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Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup

In-Person Meeting #1

June 2-3, 2011

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Welcome and Review of Meeting Objectives

Presenters

Alice Lind, Workgroup Chair
Senior Clinical Officer, Center for Health Care Strategies

Janet Corrigan
President and Chief Executive Officer, NQF

Ann Hammersmith
General Counsel, NQF

Tom Valuck
Senior Vice President, Strategic Partnerships, NQF

Diane Stollenwerk
Vice President, Community Alliances, Strategic Partnerships, NQF

Karen Adams
Vice President, National Priorities, Strategic Partnerships, NQF

Taroon Amin
Senior Director, Strategic Partnerships, NQF

Lindsay Lang
Senior Program Director, Strategic Partnerships, NQF

Sarah Lash
Program Director, Strategic Partnerships, NQF

Cheryl Powell
Deputy Director, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services

Meeting Objectives

- Review charge for the Workgroup, role within MAP, and approach to the tasks
- Receive guidance from CMS Medicare-Medicaid Coordination Office
- Discuss and prioritize unique population quality issues to form the basis for a strategic approach to performance measurement
- Provide input on healthcare-acquired condition (HAC) and hospital readmission measurement issues specific to dual eligible beneficiaries

Meeting Agenda: Day 1

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9:00	Welcome and Review of Meeting Objectives
9:10	Opening Remarks
9:20	Introductions and Disclosures of Interests
9:50	Policies and Operations
10:20	Workgroup Charge and Approach
11:00	Vision for Improved Care for Dual Eligible Beneficiaries
Noon	Working Lunch
12:30	Guiding Frameworks
1:15	Population Dynamics and Patterns
1:45	Defining Quality Care for Dual Eligible Beneficiaries
3:15	Strategic Approach to Performance Measurement
4:30	Summary of Day 1 and Look Forward to Day 2
4:45	Adjourn for the Day

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Opening Remarks

NQF Mission Statement

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The National Quality Forum (NQF) operates under a three-part mission to improve the quality of American healthcare by:

- 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.

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Quality Measurement Enterprise: NQF Contributions

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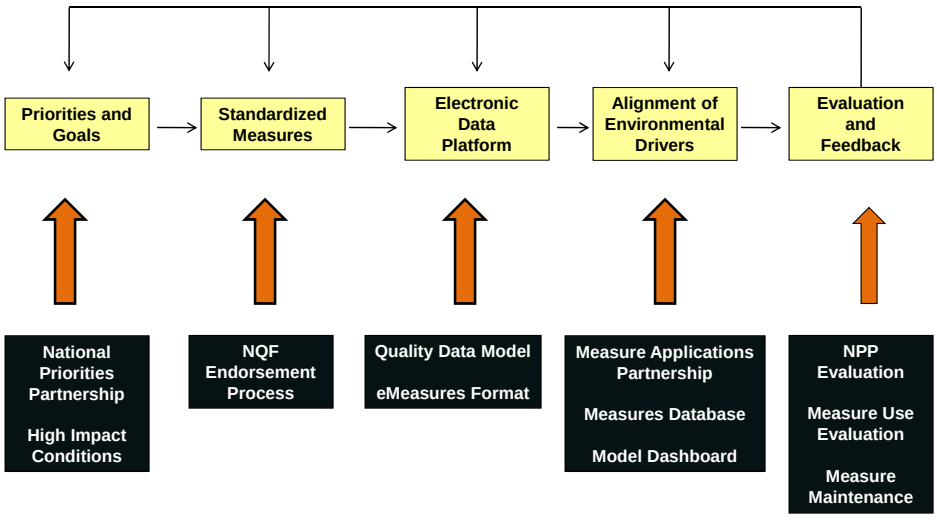

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Quality Measurement in Evolution

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- Drive toward higher performance
- Shift toward composite measures
- Measure disparities in all we do
- Harmonize measures across sites and providers
- Promote shared accountability and measurement across patient-focused episodes of care:
  - Outcome measures
  - Appropriateness measures
  - Cost/resource use measures coupled with quality measures, including overuse

Emerging Measures

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- Characteristics of good measures
  - Important problem; improvement would be valued
  - Clear what is being measured (observable)
  - Results can be attributed to individuals or groups who have the authority and capacity to change the results
- Emerging measures
  - Procedure-specific outcomes
  - Measures derived from EHRs
  - Composite measures
  - Population-based measures

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Introductions and Disclosures of Interests

MAP Two-Tiered Structure

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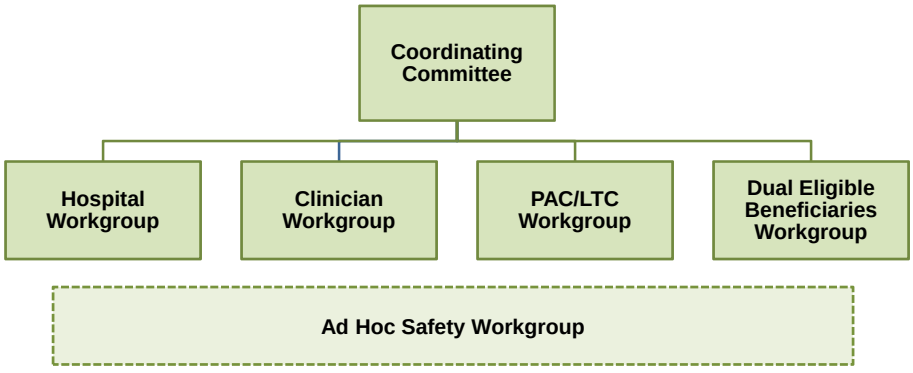

Dual Eligible Beneficiaries Workgroup Membership

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Chair	Alice Lind, MPH, BSN

Organizational Members	Representatives
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

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Dual Eligible Beneficiaries Workgroup Membership

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Subject Matter Experts	
Mady Chalk, PhD, MSW	Substance Abuse
James Dunford, MD	Emergency Medical Services
Lawrence Gottlieb, MD, MPP	Disability
Juliana Preston, MPA	Measure Methodologist
Susan Reinhard, PhD, RN, FAAN	Home and Community-Based Services
Rhonda Robinson Beale, MD	Mental Health
Gail Stuart, PhD, RN	Nursing

Federal Government Members	Representatives
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

Coordinating Committee Co-Chairs	George Isham, MD, MS
	Beth McGlynn, PhD, MPP

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MAP Policies and Support

- Member responsibilities
- Communications policies and support
  - Brochure
  - Template press release
  - Q&A
  - Core slide set
  - NQF Communications staff

Workgroup Member Terms

- While NQF's current scope of work with HHS lasts through June 2012, the MAP's work is expected to continue.
  - Specific tasks will change over time
  - The workgroup structure is designed to be flexible and groups may shift to align with evolving priorities
- The terms for MAP members are for 3 years.
- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw.
- There are equal numbers of 1-, 2-, and 3-year terms.
- Members whose terms expire are eligible to re-nominate themselves during the open Call for Nominations.
- There is no term limit for MAP members at this time.

Membership Terms

Chair	Term Length
Alice Lind, MPH, BSN	3

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

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

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

MAP Decision-Making Principles

- Overarching principle:
  - The priorities and goals of the National Quality Strategy (NQS) will provide the foundation for MAP decision making
- Additional guiding principles for consideration:
  - A two dimensional framework for performance measurement—NQS priorities and high impact conditions for dual eligible population—will provide focus
  - The patient-focused episodes of care model will reinforce patient-centered measurement across settings and time
  - HHS Multiple Chronic Conditions Framework
  - Attention to equity across the NQS priorities
  - Connection to financing, delivery models, and broader context

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Dual Eligible Beneficiaries Workgroup Charge

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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.

Analytic Strategy

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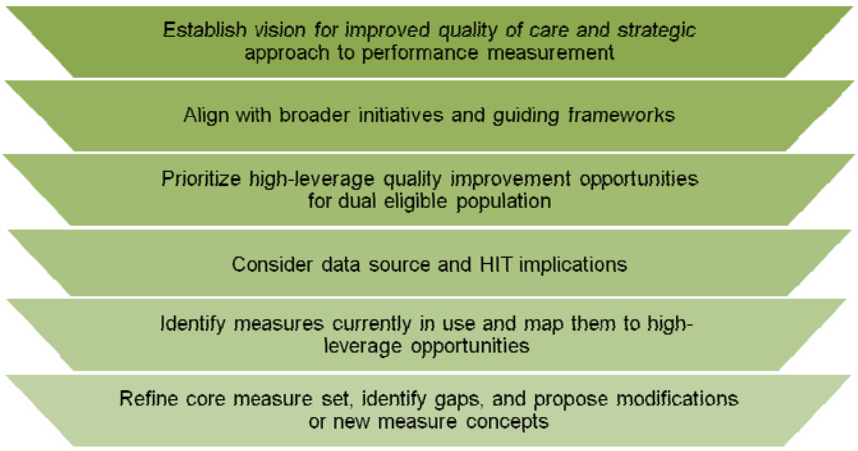

In addition, all other MAP groups will be considering the implications of their specific tasks for dual eligible beneficiaries.

Upcoming Work and Timeline for Phase I

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July 6, 2011
- MAP Dual Eligible Beneficiaries Workgroup web meeting to finalize input on HACs and readmissions, introduce measure mapping

July 25-26, 2011
- MAP Dual Eligible Beneficiaries Workgroup in-person meeting to construct proposed performance measurement strategy and map potential measures to priority areas

August 2011
- MAP Coordinating Committee meets to discuss the Dual Eligible Beneficiaries Workgroup's input and provide additional guidance for Interim Report to HHS

October 2011
- Interim Report due to HHS, followed by public comment period.

Flow of Information to Inform Reports

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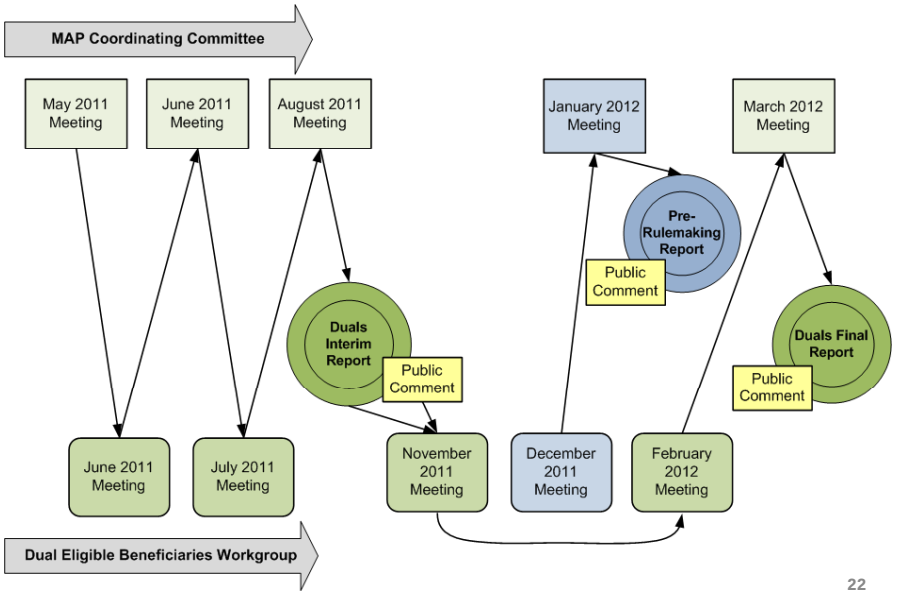

Guidance from Coordinating Committee

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- Address HHS tasks while taking into account alignment with the private sector
- Set appropriate expectations given the time constraints (e.g. identify work for subsequent phases)
- Dual Eligible Beneficiaries Workgroup should closely link to the PAC/LTC Workgroup
- Focus on models of care rather than individual measures

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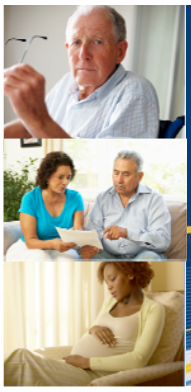
Discussion and Questions

Integrating Care for Individuals Eligible for Medicare and Medicaid



Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services

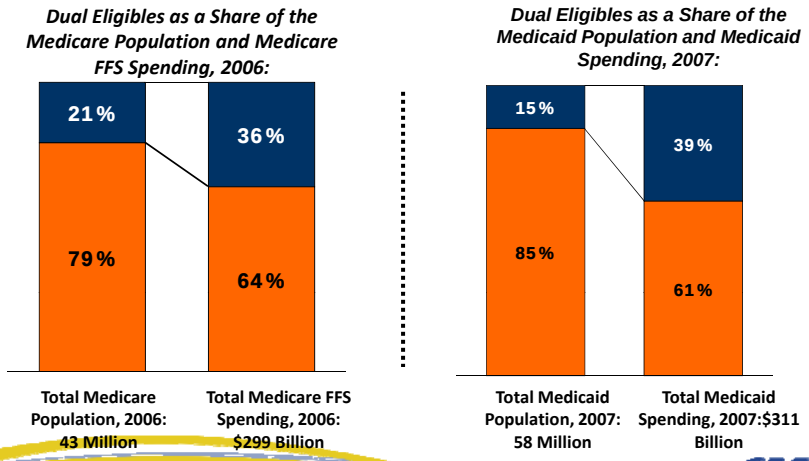
May 2011

Medicare-Medicaid Enrollees

- 9.2 million individuals (2008) that are eligible for both Medicare and Medicaid, or Medicare-Medicaid enrollees.
- More likely to have mental illness, have limitations in activities of daily living and multiple chronic conditions.
- Few are served by coordinated care models and even fewer are in integrated models that align Medicare and Medicaid.

[1] Based on 2006 data.

Medicare-Medicaid Beneficiaries Account for Disproportionate Shares of Spending



Kaiser Family Foundation, "The Role of Medicare for the People Dually Eligible for Medicare and Medicaid", January 2011. http://www.kff.org/medicare/upload/8138.pdf

Medicare-Medicaid Coordination Office

- Section 2602 of the Affordable Care Act (ACA)
- Purpose: Improve quality, reduce costs, and improve the beneficiary experience.
  - Ensure dually eligible individuals have full **access** to the services to which they are entitled.
  - Improve the **coordination** between the federal government and states.
  - Develop **innovative** care coordination and integration models.
  - Eliminate financial **misalignments** that lead to poor quality and cost shifting.

Focus on Beneficiary and Person Centered Care and Service Delivery

- Improve Medicare-Medicaid enrollees' satisfaction, program awareness, health, functional status, and well-being.
- Assure Medicare-Medicaid enrollees are receiving high quality, **person centered** acute, behavioral, and long term services and supports.

Medicare-Medicaid Coordination Office Major Areas of Work

The Medicare-Medicaid Coordination Office is working on a variety of initiatives to improve access, coordination, and cost of care for Medicare-Medicaid enrollees in the following areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations
- Other

Program Alignment

- Pursue opportunities to better align Medicare and Medicaid requirements to advance seamless care for Medicare-Medicaid enrollees.
- Develop overarching plan to measure quality for Medicare-Medicaid enrollees.
- Coordinate within CMS and across HHS for efforts to address issues impacting Medicare-Medicaid enrollees.

Data and Analytics

- Improve state access to Medicare data for care coordination, including timely availability of A, B and D data.
- Create national and state profiles of dual eligibles.
- Analyze impact of eligibility pathways to better understand beneficiary experience.
- Leverage other CMS initiatives to analyze dual population (e.g. geographic variation and potentially avoidable hospitalizations)

Targeting Interventions to Improve Care

- Data and analytics provides opportunity to focus interventions for Medicare-Medicaid enrollees
  - Aligned with strategic goals for quality improvement and reducing costs.
  - Aimed at improving specific outcomes (e.g. PAH).
  - Targeting key conditions in complex patient population.

Models and Demonstrations

- Partnership with the Innovation Center to test delivery system and payment reform that improves the quality, coordination, and cost-effectiveness of care for dual eligible individuals.
- 15 states selected receive up to $1 million to design new models for serving dual eligibles (CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA and WI).
- Planning underway for future projects that could include a focus on nursing facilities, health homes, and Special Needs Plans (SNPs).

Medicare-Medicaid Coordination Office Initiatives

- Beneficiary focus groups
- Listening sessions
- Technical assistance for states, plans and providers
- Ongoing stakeholder engagement
- Consultation with MedPAC and MACPAC

Conclusion

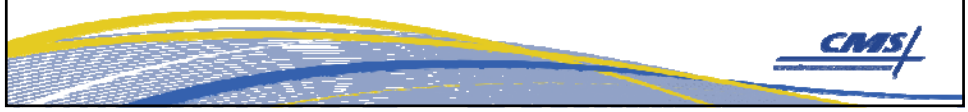
- CMS, through the Medicare-Medicaid Coordination Office, is working to ensure better health, better care and lower costs through improvement for individuals eligible for both Medicaid and Medicare.
- Tremendous opportunities exist to improve access, quality and cost of care for the nation's most complex and chronically ill individuals.

Questions & Suggestions:

MedicareMedicaidCoordination@cms.hhs.gov

For more information, visit:

http://www.cms.gov/medicare-medicaid-coordination/



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Discussion and Questions

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Guiding Frameworks

HHS Aims for the National Quality Strategy

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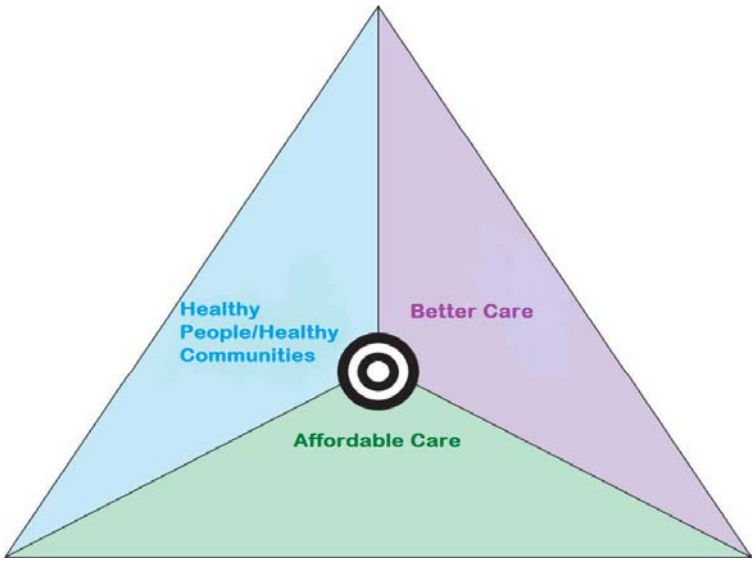

Principles for the National Quality Strategy

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1. Person-centeredness and family engagement
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage.
3. Eliminating disparities in care
4. Aligning the efforts of public and private sectors
5. Quality improvement
6. Consistent national standards
7. Primary care will become a bigger focus
8. Coordination will be enhanced
9. Integration of care delivery
10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them will be encouraged.

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HHS National Quality Strategy and NPP Goals

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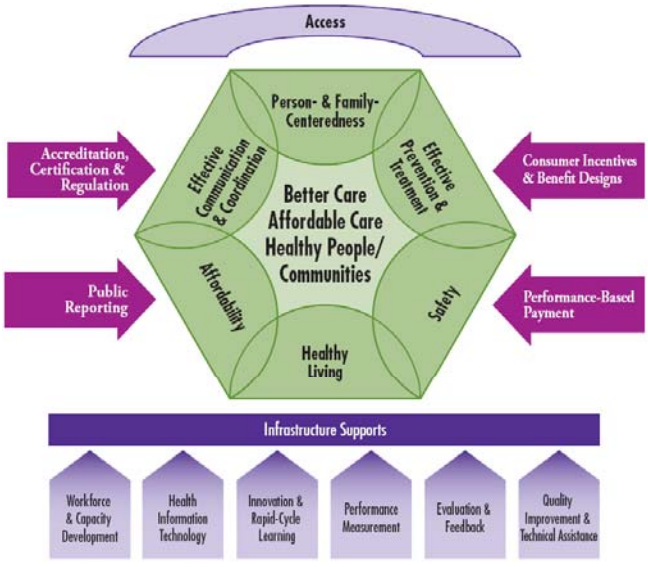

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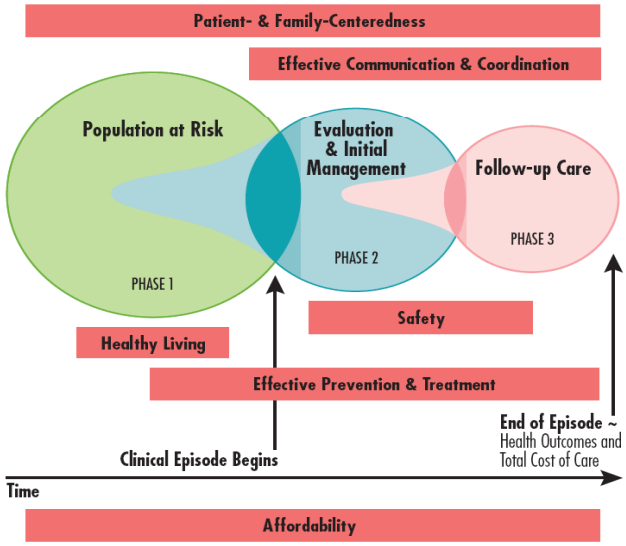
Patient-Focused Episode of Care Model



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HHS Multiple Chronic Conditions Framework

- HHS established an interagency workgroup on Multiple Chronic Conditions (MCC)
- Strategic framework released in December 2010
- Vision: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions
- Four domains:
  - Strengthening the health care and public health systems
  - Empowering the individual to use self-care management
  - Equipping care providers with tools, information, and other interventions
  - Supporting targeted research about individuals with MCC and effective interventions

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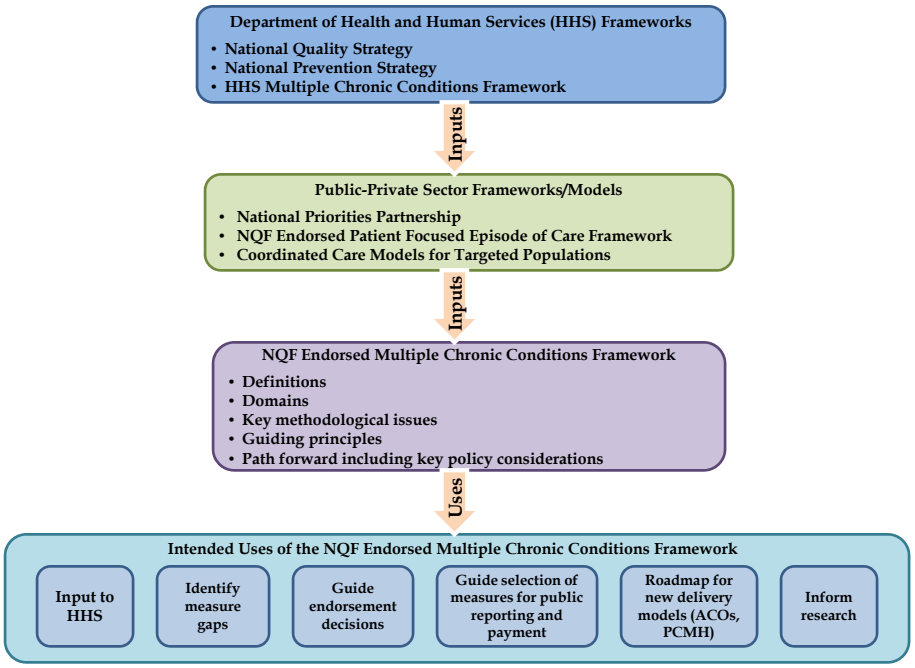
Establishing a Measurement Framework for Multiple Chronic Conditions



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Discussion and Questions

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Opportunity for Public Comment

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Dual Eligible Beneficiaries: Population Dynamics and Patterns

Background

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- Dual eligible beneficiaries receive health care coverage through both Medicare and Medicaid
- ~9.2 million people are dually enrolled (2008 data)
- While most duals are vulnerable in one or more ways, the population is not homogenous: range of physical and cognitive impairments, number of chronic conditions, settings in which care is delivered
- Population is low-income by definition/design; more than half of duals have incomes less than $10,000/year
- Considerable health care needs in the population lead to patient complexity, high utilization, and spending

Beneficiary Overlap, 2007

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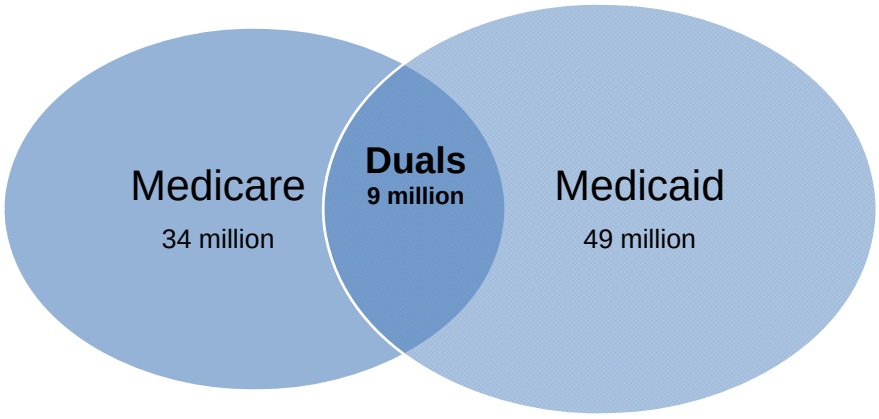
Duals comprise 21% of the Medicare population and 15% of the Medicaid population



Total Medicare beneficiaries = 43 million

Total Medicaid beneficiaries = 58 million

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2007, and Urban Institute estimates based on data from the 2007 MSIS and CMS-Form 64

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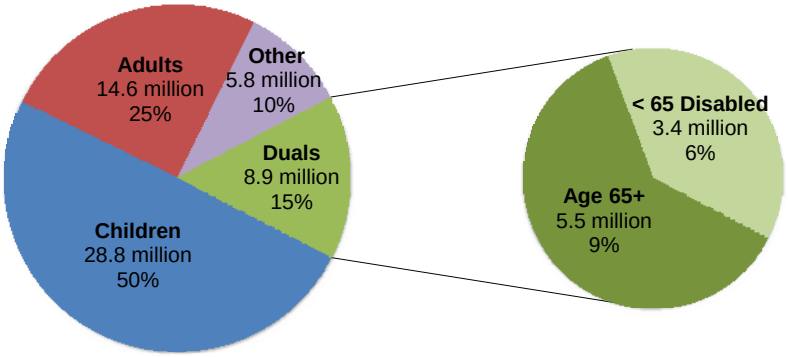
Medicaid Enrollment, FFY 2007



Total Medicaid Enrollment = 58.1 million

Duals' share of Medicaid enrollment varies significantly across states (10%-25%)
Duals account for 39% of all Medicaid expenditures, despite comprising only 15% of the beneficiary population

SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010

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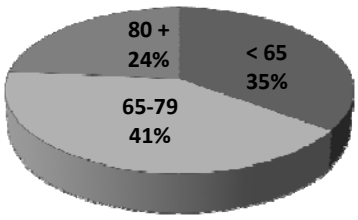
Gender and Age

Gender: Roughly 60/40 overall split between female and male beneficiaries… increases to roughly 70/30 beyond age 65.

Age:

- Approximately 1/3 of duals are younger adults with disabilities.
  - In a recent analysis of California data, 94% of duals were older than 40.
  - Very few duals are younger than 18 (<1%).
- The remaining 2/3 are older adults, and roughly one in three older adults is more than 80 years old.



SOURCES: Kaiser Commission on Medicaid and the Uninsured analysis of MSIS-MCBS 2003 linked file, California Department of Health Care Services Research and Analytic Studies Section analysis of 2007 CINByMOE analytic file.

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Ethnicity and Geography

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Ethnicity

- Dual eligible population is more diverse than the overall Medicare population
- 40% minority population vs. 20% minority in overall Medicare
  - 59% White non-Hispanic
  - 21% Black non-Hispanic
  - 12% Hispanic
  - 9% Other

Geography

- 79% of duals live in urban areas
- 21% of duals live in rural areas

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

Stability of Coverage

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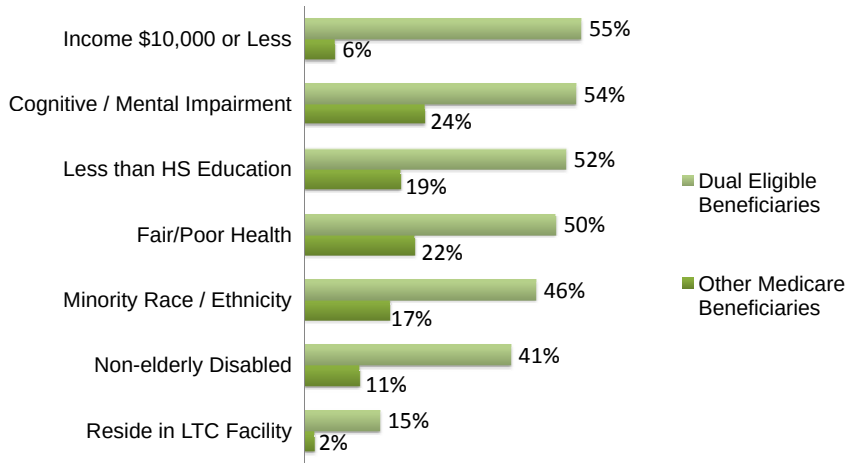
- Medicaid is a very stable source of Medicare supplementation for low-income beneficiaries.
- Unlike younger, non-disabled Medicaid recipients, the dual eligible population experiences far less "churning" due to changes in income or assets.
- In a 2006 analysis, duals had annual rates of Medicaid disenrollment that averaged only 5.4% each year.
- The cumulative probability of recipients losing Medicaid over the entire four years was just 17%. Moreover, almost 40% of individuals who lost Medicaid coverage regained it within a year.
- The primary reasons for turnover in the program are new entrants and death, not loss of coverage due either to voluntary withdrawal or administrative disentitlement.

SOURCE: Stuart and Singhal for Henry J. Kaiser Family Foundation. May 2006.

Characteristics of Dual Eligible Beneficiaries, 2008



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey 2008 Access to Care File.

Conditions and Impairments

Type and Level of Impairment Among Duals

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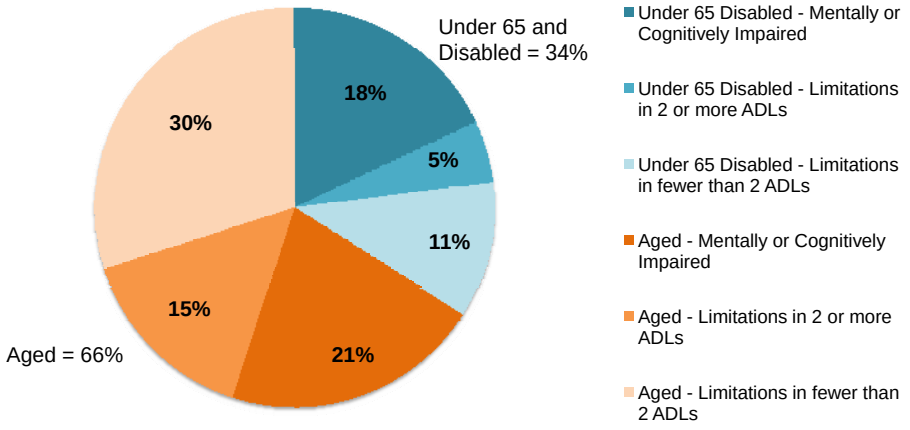
About a third of dual eligible beneficiaries have limitations in three or more ADLs, but 45% of duals did not report any impairments.



NOTES: ADL = activity of daily living. Analysis excludes beneficiaries with ESRD
SOURCE: MedPAC analysis of Cost and Use file 1999-2001 MCBS

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Prevalence of Mental/Cognitive Conditions

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	Dual Eligibles				All Other Medicare Beneficiaries
	18-64	65-79	80+	All	
Alzheimer's / dementia	5.8	12.9	39.0	16.1*	7.3
Depression	27.6	17.4	25.3	22.9*	8.4
Intellectual / developmental disability	6.7	--	--	3.1*	--
Schizophrenia	11.8	3.5	--	6.2*	0.4
Affective and other serious disorders	27.1	17.1	21.4	21.7*	8.3
Total with any mental / cognitive condition	49.2	34.1	52.5	43.8*	18.4

* = p< 0.05 using adjusted Wald F test
-- = Fewer than 30 cases unweighted
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file. 58

Prevalence of Chronic Physical Conditions

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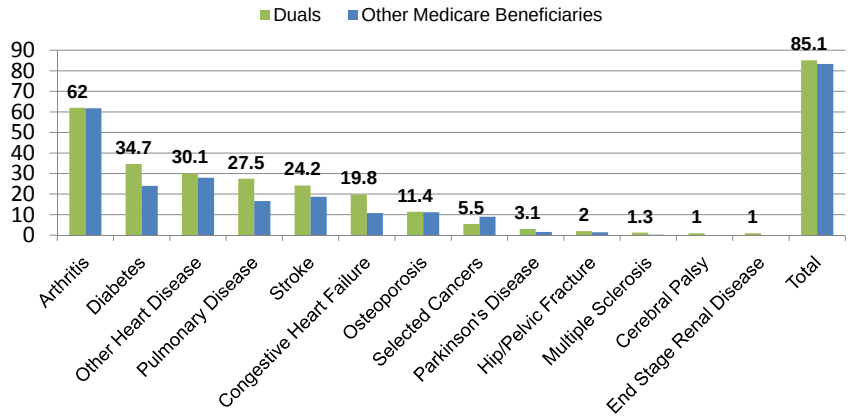
Differences in prevalence between duals and other Medicare beneficiaries are statistically significant for all conditions except arthritis and osteoporosis.



p< 0.05 using adjusted Wald F test
Selected cancers are breast, colorectal, prostate, lung, and endometrial
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file. 59

Disabled Duals: Burden of Chronic Conditions

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Clinical Classification	# of beneficiaries in CA sample of disabled duals (n=1000)	% Total
Essential hypertension	369	37%
Diabetes mellitus without complication	269	27%
Disorders of lipid metabolism	267	27%
Other lower respiratory disease	255	26%
Spondylosis; intervertebral disorders	254	25%
Blindness and vision defects	245	25%
Other connective tissue disease	225	23%
Abdominal pain	217	22%
Mood disorders	179	18%
Diabetes mellitus with complications	177	18%
Chronic obstructive pulmonary disease	169	17%
Other nervous system disorders	163	16%
Cataract	151	15%
Deficiency and other anemia	150	15%
Coronary atherosclerosis	145	15%

- *31% of the sample had a diagnosis related to diabetes, a rate nearly 4x greater than the general population.*
- *Of those in the sample with diabetes, 178 (56%) also had a diagnosis for essential hypertension.*
- *Duals with both conditions generated, on average, $35,926.79 in expenditures, excluding pharmacy.*

SOURCE: California Department of Health Care Services Research and Analytic Studies Section analysis of 2007 CINByMOE analytic file. 60

Duals' Comorbidity by Age Group

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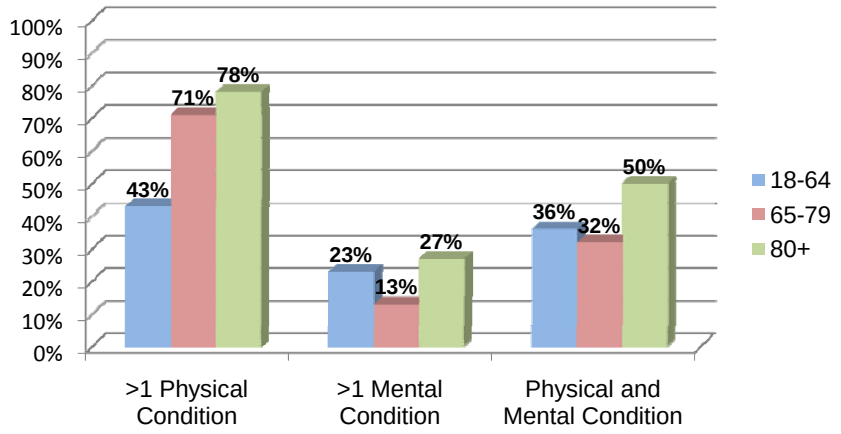

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file.

Duals' Most Expensive Clinical Conditions

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Disease	# of beneficiaries in CA sample (n=1000)	Total Cost (excluding Rx)	Cost per Beneficiary
Septicemia	30	$3,185,592	$106,186
Respiratory failure	35	$3,461,318	$98,895
Pneumonia	65	$4,717,925	$72,583
Acute cerebrovascular disease	47	$2,761,534	$58,756
Congestive heart failure	98	$5,712,677	$58,293
Chronic renal failure	65	$3,704,282	$56,989
Developmental disorders	58	$2,379,285	$41,022
Coronary atherosclerosis	145	$5,850,115	$40,346
COPD	169	$6,283,794	$37,182
Schizophrenia	133	$4,053,985	$30,481
Diabetes	313	$9,080,292	$29,011
Mood disorders	179	$5,142,973	$28,732
Hypertension	414	$11,019,614	$26,617
Spondylosis	254	$6,021,722	$23,708

NOTES: Disease categories are not mutually exclusive and members may be counted under more than one category.

Medicare and Medi-Cal combined claims data. Dates of service: 1-1-07 to 12-31-07. Classifications were assigned using AHRQ Clinical Classification algorithm.

SOURCE: California Department of Health Care Services Research and Analytic Studies Section analysis of 2007 CINByMOE analytic file.

High-Impact Conditions Affecting Duals

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High-Prevalence Conditions Among Duals

- Alzheimer's disease and other dementia
- Congestive heart failure
- Depression
- Diabetes
- Other heart disease
- Hypertension
- Pulmonary disease
- Stroke
- Others?

Conditions Disproportionately Affecting Duals

- Cerebral palsy
- End-stage renal disease
- Multiple sclerosis
- Parkinson's disease
- Schizophrenia
- Others?

We present these conditions as a starting place for discussion based on the data previously presented

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Coverage and Expenditures

Bifurcation of Coverage

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Medicare

- **Covers acute care, including physician visits, hospital admissions, and ancillary services.**
  - The prescription drug benefit that Medicaid previously paid for duals was transferred to the Medicare program in 2006 as part of the 2003 Medicare Modernization Act.
- **Covers home health and post-acute care**
  - The 100-day nursing facility benefit and limited home health care benefit are for rehabilitation therapies and follow a hospital stay.
- **Has significant premium and cost-sharing obligations**

Medicaid

- **Medicaid pays the Medicare Part B premium and cost sharing charged for many Medicare services**
- **Medicaid covers benefits not covered by Medicare, but optional benefits vary significantly by state**
  - Long term care, including nursing homes and home- and community-based services
  - Dental
  - Vision
  - Case management
  - Medical transportation

Navigating two programs with different rules and financing incentives is complex for both beneficiaries and providers, complicates care coordination, and can result in cost-shifting between the two programs.

Medicare Expenditures for Duals, 2006

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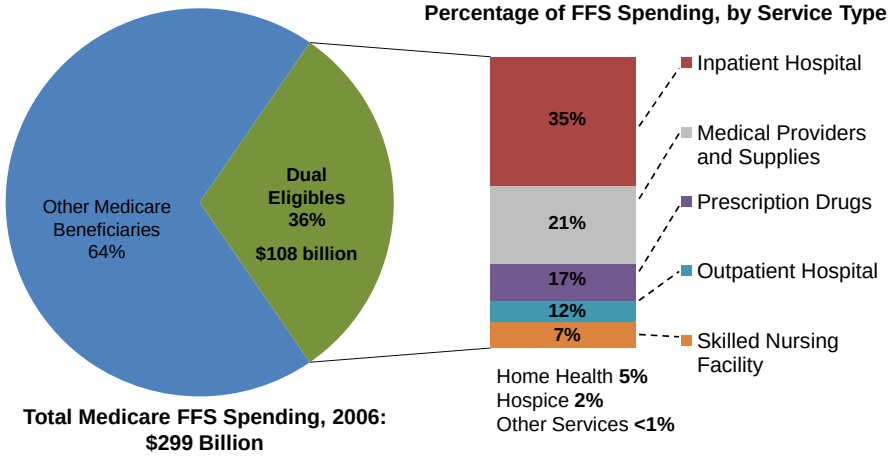
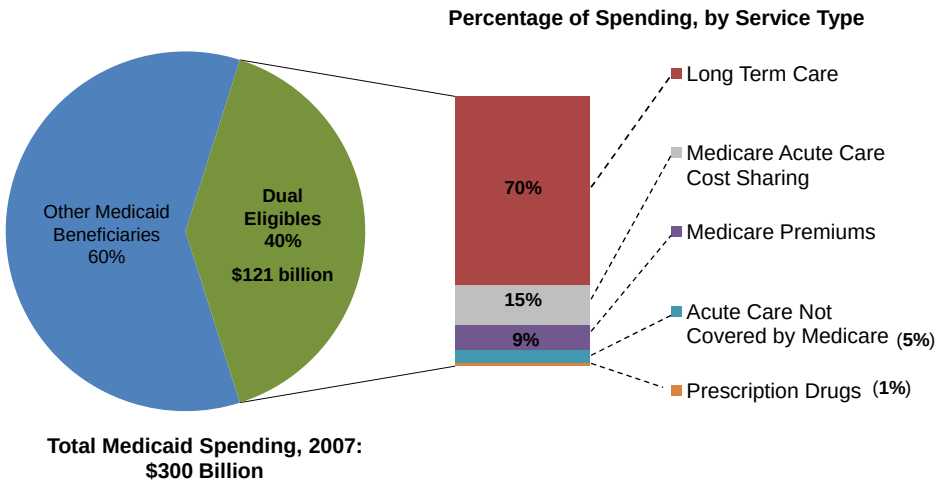


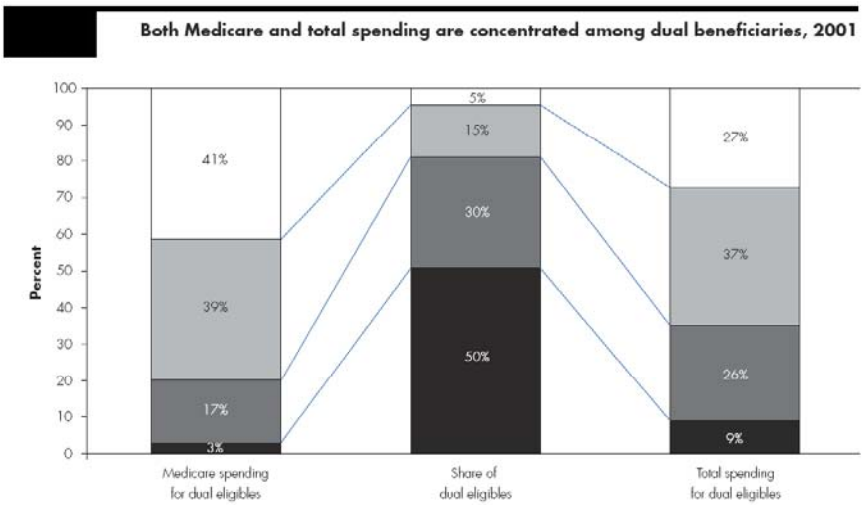
SOURCE: Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.
NOTES: Figure shows average total spending, excluding Medicare Advantage enrollees. Other services include dental and LTC facility stays.

Medicaid Expenditures for Duals, 2007



SOURCE: Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Spending Concentrated Among Duals



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

Potential Opportunities for Improvement

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- Integrated care
- Chronic disease management
- Mental health / substance abuse treatment
- Avoidable hospitalizations
- Others?
- Culturally competent care
- Palliative and end-of-life care
- Reliable access to prescription drugs
- Access to home and community-based services

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Discussion and Questions

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Vision for High-Quality Care

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Guiding Principles

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- What is our vision for improved quality of care for dual eligible beneficiaries?
- What are the unique needs of the population and sub-populations?
- What are the considerations related to the range of settings in which duals receive care?
- What are the guiding principles for a strategic approach to performance measurement?

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Discussion Themes

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- Care Coordination
  - Across and within settings, across providers, across benefits
  - Navigation of care
  - Care planning and other process measures
- Palliative and end-of-life care
  - Advance planning
- Sensitivity to personal choice / goals across aspects of care
- Workforce adequacy
- Support for family caregivers
- Access to the full range of care and community supports
  - Ease of eligibility determination, maintenance
- Segment the population by position on the trajectory of health/illness
  - Functional status
- Level of community participation
- Multi-disciplinary team approach (including psychosocial and patient/ caregiver)
- Evidence-based measures? (state of the science)
- Structure of performance measurement system
  - Feedback

Strategic Approach to Measurement

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Exercise with blank two-dimensional grid:

- How might we prioritize the high-impact areas for quality improvement?
  - Refer to slides on “High-Impact Conditions Affecting Duals” and “Potential Opportunities for Improvement”
- What are the areas of convergence?
- What are potential measure domains?

Patient-Focused Episode of Care Model

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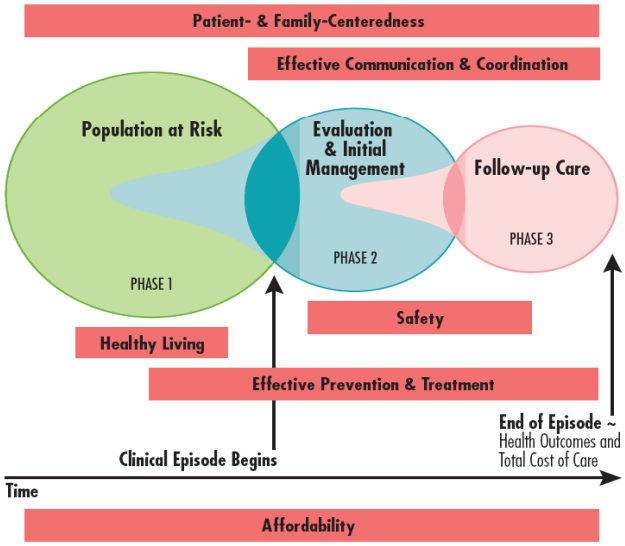

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Opportunity for Public Comment

MAP Measure Selection Criteria

Purpose

- Measure selection criteria will equip MAP with an evidence base to select measures for:
  - Public reporting
  - Payment programs
  - Program monitoring and evaluation

MAP measure selection criteria will build on, not duplicate, the NQF measure endorsement criteria.

Approach to Defining Criteria

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Inventory and compare historical criteria sets, including NQF endorsement criteria; prepare comprehensive criteria set

Conduct stress tests with focus on payment, reporting, and program evaluation to identify criteria gaps and conflicts and approaches to resolve

Evaluate findings with key informants—users of performance accountability measures for payment, reporting, and program evaluation

Recommend measure selection criteria set for consideration by MAP Coordinating Committee

Stress Test Approach

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Purpose:

- Identify criteria gaps and conflicts and evaluate harmonization across three applications (payment, reporting, monitoring/evaluation)
- Recommend approaches MAP could take to resolve gaps, conflicts, promote harmonization

Process:

- Identify sample measure sets that represent target settings/applications
- Evaluate measure sets against comprehensive criteria set, calling out:
  - *Gaps*—where do the historical criteria fall short in addressing an issue raised in applying the measures?
  - *Conflicts*—where do the criteria allow different interpretations based on user perspective? Where do the criteria pose barriers to evaluation due to uncertainty or inapplicability?
  - *Harmonization*—where do the criteria vary depending upon the application?
- Recommend approaches to MAP to resolve the above by adding or revising existing criteria

Considerations from Coordinating Committee

- Promote “system-ness”
- Enable providers to act
- Help consumers and their families/caregivers make rational judgments
- Assess burden/benefit for measurement
- Promote teams and shared accountability
- Contribute to a coherent, parsimonious measure set
- Tailor criteria for a purpose
- Address public/private alignment upstream
- Use endorsement information as a baseline
- Assess quantifiable impact

The MAP Coordinating Committee will adopt and continue to revise the proposed criteria set for measure selection.

Each MAP workgroup will employ the criteria to advise the Coordinating Committee on measures to include in input to HHS.

Discussion and Questions

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Summary of Day 1 and Look Forward to Day 2

Analytic Strategy

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- Establish vision for improved quality of care and strategic approach to performance measurement
- Align with broader initiatives and guiding frameworks
- Prioritize high-leverage quality 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

In addition, all other MAP groups will be considering the implications of their specific tasks for dual eligible beneficiaries.

Meeting Agenda: Day 2

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9:00	**Recap of Day 1 and Report Out**
10:00	**Measurement and Methodological Implications**
10:45	**Opportunities in Patient Safety: HACs**
Noon	**Working Lunch**
12:30	**Opportunities in Patient Safety: Readmissions**
1:45	**Summation and Next Steps**
2:00	**Adjourn**

Recap of Day 1

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High-Impact Areas for Quality Measurement and Improvement

- Care Coordination
  - Across and within settings, across providers, across benefits
  - Care planning and other process measures
  - Advance planning
  - Access to multidisciplinary care team
- Quality of Life
  - Community participation
  - Functional status
- Screening and assessment specific to population needs
  - Drug and alcohol history
  - Mental Health/Alzheimer's
  - Functional status
  - HIV

Additional Themes

- Diversity of the population
- Access to person-centered, culturally competent care
  - Linguistic
  - Disability-sensitive
  - Appropriate health literacy level
  - Sensitivity to personal choice and goals
- Prioritize issues unique to Duals
- Structure of performance measurement system (e.g. includes feedback loop)
- Access to the full range of care and community supports
  - Ease of eligibility determination and maintenance
- Research and data needs
  - Super-users
  - Patient/Family reported outcomes
  - HIT
- Segment the population by position on the trajectory of health/illness
- Risk-adjust to avoid unintended consequences (e.g. adverse selection, overuse)
- Multi-dimensional measures
- Palliative and end-of-life care
- Support for paid and unpaid caregivers

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Measurement and Methodological Implications

Technical Aspects of Measurement

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- Population-based, patient-centered approach
  - High prevalence conditions
  - Conditions that disproportionately affect duals
- Measure across the episode of care
  - Many settings of care involved for duals
- Benchmarking
  - Seek to examine and reward relative improvement rather then just attainment
- Exclusion critera

Technical Aspects of Measurement

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- Reference group
  - Heterogeneity of the population complicates comparison
- Risk Adjustment / Stratification
  - What is the appropriate stratification method?
- Attribution
  - Many providers, care settings and health professionals involved in care for duals
- Sample size
  - How can performance improvement be judged when providers serve small numbers of duals?

Data Sources

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- Key data sources
  - Claims data
  - Clinical data
  - Patient reported data
  - Others?
- Ideal state
  - Measures integrating information from all sources
  - Measures assessing care provided across settings and providers

Quality and Disparities Measurement

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- **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

Quality and Disparities Measurement

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- Assessment of quality by race, ethnicity, primary language and socioeconomic status should be a routine and expected part of performance measurement
- Need a framework for collecting race, ethnicity, primary language, and socioeconomic status data in an efficient, effective, patient-centered manner
  - **Endorsed HRET toolkit (cultural competency project)**
- Identify measures that are "disparity-sensitive" and routinely stratify quality data
  - **Identified disparity-sensitive criteria (ambulatory project)**

Primary Criteria: Disparity-Sensitive Criteria

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- **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

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- **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

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Discussion and Questions

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HACs and Readmissions:

Input to MAP Coordinating Committee and Ad Hoc Safety Workgroup

HACs and Readmissions

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HHS has created a new patient safety initiative called the Partnership for Patients focusing on improvement in readmissions and healthcare-acquired conditions (HACs)

Establishes two goals to achieve by the end of 2013:

- Preventable hospital-acquired conditions would decrease by 40% compared to 2010
- Preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010

Areas of Focus for HACs

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The Partnership for Patients has identified nine areas of focus for HACs.

1) Adverse Drug Events (ADE)
2) Catheter-Associated Urinary Tract Infections (CAUTI)
3) Central Line Associated Blood Stream Infections (CLABSI)
4) Injuries from Falls and Immobility
5) Obstetrical Adverse Events
6) Pressure Ulcers
7) Surgical Site Infections
8) Venous Thromboembolism (VTE)
9) Ventilator-Associated Pneumonia (VAP)

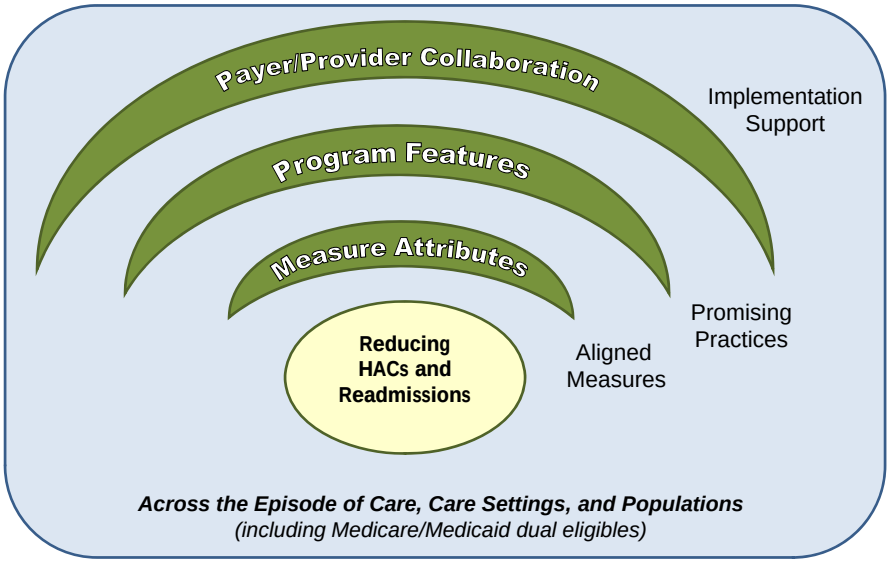
The Partnership work is not limited to these areas and will also pursue the reduction of all-cause harm.

MAP Ad Hoc Safety Workgroup Charge

The charge of the MAP Ad Hoc Safety Workgroup is to advise the Coordinating Committee on a coordination strategy for measuring readmissions and HACs across public and private payers. The Workgroup will:

- Review current readmission and HAC measures in use by both public and private payers.
- Identify available readmission and HAC measures:
  - In use regionally and nationally;
  - Applicable across a variety of settings
  - For dual eligible beneficiaries in home and community-based service waiver programs.
- Identify critical readmission and HAC measure development and endorsement gaps.
- Develop a coordination strategy of options to ensure maximum collaboration across public and private payers, including:
  - Current and ideal approaches to measurement,
  - HIT implications, and
  - Timeline.

Dimensions of Payer Alignment



HACs and Readmissions

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Considerations from the Coordinating Committee

- How to ensure joint accountability and alignment across settings?
  - What measures should be included in measure sets being suggested by other MAP workgroups to address HACs and readmissions?
- What are the relevant data and infrastructure issues?
  - What are potential issues when measuring across multiple settings and strategies to mitigate those issues?
  - What are potential issues when measuring at different levels (i.e. individual clinician, facility, regionally, nationally) and strategies to mitigate those issues?
- What is needed to support improvement in these areas within the complex dual eligible population?

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Risks Related to HACs

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Adverse Drug Event	• More than half of inpatient stays with an adverse drug event were for patients 65 or older. • Corticosteroids were most commonly responsible for adverse outcomes, followed by anticoagulants. (Elixhauser & Owens, 2011)
Catheter-Associated Urinary Tract Infection (UTI)	• Risk factors for UTI include the duration of catheterization, female gender, and diabetes. (Billote-Domingo et al., 1999) • UTIs account for 14% of potentially avoidable hospitalizations from Medicaid-funded nursing facility stays. (RTI/CMS, 2010)
Central Line Associated Blood Stream Infection (CLABSI)	• Risk factors for CLABSI include receiving care in the ICU, prolonged hospitalization prior to insertion of central line, duration of catheterization, and presence of microbes at the insertion site. • Outpatients with long-term central lines may include those with hemodialysis, malignancy, GI tract disorders, and pulmonary hypertension. (Marschall et al., 2008)
Injuries from Falls and Immobility	• Falls and fall-related injuries are among the most common complications after stroke; 24% of duals experience stroke. • Risk factors for fall-related injury include: female gender, poor general health, past injury from fall, psychiatric problems, incontinence, impaired hearing, pain, and motor impairment. (CMS, 2010; Divani et al., 2009)

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Risks Related to HACs - Continued

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Pressure Ulcers	• Duals account for 36% of hospital stays with a principal diagnosis of pressure ulcers. (Jiang et al., 2010) • Risk factors for pressure ulcers include: being bedridden or in a wheelchair, being older, being unable to move without assistance, chronic conditions that restrict blood flow (e.g., diabetes or vascular disease), incontinence, dehydration, and malnutrition. (National Library of Medicine, 2010)
Surgical Site Infections (SSI)	• Risk factors for surgical site infection include: diabetes, obesity, malnutrition, pre-existing infection elsewhere in the body, recent tobacco use, contaminated wound, and perioperative hypothermia or hyperglycemia. (Pear, 2007)
Venous Thromboembolism (VTE)	• Patients at risk for VTE include those who are: elderly, undergoing major surgery, or diagnosed with cancer, CHF, or COPD. • Other risk factors include hip fracture, lower extremity paralysis, previous VTE, presence of central venous lines, estrogens, and hematological conditions. (Anderson and Spencer, 2003). Risk factors for VTE have also been shown to overlap with those for coronary heart disease. (Goldhaber, 2010).
Ventilator-Associated Pneumonia (VAP)	• Host-related risk factors for VAP include immunosuppression, COPD, adult respiratory distress syndrome, number of intubations, and medications. (Augustyn, 2007)

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Comments on HACs from Ad Hoc Safety Workgroup Participants

Thomas James, III, MD—Humana, Inc.

Rhonda Robinson Beale, MD—Optum Behavioral Health

Laura Linebach, RN, BSN, MBA—L.A. Care

Cheryl Powell—Centers for Medicare & Medicaid Services

Discussion Questions: HACs

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- Considering the focus areas of the Partnership for Patients, what areas are particularly relevant to the dual eligible population?

Which issues are highly prevalent?

Which issues disproportionately affect duals?

- What patient safety issues unique to the dual eligible population (e.g., patient complexity) make addressing HACs more difficult?
- What can federal payers do to encourage alignment and support quality improvement?

Risks Related to Hospital Readmission

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- Nearly one-third of Medicare beneficiaries are re-hospitalized within 90 days. (Jencks et al, 2009)
- Duals are more likely than non-duals to have a hospital stay in a given year (29% vs. 19%) and more than twice as likely to have multiple stays (14% vs. 6%). (Kaiser Family Foundation)
- Patients with certain demographic characteristics and conditions are more likely than others to be readmitted. (Congressional Research Service, 2010) Likelihood increases for people who are:
  - Older
  - Female
  - African American
  - Poor
- Or who have…
  - A disability
  - A history of readmissions
  - Multiple chronic conditions

Comments on Readmissions from Ad Hoc Safety Workgroup Participants

Thomas James, III, MD—Humana, Inc.

Rhonda Robinson Beale, MD—Optum Behavioral Health

Laura Linebach, RN, BSN, MBA—L.A. Care

Cheryl Powell—Centers for Medicare & Medicaid Services

Discussion Questions: Readmissions

- What aspects of assessing hospital readmission are particularly relevant to the dual eligible population?
- What issues unique to the dual eligible population (e.g. broad range of settings in which they receive care) make addressing readmissions more complex?
- What can federal payers do to encourage alignment and support quality improvement?
- How do we link hospital readmission rates to information about residence (e.g. home vs. institution) and services (e.g. home- and community-based services waiver) in order to assess trends?

Program Design / Models of Care

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- What models of care can provide best practices for reducing readmissions and improving patient safety?
  - PACE
  - SNP
  - Care transitions models
  - Medical home models
  - QIO activities
- How do these models of care inform the measurement approach?

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Opportunity for Public Comment

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Summation and Next Steps

Flow of Information to Inform Reports

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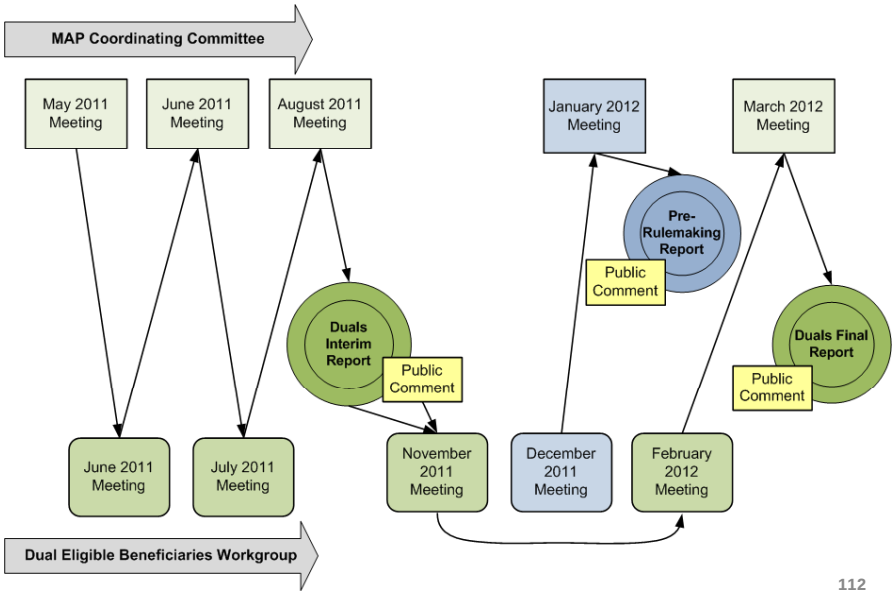

Upcoming Meetings

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Dual Eligible Beneficiaries Workgroup Web Meeting

July 6, 2011

11:00 am-1:00 pm EST

Dual Eligible Beneficiaries Workgroup In-Person Meeting #2

July 25-26, 2011

Washington, DC

Future events to follow through Spring 2012

References

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Anderson FA Jr, Spencer FA. Risk factors for venous thromboembolism. *Circulation*. 2003;107 (23 suppl 1);I-9-I-16. Available at http://circ.ahajournals.org/cgi/reprint/107/23_suppl_1/I-9 . Last accessed May 2011.

Augustyn B. Ventilator-associated pneumonia: risk factors and prevention. *Critical Care Nurse*. 2007;27,(4);32-39. Available at http://ccn.aacnjournals.org/content/27/4/32.full.pdf+html . Last accessed May 2011.

Billote-Domingo K, Mendoza MT, Torres TT. Catheter-related urinary tract infections: incidence, risk factors and microbiologic profile. *Phil J Microbiol Infect Dis* .1999; 28(4):133-138. Available at http://www.psmid.org.ph/vol28/vol28num4topic3.pdf. Last accessed May 2011.

California Department of Health Care Services, Research and Analytical Studies Section DHCS RASS). *Executive Summary: Medi-Cal's Dual Eligible Population Demographics, Health Characteristics and Costs of Health Care Services*. Sacramento, CA: DHCS RASS, April 2010. Available at http://www.dhcs.ca.gov/Documents/Dual%20Eligibles%20Summary%20California%20Data.pdf. Last accessed May 2011.

Divani AA, Vazquez G, Barrett AM, et al. Risk factors associated with injury attributable to falling among elderly population with history of stroke. *Stroke*. 2009; 40(10):3286-3292. Available at http://stroke.ahajournals.org/cgi/content/full/40/10/3286. Last accessed May 2011.

Elixhauser A, Owens P. *Adverse Drug Events in U.S. Hospitals, 2004.* Healthcare Cost and Utilization Project Statistical Brief #29. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ), 2007. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb29.pdf. Last accessed May 2011.

Goldhaber SZ. Risk factors for venous thromboembolism. *J Am Col Cardiol*. 2010;56(1):1-7.

Jacobson G, Neuman T, Damico A, et al. *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. 2011. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2011. Available at http://www.kff.org/medicare/8138.cfm. Last accessed May 2011.

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N EnglJ Med*. 2009;360(14):1418-1428. Available at http://content.nejm.org/cgi/content/full/360/14/1418?ijkey=3CQjS3yxXjOtY&keytype=ref&siteid=nejm . Last accessed May 2011.

Jiang HJ., Wier LM,, Potter DEB, et al.. *Hospitalizations for Potentially Preventable Conditions among Medicare-Medicaid Dual Eligibles, 2008.* Healthcare Cost and Utilization Project Statistical Brief #96. 2010. Rockville, MD: Agency for Healthcare Research and Quality, (AHRQ), 2010. Available at. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb96.pdf. Last accessed May 2011.

References, Continued

Kaiser Commission on Medicaid and the Uninsured. *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2010. Available at http://www.kff.org/medicaid/4091.cfm. Last accessed May 2011.

Kasper J, Watts MO, Lyons B. Kaiser Commission on Medicaid and the Uninsured. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending.* Publication #8081. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2010. Available at http://www.kff.org/medicaid/8081.cfm. Last accessed May 2011.

Marschall J, Mermel LA, Classen D, et al. Strategies to prevent central line-associated bloodstream infection in acute care hospitals. *Infect Control and Hosp Epidemiol.*2008;29,(Suppl1):S22-S30. Available at http://www.shea-online.org/GuidelinesResources/CompendiumofStrategiestoPreventHAIs.aspx . Last accessed May 2011.

Medicare Payment Advisory Commission (MEDPAC). *Coordinating the Care of Dual-Eligible Beneficiaries*. In: *Report to the Congress: Aligning Incentives in Medicare.* Chapter 5: Coordinating the care of dual-eligible beneficiaries. Washington, DC:MEDPAC, 2010, pp. 129-160. Available at http://www.medpac.gov/documents/Jun10_EntireReport.pdf . Last accessed May 2011.

National Library of Medicine (NLM). Medline Plus: *Pressure Ulcer*. Bethesda, MD: NLM, 2011. Available at http://www.nlm.nih.gov/medlineplus/ency/article/007071.htm Last accessed May 2011.

Pear SM. Patient risk factors and best practices for surgical site infection prevention. Manag Infect Control. 2007;56-64. Available at http://en.haiwatch.com/data/upload/tools/Patient_Risk_Factors_Best_Practices_SSI.pdf. Last accessed May 2011.

Rousseau D, Clemans-Cope L, Lawton E, et al. Kaiser Commission on Medicaid and the Uninsured. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007.* Publication # 7846-02. Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2010. Available at http://www.kff.org/medicaid/7846.cfm . Last accessed May 2011.

Stuart B, Singhal P. *The Stability of Medicaid Coverage for Low-Income Dually Eligible Medicare Beneficiaries. Menlo Park, CA: The Henry J. Kaiser Family Foundation,* 2006. Available at http://www.kff.org/medicare/upload/7512.pdf . Last accessed May 2011.

U.S. Department of Health and Human Services (HHS). *Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions*. Washington, DC:HHS, 2010. Available at http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf. Last accessed May 2011.

Walsh EG, Freiman M, Haber S, et al.. RTI International for Centers for Medicare & Medicaid Services. *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs.* Waltham, MA: RTI, 2010. Available at https://www.cms.gov/reports/downloads/costdriverstask2.pdf . Last accessed May 2011.