MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

WEB MEETING OF THE DUAL ELIGIBLE BENEFICIARIES WORKGROUP

DECEMBER 16, 2011

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup
Web Meeting

NATIONAL QUALITY FORUM

December 16, 2011

Welcome

Roll Call

Chair
Alice Lind

Organizational Members
Margaret Nygren
Sally Tyler
Jennie Chin Hansen
David Polakoff
Patrick Murray
Patricia Nemore
Leonardo Cuello
Thomas James
Laura Linebach
Steven Counsell
Joan Levy Zlotnik
Adam Burrows

Subject Matter Experts
Mady Chalk
James Dunford
Lawrence Gottlieb
Juliana Preston
Susan Reinhard
Rhonda Robinson Beale
Gail Stuart

Federal Government Members
DEB Potter
Cheryl Powell
Samantha Meklir
Henry Claypool
Rita Vandivort
Daniel Kivlahan

Meeting Objectives

- Review and discuss the results of MAP Hospital, Clinician, and Post-Acute Care/Long-Term Care Workgroup deliberations on pre-rulemaking input to HHS

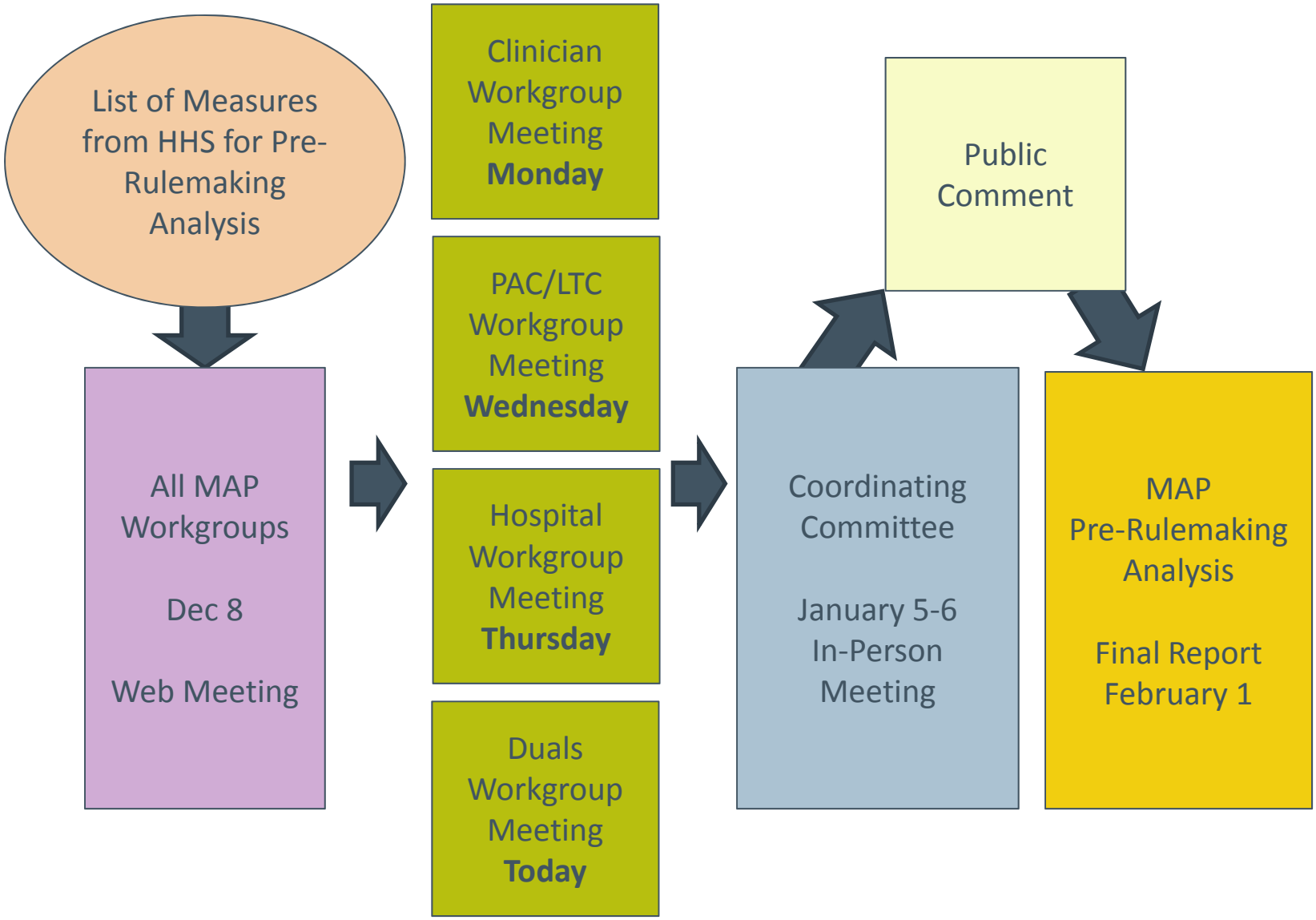
- Provide additional cross-cutting input to MAP Coordinating Committee regarding the applicability and appropriateness of measures for dual eligible beneficiaries

Agenda

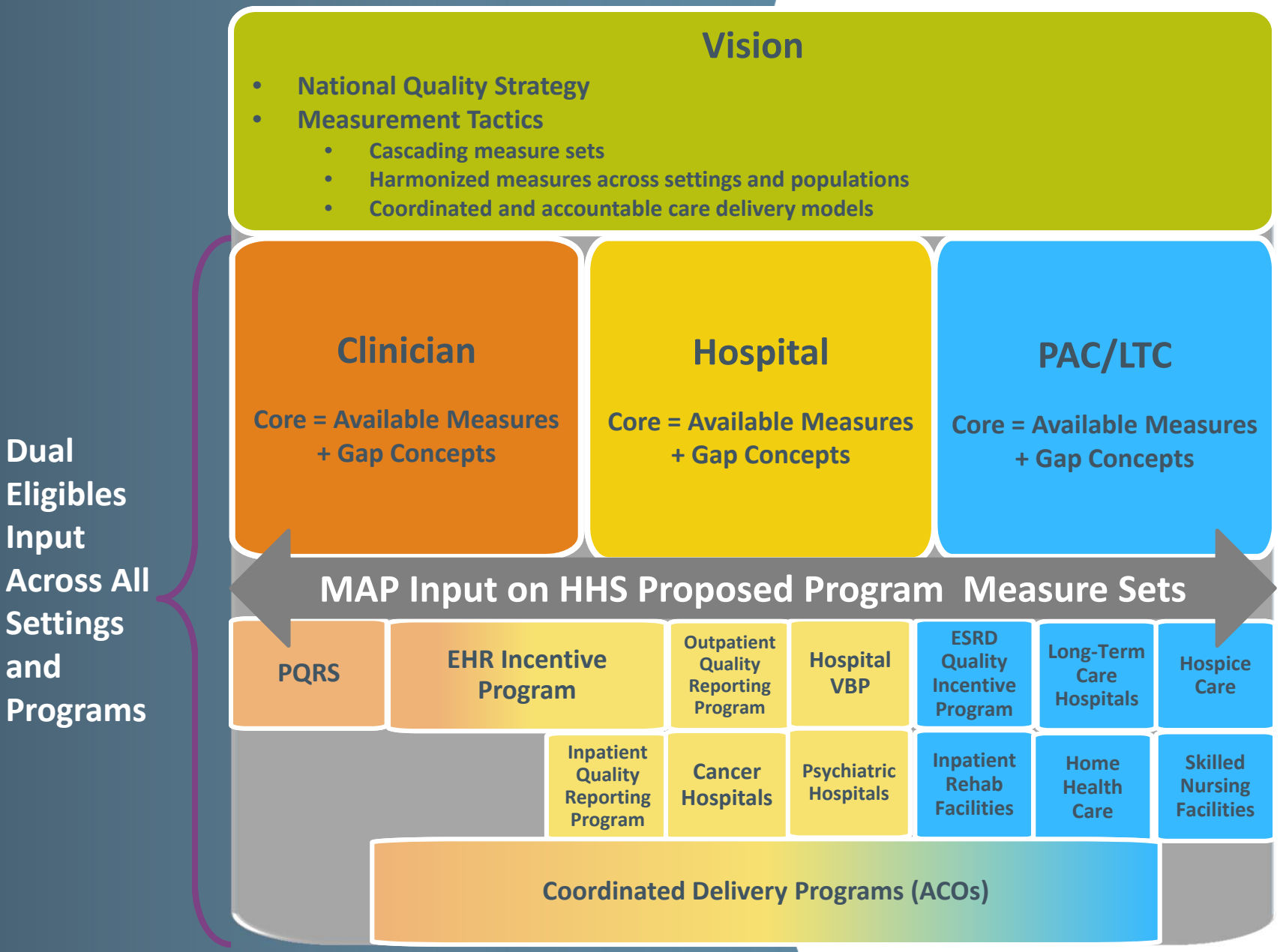
- Review and Discuss PAC/LTC Workgroup Progress
- Review and Discuss Clinician Workgroup Progress
- Review and Discuss Hospital Workgroup Progress
- Additional Input to MAP Coordinating Committee
- Next Steps

MAP Pre-Rulemaking Approach

Pre-Rulemaking Process and Timeline



MAP Pre-Rulemaking Approach



Background Materials for Other Workgroups

- MAP Measure Selection Criteria
- Discussion guide
- Reference materials
  - Program summary sheet
  - Program measure chart
  - Individual measure information
- Considerations from the Dual Eligible Beneficiaries Workgroup
  - Cross-cutting guidance
  - Five High-Leverage Areas for Improvement Through Measurement
  - Workgroup-Specific Input
  - Draft Core Set of Measures

Guidance Related to Dual Eligible Beneficiaries and Care Coordination

Across program measure sets:

- Is there representation of the issues presented in the five high-leverage opportunity areas and the list of draft core measures?
- If not, is it appropriate to add any measures to fill that gap?
- Does a measure set include measures which are inappropriate or counterproductive to use with vulnerable populations?
- Consider care coordination issues:
  - Review existing care coordination measures in the program measure set
  - Consider if available endorsed measures will fill a care coordination gap

Post-Acute Care / Long-Term Care Workgroup Pre-Rulemaking Input

PAC/LTC Measurement Programs

The PAC/LTC Workgroup considered the following program measure sets:

- Inpatient Rehabilitation Facility Quality Reporting (IRF)
  - Reviewed 8 measures under consideration
- Long-Term Care Hospital Quality Reporting (LTCH)
  - Reviewed 8 measures under consideration
- Home Health Quality Reporting
  - Confirmed previous workgroup evaluation of Home Health Compare
- Nursing Home Quality Initiative and Nursing Home Compare
  - Confirmed previous workgroup evaluation of the program measure set
- End Stage Renal Disease Quality Improvement (ESRD)
  - Reviewed 5 measures under consideration
- Hospice Quality Reporting
  - Reviewed 6 measures under consideration

Results of PAC/LTC Workgroup Deliberations

- Strong agreement between PAC/LTC Workgroup and Dual Eligible Beneficiaries Workgroup
- Core concepts, lists of gaps, and discussion themes are significantly overlapping and reinforcing each other

In considering the list of measures under consideration, the PAC/LTC Workgroup specifically supported the addition or inclusion of those related to:

- Pain management
- Functional status
- Care coordination /transitions
- Patient experience

Additional Support for Measure Gaps

- Mental health – *to be added to PAC/LTC core concepts*
- Avoidable admissions or readmissions
- Shared decision making
- Establishment and attainment of individual and family goals
- Care coordination / transitions
- Percentage of patients returning to community setting
- Advance care planning and treatment
- Delirium
- Inappropriate medication use

Measures Considered: IRFs and LTCHs

- Pain Management: % of residents on a scheduled pain medication regimen on admission who self-report a decrease in pain intensity or frequency (#0675)
  - Support direction but there are problems with the way the measure is specified
  - Suggested exploration of similar measures
    - Pain Assessment Conducted (#0523) is in the Duals Draft Core Set, specified for home health
    - Important that measures across PAC and LTC settings relate to each other and that similar tools are used when possible
- Three functional outcome measures of change over time
  - If achieved, accurate assessment of function can help to ensure care is delivered in least intense setting and may reduce overall costs
  - Measures address a core concept but need further development; numerators and denominators still unspecified and measure has not yet been submitted to NQF for endorsement

Measures Considered: ESRD

- Supported inclusion of Assessment of Health-related Quality of Life (Physical and Mental Functioning) (#0260) from Duals Draft Core Set
  - Process measure promotes use of survey and attention to quality of life issues without holding ESRD facilities accountable for ultimate outcome
  - Uncertainty about whether tool specified in the measure is best
  - Emphasized importance of measuring quality of life across PAC and LTC, also noted technical difficulty and lack of available measures in all other settings
- Most measures for ESRD very technical and narrowly focused on clinical aspects of dialysis
- Consensus on the need to broaden scope of this program's set to include PAC/LTC's core concepts and emphasize CAHPS survey specific to this type of care

Measures Considered: Hospice

- Supported inclusion of Family Evaluation of Hospice Care (#0208) from Duals Draft Core Set
  - Strongly urged expansion of this measure to look at family evaluation of all care for advanced illness and end-of-life, regardless of whether it occurs in hospice
    - 20% of non-traumatic deaths occur in PAC/LTC settings
    - Other tools are in development for this purpose
  - Supported notion that family is inherently included in unit of care
  - Noted related measures which might be considered in the future: hospice election rate, average length of stay in hospice
  - Discussed accuracy and appropriateness of data collection methods

Additional Measures from Draft Duals Core Set Identified for Further Refinement and Application in PAC/LTC

- Screening for Clinical Depression and Follow-Up Plan (#0418)
  - Emphasized as opportunity to improve outcomes and reduce costs
- Transition Record with Specified Elements Received by Discharged Patients (#0647)
- 3-Item Care Transitions Measure (CTM-3) (#0228)
- Improvement in Ambulation/Locomotion (#0167)
  - Potential to add to short-stay nursing home population
- Change in Daily Activity Function as Measured by the AM-PAC (#0430)
  - Not sensitive enough for patients with intense needs
- Medical Home System Survey (#0494)
  - Concepts are good but this measure is designed for ambulatory care

Workgroup Discussion and Questions

Opportunity for Public Comment

Clinician Workgroup Pre-Rulemaking Input

Clinician Measurement Programs

The Clinician Workgroup considered the following program measure sets:

- Value-Based Payment Modifier
  - Reviewed core measures
  - Confirmed previous workgroup evaluation of the program measure set
  - Reviewed 10 measures under consideration
- Physician Quality Reporting System (PQRS)
  - Reviewed 158 measures under consideration
- Medicare and Medicaid EHR Incentive Program (Meaningful Use)
  - Reviewed 92 measures under consideration
- Medicare Shared Savings Program (Accountable Care Organizations)
  - Evaluated the finalized program measure set

Results of Clinician Workgroup Deliberations

In considering the list of measures under consideration, the Clinician Workgroup supported the addition or inclusion of those related to:

- Mental Health, particularly depression
- Care Coordination
  - Medication Reconciliation
  - Care Transitions, particularly CTM-3 measure
  - Communication
- Patient Experience

Additional Support for Measure Gaps

Reinforced measure gaps previously identified by the Duals Workgroup

- Resource use and total cost of care
- Patient activation
- Measures of functional status
- Measures of cognitive status
- Measures of health risk
- Patient-reported data
  - Single item screener, e.g. “How Is Your Health?”
  - PROMIS measures
- Data sharing among unrelated entities
- Emergency department use (as proxy for access to care)
- Palliative and end-of-life care

Measures Considered: Value Modifier

- Previously finalized as part of program set:
  - Falls: Screening for Fall Risk (#0101)*
  - BMI Screening and Follow-Up (#0421)*
  - Tobacco Use Assessment / Tobacco Cessation Intervention (#0028)*
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#0004)*
- Support addition:
  - Post-Discharge Medication Reconciliation (#0097)
- Support but want further refinement of:
  - 30-day Post-Discharge Provider Visit
  - All Cause Readmissions
  - Medicare Spending per Beneficiary
  - Total Per Capita Cost

* Measures are in Duals Draft Core Set

Measures Considered: Physician Quality Reporting System (PQRS)

- Previously finalized as part of program set:
  - Falls: Screening for Fall Risk (#0101)*
  - BMI Screening and Follow-Up (#0421)*
  - Tobacco Use Assessment / Tobacco Cessation Intervention (#0028)*
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#0004)*
  - Screening for Clinical Depression and Follow-Up Plan (#0418)*
- Support addition:
  - Optimal Diabetes Care (#0729)*
  - Optimal Vascular Care (#0076)
  - Depression Outcomes Measures (#0710, #0711, #0712)
- Support but want further refinement of:
  - Several measures, including those related to patient self-care support, and timely follow up for care of patients with comorbid conditions

*** Measures are in Duals Draft Core Set**

Measures Considered: Meaningful Use

- Previously finalized as part of program set:
  - BMI Screening and Follow-Up (#0421)*
  - Tobacco Use Assessment / Tobacco Cessation Intervention (#0028)*
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#0004)*
- Support addition:
  - Screening for Clinical Depression and Follow-Up Plan (#0418)*
  - Depression Outcomes Measures (#0710, #0711, #0712)
  - Post-Discharge Medication Reconciliation (#0097)
- Some support for:
  - Falls: Screening for Fall Risk (#0101)*
  - Drugs to be avoided in the elderly (#0022)
  - Major Depressive Disorder: Depression Evaluation / Suicide Risk Assessment (#0103, #0104)

*** Measures are in Duals Draft Core Set**

Workgroup Discussion and Questions

Opportunity for Public Comment

Hospital Workgroup Pre-Rulemaking Input

Hospital Measurement Programs

The Hospital Workgroup considered the following program measure sets:

- Inpatient Quality Reporting (IQR)
  - Reviewed 21 measures under consideration and finalized measures
- Hospital Value-based Purchasing (VBP)
  - Reviewed 13 measures under consideration and finalized measures
- Inpatient Psychiatric Facility Quality Reporting
  - Reviewed 6 measures under consideration
- Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use)
  - Reviewed 36 measures under consideration and finalized measures
- Outpatient Quality Reporting (OQR)
  - Reviewed finalized measures
- Ambulatory Surgical Center (ASC) Quality Reporting
  - Reviewed finalized measures
- PPS-Exempt Cancer Hospital Quality Reporting
  - Reviewed 5 measures under consideration

Results of Hospital Workgroup Deliberations

Limited overlap in core concepts, measure gaps, and discussion themes between Hospital Workgroup and Dual Eligible Beneficiaries Workgroup

- Dual Eligible Beneficiaries Workgroup has previously identified that the Hospital measure sets are primarily condition-specific
- Dialogue was highly technical and often turned to methods and specifications

Two specific measures in the Draft Duals Core Set were under consideration for hospital programs and both were supported for inclusion.

Generally, the Hospital Workgroup supported the inclusion of certain measures related to:

- Patient Safety
- Care Coordination, specifically readmissions and discharge planning

Measures Considered: Inpatient Quality Reporting

- Care coordination a major topic of focus
  - Support addition of 3-Item Care Transition Measure (CTM-3) (#0228)*
  - Encouraged ongoing efforts to integrate the CTM-3 items into the CAHPS survey to ease burden of data collection and reporting
  - Coordinating Committee will consider whether a hospital-wide readmission measure is appropriate and should be supported by MAP
    - » Similar measure in Draft Duals Core Set, may require further exploration
- Substance use measures in development
  - Supported direction of a set of eight measures related to tobacco, alcohol and substance use screening, treatment, and follow-up
  - Premature to recommend for IQR program as measures are not yet fully developed and have yet to be reviewed by NQF

* Measures are in Duals Draft Core Set

Measures Considered: VBP, Psych, and OQR

- Hospital Value-Based Purchasing
  - Discussed the best measures of patient safety
  - Discussed the same "Medicare Spending Per Beneficiary" measure concept as the Clinician Workgroup; also supported its continued development
- Inpatient Psychiatric Facility
  - Supported all six measures under consideration: use of multiple antipsychotic medications, hours of seclusion and/or restraint, post-discharge care planning
    - Includes HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge (#0558)*
  - Noted gaps related to monitoring metabolic syndrome for people on antipsychotic medication, keeping follow-up care appointments, and links to primary care and substance use treatment
- Outpatient Quality Reporting
  - Supported retention of Transition Record with Specified Elements (#0649)… (outpatient version of similar inpatient measure in Draft Duals Core Set) and also Tracking Clinical Results Between Visits (#0491)

*** Measures are in Duals Draft Core Set**

Measure Gaps and Further Considerations

The Dual Eligible Beneficiaries Workgroup has previously identified gaps in the Hospital Core Set. Should any be prioritized for further discussion by the Coordinating Committee?

What quality issues are most important to measure during a hospitalization?

- Geriatric measures (i.e., presence of delirium)
- Assessment of level of function upon admission
- Appropriateness of initial hospital admission
- Mobilization during inpatient stay
- Restraint-free care
- Informed decision making
- Polypharmacy and medication reconciliation
- Advance care planning
- Discharge planning
- Coordination of follow-up care

Workgroup Discussion and Questions

Opportunity for Public Comment

Considering Success Across Workgroups

- Input was well-received and considered throughout
- All measures in the draft core already finalized for use in Federal programs continued to be supported
- All but one measure in the draft core under consideration for use in Federal programs were supported for addition or for further exploration and refinement
  - Exception was in the Meaningful Use program: Clinician Workgroup did not support Falls: Screening for Fall Risk (#0101) based on parsimony
- One measure from the draft core which was not under consideration by HHS for use in a program was explicitly added
  - PAC/LTC Workgroup supported quality of life survey for ESRD
- Many other measures which relate to the five high-leverage opportunity areas were discussed and supported

Any Remaining Opportunities?

- Six of 23 draft core measures are not under consideration for use in any program, consider why or why not
  - All-Cause Readmission Index (#0329)
    - » Similar measure will be under consideration by Coordinating Committee
  - Change in Daily Function as Measured by the AM-PAC (#0430)
    - » Better for higher-functioning patients in post-acute care
  - The Ability to Use HIT to Perform Care Management at the Point of Care (#0490), Medical Home System Survey (#0494)
    - » Structural measures largely absent from public reporting programs
  - SNP 6: Coordination of Medicare and Medicaid Coverage
    - » Health plan level measure, not applicable to providers
  - Potentially Harmful Drug-Disease Interactions in the Elderly
    - » Not endorsed, may be better measures for this issue

Additional Input

- Did the other MAP workgroups properly account for the five high-leverage opportunity areas?
  - Quality of Life
  - Care Coordination
  - Screening and Assessment
  - Mental Health and Substance Use
  - Structural Measures
- Which gaps are most important overall?
- What other issues related to dual eligible beneficiaries should the Coordinating Committee consider during pre-rulemaking deliberations?

Workgroup Discussion and Questions

Next Steps

NQF welcomes additional thoughts and comments through the end of the day on Monday, December 19.

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Thank you for joining us!

Pre-Rulemaking Considerations from MAP Dual Eligible Beneficiaries Workgroup

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

General Principles for Measure Selection

In reviewing potential measures for individual programs, other workgroups considered that the Dual Eligible Beneficiaries Workgroup has identified the areas in which performance measurement can provide the most leverage in improving the quality of care: **quality of life, care coordination, screening and assessment, mental health and substance use, as well as structural measures**. A list of measures in these areas which are collectively being considered a draft core set is provided in the last section of this document.

MAP groups also considered that the following issues are strongly related to quality of care in the dual eligible beneficiary population, regardless of the type of care being provided.

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

Considerations for Hospital Programs

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

Measure Gaps in the Hospital Core Set

The Dual Eligible Beneficiaries Workgroup identified the following gaps in the Hospital Core Set:

- Assessment of prior level of function before admission
- Appropriateness of initial hospital admission
- Geriatric measures (i.e., avoidance of delirium)
- Mobilization during inpatient stay
- Restraint-free care
- Informed decision making
- Discharge planning
- Coordination of follow-up care

Measure Exceptions

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

Actions Taken by the Hospital Workgroup as a Result

- Supported inclusion of 0558 - HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge for inclusion in Inpatient Psychiatric Facility Quality Reporting
- Supported inclusion of 0228 – 3-Item Care Transition Measure (CTM-3) in Inpatient Quality Reporting
- Supported measures similar to core regarding hospital-wide readmission rates and transition record being received by discharged patient/caregiver

Considerations for Clinician Programs

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

Measure Gaps in the Clinician Core Set

The Dual Eligible Beneficiaries Workgroup identified the following gaps in the Clinician Core Set:

- Patient understanding of treatment plan
- Pain management
- Medication adherence
- Screening, assessment, and referral to treatment for problem use of alcohol or other drugs
- Communication with patient and family, communication with other providers
- Practice's capacity to serve as a medical home
- Practice's capacity to provide assistance in accessing specialty care
- Coordination with non-medical providers of long-term supports

Measure Exceptions

The Dual Eligible Beneficiaries workgroup noticed the abundance of measures related to screening and disease monitoring. They cautioned that appropriate exclusions should be in place for such measures. For example, a 99-year old man with Alzheimer's disease does not need to have his cholesterol under tight control. In addition, maternal and pediatric measures do not apply to the dual eligible population.

Actions Taken by the Clinician Workgroup as a Result

- Value Modifier
    - Supported retention of four core measures in Value Modifier set
- PQRS
    - Supported retention of five core measures in PQRS set
    - Supported addition of 0729 – Optimal Diabetes Care to PQRS set
- Meaningful Use
    - Supported retention of three core measures in the Meaningful Use set
    - Supported addition of 0418 – Screening for Clinical Depression and Follow-Up Plan to Meaningful Use set
- Supported addition of measures on depression to PQRS set and Meaningful Use set
- Supported addition of measures on medication reconciliation to Value Modifier set and Meaningful Use set

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

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

Measure Gaps in the PAC/LTC Core Set

The Dual Eligible Beneficiaries Workgroup identified the following gaps in the PAC/LTC Core Set:

- Identification and treatment of mental illness, especially depression
- Communication across an integrated care team
- Appropriate prescribing and dosing
- Connection to home- and community-based services
- Successful transitions to less-restrictive care
- Chemical restraints
- Patient and caregiver experience
- Caregiver education and support
- Cost and/or resource use
- Structural measures related to HIT

Actions Taken by the PAC/LTC Workgroup as a Result

- Supported retention of all core measures finalized for use in programs
- Supported inclusion of 0260 – Assessment of Health-related Quality of Life (Physical and Mental Functioning) in ESRD set
- Supported inclusion of 0208 – Family Evaluation of Hospice Care in Hospice set
- Conceptually agreed with many additional core measures and asked that potential modifications be explored to make them applicable to more PAC/LTC settings:
    - 0418 – Screening for Clinical Depression and Follow-Up Plan
    - 0647 – Transition Record with Specified Elements Received by Discharged Patients
    - 0228 – 3-Item Care Transitions Measure (CTM-3)
    - 0167 – Improvement in Ambulation/Locomotion
    - 0430 – change in Daily Activity Function as Measured by the AM-PAC
    - 0494 – Medical Home System Survey

MAP Dual Eligible Beneficiaries Workgroup: Draft Core Set of Measures

The workgroup identified the draft core set presented below from an extensive list of current measures. Potential measures were considered in five areas previously identified by the workgroup as most closely linked to quality of care:

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

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

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Use in Federal Programs
0329 Endorsed	*All-Cause Readmission Index (risk adjusted)* Overall inpatient 30-day hospital readmission rate, excluding maternity and pediatric discharges		✓				Hospital	
0228 Endorsed	*3-Item Care Transition Measure (CTM-3)* Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan		✓				Hospital	Under consideration for Hospital Inpatient Quality Reporting **(Supported)**
0558 Endorsed	*HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity		✓		✓		Hospital	Under consideration for Inpatient Psychiatric Facility Quality Reporting **(Supported)**
0418 Endorsed	*Screening for Clinical Depression and Follow-up Plan* Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool and follow up plan documented			✓	✓		Ambulatory, Hospital, PAC/LTC Facility	Finalized for use in PQRS and Medicare Shared Savings, Under consideration for Meaningful Use **(Supported)**, Proposed for Medicaid Adult Core Measures
0647 Endorsed	*Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements		✓				Hospital, PAC/LTC Facility	Proposed for Medicaid Adult Core Measures
0430 Endorsed	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing	✓		✓			Ambulatory, Home Health, Hospital, PAC/LTC Facility	

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Use in Federal Programs
0576 Endorsed	*Follow-up after hospitalization for mental illness* Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner		✓		✓		Ambulatory, Behavioral Health	Proposed for Medicaid Adult Core Measures
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision Making* 37 core and 64 supplemental question survey of adult outpatient primary care patients		✓				Ambulatory	Finalized for use in Medicare Shared Savings
0006 Endorsed	*CAHPS Health Plan Survey v 4.0 - Adult questionnaire: Health Status/Functional Status* 30-question core survey of adult health plan members that assesses the quality of care and services they receive	✓					Ambulatory	Finalized for use in Medicare Shared Savings, Proposed for Medicaid Adult Core Measures
0490 Endorsed	*The Ability to use Health Information Technology to Perform Care Management at the Point of Care* Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: a. The ability to identify specific patients by diagnosis or medication use, b. The capacity to present alerts to the clinician for disease management, preventive services and wellness, c. The ability to provide support for standard care plans, practice guidelines, and protocol					✓	Ambulatory	
0494 Endorsed	*Medical Home System Survey* Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions					✓	Ambulatory	
0101 Endorsed	*Falls: Screening for Fall Risk* Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months			✓			Ambulatory	Finalized for use in PQRS, Medicare Shared Savings, and Value Modifier Under consideration for Meaningful Use **(Not Supported)**

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Use in Federal Programs
0729 Endorsed	*Optimal Diabetes Care* Patients ages 18 -75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 14090, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated			✓			Ambulatory	Components of this composite are finalized for use in Medicare Shared Savings and Value Modifier, Under consideration for PQRS **(Supported)**
0421 Endorsed	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up* Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25			✓			Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier, Proposed for Medicaid Adult Core Measures
0028 Endorsed	*Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention* Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period			✓	✓		Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0004 Endorsed	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement* The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit				✓		Ambulatory	Finalized for use in PQRS, Meaningful Use, and Value Modifier Proposed for Medicaid Adult Core Measures
0523 Endorsed	*Pain Assessment Conducted* Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	✓		✓			Home Health	Finalized for use in Home Health
0167 Endorsed	*Improvement in Ambulation/locomotion* Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care	✓		✓			Home Health	Finalized for use in Home Health

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Use in Federal Programs
0208 Endorsed	*Family Evaluation of Hospice Care* Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument	✓					Hospice	Under consideration for Hospice Quality Reporting **(Supported)**
0260 Endorsed	*Assessment of Health-related Quality of Life (Physical & Mental Functioning)* Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year	✓		✓	✓		Dialysis Facility	**Supported** for ESRD Quality Reporting
Not Endorsed	*SNP 6: Coordination of Medicare and Medicaid coverage* Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers					✓	[not available]	
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.			✓	✓		[not available]	Proposed for Medicaid Adult Core Measures
Not Endorsed	*Potentially Harmful Drug-Disease Interactions in the Elderly* Percentage of Medicare members 65 years of age and older who have a diagnosis of chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 selective NSAIDs; Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents; percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents		✓	✓			Pharmacy	