NATIONAL QUALITY FORUM

Summary Memo

July 12, 2013

Family of Measures for Dual Eligible Beneficiaries: Preliminary Findings from the MAP Dual Eligible Beneficiaries Workgroup

Background

Individuals who qualify for benefits from both Medicare and Medicaid are known as "dual eligible beneficiaries." The experience of dual eligible beneficiaries in the health system is of significant interest to policymakers and other stakeholders. People with dual eligibility are low-income (to qualify for Medicaid) and either older than 65 or permanently disabled (to qualify for Medicare). Because of their intense needs for services and the misaligned healthcare system in which they seek care, dual eligible beneficiaries incur disproportionately high healthcare costs. In this case, high cost is not correlated with high quality. The healthcare and long-term supports and services (LTSS) needed by dual eligible beneficiaries often fail to produce good outcomes. Quality measurement is needed to understand and improve performance, especially in the changing healthcare environment.

Purpose and Approach

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP was created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. Beginning in 2011, MAP has been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid.

MAP has continued to explore this topic and has completed a series of reports to DHHS that present sets of available measures appropriate for use in the dual eligible population.[1] This memo of draft findings provides an update to DHHS of MAP's most recent deliberations. Building on previous work, MAP has continued to identify measures that address the specialized needs of vulnerable beneficiaries and has further refined a set of recommended available measures.

NQF convened the MAP Dual Eligible Beneficiaries Workgroup to formulate these draft findings. The workgroup roster is provided in Appendix A. The group met via web meeting on April 30, 2013, and in person on May 21-22, 2013. Workgroup members also participated in a web-based follow-up exercise after the in-person meeting to further refine their recommendations regarding selected measures and gap areas for future development.

[1] http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx

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Family of Measures for Dual Eligible Beneficiaries

A "family of measures" is a set of measures that relate to one another and are the best available measures addressing an important quality issue across the continuum of care. Creation of a family of measures makes it easier to assess important topics (e.g., safety, diabetes) across care settings in a more purposeful way and to identify gaps in specific content areas, levels of analysis, or care settings. A family of measures is intended to be a starting place from which stakeholders can select the most relevant measures for their particular measurement needs. Because of the many differences in measures' underlying designs and specifications, it is unlikely that a single program would use all of the measures in the family. The subset of measures selected for use in the field should be implemented according to their endorsed specifications to maintain their scientific properties of validity and reliability. To date, MAP has identified families of measures for multiple topics, including safety, care coordination, diabetes care, and cardiovascular care.

The first step of MAP's process for identifying a family of measures is to establish a framework based on the National Quality Strategy and other national standards. MAP had previously identified five high-leverage opportunity areas for improvement within the dual eligible population, setting the frame for measures that would be eligible for inclusion in the family of measures. A targeted literature review and workgroup deliberations revealed the most prominent quality issues facing the dual eligible population. A subsequent measure scan provided potential measures for MAP review. The final product, the Family of Measures for Dual Eligible Beneficiaries, consists of the best available measures for the population. Families of measures are moderately fluid and are expected to experience minor change over time as new measures become available and/or previously selected measures no longer comport with current evidence.

Properties for Measure Selection

The workgroup considered the following properties when assessing an identified measure's appropriateness for inclusion in the family.

- **NQF endorsement**: Include NQF-endorsed® measures because they have met criteria for importance, scientific rigor, feasibility, and usability.
- **Potential impact**: Include measures with the most power to improve health, such as outcome measures, composite measures, and cross-cutting measures broadly defined to include a large denominator population.
- **Improvability**: Include measures that target areas in which quality improvement would be expected to have a substantial effect or address health risks and conditions known to have disparities in care.
- **Relevance**: Include measures that address health risks and conditions that are highly prevalent, severe, costly, or otherwise particularly burdensome for the dual eligible population.
- **Person-centeredness**: Include measures that are meaningful and important to consumers, such as those that focus on engagement, experience, or other individually-reported outcomes. Person-centered care emphasizes access, choice, self-determination, and community integration.
- **Alignment**: Include measures already reported for existing measurement programs to minimize participants' data collection and reporting burden. Consistent use of measures helps to synchronize public- and private-sector programs around the National Quality Strategy and to amplify the quality signal.

- **Reach**: Include measures relevant to a range of care settings, provider types, and levels of analysis.

A measure did not need to fulfill all of the properties to be selected. However, to be considered comprehensive, the family of measures should encompass all of these characteristics because they are particularly important for achieving good results within the dual eligible population. Stakeholders planning quality measurement programs can apply the properties to other measure sets to evaluate fit-for-purpose and general alignment with MAP principles.

To compile the family of measures, the workgroup considered the universe of measures previously identified by MAP for use in the general dual eligible population or one of its high-need subgroups. The workgroup also reviewed a small number of newly developed measures not previously selected. From a starting point of 97 possible measures, the workgroup conducted multiple rounds of prioritization and ultimately selected 55 measures for inclusion in the family. Of these measures, 51 are currently endorsed by NQF and 4 have been submitted for endorsement in NQF's current consensus development project for behavioral health.

Table 1 provides the measures' numbers, endorsement status, and names. Appendix B provides the detailed specifications, and Appendix C provides analyses of the measure properties.

TABLE 1: FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

NQF Number and Status	Measure Name
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0007 Endorsed	NCQA Supplemental Items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)
0008 Endorsed	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
0018 Endorsed	Controlling High Blood Pressure
0022 Endorsed	Use of High Risk Medications in the Elderly
0027 Endorsed	Medical Assistance with Smoking and Tobacco Use Cessation
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0032 Endorsed	Cervical Cancer Screening
0034 Endorsed	Colorectal Cancer Screening
0043 Endorsed	Pneumonia Vaccination Status for Older Adults
0097 Endorsed	Medication Reconciliation
0101 Endorsed	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0105 Endorsed	Antidepressant Medication Management (AMM)
0111 Endorsed	Bipolar Disorder: Appraisal for Risk of Suicide
0176 Endorsed	Improvement in Management of Oral Medications
0201 Endorsed	Pressure Ulcer Prevalence (hospital acquired)
0202 Endorsed	Falls with Injury
0228 Endorsed	3-Item Care Transition Measure (CTM-3)
0326 Endorsed	Advance Care Plan
0418 Submitted	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
0419 Endorsed	Documentation of Current Medications in the Medical Record
0420 Endorsed	Pain Assessment and Follow-Up
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0486 Endorsed	Adoption of Medication e-Prescribing

NQF Number and Status	Measure Name
0553 Endorsed	Care for Older Adults – Medication Review
0554 Endorsed	Medication Reconciliation Post-Discharge
0557 Submitted	HBIPS-6 Post Discharge Continuing Care Plan Created
0558 Submitted	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
0573 Endorsed	HIV Screening: Members at High Risk of HIV
0576 Endorsed	Follow-Up after Hospitalization for Mental Illness
0640 Endorsed	HBIPS-2 Hours of Physical Restraint Use
0641 Endorsed	HBIPS-3 Hours of Seclusion Use
0646 Endorsed	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0648 Endorsed	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0649 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care)
0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
0682 Endorsed	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)
0692 Endorsed	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
0709 Endorsed	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year
0710 Endorsed	Depression Remission at Twelve Months
0712 Endorsed	Depression Utilization of the PHQ-9 Tool
0729 Endorsed	Optimal Diabetes Care
1626 Endorsed	Patients Admitted to ICU Who Have Care Preferences Documented
1659 Endorsed	Influenza Immunization
1768 Endorsed	Plan All-Cause Readmissions
1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
1902 Endorsed	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
1909 Endorsed	Medical Home System Survey (MHSS)
1927 Endorsed	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
1932 Endorsed	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (SSD)
2091 Endorsed	Persistent Indicators of Dementia without a Diagnosis—Long Stay
2092 Endorsed	Persistent Indicators of Dementia without a Diagnosis—Short Stay
2111 Endorsed	Antipsychotic Use in Persons with Dementia
2152 Submitted	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Starter Set for Immediate Implementation

MAP also identified a "starter set" of measures from the Family of Measures for Dual Eligible Beneficiaries that are most appropriate for immediate implementation and that address priority areas for measurement. The workgroup considered the following characteristics, in addition to those for the family of measures, when selecting measures for the starter set.

- **Readiness:** Include measures that are ready to be used as-is, without modifications that may have been previously suggested by MAP. Use of measures should not lead to negative unintended consequences.
- **Feasibility:** Include measures for which the data required to calculate them are readily available or retrievable without undue burden.
- **Comprehensiveness:** Once compiled, the starter set should include measures relevant to each of the five high-leverage opportunity areas identified by the MAP Dual Eligible Beneficiaries Workgroup.

Measures in the starter set should work well for the dual eligible population *as they are currently designed and specified*. They should address areas that present significant opportunities for improving the health and well-being of the dual eligible population. Therefore, MAP recommends that stakeholders seeking to use measures for the dual eligible population should consider the starter set first, then the other measure options available within the family of measures.

MAP selected 15 measures for the starter set: 2 outcome, 8 process, 1 structure, and 4 composite measures. Additionally, three measures are disparities-sensitive, and three are reported directly by individuals receiving services. Table 2 presents the numbers, endorsement status, and names of the measures in the starter set within the family of measures.

TABLE 2: STARTER SET WITHIN THE FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

NQF Number and Status	Measure Name
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0007 Endorsed	NCQA Supplemental Items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)
0008 Endorsed	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
0018 Endorsed	Controlling High Blood Pressure
0022 Endorsed	Use of High Risk Medications in the Elderly
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0101 Endorsed	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0228 Endorsed	3-Item Care Transition Measure (CTM-3)
0418 Submitted	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
0419 Endorsed	Documentation of Current Medications in the Medical Record
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0486 Endorsed	Adoption of Medication e-Prescribing

NQF Number and Status	Measure Name
0576 Endorsed	Follow-Up after Hospitalization for Mental Illness
1768 Endorsed	Plan All-Cause Readmissions
1909 Endorsed	Medical Home System Survey (MHSS)

Measure Gaps and Future Measure Development

MAP has identified high-priority measure gaps throughout its work. The Dual Eligible Beneficiaries Workgroup revisited this theme with the goal of providing greater specificity to measure developers and funders. Figure 1 provides an updated list of prioritized measure gaps.

FIGURE 1: HIGH-PRIORITY MEASURE GAPS FOR THE DUAL ELIGIBLE BENEFICIARY POPULATION

- *Goal-directed, person-centered care planning and implementation*
- *Shared decision-making*
- *Systems to coordinate healthcare with non-medical community resources and service providers*
- *Beneficiary sense of control/autonomy/self-determination*
- *Psychosocial needs*
- *Community integration/inclusion and participation*
- *Optimal functioning (e.g., improving when possible, maintaining, managing decline)*

This list reflects MAP's vision for high-quality care, which has been articulated in previous reports. Identification of these gaps supports a philosophy about health that broadly accounts for individuals' health outcomes, personal wellness, social determinants (e.g., housing, transportation, access to community resources), and desire for a more cohesive system of care delivery. Many gaps are long-standing, which underscores both the importance of non-medical supports and services in contributing to improved healthcare quality and the difficulty of quantifying and measuring these factors as indicators of performance.

Specifically, MAP recommends continuing measure development focus on topics that are meaningful to consumers, such as individual engagement, experience, and outcomes. In addition, MAP emphasizes the need for cross-cutting measures that apply to care and supports at all levels to promote shared accountability and collaboration. Measures should incorporate information from individuals receiving services, providers, health plans, other accountable entities, and/or states. Several measure gap areas are prioritized here for the first time, including psychosocial needs, shared decision-making, and community integration/inclusion and participation. MAP will continue to communicate with measure developers and other stakeholders positioned to help fill measurement gaps.

The "pipeline" of measures in development and other types of indicators are also of interest to MAP. Specifically, MAP has explored the feasibility of using metrics developed to ensure quality in intellectual/developmental disability ID/DD services in new scenarios of accountability. Through discussions with

invited experts, MAP has considered the experience of fielding the National Core Indicators (NCI) in states and the Personal Outcome Measures (POM) with providers.[2,3] Although not structured in the same manner as many NQF-endorsed® performance measures, the NCI and POM have been proven to accurately assess quality of ID/DD services and individual outcomes, respectively. In particular, MAP noted that states' participation in the publicly reported NCI system can be viewed as a commitment to quality improvement and transparency and that the indicators themselves are designed to evaluate critical factors such as system performance; health, welfare, and rights; and individual outcomes. Use of the NCI is expected to gradually expand to all states, and several organizations have partnered to test the NCI for use in the older adult population.

Measuring Healthcare Quality in Populations with Behavioral and/or Cognitive Needs

Continuing its exploration of high-need subgroups within the dual eligible beneficiary population, MAP discussed the issues unique to measuring to the quality of healthcare for individuals with disabling behavioral and/or cognitive conditions. In this context, high-need subgroups consist of individuals with one or more of the following conditions: 1) serious mental illness (SMI), 2) substance use disorders (SUD), 3) acquired cognitive impairment (e.g., dementia), and 4) intellectual/developmental disability.

MAP continues to advocate for performance measurement strategies targeted to areas with significant opportunities for quality improvement. To identify those areas, MAP generated a list of recognized problems in healthcare that have a disproportionate impact on individuals with behavioral and cognitive needs, many of which affect multiple high-need subgroups. Staff compiled measures relevant to the identified areas for workgroup review. The workgroup selected many, but not all, of these measures for inclusion in the broader Family of Measures for Dual Eligible Beneficiaries discussed earlier. Those not selected were considered to be too narrow or less applicable in the general dual eligible population. Table 3 lists the measures identified as relevant to individuals with disabling behavioral and cognitive conditions.

TABLE 3: MEASURES APPLICABLE TO INDIVIDUALS WITH BEHAVIORAL/COGNITIVE CONDITIONS

NQF Measure Number and Measure Name	All Sub-groups	SMI	SUD	ID/DD	Cognitive Impairment
0004 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		YES	YES	YES	
0008 - Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)		YES	YES		
0027 - Medical Assistance with Smoking and Tobacco Use Cessation	YES				
0028 - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	YES				
0031 - Breast Cancer Screening				YES	

[2] The National Association of State Directors of Developmental Disabilities Services (NASDDDS). *National Core Indicators*. Cambridge, MA: Human Services Research Institute; 2012. Available at http://www.nationalcoreindicators.org/. Last accessed June 2013.
[3] The Council on Quality and Leadership (CQL). *Personal Outcome Measures*. Towson, MD: CQL; 2012. Available at http://www.thecouncil.org/index.aspx. Last accessed June 2013.

NQF Measure Number and Measure Name	All Sub-groups	SMI	SUD	ID/DD	Cognitive Impairment
0032 - Cervical Cancer Screening		YES	YES	YES	
0034 - Colorectal Cancer Screening		YES	YES	YES	
0035 - Fall Risk Management	YES				
0097 - Medication Reconciliation	YES				
0101 - Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	YES				
0105 - Antidepressant Medication Management (AMM)	YES				
0111 - Bipolar Disorder: Appraisal for Risk of Suicide		YES			
0176 - Improvement in Management of Oral Medications	YES				
0177 - Improvement in Pain Interfering with Activity				YES	YES
0201 - Pressure Ulcer Prevalence (hospital acquired)				YES	YES
0202 - Falls with Injury	YES				
0204 - Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], Unlicensed Assistive Personnel [UAP], and Contract)	YES				
0205 - Nursing Hours per Patient Day	YES				
0228 - 3-Item Care Transition Measure (CTM-3)	YES				
0326 - Advance Care Plan	YES				
0419 - Documentation of Current Medications in the Medical Record	YES				
0420 - Pain Assessment and Follow-Up			YES		YES
0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	YES				
0430 - Change in Daily Activity Function as Measured by the AM-PAC	YES				
0538 - Pressure Ulcer Prevention and Care				YES	YES
0573 - HIV Screening: Members at High Risk of HIV		YES	YES		
0576 - Follow-Up after Hospitalization for Mental Illness	YES				
0640 - HBIPS—2 Hours of Physical Restraint Use		YES	YES		
0641 - HBIPS—3 Hours of Seclusion Use		YES	YES		
0646 - Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self-Care or Any Other Site of Care)	YES				
0674 - Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	YES				
0680 - Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	YES				
0682 - Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	YES				
0687 - Percent of Residents Who Were Physically Restrained (Long Stay)	YES				
0688 - Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay)	YES				
0710 - Depression Remission at Twelve Months		YES			
0712 - Depression Utilization of the PHQ-9 Tool		YES			
1388 - Annual Dental Visit	YES				
1626 - Patients Admitted to ICU Who Have Care Preferences Documented	YES				

NQF Measure Number and Measure Name	All Sub-groups	SMI	SUD	ID/DD	Cognitive Impairment
1659 - Influenza Immunization	YES				
1909 - Medical Home System Survey (MHSS)	YES				
1927 - Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications		YES			
1932 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (SSD)		YES			
2091 - Persistent Indicators of Dementia without a Diagnosis—Long Stay					YES
2092 - Persistent Indicators of Dementia without a Diagnosis—Short Stay					YES
2111 - Antipsychotic Use in Persons with Dementia					YES
2152 - Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		YES	YES		YES

Despite the unique needs of individuals with behavioral and cognitive conditions, MAP members found that most quality issues and measures are broadly applicable across the four subgroups. As experienced during prior work to explore specialized quality issues for other subgroups, MAP members found it difficult to elaborate on the unique needs of the four subgroups. Rather than emphasizing differences, MAP favors developing integrated, person-centered approaches to measurement, with a measure's best fit depending on the particular purpose of the measurement program in question.

The selected measures are concentrated in the areas of screening and assessment, care coordination, and safety, which reflects MAP's belief that large gains in quality can be achieved for the subgroups by targeting cross-cutting improvements in basic care and facilitating communication among providers using person-centered thinking, planning, and practice at all levels of the system. Access to preventive services was particularly emphasized because of the potential to reduce downstream morbidity and mortality across subgroups. MAP members also reaffirmed the recommendation that the results of any screening or assessment should be incorporated into a person-centered plan of care and shared across providers. Simple documentation of risks or diagnoses is not sufficient; the hallmark of high-quality care is a team of health professionals and support providers working together with the individual to address his or her self-defined goals and to monitor progress over time.

Serious Mental Illness

A recent study estimated that 58 percent of dual eligible beneficiaries have a serious mental illness or other type of cognitive or mental impairment. [4] Within that group, 20 percent have more than one mental illness or impairment.[5] Adults with SMI experience a high burden of treatable chronic medical conditions and significantly

[4] The Henry J. Kaiser Family Foundation (KFF), Kaiser Commission on Medicaid and the Uninsured. *Medicaid's Role for Dual Eligible Beneficiaries*. Menlo Park, CA: KFF; 2012. Available at http://www.kff.org/medicaid/upload/7846-03.pdf. Last accessed June 2013.
[5] Ibid.

shortened lifespans, on average.[6] Consequently, MAP identified screening and treatment for cardio-metabolic conditions among the quality issues that are prominent for this subgroup. MAP also emphasized the need for broader screening for SMIs, substance use, and behaviors associated with poor health. Given the early mortality in this subgroup and the contribution of medication side-effects to poor health, two measures selected for the SMI subgroup focus on screening individuals prescribed antipsychotic medications for cardio-metabolic disease (NQF #1927 and NQF #1932). MAP also identified promising measures for monitoring the treatment of depression and bipolar disorder. Measure gap areas specific to SMI relate to psychosocial interventions (e.g., peer supports, wellness activities, supported employment) and other models that foster recovery and seek to reduce the reliance on medication.

Substance Use Disorders

An estimated 20 percent of dual eligible individuals with a disability younger than 65 have a substance use problem.[7,8] General research indicates that more than 40 percent of adults with substance use disorders have a co-occurring mental illness. However, one out of every three individuals with co-occurring mental illness and substance use does not receive treatment. Given these findings, MAP members focused discussion on an individual's ability to access needed services and supports. MAP then selected measures to assess initiation of and engagement in treatment for SUD. MAP also supported measures of experience of behavioral healthcare, and it noted a large gap in the availability of measures related to withdrawal management, stabilization, and extended engagement in SUD care following diagnosis of substance dependence and/or a crisis episode.

Acquired Cognitive Impairment

Alzheimer's and Parkinson's diseases are among the most common and costly acquired cognitive impairments affecting dual eligible beneficiaries.[9] Dementia affects 28 percent of dual beneficiaries 65 and older.[10] Dementia commonly co-occurs with SMI, further complicating individuals' needs for services.[11] Given the cognitive limitations of this subgroup, MAP members were particularly sensitive to ensuring that the advance illness care preferences for these individuals have been documented. MAP selected measures such as NQF #0326: Advance Care Plan in pursuit of this goal. MAP discussed person-centered planning as foundational for optimizing quality of life and enabling residence in a community-based setting. Safety was also identified as a key quality issue for

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[6] Manderscheid R, Druss B, Freeman E. *Data to Manage the Mortality Crisis: Recommendations to the Substance Abuse and Mental Health Services Administration*. Washington, DC, August 15, 2007.

[7] Substance Abuse and Mental Health Services Administration (SAMHSA). *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*. Rockville, MD: SAMHSA, 2012. Available at http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf. Last accessed June 2013.

[8] Washington State Department of Social and Health Services (DSHS). *Coordinating Care for Washington State Dual Eligibles*. Olympia, WA; 2011. Available at http://www.aasa.dshs.wa.gov/duals/documents/Dual%20Eligible%20Population%20Profile.pdf. Last accessed June 2013.

[9] KFF, 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*. Washington, DC: KFF; 2010. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf. Last accessed June 2013.

[10] Lin WC, Zhang J, Leung GY et al. Twelve-month diagnosed prevalence of behavioral health disorders among elderly Medicare and Medicaid members, *Am J Geriatr Psychiatry*, 2011; 19(11):970–979.

[11] Ibid.

individuals with cognitive impairment, with a particular focus on pressure ulcer prevention, identification, and care. MAP members expressed concern that some measures exclude pre-existing pressure ulcers, which may pose a challenge to determining who should be accountable for pressure ulcers for an individual transitioning between care settings. MAP also discussed and selected measures related to screening for dementia among institutionalized older adults.

Intellectual/Developmental Disability

Nearly 7 percent of dual eligible beneficiaries between the ages of 18 and 64 have an intellectual and/or developmental disability.[12] ID/DD can significantly limit individuals' intellectual functioning and adaptive behaviors. Individuals with these conditions commonly require a range of services and supports in addition to healthcare, including case management, family caregiver support, special education, habilitation, and transition services. Individuals with ID/DD are at increased risk of abuse and experience many disparities in receiving routine preventive services. Providers often lack equipment physically accessible to people with disabilities or incorrectly perceive that there is no need to conduct screening tests. MAP members selected several cancer surveillance measures and measures assessing functional status, physical accessibility, and mobility for application to this subgroup.

Measurement Challenges for Individuals with Disabling Behavioral/Cognitive Conditions

The complexity and relative rarity of conditions with effects on behavioral and cognitive abilities continue to limit the availability of easily applied performance measures. There is relatively little empirical evidence to support development of performance measures for the care and supports provided to these subgroups. Similarly, MAP members strongly expressed the need for better understanding of the effects of social determinants on health outcomes and quality measurement results.

MAP members found the measures constructed for single conditions to fall well short of their desired markers of high-quality care. High-quality care is achieved when a beneficiary and his/her caregivers are engaged in an ongoing dialogue with a team of healthcare and LTSS providers. This dialogue must account for the individual's preferences and actively weigh complex trade-offs when deciding on a plan of care. For example, an individual and physician may find that the side effects of a medication are more harmful to an individual's overall quality of life than the symptoms it was intended to alleviate. This is especially important for medication regimens involving psychotropic medications with the potential for a wide range of serious side effects including psychosis, mania, heart attack, and stroke.

MAP also discussed the trade-offs between well-intentioned but misguided paternalism and the "dignity of risk" being afforded to beneficiaries in the context of shared decision-making. For example, the healthcare team should carefully weigh an individual's risk for experiencing a dangerous fall against restrictive practices such as bed alarms or required supervision. It is not possible to completely eliminate falls; rather, programs should focus on minimizing injuries associated with occasional falls.

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[12] KFF, 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*. Washington, DC: KFF; 2010. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf. Last accessed June 2013.

MAP supported several measures that rely on data collected directly from beneficiaries, often through the use of surveys, because individuals' perceptions related to quality are of central importance. Many stakeholders from the disability community voiced concern about data collection methodologies that do not allow for a proxy to answer on behalf of a person with difficulty communicating because this results in the disabled individual's experience being excluded from measurement. MAP discussed the potential effects of proxies on data integrity and concluded that more flexibility is needed in this area. Alternatively, other methods beyond written surveys could be used to appropriately gather information from individuals who may have difficulty responding without a proxy.

Next Steps for Stakeholders

Interest in improving the quality of care for dual beneficiaries has been growing, bolstered by the nationwide imperative to reduce the cost and improve the value of healthcare. MAP is working to harness this energy by convening balanced groups of stakeholders, formulating action plans, and supporting development of new measures to address at-risk populations. As MAP has explored the measurement needs for dual eligible beneficiaries, it has identified next steps for all stakeholders.

MAP recommends four areas for action by DHHS and its partners:

1. Move forward with exploring the feasibility of making MAP's recommended modifications to the measures for which the federal government is responsible.
2. Engage measure developers beyond DHHS in creating and publishing a plan to address measurement gaps and make funding available to do so.
3. Align quality measurement and reporting requirements across programs that serve the dual eligible population.
4. Pursue research activities to support new measure development in difficult areas (e.g., social determinants of health, quality of life, "system-ness") and explore promising new methodologies for measurement.

To all stakeholders using measures in the field, the workgroup recommends careful attention to fit-for-purpose in intentionally selecting and using measures. The choice of measures at any level, from federal payment programs to local improvement projects, should promote alignment of program requirements and models of care that minimize the extra effort associated with measurement. Furthermore, measures should be implemented and applied appropriately to collect the most accurate and actionable data possible. Inappropriate measure application can produce false data, resulting in misguided action, unintended consequences, and increased burden of measurement.

MAP relies on the continued participation and feedback of all stakeholders to locate and amplify innovative ideas for quality measurement and improvement. MAP recognizes and appreciates the engagement from partners in the public and private sectors in pursuit of high-quality care for dual eligible beneficiaries.

Appendix A: Roster for MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
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	Gwendolen Buhr, MD, MHS, MEd, CMD
Center for Medicare Advocacy	Alfred J. Chiplin, JD, M.Div.
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Appendix B: Details of the Family of Measures for Dual Eligible Beneficiaries

Measure information is current as of date of publication. Measures are the intellectual property of their respective developers and stewards, not NQF. Further detail on endorsed measures can be obtained through NQF's searchable Quality Positioning System (QPS) at http://www.qualityforum.org/qps

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process	MAP Duals Family, Starter Set		Emphasis on coordination with detox facilities and incorporating alcohol and other drug dependence treatment into person-centered care plan; Particularly important for population with behavioral health needs	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Health Plan; Integrated Delivery System; Population: County or City, National, Regional	Ambulatory Care: Clinician Office/ Clinic; Urgent Care; Behavioral Health/ Psychiatric: Outpatient; Emergency Medical Services/ Ambulance; Hospital/ Acute Care Facility		NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use- EP; PQRS Medicaid Adult Core Set, Medicaid Health Home State Demonstration: CA, IL, MA, OH, VA, WA Private Programs: HEDIS
0007 Endorsed NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	Composite	MAP Duals Family, Starter Set	Care Coordination	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating	This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates. 1. Shared Decision Making Composite 1. Health Promotion and Education item 2. Coordination of Care item	Patient Reported Data/ Survey	Clinician: Group/ Practice, Health Plan, Individual; Integrated Delivery System; Population: National, Regional, State	Ambulatory Care: Clinician Office	Patient Reported Outcome	NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part D Plan Rating Medicaid Adult Core Set State Demonstration: VA Private Programs: HEDIS
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Composite	MAP Duals Family, Starter Set	Care Coordination	Expand care setting to include Behavioral Health Care; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating	52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Patient Reported Data/Survey	Health Plan	Ambulatory Care: Clinician Office/ Clinic	Disparities Sensitive, Patient Reported Outcome, High Impact Condition	AHRQ	State Demonstration: CA, IL, MA, OH

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0018 Endorsed Controlling High Blood Pressure	Outcome	MAP Duals Family, Starter Set	Cardiovascular Disease; Diabetes	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Administrative claims; Electronic Clinical Data; Paper Medical Records	Health Plan; Integrated Delivery System	Ambulatory Care: Clinician Office/ Clinic, Urgent Care	Disparities Sensitive	NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use- EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA Medicaid Adult Core Set, Medicaid Health Home, Special Needs Plan State Demonstration: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure
0022 Endorsed Use of High Risk Medications in the Elderly	Process	MAP Duals Family, Starter Set	Safety	Important due to the possibility of drug/disease and drug/drug interactions; Expand age range of measure to apply to younger at-risk groups	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Administrative claims; Electronic Clinical Data: Electronic Clinical Data, Pharmacy	Health Plan; Integrated Delivery System	Ambulatory Care: Clinician Office, Pharmacy		NCQA	Federal and State Programs: Meaningful Use- EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program Special Needs Plan State Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation	Process	MAP Duals Family		Encourage health plans to use this measure; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating; Incorporate cessation services into person-centered care plan; Particularly important for population with behavioral health needs because of historical misuse of cigarettes as incentives	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	Patient Reported Data/ Survey	Health Plan	Ambulatory Care: Clinician Office/ Clinic; Other	Patient Reported Outcome, High Impact Condition	NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS Medicaid Adult Core Set Private Programs: HEDIS; Wellpoint
0028 Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	MAP Duals Family, Starter Set	Cardiovascular Disease; Diabetes	Screening every two years may not be sufficient; Only measures clinicians despite other opportunities for tobacco use interventions; Incorporate chronic disease management and preventive services into person-centered care plan; Particularly important for population with behavioral health needs	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records; Registry	Clinician: Group/ Practice, Individual, Team	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Inpatient, Outpatient; Other	High Impact Condition	American Medical Association - Physician Consortium for Performance Improvement	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; PQRS State Demonstration: MA Private Programs: eValue8 At least 1 Beacon community; Buying Value core ambulatory measure

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0032 Endorsed Cervical Cancer Screening	Process	MAP Duals Family		Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	Administrative claims, Electronic Clinical Data: Electronic Clinical Data, Electronic Health Record; Paper Medical Records	Clinician: Group/ Practice, Individual; Health Plan	Ambulatory Care: Clinician Office/ Clinic	Disparities Sensitive	NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; HRSA Medicaid Adult Core Set State Demonstration: IL, MA Private Programs: HEDIS; Wellpoint; Aetna; AmeriHealth Mercy Family of Companies; Cigna; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
0034 Endorsed Colorectal Cancer Screening	Process	MAP Duals Family		Quality issue of particular importance to address access to care and accessible services/equipment for individuals with disabilities and/or SMI; Access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Administrative claims; Electronic Clinical Data: Imaging/ Diagnostic Study, Laboratory; Paper Records	Clinician: Group/ Practice, Individual, Team; Health Plan	Ambulatory Care: Clinician Office/ Clinic	High Impact Condition	NCQA	Federal and State Programs: Meaningful Use- EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA Special Needs Plan State Demonstration: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS ; Wellpoint; Aetna; Community Health Alliance; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0043 Endorsed Pneumonia vaccination status for older adults	Process	MAP Duals Family		Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	Administrative claims; Healthcare Provider Survey; Paper Medical Records; Patient Reported Data/ Survey	Population: County or City; Facility; Health Plan; Integrated Delivery System; Clinician: Group/ Practice, Individual, Team	Ambulatory Care: Clinician Office; Home Health; Hospital/ Acute Care Facility, Pharmacy; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility, Inpatient Rehabilitation Facility	Disparities Sensitive	NCQA	Federal and State Programs: Meaningful Use- EP, Medicare Part C Plan Rating, Medicare Shared Savings Program, Physician Feedback, PQRS Private Programs: At least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure
0097 Endorsed Medication Reconciliation	Process	MAP Duals Family	Hospice	Most recent version of measure in development requires reconciliation within a shorter time frame of 30 days; Important due to the possibility of drug/drug and drug/disease interactions; Expand age of population included to apply to other at-risk groups	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Administrative claims; Paper Medical Records; Electronic Clinical Data; Electronic Clinical Data: Electronic Health Record, Laboratory, Registry	Population: County or City; Clinician: Group/ Practice, Individual; Integrated Delivery System	Ambulatory Care: Clinic/ Urgent Care, Clinician Office/ Clinic		NCQA	Federal and State Programs: Medicare Shared Savings Program; Physician Feedback; PQRS State Demonstration: CA, IL, MA, OH, VA Private Programs: Buying Value core ambulatory measure
0101 Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Process	MAP Duals Family, Starter Set		Suggest that the measure be expanded to include anyone at risk for a fall even if younger than 65 (e.g., individuals with mobility impairments, cognitive impairments, or prescribed disorienting medication therapies); Others noted that individuals may be comfortable with some risk of falling and shared decision-making about fall prevention methods is important	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future 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 B) Multifactorial Risk Assessment for Falls: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Administrative claims	Clinician: Group/ Practice, Individual, Team	Ambulatory Care: Clinician Office/ Clinic, Urgent Care; Home Health; Hospice; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility		NCQA	State Demonstration: WA

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0105 Endorsed Antidepressant Medication Management (AMM)	Process	MAP Duals Family		Important due to the possibility of drug/drug and drug/disease interactions; Incorporate medication management into person-centered care plan	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Administrative claims; Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Ambulatory Care: Clinician Office/ Clinic	High Impact Condition	NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Physician Feedback; PQRS; Value-Based Payment Medicaid Adult Core Set, Special Needs Plan State Demonstration: CA, IL, MA, OH, VA Private Programs: HEDIS; Cigna; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
0111 Endorsed Bipolar Disorder: Appraisal for risk of suicide	Process	MAP Duals Family		Expand suicide risk screening to entire SMI population; Incorporate assessment into person-centered care plan and conduct appropriate follow-up	Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	Administrative claims	Clinician: Group/ Practice, Individual	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient	High Impact Condition	Center for Quality Assessment and Improvement in Mental Health	
0176 Endorsed Improvement in management of oral medications	Outcome	MAP Duals Family	Safety	Measure should include a patients and/or caregiver education component to ensure they understand the medications; Important due to the possibility of drug/drug and drug/disease interactions	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Electronic Clinical Data	Facility	Home Health		CMS	Federal and State Programs: Home Health Quality Reporting

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0201 Endorsed Pressure ulcer prevalence (hospital acquired)	Outcome	MAP Duals Family	Safety	Emphasized importance for individuals with limited mobility and/or cognitive impairments	The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Electronic Clinical Data; Other; Paper Medical Records	Facility; Clinician: Team	Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/ Skilled Nursing Facility		The Joint Commission	Private Programs: National Database of Nursing Quality Indicators (NDNQI); Alternative Quality Contract Wellpoint
0202 Endorsed Falls with injury	Outcome	MAP Duals Family	Safety	Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decision-making about fall prevention methods is important	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Electronic Clinical Data; Other; Paper Medical Records	Clinician: Team	Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Inpatient Rehabilitation Facility		American Nurses Association	
0228 Endorsed 3-Item Care Transition Measure (CTM-3)	Composite	MAP Duals Family, Starter Set	Care Coordination	Expand care settings to include post-acute/long-term care settings; Measure selected because it captures person/caregiver experience during care transitions but it may not be discrete enough in its assessment of individual/caregiver understanding of discharge instructions	Uni-dimensional self-reported survey that measure the quality of preparation for care transitions.	Patient Reported Data/Survey	Facility	Hospital/ Acute Care Facility	Patient Reported Outcome	University of Colorado Health Sciences Center	Federal and State Programs: Hospital Inpatient Quality Reporting State Demonstration: MA

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0326 Endorsed Advance Care Plan	Process	MAP Duals Family	Care Coordination; Hospice	Measure strongly supported for widespread use; Suggested expansion of denominator age group and application in all care settings; Measure promotes inclusion of personal preferences in care plan and this should be encouraged whenever possible	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Administrative claims; Electronic Clinical Data	Clinician: Group/ Practice, Individual	Ambulatory Care: Clinician Office/ Clinic, Urgent Care; Home Health; Hospice; Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Inpatient Rehabilitation Facility, Nursing Home/ Skilled Nursing Facility	Disparities Sensitive	NCQA	Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan
0418 Submitted Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	MAP Duals Family, Starter Set		Measure supported because it includes follow-up after screening; Incorporate behavioral health management and preventive services into person-centered care plan; USPSTF recommends measure for adults only	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Clinician: Group/ Practice, Team, Individual; Population: National, Regional, State, County or City, Community	Ambulatory Care: Clinician Office/ Clinic; Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility	High Impact Condition	CMS	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use- EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA Medicaid Adult Core Set, Medicaid Health Home State Demonstration: CA, IL, MA, OH, VA, WA Private Programs: Bridges to Excellence
0419 Endorsed Documentation of Current Medications in the Medical Record	Process	MAP Duals Family, Starter Set	Safety	Measure excludes individuals with cognitive impairment without authorized representative so workgroup recommends providers make extra effort to include caregiver in the process; Measure should include a an education component to ensure individual and caregiver understand the medications	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/ her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.	Administrative claims, Electronic Clinical Data: Registry	Clinician: Individual; Population: National	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient; Dialysis Facility; Home Health,: Other; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility, Inpatient Rehabilitation Facility		CMS	Federal and State Programs: Meaningful Use- EP; Physician Feedback; PQRS

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0420 Endorsed Pain Assessment and Follow-Up	Process	MAP Duals Family		Appropriate instruments and tools are available to assess for pain experienced by persons with communication impairments and their use should be expanded; Incorporate assessment and follow-up into person-centered care plan	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Administrative claims	Clinician: Individual	Ambulatory Care: Clinician Office/ Clinic, Other	Patient Reported Outcome	CMS	Federal and State Programs: Physician Feedback; PQRS
0421 Endorsed Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	MAP Duals Family, Starter Set	Cardiovascular Disease; Diabetes	Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	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 within the past six months or during the current visit Normal Parameters: Age 65 years and older BMI > = to 23 and <30 Age 18 – 64 years BMI > = to 18.5 and <25	Administrative claims; Electronic Clinical Data: Registry, Electronic Health Record; Paper Medical Records	Clinician: Group/ Practice, Individual; Population: National, Regional, State, County or City	Ambulatory Care: Clinician Office/ Clinic, Outpatient Rehabilitation; Behavioral Health/ Psychiatric: Outpatient; Home Health; Other	Disparities Sensitive, High Impact Condition	CMS	Federal and State Programs: Meaningful Use- EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA State Demonstration: MA Private Programs: At least 1 Beacon community; Wellpoint; Buying Value core ambulatory measure
0486 Endorsed Adoption of Medication e-Prescribing	Structure	MAP Duals Family, Starter Set	Safety	e-Prescribing has been shown to improve medication safety; Measure demonstrates important structural capability	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Administrative claims; Survey: Provider	Clinicians: Group, Individual	Ambulatory Care: Clinician Office/ Clinic; Other		CMS	Federal and State Programs: E-Prescribing Incentive Program; Physician Feedback Private Programs: Aetna
0553 Endorsed Care for Older Adults – Medication Review	Process	MAP Duals Family		Important due to the possibility of drug/drug and drug/disease interactions; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings	Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Administrative claims; Electronic Clinical Data; Paper Medical Records	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Ambulatory Care: Clinician Office/ Clinic; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility		NCQA	Federal and State Programs: Medicare Part C Plan Rating Private Programs: HEDIS; IHA

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0554 Endorsed Medication Reconciliation Post-Discharge	Process	MAP Duals Family	Safety	Important because medications are often changed during inpatient stay; Measure could benefit other complex patients, so recommend expansion to other age groups and care settings	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Health Plan; Integrated Delivery System; Population: National, Regional, County or City	Ambulatory Care: Clinician Office/ Clinic		NCQA	Federal and State Programs: Special Needs Plan State Demonstration: CA Private Programs: HEDIS
0557 Submitted HBIPS-6 Post discharge continuing care plan created	Process	MAP Duals Family	Care Coordination	Paired measure to be used with 0558; This type of transition planning/ communication is universally important and should apply to all discharges, not just psychiatric; At a minimum, the measure should include inpatient detox	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).	Administrative claims; Electronic Clinical Data; Other; Paper Medical Records	Facility	Behavioral Health/ Psychiatric: Inpatient; Hospital/ Acute Care Facility		The Joint Commission	Federal and State Programs: Inpatient Psychiatric Hospital Quality Reporting
0558 Submitted HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Process	MAP Duals Family	Care Coordination	This type of transition planning/ communication is universally important and should apply to all discharges; At a minimum, the measure should include inpatient detox; Addresses care coordination through creating and transmitting care plan; Important to also communicate plan to the individual and caregiver	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	Administrative claims; Electronic Clinical Data; Other; Paper Medical Records	Facility	Behavioral Health/ Psychiatric: Inpatient; Hospital/ Acute Care Facility		The Joint Commission	Federal and State Programs: Inpatient Psychiatric Hospital Quality Reporting
0573 Endorsed HIV Screening: Members at High Risk of HIV	Process	MAP Duals Family		Dual eligible beneficiaries may be at high risk for HIV for a variety of reasons; Access to screening and treatment services needed	To ensure that members diagnosed or seeking treatment for sexually transmitted diseases be screened for HIV.	Administrative claims	Health Plan; Clinician: Individual	Ambulatory Care: Clinician Office/ Clinic, Urgent Care; Laboratory		Health Benchmarks-IMS Health	Private Programs: Health benchmarks

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0576 Endorsed Follow-Up After Hospitalization for Mental Illness	Process	MAP Duals Family, Starter Set	Care Coordination	Expand to include care settings where substance use/detox services are provided; Follow up within 30 days is too long of a time frame to address complex care needs for persons hospitalized for mental illness	This measure assesses the 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. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	Administrative claims; Electronic Clinical Data: Electronic Health Record	Clinician: Team; Health Plan; Integrated Delivery System; Population: National, Regional, State, County or City	Ambulatory Care: Clinician Office/ Clinic, Urgent Care; Behavioral Health/ Psychiatric: Inpatient, Outpatient		NCQA	Federal and State Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS Medicaid Adult Core Set, Medicaid Health Home, Special Needs Plan State Demonstration: CA, IL, MA, OH, VA, WA Private Programs: Wellpoint; HEDIS; Buying Value core ambulatory measure
0640 Endorsed HBIPS-2 Hours of physical restraint use	Process	MAP Duals Family		This measure is only a minimum threshold and absence of restraints does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Administrative claims; Electronic Clinical Data; Other; Paper Medical Records	Facility	Behavioral Health/ Psychiatric: Inpatient; Hospital/ Acute Care Facility	High Impact Condition	The Joint Commission	Federal and State Programs: Inpatient Psychiatric Hospital Quality Reporting
0641 Endorsed HBIPS-3 Hours of seclusion use	Process	MAP Duals Family		This measure is only a minimum threshold and absence of seclusion use does not guarantee high-quality care; Emphasized importance of measure for individuals with SMI and cognitive impairments	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	Administrative claims; Electronic Clinical Data; Other; Paper Medical Records	Facility	Behavioral Health/ Psychiatric: Inpatient; Hospital/ Acute Care Facility		The Joint Commission	Federal and State Programs: Inpatient Psychiatric Hospital Quality Reporting

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0646 Endorsed Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)	Process	MAP Duals Family	Safety	Measure addresses importance of communicating reconciled medication list from inpatient facility to individual/ caregiver/ next site of care but it does not go far enough to assess recipients' understanding of reconciled medication list	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Facility; Integrated Delivery System	Ambulatory Care: Ambulatory Surgery Center (ASC); Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility, Inpatient Rehabilitation Facility	Disparities Sensitive	American Medical Association - Physician Consortium for Performance Improvement	Private Programs: ABIM MOC; Highmark
0647 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)	Process	MAP Duals Family	Care Coordination; Hospice	Measure selected to address care transitions but it does not go far enough to assess recipients' understanding of discharge instructions; Suggest broadening beyond specified care sites/ settings	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, 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	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Records	Facility; Integrated Delivery System	Ambulatory Care: Ambulatory Surgery Center (ASC); Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility, Inpatient Rehabilitation Facility	Disparities Sensitive	American Medical Association - Physician Consortium for Performance Improvement	State Demonstration: CA, MA Private Programs: ABIM MOC; Highmark
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)	Process	MAP Duals Family	Care Coordination; Hospice	Measure selected to address vital issue of care transitions and continuity; Suggest broadening beyond specified care sites/ settings	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Facility; Integrated Delivery System	Ambulatory Care: Ambulatory Surgery Center (ASC); Hospital/ Acute Care Facility; Post Acute/ Long Term Care Facility: Inpatient Rehabilitation Facility, Nursing Home/ Skilled Nursing Facility	Disparities Sensitive	American Medical Association - Physician Consortium for Performance Improvement	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Medicaid Adult Core Set State Demonstration: MA, WA Private Programs: ABIM MOC; Highmark; Buying Value core ambulatory measure

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0649 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care)	Process	MAP Duals Family	Care Coordination	Measure selected to address care transitions but it does not go far enough to assess recipients' understanding of discharge instructions; Suggest broadening beyond specified care sites/ settings	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Administrative claims; Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Facility, Integrated Delivery System	Ambulatory Care: Urgent Care; Hospital/ Acute Care Facility	Disparities Sensitive	American Medical Association - Physician Consortium for Performance Improvement	Private Programs: ABIM MOC; Highmark
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Outcome	MAP Duals Family	Safety	Some thought measure should include all injuries rather than being limited to major injuries; Others noted that individuals may be comfortable with some risk of falling and shared decision-making about fall prevention methods is important	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Electronic Clinical Data	Facility; Population: National	Post Acute Care / Long Term Care Facility: Nursing Home / Skilled Nursing Facility		CMS	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare
0682 Endorsed Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	Process	MAP Duals Family		Incorporate preventive services such as vaccination into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay.	Electronic Clinical Data	Facility; Population: National	Other; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility, Inpatient Rehabilitation Facility		CMS	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	Outcome	MAP Duals Family	Care Coordination	Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating	The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.	Special or unique data; Patient Reported Data/Survey	Facility	Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility	Patient Reported Outcome	AHRQ	State Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada
0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	Outcome	MAP Duals Family	Cardiovascular Disease; Care Coordination	These chronic conditions are common among dual eligible beneficiaries and regular access to services is needed to prevent complications; Incorporate chronic disease management and preventive services into person-centered care plan	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication. We define PAC hospitalizations and PAC professional and other services as one of three types: (A) PAC-related Hospitalizations: (1) Hospitalizations related to the anchor condition: Hospitalizations due to acute exacerbations of the anchor condition are considered PACs. For example, a hospitalization for a diabetic emergency in a diabetic patient, or a hospitalization for an acute pulmonary edema in a CHF patient. Note that for patients with CAD, many hospitalizations are part of typical care and not considered PACs. (2) Hospitalizations due to Comorbidities: Hospitalizations due to any of the patient's comorbid conditions are considered PACs. For example, a diabetic emergency or pneumonia hospitalization for a patient with heart failure. Note that hospitalizations for a major surgical procedure (such as joint replacement, CABG, etc.) are not counted as PACs.	Administrative claims; Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice; Health Plan; Population: National, Regional, County or City, State	Ambulatory Care: Clinician Office/ Clinic		Bridges to Excellence	Private Programs: Prometheus

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
					(3) Hospitalizations suggesting Patient Safety Failures: Hospitalizations for major infections, deep vein thrombosis, adverse drug events, and other patient safety-related events are considered PACs. (B) Other PACs during the calendar year studied: (1) PACs related to the anchor condition: Emergency room visits, professional and ancillary services related to the anchor condition are considered PACs if they are due to an acute exacerbation of the anchor condition such as acute exacerbation of COPD in patients with lung disease, or acute heart failure in patients with CHF. (2) PACs due to Comorbidities: Emergency room visits, professional and ancillary services are considered PACs if they are due to an exacerbation of one or more of the patient's comorbid conditions, such as an acute exacerbation of COPD or acute heart failure in patients with diabetes. (3) PACs suggesting Patient Safety Failures: Emergency room visits, professional and ancillary services for major infections, deep vein thrombosis, adverse drug events, and other patient safety-related events are considered PACs. The summary tab in the enclosed workbook gives the overview of the frequency and costs associated with each of these types of PACs for each of the six chronic conditions. Detailed drill-down tabs (e.g. DM IP Stay and DM Prof + OP fac) are also provided in the same workbook for each of the six chronic conditions to highlight high-frequency PACs. The information is based on a two-year, national, commercially insured population (CIP), claims database. The database had 4.7 million covered lives and $95 billion in "allowed amounts" for claims costs. The database was an administrative claims database with medical as well as pharmacy claims. It is important to note that while the overall frequency of PAC hospitalizations are low (for all chronic care conditions summed together, PAC frequency was 6.32% of all PAC occurrences), they amount to over 58% of the PAC medical costs.						

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0710 Endorsed Depression Remission at Twelve Months	Outcome	MAP Duals Family		Remission at 12 months preferred to remission at 6 months because outcome is more fully sustained; Concerns about reporting burden and duplicative measurement if 0712 is also implemented independently	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/ - 30 days) are also included in the denominator.	Electronic Clinical Data: Electronic Clinical Data, Electronic Health Record, Registry; Paper Medical Records	Facility, Clinician: Group/ Practice	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient	Patient Reported Outcome, High Impact Condition	MN Community Measurement	Federal and State Programs: Meaningful Use- EP; PQRS Private Programs: MN Community Measurement
0712 Endorsed Depression Utilization of the PHQ-9 Tool	Process	MAP Duals Family		An additional measure is needed for use of PHQ-9 in long-term care facilities; Concerns about reporting burden and duplicative measurement if 0710 is also implemented independently	Adult patients age 18 and older with the diagnosis of major depression or dysthymia (ICD-9 296.2x, 296.3x or 300.4) who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This process measure is related to the outcome measures of “Depression Remission at Six Months” and “Depression Remission at Twelve Months”. This measure was selected by stakeholders for public reporting to promote the implementation of processes within the provider’s office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 20% of the patients eligible for the denominator of remission at 6 or 12 months actually have a follow-up PHQ-9 score for calculating remission (PHQ-9 score < 5).	Electronic Clinical Data: Electronic Clinical Data, Electronic Health Record, Registry; Paper Medical Records	Facility; Clinician: Group/ Practice	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient	Patient Reported Outcome, High Impact Condition	MN Community Measurement	Federal and State Programs: Meaningful Use- EP; PQRS Private Programs: MN Community Measurement

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
0729 Endorsed Optimal Diabetes Care	Composite	MAP Duals Family	Diabetes	Workgroup generally supports use of composite measures; Some concern that targets within this measure are too aggressive for medically complex beneficiaries and such individuals would need to be excluded	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. 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 < 140/ 90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	Electronic Clinical Data: Electronic Clinical Data, Electronic Health Record, Registry; Paper Medical Records	Clinician: Group/ Practice; Integrated Delivery System	Ambulatory Care: Clinician Office/ Clinic	High Impact Condition	MN Community Measurement	Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented	Process	MAP Duals Family		All beneficiaries should have preferences documented in all settings of care; Intense level of care and interventions provided in the ICU amplifies the importance of personal care preferences	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Electronic Clinical Data: Electronic Health Record; Paper Medical Records	Facility; Health Plan; Integrated Delivery System	Hospital/ Acute Care Facility		The RAND Corporation	
1659 Endorsed Influenza Immunization	Process	MAP Duals Family		Expand care setting beyond acute care or harmonize with other measures - a single measure operationalized across all levels would be preferred; Incorporate preventive services into person-centered care plan; Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Administrative claims; Paper Medical Records	Facility; Population: National, Regional, State	Hospital/ Acute Care Facility	Disparities Sensitive	CMS	Federal and State Programs: Hospital Inpatient Quality Reporting

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
1768 Endorsed Plan All-Cause Readmissions	Outcome	MAP Duals Family, Starter Set		Does not exclude planned readmissions, however it is important to measure readmissions at the health plan level of analysis	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	Administrative claims	Health Plan	Behavioral Health/ Psychiatric: Inpatient; Hospital/ Acute Care Facility		NCQA	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating Medicaid Adult Core Set, Special Needs Plan State Demonstration: CA, IL, MA, OH, VA Private Programs: Wellpoint; HEDIS; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	MAP Duals Family	Care Coordination	Measure does exclude planned readmissions, depending on scope of program it may be important to evaluate at the facility level	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/ gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.	Administrative claims	Facility	Hospital/ Acute Care Facility		CMS	Federal and State Programs: Hospital Inpatient Quality Reporting

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
1902 Endorsed Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Outcome	MAP Duals Family		Health literacy is especially important among vulnerable beneficiaries; Surveys restricting proxy respondents may exclude disabled consumers who have difficulties communicating	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/ Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifies). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)	Patient Reported Data/ Survey	Clinician: Group/ Practice, Individual	Ambulatory Care: Urgent Care, Clinician Office/ Clinic	Disparities Sensitive	AHRQ	Private Programs: Highmark; Buying Value core ambulatory measure
1909 Endorsed Medical Home System Survey (MHSS)	Composite	MAP Duals Family, Starter Set	Care Coordination	Selected due to the importance of care coordination; This structural measure is very complex and labor-intensive to report yet it exemplifies features of coordinated care sought for dual eligible beneficiaries	The Medical Home System Survey (MHSS) assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home. The survey is composed of six composites. Each measure is used to assess a particular domain of the patient-centered medical home. Composite 1: Enhance access and continuity Composite 2: Identify and manage patient populations Composite 3: Plan and manage care Composite 4: Provide self-care support and community resources Composite 5: Track and coordinate care Composite 6: Measure and improve performance	Administrative claims; Electronic Clinical Data: Electronic Health Record, Laboratory, Imaging/ Diagnostic Study, Electronic Clinical Data; Healthcare Provider Survey, Management Data, Other, Paper Medical Records	Clinician: Group/ Practice, Individual	Ambulatory Care: Clinician Office/ Clinic		NCQA	
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Process	MAP Duals Family		Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Administrative claims; Electronic Clinical Data: Pharmacy, Electronic Clinical Data	Health Plan; Integrated Delivery System; Population: State	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient; Other		NCQA	

NQF Measure, Endorsement, and Title	Measure Type	MAP Dual Eligible Family	Other MAP Measure Families	Workgroup Comments	Measure Description	Data Source	Level of Analysis	Care Setting	Disparities, PROs, High Impact Condition	Measure Steward	Other Known Uses and Program Alignment
1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	Process	MAP Duals Family		Quality issue of particular importance to address access to preventive services needed to reduce disproportionate effect of chronic conditions; Incorporate chronic disease management and preventive services into person-centered care plan	The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	Administrative claims	Health Plan; Population: State	Other		NCQA	State Demonstration: IL
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay	Process	MAP Duals Family		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Electronic Clinical Data	Facility	Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility		American Medical Directors Association	
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis - Short Stay	Process	MAP Duals Family		Addresses cases of misdiagnosis or underdiagnoses of dementia within long-term care facilities as well as communication among facility's care team	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Electronic Clinical Data	Facility	Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility		American Medical Directors Association	
2111 Endorsed Antipsychotic Use in Persons with Dementia	Process	MAP Duals Family		Overuse of antipsychotics among persons with dementia is a well-documented problem with quality; contributes to clinical complications and higher costs	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Administrative claims	Health Plan	Other; Pharmacy; Post Acute/ Long Term Care Facility: Nursing Home/ Skilled Nursing Facility		Pharmacy Quality Alliance, Inc.	

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2152 Submitted Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	MAP Duals Family		Support for inclusion in family pending endorsement by NQF; Recommend expanding care setting to emergency department; Emphasis on incorporating alcohol and other drug treatment into person-centered care plan; Particularly important for population with behavioral health needs	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Electronic Clinical Data: Electronic Health Record, Registry	Clinician: Group/ Practice, Individual, Team	Ambulatory Care: Clinician Office/ Clinic; Behavioral Health/ Psychiatric: Outpatient; Other		American Medical Association - Physician Consortium for Performance Improvement	

Appendix C: Properties of the Family of Measures for Dual Eligible Beneficiaries

Measure Properties	Measure Sub-Properties	Measure Count (Total n=55)
NQF Endorsement	Endorsed	51
	Submitted	4
	Not Endorsed	0
Measure Type	Outcome	11
	Process	38
	Structure	1
	Composite	5
High-Leverage Opportunity	Quality of Life	7
	Care Coordination and Safety	24
	Screening and Assessment	12
	Mental Health and Substance Use	11
	Structural	1
Care Setting	Ambulatory Care	25
	Behavioral Health	15
	Home Health	5
	Hospital/Acute Care	18
	Post-Acute/Long Term Care Facility	16
	Other (e.g., Pharmacy)	3
Level of Analysis	Clinician	27
	Facility/Agency	22
	Health Plan	20
	Integrated Delivery System	11
	Population	17
Additional Properties	Disparities Sensitive	12
	High-Impact Conditions	12
	Patient-Reported Outcome	8
	Included in a Federal Program	34
	Included in a State Duals Integration Demonstration	19