MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP
Convened by the National Quality Forum

Summary of In-Person Meeting: June 2-3, 2011

The Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup met in person on Thursday, June 2, and Friday, June 3, 2011. An audio archive of the meeting is available on the NQF website, www.qualityforum.org.

Workgroup Members in Attendance

Alice Lind (Chair)	
Adam Burrows, National PACE Association (Maureen Amos, Day 2 substitute)	Patrick Murray, Better Health Greater Cleveland
Mady Chalk [subject matter expert: substance abuse]	Patricia Nemore, Center for Medicare Advocacy
Jennie Chin Hansen, American Geriatrics Society	Juliana Preston [subject matter expert: measure methodologist]
Henry Claypool, HHS Office on Disability	David Polakoff, American Medical Directors Association
Steven Counsell, National Association of Public Hospitals and Health Systems	D.E.B. Potter, Agency for Healthcare Research and Quality
Leonardo Cuello, National Health Law Program	Cheryl Powell, CMS Medicare-Medicaid Coordination Office
James Dunford [subject matter expert: emergency medical services]	Susan Reinhard [subject matter expert: home and community-based services]
Lawrence Gottlieb [subject matter expert: disability]	Rhonda Robinson Beale [subject matter expert: mental health]
Thomas James, Humana, Inc.	Gail Stuart [subject matter expert: nursing]
Daniel Kivlahan, Veterans Health Administration	Sally Tyler, American Federation of State, County and Municipal Employees
Chris Herman, National Association of Social Workers (Day 1 substitute for Joan Levy Zlotnik)	Rita Vandivort, Substance Abuse and Mental Health Services Administration
Laura Linebach, L.A. Care Health Plan	Samantha Wallack, Health Resources and Services Administration (Ian Corbridge, Day 1 substitute)

This was the first in-person meeting of the Measure Applications Partnership's Dual Eligible Beneficiaries Workgroup. The primary objectives of the meeting were to:

- review the charge for the workgroup, role within the MAP, and approach to its tasks,
- discuss activities of the CMS Medicare-Medicaid Coordination Office;

- discuss and prioritize unique population quality issues to form the basis for a strategic approach to performance measurement, and
- provide input on healthcare-acquired conditions (HACs) and hospital readmission measurement issues specific to dual eligible beneficiaries.

Alice Lind, Workgroup Chair, and Janet Corrigan, President and CEO of NQF, welcomed participants to the meeting and offered introductory remarks. Member introductions and disclosures of interest followed. Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, then provided an overview of the MAP structure, the roles of the MAP Coordinating Committee and workgroups, and stated the responsibilities of the workgroup members. He also presented the media engagement policy and the support available to the workgroup through NQF's communications department.

The workgroup participants drew terms of membership at random. The chair drew terms on behalf of absent members. The chart below presents the term lengths for all workgroup members.

Dual Eligible Beneficiaries Workgroup Member Terms

1-Year Term	2-Year Term	3-Year Term
American Federation of State, County and Municipal Employees	American Geriatrics Society	Alice Lind, MPH, BSN
Better Health Greater Cleveland	American Medical Directors Association	American Assoc. on Intellectual and Developmental Disabilities
Center for Medicare Advocacy	Humana, Inc.	National Health Law Program
National Association of Public Hospitals and Health Systems	National Association of Social Workers	LA Care Health Plan
National PACE Association	Mady Chalk, PhD, MSW [subject matter expert]	Juliana Preston, MPA [subject matter expert]
Lawrence Gottlieb, MD, MPP [subject matter expert]	James Dunford, MD [subject matter expert]	Susan Reinhard, PhD, RN, FAAN [subject matter expert]
Agency for Healthcare Research and Quality	Gail Stuart, PhD, RN [subject matter expert]	Rhonda Robinson Beale, MD [subject matter expert]
CMS Medicare-Medicaid Coordination Office	HHS Office on Disability	Health Resources and Services Administration
	Veterans Health Administration	Substance Abuse and Mental Health Services Administration

Diane Stollenwerk, Vice President, Community Alliances, NQF, provided an overview of the workgroup's charge, project timeline, guidance from the MAP Coordinating Committee, and a brief review of the analytic strategy that will be guiding the work. The analytic strategy involves the following steps:

- establish vision for improved quality of care for dual eligible beneficiaries and the strategic approach to performance measurement for the population;

- align with broader initiatives and guiding frameworks (e.g. National Quality Strategy [NQS] and NQF's multiple chronic conditions [MCCs] project);
- prioritize high-leverage quality improvement opportunities for the dual eligible population;
- consider data source and HIT implications;
- identify measures currently in use and map them to high-leverage opportunities; and
- refine core measure set, identify gaps, and propose modifications or new measure concepts.

Cheryl Powell, Deputy Director, CMS Medicare-Medicaid Coordination Office (a.k.a. the "Duals Office"), presented the Office's major activities. Initiatives are concentrated in the three areas of Medicare-Medicaid program alignment, data/analytics, and models/demonstrations. Specific activities include: improving states' access to Medicare parts A, B, and D data for care coordination purposes; creating national and state profiles of dual eligible beneficiaries; awarding planning grants to 15 states to design new models for serving dually-eligible individuals; conducting beneficiary focus groups; and, engaging other stakeholders such as MedPAC and MACPAC.

Cheryl Powell also highlighted four areas in which the workgroup might consider quality issues for duals: 1) examining existing measures and identifying which could be presented on this population as a subset; 2) considering if new measures or new programs should be created and targeted to dually-eligible beneficiaries or to a subset of them; 3) measuring patient-centered care across settings; and 4) identifying specific topics, conditions, and care domains to be measured. Following Ms. Powell's presentation, workgroup members raised several issues related to data and information:

- the need for more timely enrollment data;
- the need for information at the state level, noting:
    - data should be broken down by age, including the group older than 85; and,
    - current data sets are based on fee-for-service information—this is adequate for Medicare but large parts of some states' Medicaid data is not included because of beneficiaries enrolled in managed care.

In response, Ms. Powell noted that CMS is developing profiles of duals by state based on linked data. CMS will provide support for states to assist them in receiving/storing the new data and they hope to develop a business intelligence tool to assist states in easily pulling reports out of the linked database.

Karen Adams, Vice President, National Priorities, NQF, introduced the workgroup to the guiding frameworks and models that contribute to the MAP decision-making principles. These include the HHS National Quality Strategy, NQF-endorsed Patient-Focused Episode of Care Model, the HHS Multiple Chronic Conditions Framework, and the Multiple Chronic Conditions Performance Measurement Framework (currently in development as an NQF project under contract with HHS).

Workgroup members discussed that the content of a multiple chronic conditions framework can apply to people with disabilities, but not all people with disabilities have multiple chronic conditions. In addition, the episode of care must be modified for people with disability because the episode often extends for the rest of a person's life. More generally, the model's use of the term "follow-up" has a different implication than the extended care interactions required for many dual eligible beneficiaries.

Sarah Lash, Program Director, NQF, provided a series of data snapshots to profile the unique dynamics and utilization patterns of the population of dually-eligible individuals. Using that information, the group began to brainstorm and discuss its vision for high-quality care for dual eligible beneficiaries and the potential guiding principles for a performance measurement strategy. The workgroup identified a draft vision and several guiding principles and themes.

> *Vision: Individuals should have reliable access to a person and family-centered, culturally competent support system that helps them in reaching their personal goals through access to a range of healthcare services and community resources.*

Guiding principles for a strategic approach to performance measurement include:

- The population is defined by its heterogeneity and diversity; the group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness.
- Culturally competent care must incorporate many dimensions, including race/ethnicity, language, level of health literacy, accessibility of the environment for people with disability, etc.
- Strategy for performance measurement should emphasize data exchange through portable, interoperable electronic health records with ways to gather/share information with the beneficiary, feedback to providers in order to facilitate continuous improvement, and a risk adjustment strategy to mitigate potential unintended consequences (e.g., adverse selection, overuse).
- The workgroup identified significant research needs and gaps in information related to quality of care for specific subpopulations (e.g., high cost/high need patients, patient-reported outcomes)

Based on discussion themes and a grid worksheet that presented the goals of NQS, the workgroup identified many opportunities for improving quality through performance measurement. The three "high-leverage" areas initially prioritized by the group are: (1) care coordination by a multi-disciplinary team, (2) quality of life beyond clinical aspects, and (3) appropriate screening and assessment. As an overnight thought exercise, members were asked to complete the blank grid of NQS goals and "high-leverage" areas with additional detail on the potential opportunities for improvement through performance measurement.

To conclude the first day of the meeting, Tom Valuck presented the MAP's ongoing work to define selection criteria for performance measures. He clarified that the measure selection criteria will not duplicate the NQF Endorsement Criteria and are meant to extend the foundation endorsement provides. As part of their overnight exercise, workgroup members were also asked to note any special considerations for measurement related to dual eligible beneficiaries that should be incorporated into the development of the selection criteria.

On the second day of the meeting, Alice Lind provided a recap of the themes of the first day's discussion. Workgroup members shared the results of their overnight thought exercise, providing details regarding each high-leverage area. Key issues include:

- Care coordination
    - should take place across and within settings where care and community support is provided, across provider types, and across Medicare and Medicaid benefit structures;
    - include process measures, such as presence of a person-centered plan of care and medication reconciliation;
    - include measures of access to multi-disciplinary team to provide care and support; and
    - include measures related to advance planning and/or palliative care.
- Quality of life
    - care and support are provided to enhance quality of life and enable individual to reach his/her self-determined goals;
    - include measures of functional status to be evaluated over time; and
    - include measures of an individual's ability to participate in his/her community.
- Screening and assessment
    - to enable effective care, screening should be thorough and tailored to address the many complexities of the dual eligible beneficiary population;
    - assess home environment and availability of family and community supports; and
    - screen for underlying mental and cognitive conditions, drug and alcohol history, HIV status, risk of falling, etc.

Taroon Amin, Senior Director, NQF, provided a brief overview of the unique methodological issues to consider when measuring services delivered to the dual eligible beneficiary population. He noted difficulties related to attribution, benchmarking, sample size, stratification, data sources, defining a comparison group, and other complexities. Workgroup members raised questions related to the effects of small sample size on the use of incentives as well as the need to test measures in a complex population before the metrics can be used reliably to measure care delivery in such a population.

Nicole McElveen, Senior Project Manager, NQF, introduced the workgroup to NQF's ongoing work with healthcare disparities. In 2006, NQF endorsed a set of 35 "disparities-sensitive" measures, including both clinician-level measures and AHRQ's Prevention Quality Indicators (PQI) measures, which are suitable for community-level use. Primary criteria for identifying disparity-sensitive measures are: prevalence, impact of the condition, impact of the quality process, and the size of the quality gap. NQF has also endorsed the HRET Disparities Toolkit to provide a framework for collecting race, ethnicity, primary language, and socioeconomic status data in an efficient, effective, patient-centered manner.

Lindsay Lang, Senior Program Director, NQF, introduced the workgroup to the task of the MAP's Ad Hoc Safety Workgroup, which is tasked with providing recommendations on public-private payer alignment in measurement of HACs and hospital readmissions. She presented a brief background on the

HHS Partnership for Patients, risks factors for HACs and readmissions specific to dual eligible beneficiaries, considerations from the MAP Coordinating Committee, and a conceptual framework.

The workgroup members representing health plans provided brief remarks on how their organizations are addressing HACs and readmissions for dual eligible populations.

- Tom James noted Humana runs a program that uses predictive modeling to identify beneficiaries at risk for an adverse drug event after hospitalization. The plan provides a telephonic assessment and home visit to perform medication reconciliation, and evaluate functional status, social status, cognitive status, health status, financial ability, behavioral status, and the home environment.
- Rhonda Robinson Beale from OptumHealth Behavioral Solutions commented on the difficulty of providing coordinated care due to fragmented funding streams across different settings of care. To overcome quality challenges, she suggested further use of performance measures as part of a health plan's contracting process.
- Laura Linebach explained that case managers at L.A. Care play an important role in Medicare/Medicaid alignment and navigation of the complex benefits. The HACs which are most prevalent in L.A. Care's Special Needs Plan are catheter-associated urinary tract infections, injuries from falls/immobility, and pressure ulcers. The plan is now paying more attention to hospitals' track records for quality and patient safety when defining its network of providers.
- Cheryl Powell shared that CMS and the Duals Office have been addressing consistency across Medicare and Medicaid related to the Medicare payment policy on HACs.

While all of the HACs targeted by the Partnership for Patients are important points of focus, the workgroup prioritized the conditions in order of significance for the dual eligible beneficiary population, clustered as follows:

- 1st tier: Adverse Drug Events and Injuries from Falls/Immobility
- 2nd tier: Catheter-Associated Urinary Tract Infection, Pressure Ulcers, Central Line-Associated Bloodstream Infection, Venous Thromboembolism, and Ventilator-Associated Pneumonia
- 3rd tier: Surgical Site Infections and Obstetrical Adverse Events

The workgroup discussed the need to maintain a person-centered, population-based approach rather than a payer-centered strategy. Members also commented on the need to support shared responsibility across settings of care by thinking beyond hospital walls and into the community. Home health, adult day care centers, and other settings play an important role in preventing HACs. Furthermore, community resources can be engaged as surveillance and intervention partners (e.g. EMS, homeless outreach teams). Finally, the workgroup considered the influence of specific population issues on HACs including polypharmacy and behavioral health needs.

Related to hospital readmissions, the workgroup identified several targets for possible improvement:

1. addressing the readmissions cycle between institutional and acute care settings;
2. providing thorough transition planning, including screening for substance use and/or an underlying mental/cognitive condition, coaching to enhance self-management ability, functional status assessment, home assessment, and follow-up; and

3. addressing inappropriate admissions/readmissions at the end of life.

Members viewed timely information exchange as a vital cross-cutting factor for improving readmissions.

When measuring readmissions, the workgroup noted that the use of “observational” and “involuntary” status in hospitals may complicate or confound results. Further, members commented on the need to distinguish between readmissions that result from a relapse in a person’s health condition versus a lack of appropriate support in the community.

The meeting concluded with a summary of the workgroup’s accomplishments and a discussion of next steps. The Dual Eligible Beneficiaries Workgroup will next convene via web meeting on July 6 from 11:00 am – 1:00 pm ET.