality rate divided by the white mortality rate. The rate difference is calculated as the black mortality rate minus the white mortality rate.
Source: Authors' calculations using SEER*Stat Software (National Cancer Institute Surveillance Research Program 2009), with underlying data provided by the National Center for Health Statistics 2009a, 2009b.

FIGURE 1. Trends in Prostate Cancer among Black and White Males, and Percentage Change in the Black-White Rate Ratio and Rate Difference, 1990–2005.

Source: Harper, et al.[62]

In addition to deciding on absolute versus relative measures, one must also consider the choice of reporting favorable or unfavorable (i.e., adverse) events. Many health indicators are based on extremely rare events, such as mortality rates. Say the mortality rate for the dominant group is 1 percent (for a given condition in a given period of time), and 1.25 percent for the minority group. It is a relatively small difference, but it could be represented as a 25 percent difference in mortality, i.e., (1.25-1)/1. Instead, assume now that survival is the indicator. The difference then is (99-98.75)/99 = 0.252525 percent, nearly a 100-fold difference. An article by Trivedi, et al.[64] concluded that disparities between black and white Medicare enrollees who received preventive services declined for seven of nine HEDIS quality measures from 1997-

2003. When the results were recalculated using *relative* instead of absolute disparities and *adverse events* of failing to receive indicated services instead of receiving the service, four of the reductions in absolute disparities became relative increases.[65] These discrepancies in interpretation—using the same underlying statistics—can become important when communicating disparities to the media.[6]

Recommendation: As above, with respect to absolute and relative comparisons, public reporting of disparities should calculate statistics using both favorable and adverse events. If the results are notably different, both statistics should be reported, allowing the reader to judge the importance by taking the context of the report into consideration.

4.d. Paired Comparisons versus Summary Statistics

Comparisons between two (paired) groups in a single domain are easy. But when multiple groups make up a domain, problems arise. First, making comparisons among all possible pairs of groups can be cumbersome. Second, if the groups in an ordered domain are arbitrarily defined (e.g., persons below poverty, 100 percent to 200 percent of poverty, and so on), then changing the group definition could arbitrarily change the results. Third, the sample size of one or more of the individual groups of interest may be too small to make stable estimates (see below for more detail). In these cases, it may be desirable to use a summary disparity statistic.

Healthy People 2010, for example, uses a summary measure, the index of disparity (ID), which is calculated as the average of the percentage differences from the best group rate.[66, 67] The Massachusetts Office of Medicaid found that many of the hospitals participating in its statewide pay-for-performance program had very few minority patients in their fee-for-service Medicaid program and so decided to use a summary statistic similar to the index of disparity, called the Between Group Variance (BGV), to assess disparities in the quality of hospital care.[68] The BGV provides a single measure of the consistency of care provided across all racial/ethnic groups treated in a hospital. It is derived by summing the variation from the average quality of care provided by the hospital that is received by members of different racial/ethnic groups, calculated as:

$$\mathrm{BGV} = \Sigma\ ((n_i/d_i - N/D)^2\ (d_i/D))$$

Where: n_i = the number of successfully achieved opportunities for a given racial/ethnic group

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[6] A problem communicating with the media about disparities led to a controversy surrounding Kevin Schulman's high-profile 1999 *NEJM* article showing large odds ratios comparing whites with blacks for the likelihood of being referred for cardiac catheterization (Schulman, et al., 1999). The authors reported an odds ratio (OR) of 0.6, and the press picked up on this as blacks being 40 percent less likely to be referred. However, a letter to the editor by Frank Davidoff noted that the actual referral rates were 91 percent and 85 percent, and so in fact the black rate ratio (RR) was 93 percent that of whites, which would have appeared much less dramatic. This discrepancy occurred because of the statistical properties of ORs and RRs. In this case, had the authors reported the likelihood of *not* being referred, the OR and RR (blacks/whites) would have been nearly identical: 1.7 and 1.6, respectively.

d_i = the total number of eligible opportunities for a given racial/ethnic group
N = the total number of successfully achieved opportunities (for all groups)
D = the total number of eligible opportunities (for all groups)

Summary measures have several disadvantages. First, they do not indicate which groups are doing poorly and which are doing better. This may be important for public reporting and can be essential for identifying opportunities for improvement. Second, summary statistics lack "directionality," meaning that they may indicate that disparities exist even in cases where the direction of the comparison is one in which the historically disadvantaged group performs better than the other groups. Third, some summary measures are sensitive to the numbers of patients within each racial/ethnic group. For example, using the BGV, a provider with few minority patients would have a lower disparity than other providers even if it offered the same level of care to each group. In other words, hospitals with more diverse populations (more minorities) will appear to provide less equitable care (higher disparities) when assessed using the BGV.[68]

Recommendation: Because most summary measures of disparities lack "directionality," great care must be taken before using them to track disparities. Comparisons using the historically advantaged group as the reference point should be checked to see if a positive finding from the summary statistic reflects superior care received by the disadvantaged group. If so, the context of the report and relevant policy goals need to be explicitly considered.

4.e. Normative Judgments about Disparity Measures

Sometimes the choice of reporting statistics is deliberate and meant to support a particular agenda. Harper, et al. make the case that the choice of disparity measures, even if they are mathematically correct, carry with them normative judgments about which aspects of disparity reductions matter most.[62] Although they cite many examples using six different case studies, one stands out for the stark contrast in values. They illustrate this point by examining a hypothetical change in smoking prevalence disparities as measured by the Index of Disparity [67] and the Mean Log Deviation. The former measure tends to weight improvements whether or not the least health group or the healthiest group makes progress. The latter measure values reductions in inequality among the least healthy groups. Their example shows a threefold difference in the change in inequality using the two measures. Another example of normative values influencing statistics is illustrated by the choice of a summary index of disparities selected for use by the CDC in its Healthy People 2010 report (http://www.healthypeople.gov/2010/data/midcourse/html/tables/dt/dt-01a.htm).[69] The report includes tables that list each indicator stratified by the OMB categories and indicates the size of the relative disparity from the best group rate (the percentage difference between the best group rate and each of the other group rates). The summary index is the average of these percentage differences for a characteristic. The summary index is *not* weighted by the size of the population, even though some groups, such as the American Indian or Alaska Native, are quite small. This was a conscious decision at CDC to avoid a situation in which a summary index might completely miss major disparities of a small group.[70]

Clearly, whether one believes it is important for society to reduce overall inequality or whether it is more important to reduce inequality among the least healthy groups, or among small minorities, will influence the choice of measure.

4.f Research Resources for Disparity Measurement

In addition to those highlighted above, there exist a number of absolute and relative disparity methods from which to choose, as well as summary indexes (see Table 9). The most complete review of these methods can be found in a series of monographs published by CDC and the National Cancer Institute (NCI),[60, 62, 67, 71, 71, 72] and a critique of those methods.[73] In addition, NCI publishes a statistical software program, HD*Calc, which imports data from population-based health registries (e.g., NCI's Surveillance, Epidemiology, and End Results Data [SEER], the National Health Interview Survey, National Health and Nutrition Examination Survey) and can be used to monitor and trend health disparities in cancer in the United States. It can be downloaded from the NCI website at http://seer.cancer.gov/hdcalc/. The software calculates several absolute and relative disparities measures:

Absolute Disparity: which includes Range Difference (RD), Between Group Variance (BGV), Absolute Concentration Index (ACI), and Slope Index of Inequality (SII).

Relative Disparity: which includes Range Ratio (RR), Index of Disparity (IDisp), Mean Log Deviation (MLD), Relative Concentration Index (RCI), Theil Index (T), Kunst Mackenbach Relative Index (KMI), Relative Index of Inequality (RII).

The tables and graphs that the program generates can be exported. Software development was guided by NCI's report *Methods for Measuring Cancer Disparities: A Review Using Data Relevant to Health People 2010's Cancer-Related Objectives* (Harper & Lynch, 2005).[72]

Table 9. Measures of Absolute and Relative Health Disparity

Measures of Absolute Disparity
Rate Difference = Simple arithmetic difference between two groups (usually between the less-advantaged group and the more-advantaged group).

Between-Group Variance = The sum of squared deviations from a population average. The variance that would exist in the population if each individual had the average health of their social group.

Absolute Concentration Index = Measures the extent to which health or illness is concentrated among a particular group.

Slope Index of Inequality = Absolute difference in health status between the bottom and top of the social group distribution.

Measures of Relative Disparity
Rate Ratio = Measures the relative difference in the rates of the best and worst group.

Index of Disparity = Summarizes the difference between several group rates and a reference rate and expresses the summed differences as a proportion of the reference rate.

Relative Concentration Index = Measures the extent to which health or illness is concentrated among a particular group.

Relative Index of Inequality = Measures the proportionate rather than the absolute increase or decrease in health between the highest and lowest group.

Theil Index and Mean Log = Measures of disproportionality. Summaries of the difference between the natural logarithm of shares of deviation health and shares of population.

NOTE: Although this table is on measures of health disparities rather than healthcare disparities, the same concepts can be applied to measuring disparities in healthcare performance.

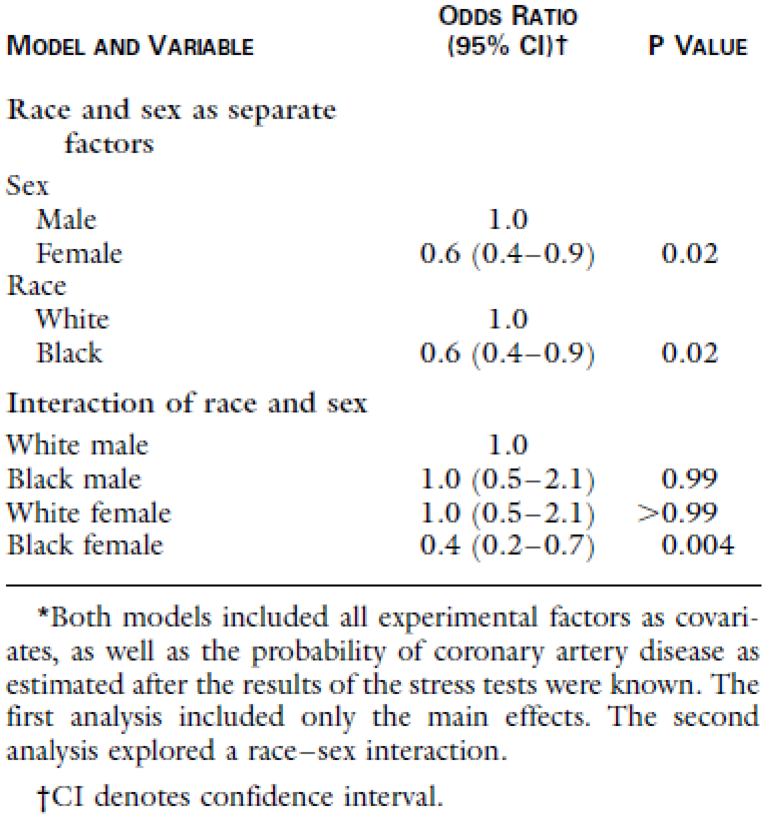
SOURCE: Harper and Lynch, 2007, as cited in Institute of Medicine, *Future directions for the national healthcare quality and disparities reports*.[74]

4.g. Interaction Effects

The most common disparity comparison is made within a single domain, such as differences among racial groups or ethnicities. However, disparities may in some cases exist only for subsets of a particular racial/ethnic group. This is known in statistical terms as an *interaction effect,* defined as the situation in which the effect of one group differs depending on the characteristics (or level) of the other group. This occurred in reporting the effects of the Schulman article mentioned earlier, reporting racial and gender disparities in referral for cardiac catheterization (see Table 10).[75] The findings as reported by the media were that blacks and women were 40 percent less likely to be referred. However, as described in a subsequent *NEJM* Sounding Board, the effect of race was modified depending on whether the patient was male or female, and vice versa.[76] In fact, the care was the same for white men, white women, and black men. Only black women were referred at lower rates (see Table 10).

Recommendation: When clear differences in quality exist by racial/ethnic sub-strata, further stratification of results will serve to highlight areas of the greatest potential for intervention.

Table 10. Predictors of Referral for Cardiac Catheterization*



MODEL AND VARIABLE	ODDS RATIO (95% CI)†	P VALUE
Race and sex as separate factors		
Sex		
Male	1.0	
Female	0.6 (0.4–0.9)	0.02
Race		
White	1.0	
Black	0.6 (0.4–0.9)	0.02
Interaction of race and sex		
White male	1.0	
Black male	1.0 (0.5–2.1)	0.99
White female	1.0 (0.5–2.1)	>0.99
Black female	0.4 (0.2–0.7)	0.004

*Both models included all experimental factors as covariates, as well as the probability of coronary artery disease as estimated after the results of the stress tests were known. The first analysis included only the main effects. The second analysis explored a race–sex interaction.

†CI denotes confidence interval.

Source: Schulman, et al., 1999.[75]

4.h. Sample Size Considerations

The identification of disparities is often hampered by sample sizes because many racial/ethnic groups are in the minority. Thus, disparities measurement programs (and incentive programs) face a major challenge when providers or institutions have small numbers of minority patients. Pay-for-performance programs need to reliably identify providers that perform well or poorly in the area of interest.[77] For a program that is designed to identify providers with low levels of disparity, this means the disparities statistic should consistently identify the same providers as either high or low performers, if their performance were to be measured repeatedly. The smaller the numbers, the more likely it is apparent disparities will reflect chance rather than true differences.

Even national data sources may lack sufficient numbers of minorities for some purposes. For example, research using the CMS Hospital Quality Alliance data demonstrated that only 1/3 to 1/2 of U.S. hospitals had sufficient numbers of minority patients, depending on the condition of interest, to make stable enough estimates for ranking them to be eligible for incentive payments when disparities in care are being considered.[78, 79] Likewise, even national surveys with large sample sizes may be able to provide reliable estimates for smaller racial/ethnic groups. The National Health Interview Survey (NHIS) surveys more than 75,000, and yet has small numbers of Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native and persons self-identifying as having more than one race (see Table 11).

Table 11. Racial Frequencies in the 2006 National Health Interview Survey

Race	Frequency	Percent
White only Black only Asian only	56,348 12,349 4,802	74.4 16.3 6.3
AIAN only NHOPI only White/black	621 111 420	0.8 0.1 0.6
White/Asian White/AIAN Other combinations	308 423 334	0.4 0.6 0.4
SOURCE: Division of Health Interview Statistics, National Center for Health Statistics. **NOTES:** AIAN is American Indian or Alaska Native. NHOPI is Native Hawaiian or other Pacific Islander. As appearing in Bilheimer 2008		

Source: Bilheimer, et al., 2008.[80]

There are a number of options to consider. Pros and cons are described in the accompanying table (see Table 12).

1. The racial/ethnic categories can be "rolled up" into broader categories containing more than one group. Commonly, researchers will use the OMB categories, or some combination, or even minority to non-minority.
2. Use a summary statistic such as the BGV, which considers all of the racial/ethnic groups simultaneously. This is what the Massachusetts Office of Medicaid decided to do when confronted with small sample sizes for their Pay 4 Performance program.[68]
3. Use composite quality measures. Composite measures provide a global comparison of the quality of care by combining across indicators to produce a

"composite" or "aggregate" score. Composite scores can be generated using much smaller sample sizes than those required for single indicators.

4. Over-sample minority patients,
5. Combine data from two or more years.

Table 12, Pros and Cons of Options for Dealing with Insufficient Sample Sizes

Option	**Pros**	**Cons**
Rolling up	Allows analyst to choose groupings with sufficient numbers for analysis that best represent the population and the policy question	Loses data on important subgroups, potentially masking disparities
Summary statistics	Provides a single measure of disparity, allowing easy comparisons across place and time	• Lacks "directionality", potentially penalizing providers that provide superior quality to disadvantaged minorities • Hard to understand and thus are not very transparent • Choice of summary statistic may reflect value judgments, such as the importance of equity across all groups in a domain regardless of size • May have less well-understood statistical properties, such as rewarding providers serving less diverse populations even if quality is no better than others
Composites	Intuitively appealing since composites are often created around a condition of interest rather than specific processes of care that are not well understood by lay public	• Loss of transparency, since the user may not understand what factors influence their creation • Certain composites have undesirable properties, e.g., may be influenced by the number of measures used or by the proportion of the population eligible for each measure

		• Composites created across clinical condition lack meaningfulness • Composites created without proper statistical analysis may not "hold together" as a single construct
Over-sample minorities	Boosts sample size of smaller sub-groups	• May add to cost of data collection; • Requires knowledge of important subgroups ahead of time.
Combine data from two or more years	More stable estimate of performance	Loses sense of immediacy for quality improvement purposes

The selection of disparity measures will of necessity be context specific.

- Some applications (for example, statewide report cards) may need to rely on broad disparity indexes and composite measures to avoid overly cluttered tables. However, more detailed data tables should probably be included as appendices, and areas noted where the detailed data present might lead to different conclusions.

- Disparities reporting for internal quality purposes might focus on granular groups, even if differences are not statistically significant, and might examine differences in measures that are not yet nationally vetted.

- Programs for public reporting and incentive payments need to be highly transparent and more rigorous than for internal QI purposes, and therefore need to pay attention to stable group sizes and the use of strong evidence-based measures.

Despite limits on statistical testing with small sample sizes, it may still be useful and important to examine quality data stratified by race, ethnicity, and language. Weinick, et al.[28] suggest four rationales:

- Stratified data can provide a first look at trends that might be indicative of true disparities. These instances could be further explored via anecdotes and case studies.

- Even anecdotal evidence of failure to receive high-quality care may be of interest to providers seeking to improve quality.

- In some cases there will likely never be statistical significance for certain units, such as the practice level, yet these differences could still be clinically meaningful to practitioners.

- Small groups may represent "low-hanging fruit" for quality improvement.

4.i. Risk Adjustment and Stratification

Because high-stakes performance reporting, whether as a pay-for-performance program or as public reporting, can significantly affect provider revenues, the manner in which disparities in care are examined and documented likewise has the potential to impact the resources and actions of different providers. This section considers two purposes of risk adjustment: 1) making fair comparisons among different entities (e.g., health plans, providers, health insurance exchanges) on overall quality of care metrics; and 2) reporting racial/ethnic disparities among different entities. The issues and rationales for risk adjustment are different for each purpose and so must be considered separately.

Risk adjustment and stratification defined. The two major approaches to framing performance by demographic characteristics are case mix adjustment and stratification. Risk adjustment and stratification are both ways of addressing the confounding influence of variables such as race/ethnicity, SES, primary language, and insurance status on health outcomes. In stratification, a given population is divided into subpopulations. For categorical variables, such as ethnicity, this yields groups such as Hispanic and Asian. Continuous variables, such as income, must be grouped into strata, e.g., less than 300 percent of the Federal Poverty Level (FPL) versus greater than 300 percent FPL. The relative risk of the outcome or variable of interest is then calculated for each substratus and can be compared among groups. Risk adjustment uses multivariable regression analyses to account for the effect of confounders.

Exception reporting. While it does not directly use demographic characteristics, exception reporting, as practiced in the United Kingdom, may also affect the way that a provider's demographic case mix influences performance.[7] In 2004 the United Kingdom implemented a pay-for-performance contract for family practitioners in which providers received additional reimbursement for meeting specific quality indicators. To decrease the pressure this generates for providers to avoid high-risk patients, providers were allowed to exclude certain patients from the calculation of their performance data, known as "exception reporting." The basic idea is that by excluding certain patients from their denominator populations, this design

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[7] Doran, et al. show that practices caring for higher proportions of disadvantaged patients had only marginally higher exclusion rates. Additionally, although the performance of practices caring for large proportion of "deprived" populations had somewhat lower performance than those caring for predominantly "non-deprived" populations (4.6 percent lower than that serving the least-deprived population), this gap narrowed over just 2 years to 1.21 percent, suggesting that, even without reimbursement tied directly to reduction of disparities, the United Kingdom pay-for-performance initiative had the effect of reducing disparities in care. However, the authors note the poorest performing practices still remained in the most deprived areas (Doran, et al., 2008), with these providers still exposed to financial liability due in part to the high-risk communities they serve.

feature protects physicians from being penalized for avoiding the provision of inappropriate care to patients simply to boost performance (e.g., patients with terminal illness or intolerance of standard therapy).[81] Other reasons for exclusion (e.g., new patients, patients who miss appointments, and patients refusing treatment) insulate physicians from patient or practice considerations that undermine the ability to meet quality metrics. To avoid gaming or attempts to avoid addressing underlying performance issues, the rates of exclusion reporting must be monitored carefully.

4.i.i. Risk Adjusting Overall Quality Metrics for Race/Ethnicity

High-stakes incentive programs, such as pay-for-performance and public reporting, have been criticized for fostering concentration of resources among providers of care to low-risk patients or populations, thereby encouraging provider selection of these low-risk populations.[82] This both undermines access to care for vulnerable populations, such as the poor and racial and ethnic minorities, and leaves their existing providers with fewer resources to provide care and invest in quality improvement.[83] In addition, the revenue sources of these providers may be further diminished if employers, health plans, and consumers opt not to use the services of these institutions on the basis of their performance.[84] This point of view is illustrated by a recent letter from the American Hospital Association (AHA) to Donald Berwick, M.D., M.P.P, Administrator for CMS, to add variables for race and limited English proficiency to its risk-adjustment methodology as part of the Hospital Readmissions Reduction Program (HRRP).[85] AHA expressed concerns that “the HRRP may disproportionately affect hospitals serving a large number of minorities. And, by penalizing these hospitals, the HRRP will in turn disproportionately harm minority patients.” Demographic case-mix adjustment, demographic stratification, and exclusion of outliers collectively mitigate these pressures. However, each approach has limitations.

Demographic case mix adjustment accounts for the generally poorer performance of racial/ethnic minorities and the poor on quality measures. In so doing, it provides some financial protection for providers of these vulnerable populations and reduces incentives for providers and health plans to avoid serving these groups. However, risk adjustment has been criticized for its low transparency and potential to institutionalize poor performance by “setting a lower bar” for providers with large numbers of minority patients. Because the performance of different groups is obscured, it does not provide any mechanism for tracking and rewarding the improvement of care for vulnerable populations who may be receiving substandard care. For example, when quality scores are adjusted by race/ethnicity case mix, it may be easier for a provider to improve its overall quality score by focusing on low-risk groups, rather than addressing the group receiving poorer quality care.[84] In addition, adjustment by race/ethnicity may only affect performance on quality measures for a few institutions caring for large portions of racial/ethnic minorities.[86] In other words, for all but the providers of large numbers of the vulnerable, risk adjustment may fail to take advantage of the tremendous potential of quality measures to help eliminate disparities among providers of smaller portions of vulnerable communities. NQF notes that, "In order to drive improvement…National and local healthcare quality efforts and activities should adopt a specific goal of eliminating disparities in healthcare quality."[20] By rendering opaque the performance of the poor and racial/ethnic minorities, adjustment removes incentives to eliminate disparities and may therefore act to institutionalize low-quality care.[83, 84]

In lieu of demographic case-mix adjustment, a number of consensus-building organizations and researchers, including the IOM,[1, 3] AHRQ,[23] and previous NQF reports, have advocated for racial/ethnic stratification of quality measures.[20, 84] Stratification makes the quality of care of the most vulnerable groups plain, highlighting disparities in care between groups where adjustment obscures them.[87] This helps raise awareness of disparities in care, supporting its presence on the national healthcare agenda and the development of accountability for these differences within and between institutions. In addition, the improved transparency afforded by stratification produces opportunities for providers to develop targeted interventions and allows the construction of pay-for-performance practices that provide targeted rewards to providers who give high-quality care to vulnerable groups and also to reward improvement over time in minimizing disparities in quality of care.[83, 84]

Illustrating the advantage of stratifying results by demographic variables, the IOM Subcommittee notes in its 2009 report, "Common to virtually all successful [quality improvement] projects are some fundamental steps, including the acquisition of data on race and ethnicity, the stratification of quality-of-care data by race and ethnicity, the use of race and ethnicity to identify members of a target population to whom elements of an intervention would apply, and reanalysis of stratified quality data to evaluate the impact of the activities."[23] Furthermore, during this nascent phase of measuring disparities in healthcare, stratifying results will help identify the measures that have the greatest potential to highlight disparities and therefore provide opportunities for intervention and improvement.[20]

Despite these advantages, stratification is not without pitfalls. As with adjustment, it may have limited utility for providers of smaller numbers of the poor or racial/ethnic minorities, because meaningful stratified results require that a provider/organization have a certain number of racial/ethnic minority patients.[83] In addition, data, reported by provider, can create a scenario in which the provider both appears to be responsible and is financially liable for providing low-quality care, when many of the forces leading to health disparities are beyond the scope of interventions available to individual providers, groups, and even institutions. Stratification also does not account for the impact of providing care to a very large portion of high-risk, vulnerable people on an institution's resources and operations. Such providers may still perform worse on performance measures, even for their low-risk populations. In these matters, stratification still leaves providers who serve predominantly disadvantaged communities vulnerable to financial liability that may ultimately undermine their ability to invest in quality improvement.

In summary, by increasing the transparency of healthcare disparities, stratifying performance on quality measures by racial/ethnic and demographic variables offers the advantages of an integrated approach to measurement, incentive, and intervention, although it still leaves providers financially vulnerable to forces beyond their control. The optimal approach will depend on the purpose of quality measurement and may ultimately require a combination of approaches to provide a balance of incentives and financial protection. Work by the VA suggests that inclusion or exclusion depends on the level of control attributed to the provider. Hebert, et al. (2010) argue that models of hospital quality *should not* control for race/ethnicity for process measures that occur within the institution, but *should* control for race/ethnicity when looking at outcomes such as survival, which depends more on community level resources (over which hospitals have less influence).[88] Even this reasoning may change in the future as more incentive programs such as CMS's readmission program and many of the medical home pilots based on Wagner's chronic care model encourage providers to connect with community partners.

Recommendation: Stratification by race/ethnicity and primary language should be performed when there is sufficient data to do so. Risk adjustment may be appropriate when performance is highly dependent on community factors beyond a provider's control.

Finally, it may be that we are considering risk adjustment at the incorrect leverage point. If indeed disadvantaged populations are more difficult to treat and require more resources in to bring performance levels up to those of providers with more advantaged patients, then perhaps a better strategy would be to risk adjust *payments* to providers, while holding them accountable for equitable performance and outcomes. Clearly such an approach would need testing before implementation.

4.i.ii. Risk Adjusting Racial/Ethnic Disparities for Socioeconomic and Other Contributory Factors

The issue addressed here is whether equity reports that stratify results by race/ethnicity and language should be adjusted (or controlled) for socioeconomic status. Socioeconomic status is one of the most important determinants of health and healthcare utilization. Low-income persons are exposed to more life stresses, live in less healthful environments, are subjected to advertisements for unhealthy products, and live in "food deserts" where healthy foods are less available.

Given that a racial/ethnic disparity exists, risk adjustment is an important research tool that can be used to identify the underlying mechanisms or contributory factors that explain the observed differences. For example, members of a Latino population may have relatively low incomes and lower rates of insurance. If health insurance and low income are also related to the performance measure, then controlling or adjusting for these variables will tend to make the significant disparities findings "go away," or at least become non-statistically significant.

The question is, "…If the discrepancies in service use between whites and minorities are 'explained' by SES or insurance, does that mean there are no racial/ethnic disparities?"[90] We believe the answer is "no." First, once one begins to control for selected socioeconomic variables, there is no logical limit to how many variables might be added to the equation, including such important mechanisms as patient preferences, availability of good public transportation, literacy levels, and so on. The more variables that are considered, the less likely the main effect of racial/ethnic grouping will remain significant. Second, one should consider the end user, in this case perhaps a minority patient trying to choose among different health plans, providers, or health insurance exchanges, based upon the equity of care provided to its members. Would providing information that says there are no disparities because they are explained by SES serve the needs of that consumer? We think not.

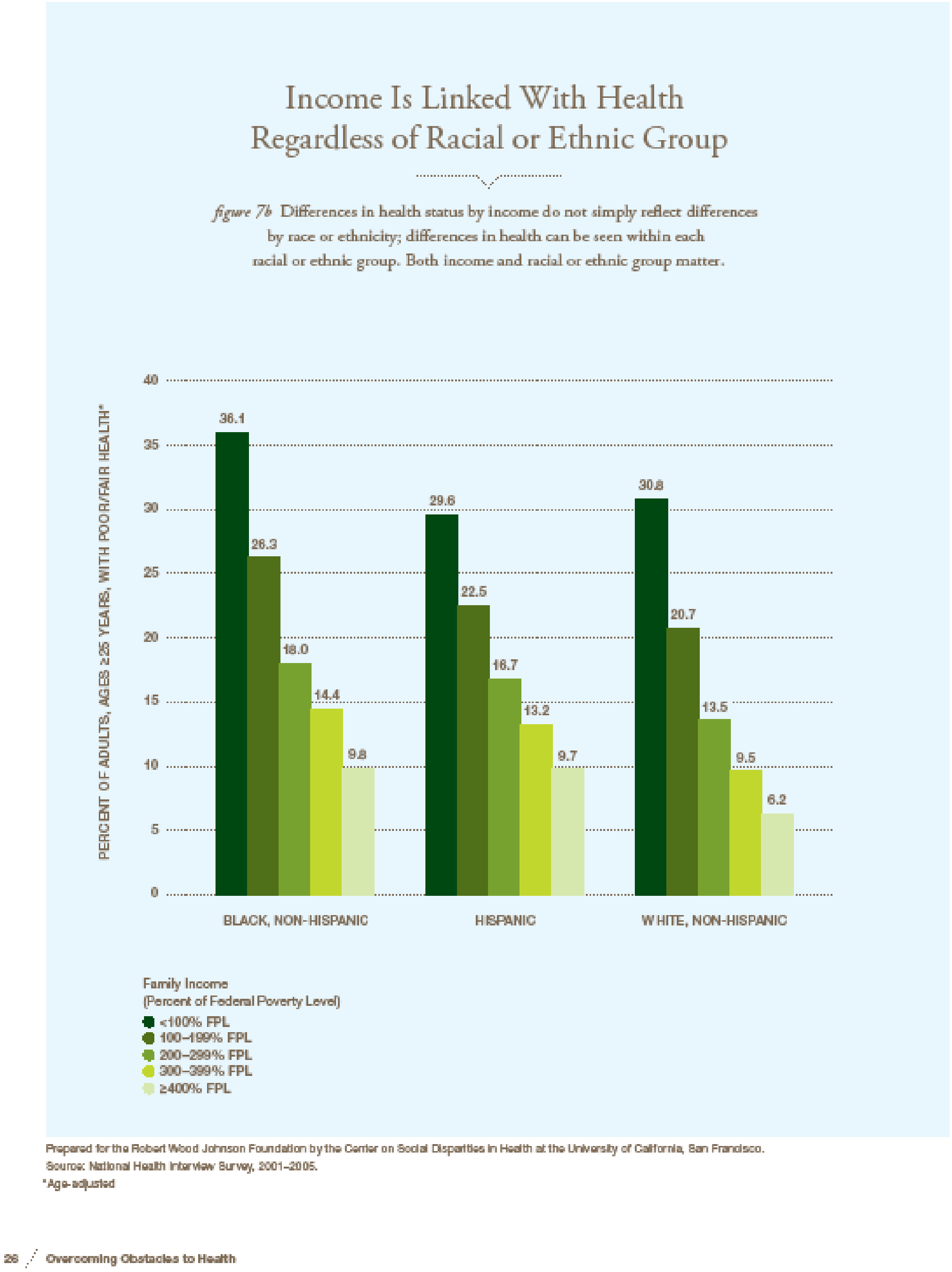
For these reasons, we recommend that stratified models should not be adjusted for SES. The basis of this belief is that differences in income and other aspects of SES are part of the social disadvantage that a racial/ethnic group might experience; controlling for SES variables therefore corresponds to an unrealistic hypothetical world in which such disadvantages have been eliminated, rather than describing the current situation of the racial/ethnic group. Disparities are still unfair, even if they can be explained by differences in socioeconomic position.

An optional strategy would be to stratify the race/ethnicity rates by a limited number of explanatory variables such as SES, insurance status, gender, age, or primary language, when there is sufficient data to do so.[74,89] By stratifying by more than one demographic characteristic simultaneously, stratification can also help focus attention on particularly vulnerable communities at the intersection of multiple risk factors, such as care of racial and ethnic minorities with low SES or racial/ethnic minorities who speak English as a second language,[91] while illustrating the independent and combined contributions of each demographic risk factors. Indeed, in the IOM report *Future Directions for the National Healthcare Quality and Disparities Reports,* the committee recommended that data be presented by race, ethnicity, SES, insurance status, and language, and that data stratified by race and ethnicity be reported simultaneously in two ways: both stratified by SES and adjusted for SES to examine further the potential mediating role of SES in quality performance.[74]

It may be possible to display the data in a manner that recognizes the contribution of both racial/ethnic and SES variables. See, for example, the bar charts in Figure 8 and Figure 9, where each bar represents an income group within a specific race/ethnicity. Such a display allows the viewer to separate racial/ethnic and SES aspects of disparity and avoids masking the "main effects" differences.

Recommendation: Performance reports stratified by race/ethnicity should not be risk adjusted by SES or other contributory factors, and instead could optionally be stratified by SES if the data permit.

Figure 8. Income and Disparities



Income Is Linked With Health Regardless of Racial or Ethnic Group

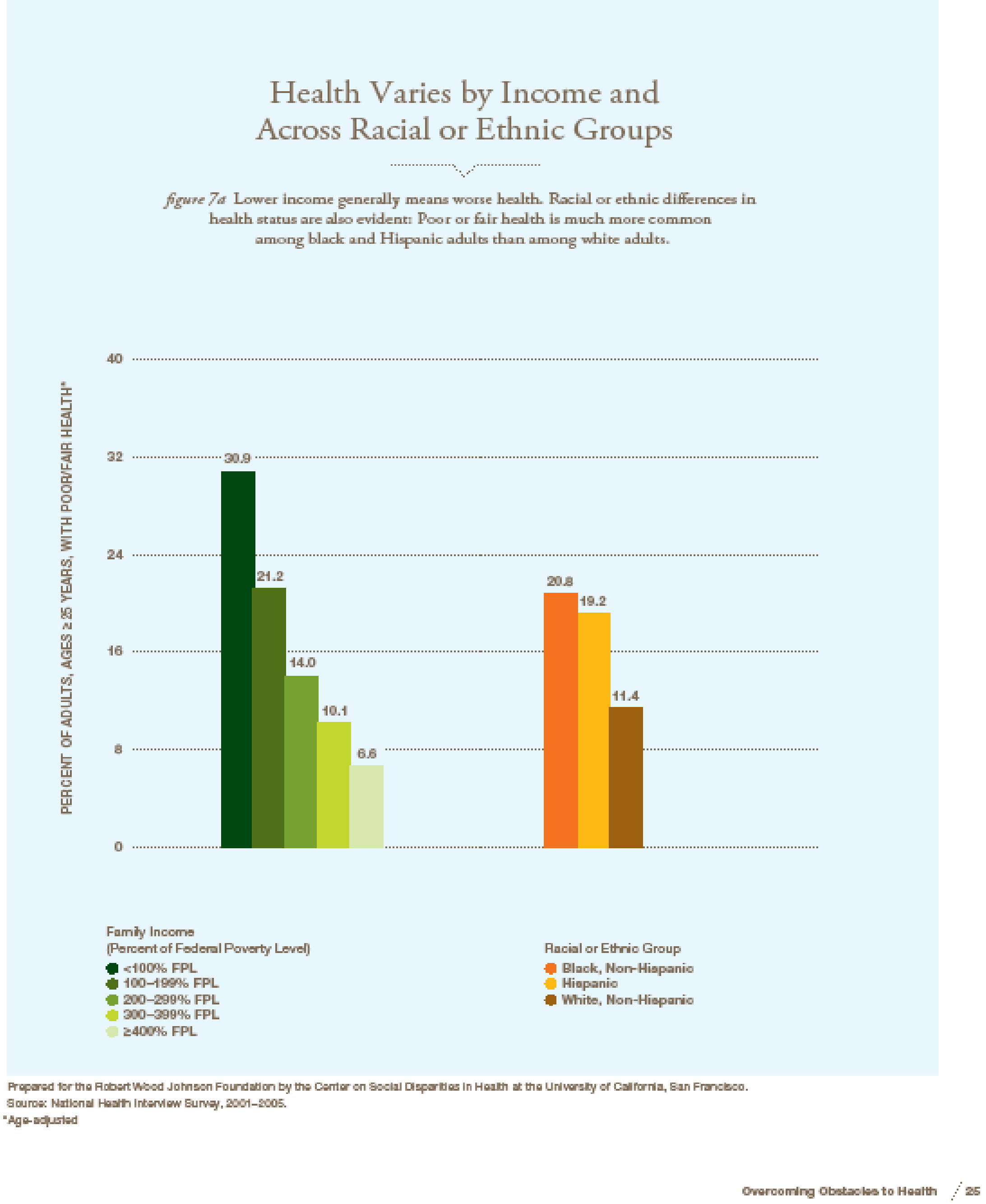
figure 7b Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

26 / Overcoming Obstacles to Health

Source: Robert Wood Johnson Foundation, Overcoming Obstacles to Health. Available at www.rwjf.org/files/research/obstaclestohealth.pdf. Last accessed July 2011.

Figure 9. Income and Disparities



Health Varies by Income and Across Racial or Ethnic Groups

figure 7a Lower income generally means worse health. Racial or ethnic differences in health status are also evident: Poor or fair health is much more common among black and Hispanic adults than among white adults.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

Source: Robert Wood Johnson Foundation, Overcoming Obstacles to Health. Available at www.rwjf.org/files/research/obstaclestohealth.pdf. Last accessed July 2011.

4.j. Disparities Between and Within Providers (Geographic Variation)

Whereas much of the literature on disparities implies differential treatment by practitioners or institutions, perhaps due to bias, racism, or lack of cultural competency, another possible explanation is that minorities tend to receive care from lower-quality providers. This may be due to where they live, where they seek care, or where they are steered to seek care. An emerging literature now suggests that aggregate (e.g., national or regional) differences in care are probably due to a mix of the two phenomena.[92, 93]

A study by Gaskin, et al., for example, found that when whites, blacks, Hispanics, and Asians were admitted for similar conditions to the same hospital, performance on AHRQ's risk-adjusted quality and safety indicators was not different.[94] However, what is becoming increasingly clear is that care of racial minorities is concentrated among certain providers,[92] and that they tend to perform poorly on quality measures. Jha, et al.[95] showed that hospitals with higher volumes of black patients were associated with having lower quality care for acute myocardial infarction (AMI). Werner, et al. [63] found that hospitals with high percentages of Medicaid patients (disproportionately minority) had lower performance using CMS' Hospital Compare data. In a study of hospital quality of care using the National Hospital Inpatient Quality Measures from the Hospital Quality Alliance, national disparities persisted after controlling for age, gender, source of payment, and comorbidities. Once site of care was taken into consideration, the adjusted disparities were smaller and in some cases not significantly different from zero.[49] A similar pattern can be seen at the level of the health plan, with racial and ethnic minorities enrolled disproportionately in inferior plans. For example, Schneider, et al. found that health plans in the lowest tertile of black enrollment had breast cancer screening rates of 76 percent for whites and 74 percent for blacks, while health plans in the highest tertile of black enrollment had breast cancer screening rates of 60 percent for whites and 58 percent for blacks, with no significant difference in quality of care between blacks and whites once health plan was taken into consideration.[96] There was greater difference in quality of care between health plans than within health plans. Differences in health plan quality also accounted for more than half of the racial disparities in rates of eye exams in diabetics and use of beta blocker post-MI. Because people tend to obtain medical care close to where they live, examinations of geographic patterns in disparities also suggest that inter-provider practice differences play an important role in generating disparities. In other words, racial and ethnic minorities may live in areas where they have less access to care or access to a generally lower quality of care. Skinner, et al., [97] found that black women and Hispanic men and women tended to live in regions where lower rates of knee arthroplasty (a surgical procedure to relieve pain and improve function of patients with disease of the knee) were observed even for whites. In some regions there was no significant difference between rates of arthroplasty between white and black women; regions where there was a significant difference were characterized by higher degrees of residential segregation. Because geographic barriers are particularly significant for people with limited resources, racial and ethnic minorities and people with low incomes have less opportunity to seek alternative providers.

What is not clear from these studies is the degree to which the quality of care is diminished by the inferior qualifications of the providers or the inferior resources available to them. Demonstrating the importance of both of these factors, Bach, et al., [92] showed that physicians who treated predominantly black patients were less likely to be board certified than physicians who treated mostly white patients, but also were more likely to report greater difficulty accessing specialty care and radiology. This latter point was demonstrated clearly in a study of revascularization (heart surgery) looking at rates of underuse, that is, failure to receive the procedure even when the benefits clearly outweighed the risks.[98] No differences were found by race or ethnic group within hospitals, but hospitals that provided on-site revascularization had significantly higher procedure rates. In that study, which took in New York City, eight out of nine private hospitals provided on-site revascularization, whereas only one out of four municipal hospitals provided that service.

This debate over “who you are versus where you are treated” has policy significance because the answer may determine whether resources are committed to efforts to reduce prejudicial treatment by practitioners, to improve the quality of care in organizations that serve high volumes of minorities, or to implement policies that equalize access to high-quality providers. Some approaches that policymakers might consider are described in the following section 5.

4.k. Summary Table

Table 13. Summary Table of Recommendations for Measuring and Monitoring Disparities

Methodological Choice	Issue	Recommendation
Reference Points	A reference point is “the specific value of a rate, percent, proportion, mean or other quantitative measure relative to which a disparity is measured.”[60] Disparities are frequently measured among groups in a domain.[8]	In this report, we believe that for purposes of achieving equity in healthcare that is fair and just, the choice of the reference group should always be the historically advantaged group.
Absolute versus Relative Disparities	Absolute and relative changes in disparities can yield different conclusions about whether or not gaps are closing.	The choice of a disparity measure can lead to different interpretations when making comparisons over time or among providers. Therefore, both absolute and relative statistics should be calculated, and if they

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[8] Disparities can also be measured from a reference point that is not a group characteristic. For example, one could compare each group against the unweighted mean of all the groups in the domain or to a benchmark or goals. The goal (e.g., from Healthy People reports) has intuitive appeal because it implies that all groups could improve. However, in this paper we have chosen to concentrate on differences between groups.

		lead to conflicting conclusions, both should be presented, allowing the reader to make their own interpretation.
Favorable versus Adverse Measures	Measuring rates of adverse and positive events can yield different conclusions about whether or not gaps are closing.	As above with respect to absolute and relative comparisons, public reporting of disparities should calculate statistics using both favorable and adverse events. If the results are notably different, both statistics should be reported, allowing the reader to judge the importance by taking the context of the report into consideration.
Paired Comparisons versus Summary Statistics	Comparisons among multiple groups can be difficult because they can be cumbersome, changing the group definition could arbitrarily change the results, or the sample size of one or more of the individual groups of interest may be too small. Summary statistics can address these issues but obscure important information.	Because most summary measures of disparities lack “directionality,” great care must be taken before using them to track disparities. Comparisons using the historically advantaged group as the reference point should be checked to see if a positive finding from the summary statistic reflects superior care received by the disadvantaged group. If so, the context of the report and relevant policy goals need to be explicitly considered.
Interaction Effects	Interaction effect is defined as the situation inw hich the effect of one group differs depending on the characteristics (or level) of the other group.	When clear differences in quality exist by racial/ethnic substrata, further stratification of results will serve to highlight areas of the greatest potential for intervention.
Risk Adjustment and Stratification	Case mix adjustment and stratification are ways to avoid punitive effects of pay-for-performance affecting providers with disproportionately large poor and vulnerable populations.	Stratification by race/ethnicity and primary language should be performed when there are sufficient data to do so. Risk adjustment may be appropriate when performance is highly dependent on community factors beyond a provider’s control.
Consideration of Socioeconomic and Other Demographic Variables	Should displays stratified by race/ethnicity be adjusted for income or other SES variables?	Performance reports stratified by race/ethnicity should not be risk adjusted by SES or other contributory factors, and instead should be further stratified if the data permit.

5. Priorities and Options for Quality Improvement and Public Reporting of Healthcare Disparities

5.a. What Should be Achieved from Disparities Measurement?

The purpose of this report is to provide guidance to an NQF Steering Committee charged with selecting and evaluating disparity-sensitive quality measures, to describe methodological issues with disparities measurement, and to identify cross-cutting measurement gaps in disparities and cultural competency. Performance measurement has become one of the fundamental strategies for monitoring the quality of care that health plans and medical groups deliver. To date, quality measurement has not been used on a large scale to assess whether that quality is provided equitably. Therefore, the ability to measure and compare performance for subpopulations of patients both within and across providers is key to improving clinical care and should serve to counter social biases and perhaps financial incentives to under-provide care to select populations. Disparities measurement should achieve the following policy goals (adapted from RAND 2011[99]):

- monitor progress toward disparities reduction;
- inform consumers and purchasers to enable selection of providers based on the provision of equitable care;
- stimulate competition among providers to provide the highest quality of care to disadvantaged populations;
- stimulate innovation in methods for providing culturally sensitive care to all populations, regardless of race/ethnicity or English proficiency; and
- promote the “values” of the health system.

5.b. What Should be Avoided? Challenges in Program Design and the Potential for Unintended Consequences

Disparities and quality measurement can lead to unanticipated and adverse consequences in a variety of ways, especially given how these measures may be used for payment reform.[20] Pay-for-performance (P4P) programs, for example, have been increasingly used to incent quality improvement and decrease costs of healthcare. P4P programs work by ranking providers (or setting performance targets) and then awarding incentives based on achievement. The idea is that payers need to counteract the occasionally perverse incentives of the fee-for-service system, which many feel over-produces certain services while under-producing value. While evidence is still accumulating about whether P4P improves care, [100] questions have been raised as to whether this payment strategy might reduce—or exacerbate—disparities (see Figure 10).

- Minority patients tend to have poorer outcomes than majority patients.[17] Providers may be motivated to "cherry-pick" patients they perceive as most likely to improve their quality scores (or may take the converse action of "lemon-dropping"). This could lead to reduced access for minorities.[83, 101-103]

- Hospitals that serve large numbers of minority patients could be disadvantaged in high-stakes incentive programs. Research suggests that P4P mostly rewards well-resourced providers—"the rich get richer" phenomenon.[104] If hospitals serving many minorities have lower quality than other hospitals, [95] then excluding these under-resourced hospitals from receiving incentive payments could worsen care for their populations.[105, 106] For example, the Affordable Care Act directs the Center for Medicare and Medicaid Services (CMS) to reduce payments to hospitals with excessively high readmission rates starting in 2014. Although the details of who will be penalized are not yet finalized, a substantial number of hospitals are likely to experience reductions in payments due to their high readmission rates. Minority patients are doubly disadvantaged in this regard. Black patients have higher readmission rates than whites, and patients from high-minority hospitals have higher readmission rates than those from other institutions.[17]

- "Teaching to the test" refers to focusing on what is measured rather than what is most important for improving patient outcomes. This may result in the inappropriate provision of services to patients (e.g., antibiotics for patients before the diagnosis of pneumonia is confirmed).[107]

- "Shifting unsustainable resources"—Another possible consequence of teaching to the test is that real improvements may be achieved in the short term but only through a level of resource commitment which in certain facilities cannot be sustained. As a result there is a tendency for resource commitment and performance to drop back to the pre-incentive baseline after the incentive is gone. It is also essential to choose the metrics wisely because there will always be a shift of resources to improve incented performance that will come at the expense of other potentially worthy initiatives.

- "Gaming the system"—If not carefully designed, healthcare providers faced with third-party quality measures may change what they do in a way that yields better *measured* quality but no real improvement in quality of care. For example, at Kaiser Permanente, the performance improvement department found that certain minority physicians were leaving high-minority services areas to avoid a disproportionate number of minority patients, who tended to rate physicians lower compared with non-minority patients.[108]

- “Color–blind” quality improvement programs could fail to reduce disparities if minority patients do not benefit from them to the same degree as majority patients. One study simulated the effects of P4P using the national Hospital Quality Alliance data for all U.S. non-federal acute hospitals and found that traditional “color-blind” programs would have only small effects on disparities, and recommended that hospitals be judged directly on quality gaps between minority and majority patients.[78]

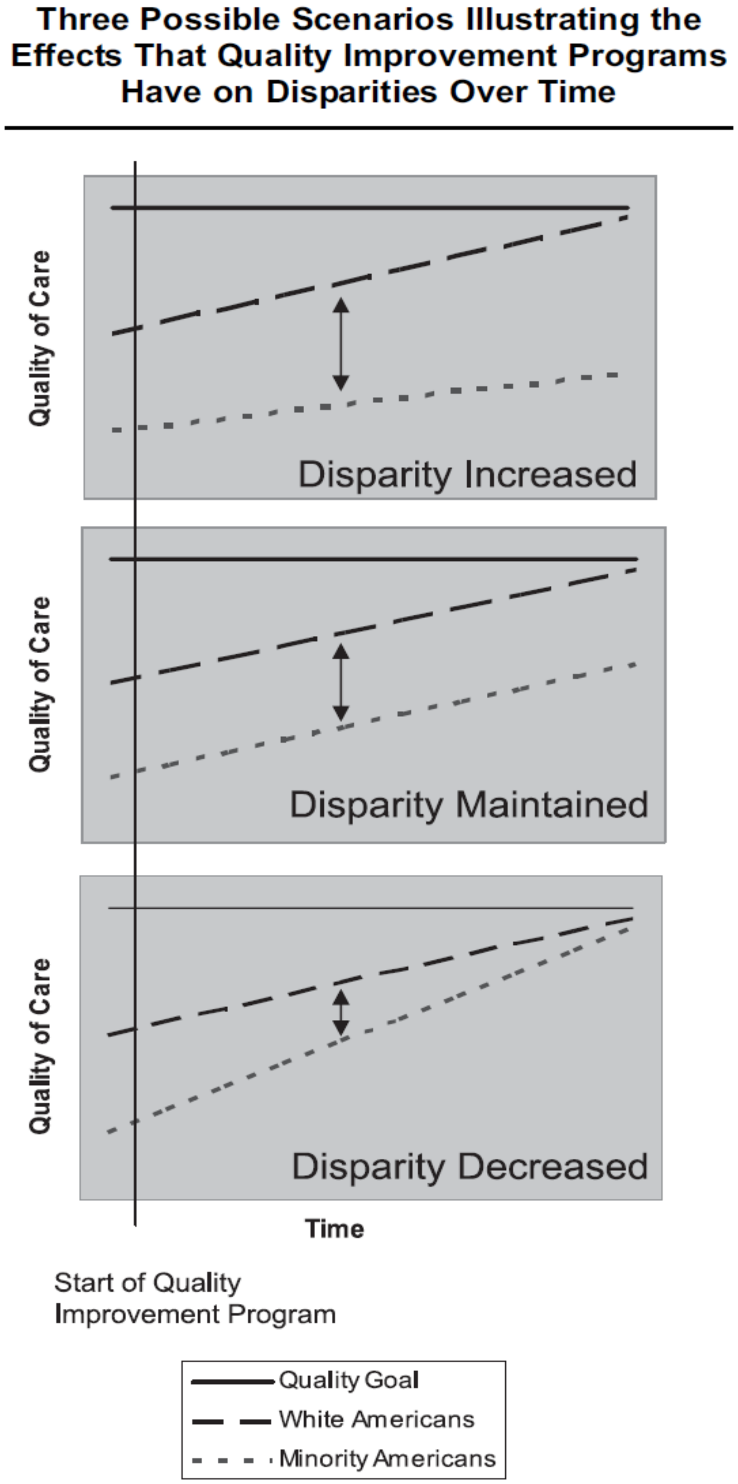
- Patients differ in their ability to take advantage of public reporting. Patients with LEP or poor literacy skills may be unable to benefit from publicly reported information.[83]

- National or regional disparities may be due to differences in where minority patients receive their care rather than differences among race/ethnicities within provider settings. P4P programs be definition focus on within-provider disparities, and thus may miss important opportunities.

- Disparities in care may reflect overuse among privileged populations rather than underuse among minority populations. Reducing the disparity in such a situation would not improve the overall quality of care.

Despite the concerns raised above, there is a remarkable lack of evidence to guide the design of incentive programs to reduce disparities. A systematic review of the P4P literature conducted in 2007 found only one empirical article out 536 that examined both performance incentives and racial disparities.[101] However, to date no large-scale P4P program has fully implemented this approach, although Massachusetts began such an initiative for its Medicaid fee-for-service program as mandated by the state’s 2006 health reform law. A recent study of that program [68] found that its implementation was hampered because of relatively small disparities among the measures used, lack of buy-in from the provider community around structural measures, and the concentration of minorities in only a few hospitals. In the final section in this paper, we explore alternative policy options that address these design challenges.

Figure 10. Possible Unintended Effects of QI Programs



Source: Green, et al., 2010.

5.c. What Measures Should be Selected?

We recommend the following to create a set of measures that organizations can use to identify and track disparities in healthcare.

Step 1: Assess the portfolio of NQF performance measures using disparities-sensitive principles, with special emphasis on quality gap and prevalence.

Recommendation: We recommend that all existing performance measures should be evaluated against the guiding principles established by the NQF Steering Committee and TAP that produced the report on consensus standards in 2008.[20] The guiding principles are: 1) prevalence, 2) impact of the condition, 3) impact of the quality process, 4) quality gap, and 5) ease and feasibility of improving the quality process.

Recommendation: We recommend that all of the NQF measures should be cross-walked with the literature on known areas of disparities, beginning with AHRQ's National Healthcare Disparities and Quality Report, the Institute of Medicine's *Unequal Treatment Report*,[1] and then a new review of the disparities literature since the publication of *Unequal Treatment*. All NQF measures that can be matched (at least partially if not identically) to disparities that have been documented in at least one of the sources mentioned should be considered as candidates for disparities-sensitive measures.

Recommendation: We recommend the use of the 35NQF-endorsed ambulatory practitioner- and group-level performance measures that are sensitive to disparities.

Step 2: Apply new criteria for disparities sensitivity.

Recommendation: When NQF does not have access to performance data stratified by race/ethnicity, or when known disparities do not exist, a set of additional criteria can be applied to determine potential disparities sensitive measures. [1] These include: *care with a high degree of discretion*, *communication-sensitive services, social determinant-dependent measures,* and *outcomes rather than process measures.*

Recommendation: In reviewing the NQF endorsed standards for sensitivity to disparities, we identified six different types of disparities sensitive measures: 1) practitioner performance measures; 2) consumer surveys that measure the patient experience; 3) hospital, ambulatory care center, home health nursing home performance measures; 4) measures of ambulatory care-sensitive conditions and management; 5) measures associated with cultural competency; and 6) patient-centered measures. After assigning a measure to a category, each measure should be assessed further according to a set of characteristics that include whether: 1) a measure is condition specific (CC) or cross-cutting (CS); 2) whether it is considered structure, process or outcome; and 3) whether the roots of the disparities are provider based, patient based, system based, or related to health insurance. Our recommendation is that a full set of NQF-endorsed measures should be analyzed according to this system of categorization, not as a way of determining disparities sensitivity, but rather as a way of understanding the range of measures used to identify disparities.

Step 3: Developing new disparities-specific measures.

Recommendation: We recommend developing disparities-specific measures for areas of care in which research has shown disparities exits but for which no current quality measure exits. These are distinguished from disparities-sensitive measures, a term that includes any current quality measure in which disparities have already been identified. These measures can be developed based on a review of the disparities literature, cross-walking this with the existing NQF measures to ensure that no current measure exists, and developing a new disparities-specific measure.

Recommendation: Another option for identifying new disparities-sensitive measures is to search for processes or services that occur at various points along the clinical pathway. We recommend that disparities measures represent a complete and comprehensive view of care, not just one point along the clinical pathway.

Recommendation: Finally, our recommendation includes tracking the progress of NPP and MAP because any effort in disparities measurement should be synchronized with their work whenever possible. Priorities NPP has targeted for improvement are proven ways to eliminate harm, waste, and disparities, including action in the areas of payment, public reporting, quality improvement, and consumer engagement. MAP will provide direction direct input to HHS on preliminarily identifying performance measures available for benchmarking and improvement purposes, including advice on measures needed for specific care settings, care providers, and patient populations. These priorities and goals provide opportunities for immediate action and measurement and include measures such as preventable re-admission and equitable access to care, which can be included in disparities-sensitive measures.

5.d. Current Practices and Real-World Lessons

There are a limited number of healthcare organizations nationally that are routinely monitoring quality by race and ethnicity, and thus few lessons from the field. Here is a brief overview of research and examples from the field, as well as current practices and key lessons:

5.d.i. Federal and State Government

Although CMS obtains self-reported data on race or ethnic background from Social Security Administration records, beneficiaries who enrolled before 1980 were recorded only as "black," "white," or "other."[109] Thus, CMS recently imputed data on race or ethnic background for all Medicare beneficiaries, allowing researchers to begin to examine disparities in more detail.[110]

At the state level, Massachusetts mandated the collection of race/ethnicity data in hospitals and health plans as part of the disparities reduction legislation in the nationally recognized healthcare reform initiative that the state passed in 2007.[111]

Massachusetts is also one of only a few in the country to require self-reported race/ethnicity by health plans; but due to pressure from stakeholders, the state set a floor that requires reporting on only 5 percent of membership by 2012.[37] Thus, the majority of race/ethnicity fields in the submitted claims are empty.

The Massachusetts Health Disparities Council has devoted considerable effort to preparing a Health Disparities Report Card that will help policymakers, payers, providers, and consumer advocates focus on key disparities. The Report Card Working Group (RCWG), convened in February 2009, was tasked with developing a Massachusetts Report Card. The report card is intended to provide the Health Disparities Council with current health outcome data by race and ethnicity, highlight emerging trends, and inform policy recommendations.

Through a deliberative process, consensus was reached to have the Report Card emphasize how rates of asthma, diabetes, obesity, heart disease and stroke, and infant mortality vary by race and ethnicity. Social determinants such as education and income, and environmental factors will also be included to provide insight on possible remedies outside of strictly medical interventions. Communities with poor health indicators will also be compared to communities with good health indicators. The RCWG met approximately monthly. The meetings resulted in the RCWG presenting an outline of tasks for developing the report card, which included:

- identifying a subset of all useful indicators from which high-priority indicators will be selected for publication in the report card;
- selecting initial indicators to work on for initial inclusion on the report card;
- selecting criteria for justifying inclusion;
- looking at policies that address specific issues identified by the group for initial inclusion on the report card;
- creating a scoring system for describing how Massachusetts is performing in areas identified as part of the report card; and
- producing a summary report card .

In addition, the following criteria were established and considerations presented by the RCWG in consultation with the HDC for including indicators on the MA report card. They were:

- availability of information;
- size of the disparity;
- amenability to intervention;

- presence of policies that would impact the disparity;
- provision of justification for inclusion; and
- consideration of grouping disparities that may be amenable to a common set of interventions.

Finally, the RCWG imbedded the Report Card within the Massachusetts Framework for the Elimination of Racial and Ethnic Health Disparities by recommending that the framework be used to evaluate how each indicator selected by the RCWG is impacted by each sector identified in the framework.

Key Lessons:

- Mandating the collection of data on patient race, ethnicity, language, and highest level of education is a successful way of building the foundation for monitoring quality by race and ethnicity.
- Hospitals can effectively collect these patient demographics, and some hospitals in the state have distinguished themselves by producing disparities dashboards and reports.
- State efforts to mandate race, ethnicity, and language proficiency by health plans have been limited by a "floor" of membership collection.
- The creation of statewide Health Disparities Report Cards hold promise as a very general health disparities measurement tool but will not allow real comparisons of quality of care, as its primary focus is simply stratifying health outcomes by race/ethnicity and looking at social determinants that might contribute to health disparities.

5.d.ii. Health Plans

AHIP conducted two surveys of member and nonmember health plans—one in 2003 and the other in the 2006—to determine whether information about its members' race/ethnicity was being collected. In 2003, from the 137 health plans (of 300) surveyed, 53.5 percent of enrollees were in plans that collected race/ethnicity data; and in 2006, from the 156 health plans (of 260) surveyed, 67 percent of enrollees were in plans that collected such data.[33] This information was obtained from the enrollees, usually during their enrollment in the plan or in special programs. Some plans collected this information indirectly through geocoding and surname analysis of their members.[112] The earliest examination of health plan collection of race/ethnicity data was the "Minority Health Report Card Project," a collaborative effort of researchers and initially 8, but later 13, health plans (commercial, Medicaid, and Medicare).[113] The demonstration created report cards, and the researchers recommended that race/ethnicity data be collected and used to measure the quality (i.e., Healthcare Effectiveness Data and Information Set [HEDIS], Consumer Assessment of Health Plans Survey [CAHPS]) of health plans and also for external reporting and internal quality purposes. The National Health Plan Collaborative, established in December 2004, was supported by the Robert Wood Johnson Foundation, the Agency for Healthcare Research and Quality, and coordinated by AHIP is a project that brings together 11 major health insurance companies, in partnership with organizations from the public and private sectors, to identify ways to improve the quality of healthcare for racially and ethnically diverse populations.

The National Health Plan Collaborative has used both direct and indirect methods to identify at-risk populations and then design and implement disparity-reduction programs, such as initiatives for increasing the rates of retinal examinations for Hispanics with diabetes.

Ultimately, health plans do not routinely report quality measures by race/ethnicity. There are a few notable exceptions:

- Aetna began collecting race/ethnicity from its members in 2003 in a voluntary, optional fashion. Most recently, they have completed their first Disparities Dashboard, which stratifies HEDIS measures by race, ethnicity, language, and region. They plan to do this routinely and are in the process of developing interventions to identify disparities in diabetes management in Texas.
- Neighborhood Health Plan (NHP) in Boston, MA, has been stratifying its HEDIS® quality measures by race/ethnicity, and in 2007 partnered with Federally Qualified Health Centers to collect race and ethnicity data on membership for the purpose of conducting disparities analyses. NHP identified disparities in comprehensive diabetes management in Latinos and breast cancer screening in African Americans and developed interventions to target disparities in both those areas.
- Kaiser Permanente has begun stratifying some quality measures by race/ethnicity and are in the early stages of work in this area.
- WellPoint uses imputed racial and ethnic data to identify disparity “hot spots” and inform outreach to members of disadvantaged populations.

Key Lessons:

- Routine collection of race/ethnicity data among health plans remains a challenge for future efforts to monitor quality by race/ethnicity primarily because it is difficult for them to collect these data.
- Currently health plans are using different techniques for race/ethnicity data collection to address this challenge, ranging from self-report to indirect estimation (geocoding and surname analysis).

- Local, smaller plans are in a better position to monitor quality routinely by race/ethnicity because they may have better access to these data (particularly Medicaid plans).

5.d.iii. Hospitals

In the past few years, two major studies examined whether hospitals routinely collect race/ethnicity data about their patients. In 2004, of 272 hospitals surveyed (from a sample of one thousand members of the American Hospital Association), 82 percent collected data on their patients' race and ethnicity, and 67 percent collected information on their patients' primary language, but the data were not collected in a systematic or standard manner. For example, the categories of race/ethnicity and the collection methods were different (such as patients' self-reports versus clerks assigning race/ethnicity to patients based only on appearance). In addition, the data were often not shared, even among different departments within the same hospital.[114] In 2006, of 501 hospitals (of 1,100) that were similarly surveyed, 78.4 percent collected race information, 50 percent collected data on patient ethnicity, and 50 percent collected data on primary language.[19] Most importantly, fewer than one in five of the hospitals that collected race/ethnicity information routinely used it to assess disparities in quality of care, health care outcomes, or patient satisfaction.

Similarly, researchers recently investigated public hospitals to find out whether current public reporting efforts could include data by race or ethnicity.[115] In particular, they looked at the feasibility of using the Hospital Quality Alliance framework to collect quality measures by race/ethnicity and to gauge these measures' usefulness for supporting hospitals' quality improvement activities designed to reduce disparities.[115] The Hospital Quality Alliance is a public-private collaboration (AHA, CMS, the Federation of American Hospitals, and the Association of American Medical Colleges) to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting the management of patients with congestive heart failure, acute myocardial infarction, and community-acquired pneumonia.[116] A useful lesson from this work was that race/ethnicity data could be used to measure quality to identify those disparities that could be addressed by quality improvement initiatives.

Similar to health plans, hospitals do not routinely use race and ethnicity date to monitor quality and equity, with a few notable exceptions:

- Massachusetts General Hospital (MGH) created an annual Disparities Dashboard in 2007. This is distributed to leaders throughout the organization and identifies the hospital's patient population by race/ethnicity and stratifies the National Hospital Quality Measures (congestive heart failure, acute myocardial infarction, and pneumonia), HEDIS outpatient measures, H-CAHPS patient satisfaction measures, all-cause admissions, ambulatory care-sensitive admissions, congestive heart failure readmissions, and several disparities-sensitive measures (pain management for long bone fractures in the emergency room), by race/ethnicity and language. MGH also began public reporting its disparities and equity measures in 2009. This can be found at http://qualityandsafety.massgeneral.org/measures/equitable.aspx?id=4.

- Baylor Health Care System, in Dallas-Ft. Worth, began health equity reporting in 2007. This included stratification of the National Hospital Quality Measures, ambulatory care measures (i.e., mammography screening), and other care process measures by various sociodemographic characteristics. The first among these targets was surgical infection prophylaxis. Initial analyses showed variations in surgical infection prevention measures, particularly by payer status where statistically significant differences were identified between commercially insured and self-pay (i.e., uninsured) patients. The Office of Health Equity worked with high- and low-performing hospital facilities within BHCS to identify root causes of the observed differences and best practices that could be implemented to improve equity in SIP performance across the system.

- Barnes Jewish Hospital, in St. Louis, MO, is currently collecting race, ethnicity, and language demographics at admission points throughout the organization. In February 2010, along with partners from Washington University School of Medicine, they implemented a pilot readmission project to reduce the readmission rate for patients with certain chronic diagnoses. Barnes-Jewish Hospital is working to develop a strategic plan to utilize patient demographics to evaluate patient health outcomes and to address health disparities by creating a database that will allow them to track patient admissions, diagnosis, DRGs, inpatient, outpatient, ED services, etc. The database will also include patient demographics including race, ethnicity, language, religion, and geography.

Key Lessons:

- It is possible to create routine disparities measurement and monitoring tools (such as disparities dashboards or disparities reports). These are facilitated by standardized patient race/ethnicity data collection.

- Initially, healthcare organizations might begin by stratifying measures that are already collected, then graduate on to particular measures of interest.

- Depending on the diversity of a healthcare organization’s population, small minority sample size for particular conditions/procedures might limit statistically significant comparisons between racial/ethnic groups, requiring more gross, white/non-white comparisons.

- To address concerns among health care leaders about publicly reporting disparities, an appropriate communication strategy is essential, as well as a commitment to action, transparency, and accountability when disparities are found.

5.e. Policy and Dissemination Considerations

Disparities measurement is undoubtedly an area that will grow in the years to come. To date, regulating bodies and federal and state legislative efforts are fostering the collection of race, ethnicity, and language proficiency data as a precursor to measurement efforts that will allow us to monitor quality and equity of care across the nation. As more robust efforts focusing on disparities measurement evolve, there are a series of policy and dissemination considerations that must be taken into account, both for external reporting to regulatory bodies, as well as public reporting:

- Standardization of disparities measures will be essential so as to allow meaningful conclusions and comparisons to be made about quality of care and care gaps. These measures should also be easily understandable and actionable.
- Initial efforts in disparities measurement should capitalize on the stratification of measures that are already available and used for quality reporting.
- While race, ethnicity, and language proficiency data evolve, basic and current OMB categories should be used for measurement and comparison and adapted over time to meet caregiver and local needs.
- Section 4 of this paper highlights the key issues and provides guidance and recommendations that can help address the key decisions that need to be made about:
    - When is a difference in quality a disparity and what should be the burden of evidence (percentage difference versus statistical significance)?
    - What is the correct level of aggregation for comparison purposes? Individual provider? Hospital? Health plan? Geographic area? How will disparities measurement be used? Will it be utilized simply to monitor quality and equity internally for healthcare organizations as a basis for quality improvement, or will it be used as for benchmarking against yet undefined standards?
- Regarding public reporting of disparities measurement:
    - How should public reporting be used?

    - For payment and reimbursement purposes? For consumer choice? There is a concern that certain organizations might be penalized for caring for more vulnerable and needy minority populations.

    - To motivate providers to improve performance? Public reporting alone can provide a powerful incentive for improvement, but attention to the analytic and reporting recommendations above is essential to avoid dismissal or mistrust of the results. [117]

    - How should this information be packaged, given the inherent sensitivity about disparities, and the potential public perception that they may emerge from intentional actions?

- Current efforts in the field demonstrate the importance of carefully explaining what disparities are, their root causes, and the need to immediately link any disparities that are identified with quality improvement efforts (even if as simple as further exploring the problem).

Above, we discussed some of the challenges and potential for unintended consequences that could ensue from programs seeking to incent disparities reduction. While this paper was intended to focus on methodological issues in disparities measure selection and measurement and not on the design of incentive programs, this topic deserves some consideration. Therefore, we list below a number of approaches that can be used to address those challenges. Each of these should be considered as either alternatives to, or more likely supplements to be used in combination with, standard incentive program design features. Among these are:

- Using payment for improvement (versus payment to achieve quality benchmarks or thresholds). The CMS Value-Based Payment program for example uses a mix of achievement (median), benchmark (90th percentile) and improvement thresholds.[107]

- Paying for performance based on lower racial/ethnic disparities (versus paying for higher quality performance applied generally to all patients).

- Conducting special studies that monitor for potential unintended consequences, such as increased difficulty accessing care, or adverse financial impacts on safety net providers.[118]

- Paying for performance focused on improving quality of care for minority populations.

- Exception reporting (as used in the United Kingdom).

- Quality improvement efforts targeting safety net providers and high-minority providers (and directing supplemental resources to those providers including the sharing of best practices).

- Assessing structural characteristics of providers until more evidence-based process and outcome measures are developed.

- One option that has not appeared in the literature to our knowledge is the idea of risk-adjusting *payments to providers* rather than risk adjusting performance measures. Such an approach recognizes the greater resource needs of providers to reach populations with multiple social disadvantages. Once these resources are available, it may then be more reasonable to hold all providers to the same quality performance standards applied to everyone without risk adjustment.

The information provided in this commissioned paper is intended to provide the appropriate background, evidence, and context for these key issues and considerations. As with any policy decision, there is no one right answer, or one-size-fits-all solution. An incremental approach to disparities measurement that involves key stakeholders in the process, and that builds on the foundation of work to date and key lessons from the field, will ultimately provide the foundation for identifying disparities and achieving equity.

Appendix I. NQF Measures Cross-Walked with AHRQ's National Healthcare Disparities and Quality Report

I. TREATMENT OF DEPRESSION						
NQF#	**NQF Endorsed Measure**	**Description of NQF Endorsed Measure**	**AHRQ Disparities Measure**	**Description of AHRQ Disparities Measure**	**Is there a Known Disparity for this Measure?**	**Quality of Match between NQF and AHRQ Measure**
105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment	a. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase. b Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day Acute Treatment Phase. c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.	Adults with a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months.	National Denominator: Persons age 18 or older with a major depressive episode in the past year. National Numerator: Subset of the denominator who received treatment or counseling in the past year.	Disparity found for Asians,[119] blacks,[119, 120] and Hispanics.[119, 120]	Medium

Appendix I. NQF Measures Cross-Walked with AHRQ's National Healthcare Disparities and Quality Report

II. CARDIOVASCULAR DISEASE						
NQF#	**NQF Endorsed Measure**	**Description of NQF Endorsed Measure**	**AHRQ Disparities Measure**	**Description of AHRQ Disparities Measure**	**Is there a Known Disparity for this Measure?**	**Quality of Match between NQF and AHRQ Measure**
137	ACEI or ARB for left ventricular systolic dysfunction-Acute Myocardial Infarction (AMI) Patients	Percentage of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.	Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) at discharge.	National Denominator: Discharged hospital patients with a principal diagnosis of acute myocardial infarction (AMI), and documented left ventricular ejection fraction, and without contraindication for ACE inhibitors or angiotensin receptor blockers. National Numerator: Subset of the denominator prescribed an ACE inhibitor or ARB at hospital discharge.	Disparity found for Hispanics[120,121] but not blacks[10]	High
730	Acute Myocardial Infarction (AMI) Mortality Rate	Number of deaths per 100 discharges with a principal diagnosis code of acute myocardial infarction.	Deaths per 1,000 adult hospital admissions with acute myocardial infarction (AMI).	National Denominator: All hospital inpatient discharges among persons age 18 and over. Excluded from the denominator are patients transferring to another short-term hospital. National Numerator: Subset of the denominator	Disparity found for Asians[120]. Blacks have lower mortality rate after AMI; this effect is augmented by adjustment for within-hospital effects.[122]	Medium

				who died.		

Appendix I. NQF Measures Cross-Wwalked with AHRQ's National Healthcare Disparities and Quality Report

III. MANAGEMENT OF ASTHMA						
NQF#	**NQF Endorsed Measure**	**Description of NQF Endorsed Measure**	**AHRQ Title**	**Description of AHRQ Disparities Measure**	**Is there a Known Disparity for this Measure?**	**Quality of Match between NQF and AHRQ Measure**
47	Asthma: pharmacologic therapy	Percentage of all patients with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	People with asthma who were taking prescription medication to control asthma during the past 12 months.	National Denominator: U.S. civilian noninstitutionalized population who currently have active asthma. National Numerator: Subset of denominator who are taking daily or almost daily preventive medicine.	Disparity found for Asians,[120] Mexicans,[120] and Hispanics[120]. Corticosteroid metered dose inhalers were taken up more slowly by minorities than by whites [123].	Medium
728	Asthma Admission Rate (pediatric)	Admission rate for asthma in children ages 2-17, per 100,000 population (area level rate)	Hospital admissions for asthma per 100,000 population by age group.	National Denominator: As appropriate to each measure, the U.S. population of children ages 2-17 and adults age 18 and over or age 65 and over, excluding patients with cystic fibrosis or anomalies of the respiratory system and transfers from other institutions. National Numerator: Subset of denominator with a principal hospital admission diagnosis of asthma.	In the late 1990s, black children were more than three times more likely than whites to have been hospitalized for asthma.[124] A 2009 study found that white patients admitted for acute asthma are less likely than minority patients to have been admitted for asthma in the past.[125]	Medium

Appendix II. Sample Analysis of NQF-Endorsed Measures for Sensitivity to Disparities

NQF #	Title	NQF-Designated Ambulatory Care Sensitive (Yes/No)	Disparities Sensitive: (Yes/No)	Measure Specification: Condition Specific or Cross-Cutting	Donabedian Category: Structure/Process/Outcome	Root(s) of Potential Disparities: Provider/ Patient/ System/ Insurance
1	Asthma assessment					
2	Appropriate testing for children with pharyngitis					
3	Bipolar Disorder: Assessment for diabetes					
4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement					
5	CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)					

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Measure Applications Partnership: Proposed Core Measures
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Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention & treatment of leading causes of mortality & morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival and OP-2: Fibrinolytic therapy received within 30 minutes	164 Endorsed and 288 Endorsed	Process			X			
Cardiac	AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	163 Endorsed	Process			X			
Cardiac	Acute myocardial infarction (AMI) 30-day mortality rate	230 Endorsed	Outcome			X			
Cardiac	Heart failure (HF) 30-day mortality rate	229 Endorsed	Outcome			X			
Cardiac	Acute myocardial infarction 30-day risk standardized readmission measure	505 Endorsed	Outcome	X	X	X			
Cardiac	Heart failure 30-day risk standardized readmission measure	330 Endorsed	Outcome	X	X	X			
Cardiac	OP–3: Median time to transfer to another facility for acute coronary intervention	290 Endorsed	Process		X	X			
Cancer	Family Evaluation of Hospice Care	0208 Endorsed	Composite				X		
Cancer	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed	Outcome				X		

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention & treatment of leading causes of mortality & morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cancer	Post breast conserving surgery irradiation	0219 Endorsed	Process			X			
Cancer	Adjuvant hormonal therapy	0220 Endorsed	Process			X			
Cancer	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed	Process			X			
Cancer	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed	Process			X			
Cancer	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed	Process		X	X			
Cancer	Completeness of pathology reporting	0224 Endorsed	Process			X			
Cancer	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed	Process			X			
Cancer	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed	Process		X				

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention & treatment of leading causes of mortality & morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Complications	Complication/patient safety for selected indicators (composite) Includes potentially preventable adverse events for: • Accidental puncture or laceration • Iatrogenic pneumothorax • Postoperative DVT or PE • Postoperative wound dehiscence • Decubitus ulcer • Selected infections due to medical care • Postoperative hip fracture • Postoperative sepsis	531 Endorsed	Other (composite)	X					
Maternal/ child health	Elective delivery prior to 39 completed weeks gestation	0469 Endorsed	Outcome	X					X
Maternal/ child health	Cesarean Rate for low-risk first birth women (aka NTSV CS rate)	0471 Endorsed	Outcome	X					X
Maternal/ child health	Healthy Term Newborn	0716 Endorsed	Outcome	X					
Mental Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement [‡]	0004 Endorsed	Process					X	

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Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	**Effective care coordination**	**Prevention & treatment of leading causes of mortality & morbidity**	**Person and family centered care**	**Supporting better health in communities**	**Making care more affordable**
Mortality	Mortality for selected medical conditions (composite) Includes in-hospital deaths for: • CHF • Stroke • Hip fracture • Pneumonia • Acute myocardial infarction • GI hemorrhage	530 Endorsed	Other (composite)			X			X
Patient Experience	HCAHPS survey	166 Endorsed	Patient Experience				X		
Respiratory	PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	148 Endorsed	Process			X			
Respiratory	Pneumonia (PN) 30-day mortality rate	468 Endorsed	Outcome			X		X	
Respiratory	Pneumonia 30-day risk standardized readmission measure	506 Endorsed	Outcome	X	X				X
Respiratory	Asthma Emergency Department Visits	1381 Endorsed	Outcome	X					
Safety	SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	529 Endorsed	Process	X		X			X

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention & treatment of leading causes of mortality & morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Safety	SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	218 Endorsed	Process	X					
Safety	Death among surgical inpatients with treatable serious complications (failure to rescue)	200 Withdrawn	Outcome	X					
Safety	Surgical site infection	299 Endorsed	Outcome	X					
Safety	OP-24 surgical site infection	299 Endorsed	Outcome	X					
Safety	Death in Low Mortality DRGs (PSI 2)	0347 Submitted	Outcome	X					
Stroke	STK-4: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke	0434 Endorsed	Process	X		X			
Stroke	STK–2: Ischemic stroke patients discharged on antithrombotic therapy	0435 Endorsed	Process	X		X			
Stroke	STK–5: Antithrombotic therapy by the end of hospital day two	0438 Endorsed	Process			X			
Stroke	STK–10: Assessed for rehabilitation services	0441 Endorsed	Process			X	X		

NOTE: ǂ *denotes measures that have been identified as Disparities-Sensitive*

Hospital Measure Gaps:

- Alzheimer's disease
- Atrial fibrillation
- Behavioral health; major depression
- Chronic obstructive pulmonary disease (COPD)
- Composites containing outcome and process measures
- Cost of care
- Disparities-sensitive
- ED visits
- Medication errors/adverse drug events
- Mortality rate composite – all-payer with condition-specific rate reporting
- Nursing-sensitive
- Patient-reported outcomes
- Serious reportable events – inclusion for reporting; best methodology needs to be explored
- Transitions in care/communication

Measure Applications Partnership: Proposed Core Measures
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Proposed Clinician Core Measures

NQF Measure Number and Status	Measure Name
0028 Endorsed	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention ‡
0001 Endorsed	Asthma: Asthma Assessment
0002 Endorsed	Appropriate Testing for Children with Pharyngitis
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement ‡
0012 Endorsed	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) ‡
0014 Endorsed	Prenatal Care: Anti-D Immune Globulin ‡
0017 Endorsed	Hypertension (HTN): Plan of Care
0018 Endorsed	Controlling High Blood Pressure ‡
0024 Endorsed	Weight Assessment and Counseling for Children and Adolescents
0031 Endorsed	Preventive Care and Screening: Screening Mammography ‡
0032 Endorsed	Cervical Cancer Screening ‡
0033 Endorsed	Chlamydia Screening for Women
0034 Endorsed	Preventive Care and Screening: Colorectal Cancer Screening ‡
0036 Endorsed	Use of Appropriate Medications for Asthma ‡
0038 Endorsed	Childhood Immunization Status ‡
0041 Endorsed	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
0043 Endorsed	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older ‡
0045 Endorsed	Osteoporosis: 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
0047 Endorsed	Asthma: Pharmacologic Therapy ‡
0052 Endorsed	Low Back Pain: Use of Imaging Studies
0055 Endorsed*	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient ‡
0056 Endorsed	Diabetes Mellitus: Foot Exam ‡
0059 Endorsed	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus ‡
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus ‡
0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients ‡
0064 Endorsed	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

NQF Measure Number and Status	Measure Name
0066 Endorsed	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD) ‡
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) ‡
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl ‡
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment ‡
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) ‡
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089 Endorsed	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
0091 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
0101 Endorsed	Falls: Screening for Fall Risk
0102 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
0105 Endorsed	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
0385 Endorsed	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
0387 Endorsed	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0555 Endorsed	Monthly INR for Beneficiaries on Warfarin
0575 Endorsed	Diabetes: HbA1c Control < 8%
0729 Endorsed	Diabetes Mellitus: Tobacco Non-Use
0729 Endorsed	Diabetes: Aspirin Use

NQF Measure Number and Status	**Measure Name**
NA1	Heart Failure: Left Ventricular Function (LVF) Testing
NA2	30 Day Post Discharge Physician Visit
NA5	Coronary Artery Disease (CAD): LDL level < 100 mg/dl
NA88	Chronic obstructive pulmonary Disease (COPD): smoking cessation counseling received
NA89	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years
NA90	Preventive Care: Cholesterol-LDL test performed
Note: NA denotes measures that have not been submitted to NQF. **0055 Endorsed was discussed by the Coordinating Committee to be removed* *‡ denotes measures that have been identified as Disparities-Sensitive*	

Clinician Measure Gaps: (bolded=prioritized)

- **Patient and family experience**
- **Child health**
- **Resource use**
- **Physician (specialty groups) and conditions**
- Stroke care
- Multi-morbidity chronic diseases and functional status
- Care coordination – team approach to care
- Outcome measures – included patient reported outcomes
- Patient Safety
- Surgical care
- Oral health
- Behavioral health/cognitive
- Disparities

Proposed PAC/LTC Core Measures

This table is a mapping of the MAP PAC/LTC Workgroup's proposed measure concepts to measures that are or will be used in PAC and LTC settings, as defined in federal regulations. Measures included for Nursing Home Compare and Home Health Compare are finalized for implementation for 2012. Measures included for Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs) are finalized for use in 2014 when measure requirements will go into effect for IRFs and LTCHs.

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY2014
Transition planning		• Timely initiation of care		
Falls		• Multifactor fall risk assessment conducted for patients 65 and over		
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay) • Percent of high risk residents with pressure ulcers (long- stay) • Percent of low-risk long-stay residents who have pressure sores	• Increase in number of pressure ulcers • Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented during short term episodes of care	• Pressure ulcers that are new or have worsened	• Pressure ulcers that are new or have worsened
Avoidable admissions		• Acute care hospitalization	• 30-day comprehensive all-cause risk standardized readmission	

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY2014
Functional and cognitive status assessment	• Percent of residents whose need for help with activities of daily living has increased (long-stay) • Percent of residents whose ability to move in and around their room and adjacent corridors got worse (long -stay) • Percent of short-stay residents who have delirium • Percent of residents who have depressive symptoms (long-stay) • Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period • Percent of residents who self-report moderate to severe pain (short-stay) • Percent of residents who self-report moderate to severe pain (long-stay) • Percent of residents who lose too much weight (long-stay) • Percent of low risk residents who lose control of their bowel or bladder (long-stay) • Percent of residents who were physically restrained (long-stay)	• Improvement in ambulation/ locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Depression assessment conducted • Pain assessment conducted • Pain interventions implemented during short term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/caregiver education implemented during short term episodes of care		

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY2014
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications		
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)		• Urinary Catheter-Associated Urinary Tract Infections (CAUTI)	• Urinary Catheter-Associated Urinary Tract Infections (CAUTI) • Central Line Catheter-Associated Bloodstream Infection (CLABSI)
Measures not mapped to a core measure concept	• Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (short-stay) • Percent of residents assessed and appropriately given the seasonal influenza vaccine (long-stay) • Percent of residents assessed and appropriately given the pneumococcal vaccine (short-stay) • Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long-stay)	• Influenza immunization received for current flu season • Pneumococcal polysaccharide vaccine (PPV) ever received • Heart failure symptoms addressed during short -term episodes of care		

PAC/LTC Measure Gaps

- Establishment and attainment of patient/family/ caregiver goals
- Advanced care planning and treatment
- Experience of care
- Shared decision making
- Inappropriate medication use

MAP's PAC/LTC workgroup considered a broader list of measure concepts in the process of determining core measure concepts. MAP concluded that the following concepts, which were all identified as important but not adopted as core, are difficult to define for measurement, are better measured by the concepts adopted, are not relevant to all settings, or do not rise to the level of being a core measure concept when the parsimony criterion is applied.

- Unnecessary services
- Staffing turnover
- Appropriate level of care
- Access to community supports
- Mental health assessment
- Timeliness of initiation of care
- Restorative care management

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Bios of the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)

Alice Lind, MPH, BSN

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

Organizational Members (voting)

American Association on Intellectual and Developmental Disabilities
Margaret Nygren, EdD

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

American Federation of State, County and Municipal Employees
Sally Tyler, MPA

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

American Geriatrics Society
Jennie Chin Hansen, RN, MS, FAAN

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

American Medical Directors Association
David Polakoff, MS, MsC

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

Better Health Greater Cleveland
Patrick Murray, MD, MS

Dr. Patrick Murray is an associate professor of Physical Medicine and Rehabilitation at Case Western Reserve University School of Medicine. Dr. Murray has more than 30 years experience in practice, administration, and research related to long term care services and supports and rehabilitation services. He has worked in Cleveland for 26 years at both MetroHealth Medical Center and Case Western Reserve University serving as Director of the Department of Physical Medicine and Rehabilitation and as medical director of the PACE program in Cleveland. He was co-director of the Program for Research and Education on Aging in the Center for Health Care Research and Policy where he is currently a senior scholar. Before coming to Cleveland, Dr. Murray was on the faculty at the University of Rochester and was in medical practice in rural West Virginia in a practice focused on geriatrics at a community clinic sponsored by the United Mine Workers. Dr. Murray's research has focused on rehabilitation issues in long term care especially in the post acute settings. He serves on the editorial board of the Archives of Physical Medicine and Rehabilitation. He has participated with Better Health Greater Cleveland over the past three years with special interests in the care of persons in nursing homes. Presently his work is focused on developing and evaluating approaches that improve the efficiency and quality of long term services and supports in underserved urban settings. Dr. Murray has a bachelor's degree in Biology from the University of Chicago, an MD degree from SUNY at Stonybrook, and a Master's Degree in Health Services Research from Case Western Reserve University. He is board certified in both Internal Medicine with Special Qualifications in Geriatrics and Physical Medicine and Rehabilitation.

Center for Medicare Advocacy, Inc.
Patricia Nemore, JD

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

National Health Law Program
Leonardo Cuello, JD

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

Humana, Inc.
Thomas James, III, MD

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

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

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

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

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

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

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

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

National PACE Association

Adam Burrows, MD

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

Individual Subject Matter Expert Members (voting)

Substance Abuse

Mady Chalk, MSW, PhD

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

Emergency Medical Services

James Dunford, MD

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

Disability

Lawrence Gottlieb, MD, MPP

Larry Gottlieb is a board-certified internal medicine physician with 25 years of experience in health care quality management and improvement with numerous publications on quality in the medical and health policy literature. He has held several senior leadership positions in managed care and clinical information systems development and has been widely recognized for strategic thinking and effective leadership among healthcare industry executives. Larry has also been a leader in the launching and ongoing success of several healthcare collaborative efforts designed to improve care for patients and simplify processes for providers and has numerous publications. Immediately prior to joining Commonwealth Care Alliance, Larry served as Vice President and Senior Medical Director at Health Dialog, a Boston-based international wellness and chronic care support organization. From 2000 to 2007, Larry served as Senior Vice President and Chief Medical Officer of two early stage care management information technology companies using internet technology and home monitoring technology to support improved care for patients with chronic diseases. From 1987 to 2000, Larry served as a Medical Director at Harvard Community Health Plan and Harvard Pilgrim Health Care in a variety of leadership positions focused on improving the quality of care delivered to the Health Plan’s members. During that time, Larry led multiple successful NCQA accreditation efforts, oversaw the development of highly successful preventive care and chronic disease management programs, and developed and implemented the first comprehensive managed care evidence-based clinical practice guidelines program in the United States, achieving international recognition. Larry also played a leadership role in the launching of several Massachusetts healthcare collaboratives, including the Massachusetts Healthcare Quality Partnership, the Alliance for Health Care Improvement, the New England Region Public Health Managed Care Collaborative, and the Massachusetts eHealth Collaborative. He has served on the Board of Directors of several other healthcare organizations, including Health New England, Network Health, and MassPRO. Larry obtained his undergraduate degree in engineering and his medical degree from Tufts University and a Master of Public Policy degree from Harvard’s Kennedy School of Government. He completed a residency in internal medicine at Tufts New England Medical Center and was a Robert Wood Johnson Clinical Scholar at Stanford University.

Measure Methodologist
Juliana Preston, MPA

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

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

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

Mental Health
Rhonda Robinson Beale, MD

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

Nursing

Gail Stuart, PhD, RN

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

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)

D.E.B. Potter, MS

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

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

Cheryl Powell

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

Health Resources and Services Administration (HRSA)

Samantha Wallack Meklir, MPP

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

HHS Office on Disability

Henry Claypool

As the Director of the Office on Disability, Mr. Henry Claypool serves as the primary advisor to the HHS Secretary on disability policy and oversees the implementation of all HHS programs and initiatives pertaining to Americans with disabilities. Mr. Claypool has 25 years of experience with developing and implementing disability policy at the Federal, State, and local levels. As an individual with a disability, his personal experience with the nation's health care system provides a unique perspective to the agencies within HHS and across the Federal government. Mr. Claypool sustained a spinal injury more than 25 years ago. In the years following his injury, he relied on Medicare, Medicaid, Social Security Disability Insurance and Supplemental Security Income, which enabled him to complete his bachelor's degree at the University of Colorado. After completing his degree, he spent five years working for a Center for Independent Living, after which he became the Director of the Disability Services Office at the University of Colorado-Boulder. Mr. Claypool also served as the Director of Policy at Independence Care System, a managed long-term care provider in New York City. Mr. Claypool served for several years as an advisor to the Federal government on disability policy and related issues. From 1998-2002, he held various advisory positions at HHS, including Senior Advisor on Disability Policy to the Administrator of the Centers for Medicare and Medicaid Services during the Clinton administration. From 2005-2006, he served as a Senior Advisor to the Social Security Administration's Office of Disability and Income Support Programs. In 2007, Mr. Claypool was also appointed by Governor Tim Kaine of Virginia to serve on the Commonwealth's Health Reform Commission.

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

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

Veterans Health Administration (VHA)
Daniel Kivlahan, PhD

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

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

George Isham, MD, MS

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

Elizabeth McGlynn, PhD, MPP

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

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

National Quality Forum Staff

Janet Corrigan, PhD, MBA

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

Thomas Valuck, MD, JD, MHSA

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

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

Diane Stollenwerk, MPP

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

Sarah Lash, MS, CAPM

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