MEASURE APPLICATIONS PARTNERSHIP

Finding Common Ground for Healthcare Priorities: Families of Measures for Assessing Affordability, Population Health, and Person- and Family-Centered Care

FINAL REPORT

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NATIONAL QUALITY FORUM

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Cross-Cutting Issues

- Measures need to be aligned with important concept areas, such as the aims of the National Quality Strategy, which will promote broad improvement across the health system.
- Families of measures provide a tool that stakeholders can use to identify the most relevant available measures for particular measurement needs, promote alignment by highlighting important measurement categories, and can be applied by other measurement initiatives.
- While families include important current measures, the deliberations also found that there are not sufficient measures for assessing several priority areas, which highlights the need for further development of measures that matter in affordability, population health, and person- and family-centered care.

Affordability Measurement

- Rising healthcare costs are affecting all stakeholders, and all stakeholders have a shared responsibility for making care affordable.
- Current measures are limited in their ability to describe the full cost picture, so further work is needed to produce measures that comprehensively capture cost at multiple levels.
- Greater transparency of costs and prices is required for improving affordability.

Population Health Measurement

- Population health measures should align with the National Quality Strategy aim of achieving healthy people and communities in order to improve length and quality of life.
- Measuring the upstream determinants of health, in both healthcare and community settings, is important for improving population health.
- Although it is important to focus on the health of the entire population, attention should also be given to health disparities and the unique needs of subpopulations.

Person- and Family-Centered Care Measurement

- Measurement should capture patients' experience of care as well as include patient-reported measures that evaluate meaningful outcomes for patients.
- Collaborative partnerships between persons, families, and their care providers are critical to enabling person- and family-centered care across the healthcare continuum.
- Future measure development should focus on patient-reported outcomes that offer a more holistic view of care, considering individuals' goals, needs, and preferences as well as their overall well-being.

ADVANCING MEASUREMENT IN PRIORITY AREAS: CROSS-CUTTING THEMES

Key Themes

- Measures need to be aligned with important concept areas, such as the aims of the National Quality Strategy, which will promote broad improvement across the health system.
- Families of measures provide a tool that stakeholders can use to identify the most relevant available measures for particular measurement needs, promote alignment by highlighting important measurement categories, and can be applied by other measurement initiatives.
- While families include important current measures, the deliberations also found that there are not sufficient measures for assessing several priority areas, which highlights the need for further development of measures that matter in affordability, population health, and person- and family-centered care.

Measurement is an important tool for improving healthcare. It can be used to track progress, learn what works, and promote accountability for high-quality and better health outcomes. For example, one state-wide health initiative used core sets of measures to build out their electronic health record system; a hospital system used a common framework to identify best practices that achieve the best outcomes in cardiac surgery; and a regional health improvement organization shared measured performance with its members to help them identify areas to improve.[1]

While these examples demonstrate how measures can lead to improvement, current measurement does not fulfill its full potential. Clinicians and healthcare organizations feel burdened by the number of measures they have to report, and oftentimes report multiple metrics assessing the same concept.[2] For example, Massachusetts General Hospital and Massachusetts General Physicians Organization report over 120 measures to different external entities, and this reporting costs over 1 percent of its net patient service revenue.[3]

Beyond the administrative burden, the current measurement volume makes it difficult to identify the right measures for assessing improvement toward specific goals. For some priorities of the National Quality Strategy, there may be hundreds of measures that could be used to assess progress. However, measure availability is uneven, with some limited numbers available for several important priorities and subpopulations. Furthermore, even though there are many measures available, they may not be the right ones for gauging progress. Many metrics only assess clinical processes instead of broader outcomes, cannot be used to assess the health of populations, or do not take advantage of new data sources. More work is needed to advance the nation's measurement capabilities across all priority areas.

Seeking to help with these challenges, the National Quality Forum established the concept of families of measures. Families of measures are intended as a tool that stakeholders can use for assessing progress in important areas and a tool that can help promote alignment in measurement across the health system. Their capabilities are further described in the following sections.

Families of Measures: Tool for Assessing Progress

A family of measures is a starting place that stakeholders can use to identify the most relevant measures for their particular measurement needs. Stakeholders can use these families to assess National Quality Strategy concepts across care settings, levels of aggregation, and populations.

The NQF-convened Measure Applications Partnership (MAP) previously developed seven families, including cancer care, cardiovascular disease, care coordination, diabetes, dual eligible beneficiaries, hospice care, and patient safety. This report adds to this existing work by developing families of measures for affordability, population health, and person- and family-centered care. With this report, there are now families for assessing all parts of the National Quality Strategy.

In examining the use of all families of measures, it was found that approximately 80 percent of these measures are applied in at least one public or private program. This is likely a conservative estimate of measure use, considering that this assessment is based on only a subset of potential applications for the measures, and many of these measures are used in multiple programs. Evidence that measures in MAP families are in active use is important for establishing the practical significance of these measures in real-world applications. Moving forward, the utility of MAP measure families will need to be monitored and built upon based on feedback following practical experience with their application.

Families of Measures: Tool for Promoting Alignment

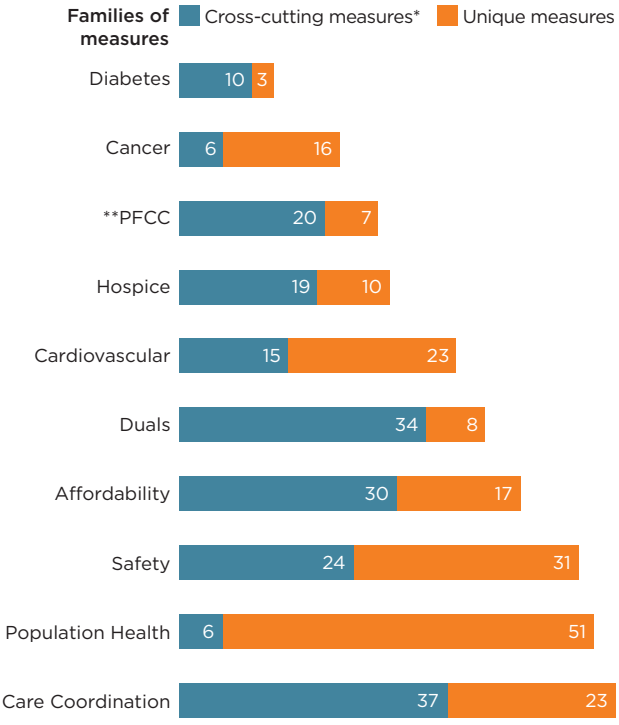
Families of measures are intended to promote alignment. By highlighting priorities for measurement and specific metrics to utilize for these priority areas, a consistent message can be conveyed to individuals and organizations about how to move toward a more aligned approach. Increased alignment of performance measures for health and healthcare may provide substantial benefits, including increased clarity on the most important topic areas, reduced confusion in interpreting the results of similar but slightly different measures, and decreased burden associated with data collection and reporting for various measures addressing similar topics.

Since their inception, measure families have started to drive alignment. MAP uses families of measures to guide its pre-rulemaking recommendations on the selection of measures for specific federal programs. In addition, measure families can be a resource for the multiple efforts underway to identify core measure sets, as the families provide pre-screened measures in priority areas. For example, the **Buying Value Initiative** has been bringing stakeholders together to identify key measures for alignment at the state and national levels, and the **IOM Committee on Core Metrics for Better Health at Lower Cost** is completing a study and report to establish a minimum set of relevant core measures. Not only is there potential for measure families to be useful in these types of efforts, but the results of these alignment initiatives can also help inform the next phases of measure families work.

One reason that measure families are useful tools for alignment is their cross-cutting nature, with each family including measures that span other families. As seen in Figure 1, the total number of measures and proportion of measures used in multiple families varies. For example, over 80 percent of measures in the Duals family are included in at least one other family, while this is true for around 10 percent of measures in the Population Health family. The

reasons for this variability may be due to multiple factors, such as some families having a greater cross-cutting nature, and the balance between parsimony and comprehensiveness for the family. In the case of the Duals family, a very concerted effort was made to draw from other families when selecting measures. At the other end of the spectrum, the Population Health family focused on many upstream health determinants that were not as relevant to the healthcare orientation of other families.

FIGURE 1. NUMBERS OF CROSS-CUTTING VERSUS UNIQUE MEASURES IN 10 MAP FAMILIES OF MEASURES



*measures used in more than one family
** PFCC = Person- and Family-Centered Care

Taking this one step further, a relatively small subset of 31 measures was found to be included in three or more families (see Appendix B for details). Themes among these measures do align strongly with the National Quality Strategy (NQS) priorities – particularly in assessing experience of care. However, the measures in this subset are unevenly distributed among different families, similar to that described above for measures in two or more families. Different topical specificities of the families, slightly variable approaches to measure selection by the task forces, and unequal availability of measures to address the array of issues covered were all likely contributors to these outcomes. Overall, these findings illustrate some of the key opportunities and challenges in striving for balance in measure alignment, while also taking a sufficiently broad approach.

Structure of Report

This report considers how to improve measurement by:

- Helping to ensure care is affordable,
- Driving improvements in health through wellness and prevention, and
- Centering care on the needs and preferences of patients, their families, and the broader public.

The measures for each area were reviewed by task forces and the MAP Coordinating Committee according to the approach outlined in Appendix A. Additionally, this report builds on prior analyses of gaps in the nation's measurement capabilities,[4] and it articulates a clear vision on where measurement needs to be and outlines specific opportunities where progress can be made. This vision will be accelerated by new structures for measure development, such as a measure incubator, that can link measurement expertise with the necessary resources for creating metrics. The report concludes with a series of appendices that provide further background on the families selection process and more detailed results from the MAP deliberations.

AFFORDABILITY FAMILY OF MEASURES

Key Themes

- Rising healthcare costs are affecting all stakeholders, and all stakeholders have a shared responsibility for making care affordable.
- Current measures are limited in their ability to describe the full cost picture, so further work is needed to produce measures that comprehensively capture cost at multiple levels.
- Greater transparency of costs and prices is required for improving affordability.

Rising healthcare costs are challenging the U.S. health system. They are hurting the competitiveness of U.S. businesses and leading to difficult choices for state and federal government. Families have seen their health insurance premiums increase by almost 130 percent in the past decade while their out-of-pocket spending has risen by almost 80 percent.[5] As a result of these increases, families' real income has been essentially flat for the past decade as all increases in people's wages and income have been consumed by growing healthcare costs.[6] Because of these challenges, the National Quality Strategy set a national aim of affordable care to reduce the cost of quality healthcare for individuals, families, employers, and government.

Measurement plays a critical role in improving affordability. This section describes the different perspectives on affordability and emphasizes how all stakeholders will need to be involved for sustainable progress. It then describes a suite, or family, of measures aimed at assessing current costs and affordability, as well as identifies the key drivers of costs. (Methodological details on how this family was constructed are included in Appendix A.) Given that cost measurement is in a nascent phase, this section also outlines opportunities for further measurement development. The section concludes by describing the importance of greater transparency in costs and prices, as that can lead to better affordability.

Multiple Perspectives of Affordability

Different stakeholders have different perspectives on affordability in healthcare. This is partially due to the fact that different groups are responsible for paying different costs. For example, patients may be concerned about their out-of-pocket costs while a payer would be interested in the total cost of care. Furthermore, the affordability of healthcare depends on the stakeholders' other competing priorities. State and national governments have to balance healthcare costs against other budget priorities, from education to economic development to tax rates; patients and people consider trade-offs in their family budget, such as between groceries, transportation, housing, and other expenses; and employers make trade-offs between total compensation, innovation, and profitability and overall competitiveness. While there are multiple perspectives, this project centered on affordability for patients and people by considering whether

individuals were able to pay for the healthcare services they need. While the project emphasized the importance of the patient perspective, success will depend on improving affordability for all stakeholders. Public comments received agreed with MAP's conclusion that affordability is based on stakeholder perception as well as MAP's focus on affordability from the perspective of patients and their families.

Different stakeholders and organizations have developed different language when discussing affordability concepts. For this project, MAP used definitions developed by a consensus-based process (see Box 1).[7] In addition, this project built on other existing work, including the National Quality Strategy; the Choosing Wisely initiative; AHRQ-sponsored research into efficiency measures; and prior NQF publications on cost, resource use, and efficiency.[8] Furthermore, this work drew from lessons learned by a portfolio of NQF projects on cost and affordability, including projects seeking to **link cost and quality information**, **endorsing cost and resource use measures**, **understanding the optimal method for assessing the cost of a care episode**, and a project focused on **patient and consumer perspectives on affordability**.

Stakeholders also have different levers at their disposal for improving affordability. For example, clinicians can help coordinate care, thereby limiting redundant tests and imaging; payers can help reduce administrative inefficiencies; and patients can select high-quality, high-value providers and services. Furthermore, many factors outside the traditional healthcare system affect health, and progress depends on coalitions of community organizations, first responders, local governmental agencies, public health, healthcare, patients, and others. Given the scope of the problem, all stakeholders will need to be involved to reduce waste and excess costs.

Framework for Selecting Measures of Affordability

As described in Appendix A on the general approach to measure selection, MAP and staff went through a multistage process to identify the most promising affordability measures. In particular, measures were selected in each of the opportunity areas based on evidence of impact, such as the leading causes of preventable death or the conditions associated with highest healthcare spending.[10,11] In addition, this project built on other MAP families of measures, including the existing

BOX 1. DEFINITIONS OF IMPORTANT AFFORDABILITY TERMS

Charge. The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Cost. The definition of cost varies by the party incurring the expense:

- To the patient, cost is the amount payable out of pocket for healthcare services.
- To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
- To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- To the employer, cost is the expense related to providing health benefits (premiums or claims paid).

Price. The total amount a provider expects to be paid by payers and patients for healthcare services.

Reproduced from: HFMA, 2014, p 29.[9]

safety and care coordination families and the simultaneous projects on population health and person- and family-centered care. Furthermore, MAP separated the measures it selected into two overarching categories—measures of current spending and measures of cost drivers.

Identifying Measures Describing Current Costs and Spending

Given the multiple perspectives on affordability, MAP sought to assess costs for different stakeholders and at different levels of the system. In its deliberations, MAP found that the term "costs" can refer to a number of concepts and therefore chose to focus on measures addressing healthcare spending. Further, they recognized that healthcare spending can be separated into two underlying concepts, as described by the following equation:

Healthcare Spending = Price x Utilization

Given the multiple perspectives and components of spending, MAP identified the following high-leverage opportunities for measuring spending:

- Total Spending – All stakeholders
- Spending by condition, episode, or intervention
- Spending by the patient
- Utilization
- Prices

Table C1 in Appendix C outlines the measures selected for each of these opportunity areas.

In selecting these measures, MAP found that cost measurement capabilities are currently limited, with data posing a major challenge. Claims data is generally fragmented between different health plans, as capitated plans may not generate claims, and current cost accounting systems do not always provide the type of granular information needed for improvement. As payment systems evolve, such as to accountable care organizations and bundled payments, there may be less information stored in claims data, which could limit cost measurement abilities. While there are challenges, there are potential opportunities for short-term improvements in cost measurement —ranging from multipayer data sources, such as those reported by Minnesota Community Measurement; to national surveys, like the Medical Expenditure Panel Survey; to economic accounting approaches, like the National Health Expenditure Accounts.

Public comments received agreed with MAP's approach but reiterated the importance of considering cost measures in the context of quality. Commenters also noted that spending by the patient should consider factors such as benefit design and out of pocket costs and encouraged the development of utilization and cost measures that are patient-centered and incorporate the patient's point of view.

Additionally some commenters noted the challenges that current cost accounting systems pose to obtaining total cost of care data. Commenters suggested that for physician practices, spending by condition, episode, or intervention may be the most valuable indicators as these can be impacted using evidence-based guidelines and benchmark data. However, other commenters stressed the importance of assessing total cost of care at different levels of the system (episode, provider, community, and national). Commenters noted the need to account for variation across markets and purchasers as well as to account for market shifts toward more coordinated and integrated models of care.

Providing Tools for Reducing Waste and Excess Costs

Beyond understanding the current state of healthcare costs, MAP sought to provide tools that individuals and organizations could use for improving affordability. MAP agreed that there were opportunities to reduce costs while improving healthcare quality or health outcomes. In particular, this project utilized the critical analysis of excess healthcare costs from the IOM's *Healthcare Imperative*, which identified 6

domains of waste: unnecessary services, prices that are too high, inefficiently delivered services, excess administrative costs, missed prevention opportunities, and fraud.[12] Drawing from this framework, MAP identified the following high-leverage opportunities for measuring the drivers of healthcare costs:

- Overuse/underuse/appropriateness
- Efficient use of services, providers, and settings
- Person- and family-centered care
- Errors and complications
- Lack of care coordination
- Prevention

Table C2 in Appendix C outlines the measures selected for each of these opportunity areas.

One promising initiative for reducing unnecessary care is through the *Choosing Wisely* initiative, which seeks to reduce overuse of specific tests and procedures.[13] As the lists of tests and procedures have been reviewed by specialty societies, there is an opportunity to develop measures that assess appropriate use of procedures. However, there are multiple challenges, both logistical and conceptual, in developing such measures, and further work is needed.

Similarly, it can be difficult to identify whether care is appropriate or inappropriate for all patients. For example, discussions about end of life are fraught with cultural, emotional, political, and ethical considerations, and there is not one right approach for all patients. The appropriateness of many healthcare services will depend on an individual patient's goals and preferences, and the process of shared decisionmaking can ensure those factors are accounted for in the medical decision.[14]

One public commenter suggested the consideration of an additional high-leverage opportunity addressing new and emerging healthcare technologies to ensure measurement of the costs, affordability, and benefits of new healthcare technologies.

Multiple Opportunities to Improve Cost and Affordability Measurement

MAP noted that the current measures are largely inadequate to address affordability from the perspectives of all stakeholders. However, many public- and private-sector initiatives are working to improve the affordability of healthcare, and the group recommended aligning with these efforts to continue to drive progress.

MAP highlighted that there are direct and indirect costs from disease and treatment. While current measures focus on direct costs, patients have many indirect costs, including the time spent navigating the healthcare system, transportation costs for traveling to appointments, and missed work or school. Additionally, caring for a loved one can place significant financial and time burdens on family members. Future measures should seek to capture and measure these opportunity costs and other indirect costs, as they determine whether people view care as affordable.

Another current challenge is the limited number of composite measures. Composite measures could provide consumers, payers, and purchasers with needed high-level information that allows them to track broader progress in affordability. To be useful for improvement, the composite needs to allow for detailed analysis of variations and the specific factors driving cost.

As multiple social and environmental factors could impact several of the identified affordability measures, there may be a need to adjust the measures for these factors. Risk adjustment could highlight disparities in cost and quality while accounting for differences in the patients seen by different providers. In addition, risk adjustment could highlight distinctions between high and low cost providers without jeopardizing resources to underserved and vulnerable populations. As there are multiple technical and conceptual considerations with risk adjustment, MAP cautioned that risk adjustment should not be used

to reduce attention to disparities but rather to encourage action to address them.

Greater Transparency Required for Progress

The current system is opaque in terms of price and cost. This particularly challenges patients, who are responsible for greater portions of their healthcare costs,[15] yet they cannot necessarily find out in advance what any given healthcare service will cost. This opacity has multiple causes—prices are generally set by negotiations between each insurer and each provider, and these negotiated rates are confidential. Moreover, each insured patient pays different amounts out of pocket based on their insurance plan's benefit design. Yet to support consumers in their healthcare decisions, greater transparency is required.

The deliberations found that consumers' perspectives on affordability differ between expenses that can be planned and those expenses resulting from urgent or emergency care, especially when conditions are life-threatening. While transparency is important throughout the healthcare system, consumers can most readily apply cost information when faced with high-cost but non-emergent services.

As there are multiple perspectives on transparency, this project uses a definition drawn from a multistakeholder consensus process:

> *In healthcare, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.*[16]

While increased price transparency is an important goal, there are challenges in implementation. To avoid unintended consequences, transparency initiatives must monitor for anticompetitive behavior or increased prices.[17] However, there are opportunities to learn from existing state price transparency initiatives, such as the Massachusetts law requiring estimates on charges and out-of-pocket costs or the Minnesota HealthScores project on average cost by procedure or cost tiers by insurance plans.[18] As price transparency is evolving, MAP cautioned that the field needs the opportunity to innovate.

Implementation Considerations and Next Steps

To fully understand efficiency and value, cost measures must be considered in conjunction with measures of quality. This allows the measure user to understand the trade-offs between cost and quality and to avoid any potential unintended consequences.[19] Further, it allows the user to identify when cost can be reduced while maintaining or improving quality. In addition to pairing cost and quality, MAP considered whether measures of overuse should be balanced with underuse measures. Pairing these measures can help to ensure that patients are provided with appropriate types of care, but recognize the potential administrative burden of collecting data for additional measures.[20]

As noted earlier, there is a need for more nuanced data sources that would enable improved assessment of affordability. Improved data will build on existing claims data sources, as well as the detailed health information contained in electronic health record systems. To better capture the patient experience of affordability, there is a need to develop better patient reported data on spending and their experience of quality. Moreover, further capabilities are needed in administrative data sources that account for the production of healthcare, and can be used by improvement initiatives seeking to improve efficiency and value.

POPULATION HEALTH FAMILY OF MEASURES

Key Themes

- Population health measures should align with the National Quality Strategy aim of achieving healthy people and communities in order to improve length and quality of life.
- Measuring the upstream determinants of health, in both healthcare and community settings, is important for improving population health.
- Although it is important to focus on the health of the entire population, attention should also be given to health disparities and the unique needs of subpopulations.

Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[21] Clinical care is estimated to account for about 20 percent of health outcomes; in comparison, health behaviors (30 percent) and social and economic factors (40 percent) together have a much larger influence on health.[22] These findings contrast sharply with the nation's high monetary expenditures and strong focus on healthcare issues, relative to much smaller societal investment in improving and maintaining health and well-being.

The public health system has traditionally led efforts to address the health of groups of people in geographic or geopolitical areas. However, there is also increasing recognition that healthcare providers and systems will need to focus on population-based outcomes, particularly under evolving care delivery models (e.g., Accountable Care Organizations) and value-based payment mechanisms. Broad and lasting improvement in population health requires the active participation of many stakeholders, and can be hastened by closer integration between public health and medical systems.

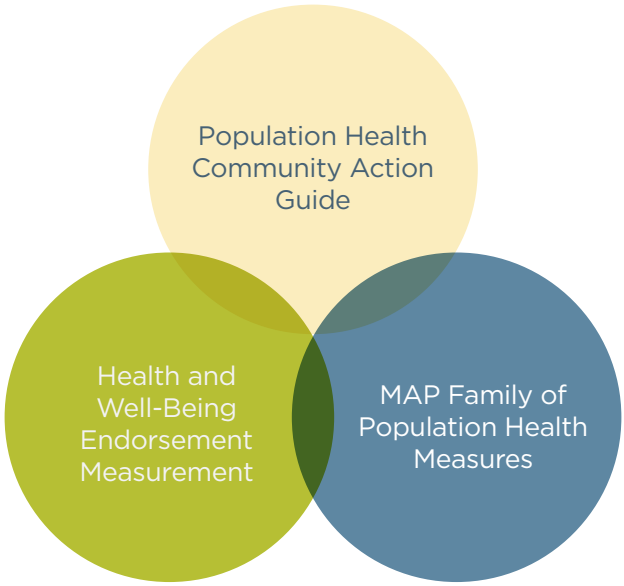
Underscoring the importance of population health, the National Quality Strategy (NQS) included it as a central component, specifically highlighting "healthy people and healthy communities" as one of the three NQS aims. There are also several long-term goals specified in the NQS pertaining to working with communities to promote best practices for healthy living, including: focusing on interventions that result in improvement of social, economic, and environmental factors; adoption of healthy behaviors across the lifespan; and ensuring that effective clinical preventive services are received in clinical and community settings. Quality measures can play an important role in assessing progress toward achieving all of these goals.

Consistent with this holistic approach, MAP selected measures of clinical preventive services, such as screenings and immunizations, as well as a number of measures that address topics outside of the traditional healthcare system. Furthermore, MAP considered how measures could be used in applications such as a community health needs assessment and public health activities. This approach coincides with efforts to shift more focus from individual sick care to the health and well-being of populations.

Current and Prior Work on Population Health at NQF

NQF's prior and current work on population health has emphasized alignment with the NQS and seeks to utilize opportunities to advance stakeholder engagement on several related projects. A previous NQF project focusing on endorsement of population health measures resulted in an NQF-commissioned paper that served as a primer for work on the MAP Population Health Family, and has been foundational for various NQF population health projects.[23] As shown in Figure 2, two other ongoing NQF population health projects have benefited from the lessons learned in these separate but related efforts. The **Health and Well-Being Endorsement Measurement project** involves reviewing population health measures for new or continued NQF endorsement, and a **Population Health Community Action Guide project** is using NQF's multi-stakeholder, collaborative process to develop a common framework and practical guidance for groups seeking to improve population health in their communities.[24]

FIGURE 2. CURRENT NQF PROJECTS RELATED TO POPULATION HEALTH



A common theme among these projects has been an emphasis on looking beyond the medical model to address conditions with a high preventable burden at the root causes, such as exposure to unhealthy or unsafe environments. Another cross-cutting issue has been how to best balance use of measures of health for overall populations while not neglecting potentially vulnerable subpopulations, such as racial minorities or individuals with disabilities. In addition, each of the population health projects recognized the critical importance of measurement in identifying issues and tracking progress.

Conceptual Framework and Measure Selection Approach

MAP began the task of selecting a family of population health measures based on an overarching framework and broad measurement domains, which included consideration for measures of total population health, determinants of health, and health improvement activities.[25] MAP refined this conceptual framework to identify discrete topic areas that address key aspects of population health, with the final groupings largely aligning with the Healthy People 2020 Leading Health Indicator topic areas.[26]

Each of the topic areas chosen encompasses high-leverage opportunities for health improvement. Some of the topics were more focused on medical care, including access to quality healthcare, secondary prevention of chronic illness, and receipt of recommended clinical preventive services. However, the majority of topic areas addressed behavioral, social, and environmental factors, such as nutrition, physical activity, and obesity; tobacco/smoking; community safety; family and social support; social determinants of health; and the physical environment. Several public commenters expressed support for the various topic areas included, although one commenter felt that the topic areas did not include enough emphasis on population health outcomes and quality of life.

MAP discussed the need to promote integration between healthcare delivery and public health when selecting measures for the family. Despite consensus on the importance of this issue, establishing shared accountability for improving population health remains a critical challenge. In addition, the broad number of areas relevant to population health requires a diverse set of measures. MAP therefore considered both NQF-endorsed measures and measures used in major population health initiatives, including the Healthy People 2020 Leading Health Indicators and the County Health Rankings measures.[27] The final topic areas and measures selected for the family are shown in Appendix D.

Public commenters were generally supportive of the specific measures chosen for the population health family. However, some commenters questioned why certain measures were or were not included. Additional details are available in Appendix J.

Implementing Measures to Advance Population Health Goals

During the course of discussions, MAP sought to provide more insight about how different measures and indicators in the population health family might be applied in real-life scenarios through development of potential use cases. This approach was intended to delineate applications for which the various measures might be most relevant. Ultimately, four use cases were chosen that span healthcare and public health settings, and various levels of analysis:

1. Federal programs for healthcare providers,
2. Accountable Care Organizations (ACOs),
3. Community Health Needs Assessments (CHNAs), and
4. Public health.

The four use cases highlight different approaches to improving population health. First, federal programs for healthcare providers was chosen as a use case given MAP's traditional role of reviewing measures proposed for use in federal programs, with most of the measures assessing healthcare issues. Second, ACOs may provide a greater opportunity to measure large populations of patients at a system level, and address topics like high prevalence of obesity and low birth weight rates. Third, CHNAs offer a mechanism to bring together healthcare, public health, and community stakeholders to understand broader health issues, such as the occurrence of unhealthy behaviors in an entire community. Lastly, a public health use case was deemed useful for considering issues that are generally not covered through the healthcare system, such as air quality, education, and poverty.

As an illustrative example, the types of measures that may be most relevant to each of the use cases are shown in Table 1. However, MAP recognized that there may be considerable overlap in how measures could be applied across use cases.

TABLE 1. ILLUSTRATIVE EXAMPLE OF MEASURES APPLIED TO USE CASES

Federal Program for Healthcare Providers	ACOs
Healthcare-focused measures attributable at the provider level, such as: • Adult and childhood immunizations • Blood pressure & diabetes control • Cancer screening • Counseling • Developmental screening • Preventive medical care visits	All measures applicable to providers, plus healthcare-oriented measures that might be better addressed at a system level, such as: • Admission rates for selected conditions • Effective care coordination • Low birth weight rates • Obesity rates
Community Health Needs Assessments	**Public Health**
Measures that bridge healthcare and community settings, such as: • Access to medical insurance • Prevalence of unhealthy (e.g., smoking) and healthy (e.g., physical activity) behaviors in a community • Issues that indicate community health concerns, such as prevalence of fatal injuries	Measures focused on geographic populations, particularly for upstream health determinants: • Measures intended for use at the national, state, or county level • Leading Health Indicators and County Health Rankings measures addressing: – Social determinants, such as education, poverty, housing, etc. – The physical environment, such as air and water quality

An overarching issue when implementing population health measures is whether measures should apply to the entire population, or if measures should be targeted to various subpopulations. Similarly, there are challenges with how to best capture health inequities. MAP recognized the importance of these issues and emphasized that measure results should be stratified when relevant, with targeted assessments to consider subpopulations where needed. One public commenter expressed support for this approach, while another public commenter recommended additional measures from other existing sources that may be relevant to specific subpopulations.

Another important implementation challenge discussed by MAP is the availability of data. In many cases, data may not be available to assess progress at a local level, or different data sources do not provide comparable information. These issues need to be taken into account by groups that plan to use measures to assess and track progress on the health of their communities. A public commenter noted that when communities share their experiences with measures and associated data that have been found to be most useful, it may help promote more widespread adoption of those measures and development of infrastructure for data generation when needed.

Improving the Measures Used to Assess Population Health

In some important areas of population health, there are relatively few measures available. An example is the lack of many well-established measures for certain subpopulations, such as the elderly or individuals with a disability. For instance, it may be difficult to accurately assess physical activity among individuals with certain disabilities if monitors and devices that measure physical

activity are not validated or standardized on people with a range of mobility limitations.

However, MAP did not necessarily signal a gap when choosing to not select measures for some topic areas. Those areas may have been covered more extensively by other families of measures, or the group weighted parsimony over the need to assess a specific topic. For example, although cardiovascular disease is a leading cause of death, measures for heart disease were not chosen for the population health family since a cardiovascular family of measures was previously defined, and a more upstream measure on controlling blood pressure was instead determined to be more meaningful to include.

Overall, consensus was established that more and/or better measures are needed to effectively address population health. MAP generally agreed that stronger measures of accountability should be sought for the social and physical environmental determinants of health, including education, employment, the built environment, and air/water quality. Other topics identified as measurement gaps were varied, such as nutrition, food security, home and community living, health of specific subpopulations, policy interventions (e.g., smoke-free zones), productivity, and public health preparedness. Public commenters also recommended exploring measures on topics including economic security, the effects of care on long-term population health, and external drivers of unhealthy and healthy behaviors.

PERSON- AND FAMILY-CENTERED CARE FAMILY OF MEASURES

Key Themes

- Measurement should capture patients' experience of care as well as include patient-reported measures that evaluate meaningful outcomes for patients.
- Collaborative partnerships between persons, families, and their care providers are critical to enabling person- and family-centered care across the healthcare continuum.
- Future measure development should focus on patient-reported outcomes that offer a more holistic view of care, considering individuals' goals, needs, and preferences as well as their overall well-being.

A growing body of literature suggests that patient engagement can lead to better health outcomes and improved quality and patient safety, and help control healthcare costs.[28] Family involvement has also been correlated with improved patient and family outcomes and decreased healthcare costs. For example, family presence in pediatric care has been shown to contribute to reduced anxiety during healthcare procedures, faster recovery, and earlier discharge in children.[29]

Given the positive impact that person- and family-centered care can have, as well as the commitment to center care around those who receive it, the National Quality Strategy (NQS) put forth the priority of "ensuring that each person and family are engaged as partners in their care."[30] This is further illustrated through three specific goals in the strategy: 1) improve patient, family, and caregiver experience of care related to quality, safety, and access across settings; 2) in partnership with patients, families, and caregivers—and using a shared decisionmaking process—develop culturally sensitive and understandable care plans; and 3) enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively.[31] The IOM reinforced these goals in the vision of a continuously learning healthcare system, including the need to anchor healthcare in patient needs and perspectives, and ensuring that patients, families, and caregivers are vital members of the care team.[32]

As healthcare organizations work to create care practices that support person- and family-centered care, it is essential to assess and monitor progress toward meetings these goals. This section describes the guiding framework that MAP used to define a family of measures that focuses on evaluating patient and family experience of care and outcomes that are most meaningful to patients. Accordingly, MAP recommended that future measure development should focus on patient-reported outcomes that offer a more holistic view of care, considering individuals' goals, needs, and preferences as well as their overall well-being. The approach to developing this family is included in Appendix A.

BOX 2. ILLUSTRATION OF PERSON-CENTERED CARE TERMINOLOGY

"Person" includes all individuals allowing for flexibility of terminology depending on setting, age, and health status. Examples:

- Patient (e.g., acute care; ambulatory; inpatient rehabilitation; home health)
- Resident (e.g., skilled nursing facility; group home)
- Client (e.g., community programs; mental health; behavioral health)
- Person (e.g., population health/primary prevention; disability community; otherwise healthy)

Other important concepts in person-centered care are:

"Family" includes individuals engaged in or responsible for the person's care (i.e., parents, children, and/or caregivers of the person's choosing).

"-Centered Care" implies that care is centered on the priorities and goals of the person/patient/family and that the relationship between persons and providers is one of a collaborative partnership.

Defining the Different People Involved in Receiving Care

One single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time. Given the many terms used to describe individuals receiving care, MAP agreed to use the word "*person*" as an overarching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status. Importantly, use of the term "person" conveys that the family of measures should address the needs of all individuals, and that terminology should not unintentionally limit measurement to certain populations to the exclusion of others. To span populations, time, and settings, the term "person" will be most inclusive, recognizing that in certain instances, a more specific, narrower term may be more appropriate. In addition, this report uses the terms "person" and "patient" interchangeably to refer to recipients of care regardless of setting.

MAP identified several other terms for important concepts. The term "family" connotes family members and caregivers as identified by the care recipient. The term "-centered care" is intended to encourage care that is centered on a person's priorities and goals and a commitment by providers to collaborative relationships with care recipients and their families. Box 2 above illustrates the intended terms for person- and family-centered care.

Defining Person- and Family-Centered Care

Building on prior and current NQF work, including the patient-reported outcomes (PROs) domains developed through the **Patient-Reported Outcomes in Performance Measurement** project, and the person- and family-centered care

definition and core concepts established in the **Prioritizing Measure Gaps: Person-Centered Care and Outcomes** project, MAP used the following description as a touchstone for person- and family-centered care:

> *Person- and family-centered care is an approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their families (as defined by each individual), and their providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's preferences, needs, and values.*

To aid in the selection of measures, MAP focused a significant amount of its discussion on refining the following high-priority topic areas for measurement, emphasizing that a primary mechanism for evaluating the person-centeredness of care will be through the capture of patient and family experience of care information. The priority measurement areas identified below signal whether the care received has helped them to achieve their desired outcomes, particularly in terms of functional status and quality of life—two critical areas for the use of patient-reported outcomes. The high priority topics and subtopics identified by MAP are listed in Table 2.

Building on Existing Work: CAHPS Surveys

Because of the potential to address many of the topic areas mentioned above, MAP recommended using Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures as part of the family in the settings for which they were developed. Although the surveys have limitations, the instruments—in particular certain constructs and questions—can serve as a mechanism for better understanding patient experience as a starting point for better assessing quality. MAP highlighted that CAHPS surveys are limited to predetermined survey options which may not fully capture patients' experience of care and other aspects of care important to patients. However, it was noted that AHRQ is currently investigating the use of qualitative components for inclusion in CAHPS. To better elucidate the extent to which the CAHPS instruments address the above topics, Appendix E includes a crosswalk of each survey tool, at the measure level, to the priority areas.

TABLE 2. HIGHEST PRIORITY TOPICS AND SUB-TOPICS IN PERSON- AND FAMILY-CENTERED CARE

High Priority Topics	Subtopics
Interpersonal relationships	• Dignity, respect, compassion, trust, perception of equity • Communication and collaboration • Cultural and linguistic responsiveness
Patient and family engagement	• Shared decisionmaking and informed choice • Advance care planning
Care planning and delivery	• Establishment and attainment of patient/family/caregiver goals • Care concordant with person values and preferences • Care integration (coordination, transitions)
Access to support	• Patient and caregiver needs and support • Timely and easy access to care and knowledge
Quality of Life	• Physical and cognitive functioning • Behavioral, physical, social, emotional, and spiritual well-being • Symptom and symptom burden (e.g., pain, fatigue, dyspnea, mood) • Treatment burden (on patients, families, caregivers, siblings)

Guiding Principles for Selecting Measures

The following guiding principles informed the discussions and decisions in developing this measure family:

- MAP emphasized the importance of measures that assess whether individuals' needs, preferences, values, and goals are actively solicited and adequately addressed, and whether they are treated with respect and dignity.
- MAP encouraged measurement through the persons' eyes to assess their interactions with care providers, to gauge their level of involvement and engagement in their care, and to assess whether they have received adequate and timely support to optimize their quality of life.
- Because of the interrelatedness of the high priority areas and their subcomponents, MAP used them as an organizing structure to guide its work rather than as specific items to which to assign measures. For example, the need for timely and easy-to-understand information is critical for engaging patients in their care and ensuring that they can make informed choices, but measures were not considered for each of these areas in isolation.
- MAP favored a parsimonious set of measures and cautioned against measures that could increase measurement burden without adding value or moving the needle. Notably, MAP preferred measures that address a broader population as opposed to a specific disease process or setting.
- MAP recognized the importance of safe and evidence-based care as an overlay for delivering high-quality, person- and family-centered care, but deferred these as topic areas because they were previously addressed through the MAP families for safety, care coordination, and diabetes and cardiovascular disease. This measure family should be complementary and not redundant.

Selecting Measures in Key Person- and Family-Centered Care Areas

This section outlines the highest leverage opportunities for improving patient- and family-centered care, and identifies measures that could be used in each area. Table E1 in Appendix E highlights the measures selected by MAP for inclusion in the MAP family. A sample of CAHPS surveys and their respective measures are also included for illustrative purposes.

Interpersonal Relationships

Interpersonal relationships between persons, families, and their care providers are foundational for achieving other aspects of high quality care and are best measured through a patient's experience of care. MAP identified the following as important aspects of patient-provider relationships: being treated with dignity, respect, compassion, and equity; communication from and with their providers; and their level of trust. Cultural and linguistic responsiveness can also assess whether patients and families feel that their culture and language are respected, that they are treated in a dignified manner, and that care is congruent with their values. This high priority area was well represented by the majority of the CAHPS surveys. For example, the CAHPS Clinicians and Group survey measure of *"provider communication"* assesses whether providers show respect for what patients say and whether they spend sufficient time with their patients, while the CAHPS Hospital Survey measure *"communication with nurses"* assesses whether nurses listened carefully to patients and explained things in a way that patients could understand.

Patient and Family Engagement

Collaborative partnerships between persons, families, and their providers of care are critical to enabling informed choice and shared

decisionmaking about the plan of care. A partnership based on open and reciprocal communication and a free flow of information will encourage and empower patients to fully participate in their care. Public comment further emphasized the importance of helping patients understand their illness, maximize their ability to self-manage, and understand the importance of taking an active role in their care. Involvement in decisionmaking is captured in several CAHPS surveys, including the *"parents' experiences with shared decisionmaking"* measure in the CAHPS Item Set for Children with Chronic Conditions, and the *"nursing home provides information/ encourages respondent involvement"* measure in the CAHPS Nursing Home Family Survey, yet MAP noted a significant gap in patient-reported outcome data of shared decisionmaking.

In addition to CAHPS, MAP identified advance care planning as an integral component of patient and family engagement, and that measures should expand beyond end-of-life to encompass all persons with complex or chronic illness, especially those with advanced illness and multiple comorbidities. MAP noted a gap in this measurement area and concluded that NQF-endorsed measure *#0326 Advance Care Plan* and other process and structural measures assess only whether a care plan is documented in the chart or people were offered advanced care planning. Future measure development should expand on this measure to ensure that advance care planning is more fully integrated to improve care planning and delivery. Specifically, MAP emphasized that advance care planning is a dynamic process that includes ongoing discussion, documentation, reassessment, and modification of patients' values, short- and long-term goals of care, and potential benefits and risks of various treatment options. One public comment noted the persistent gaps in team-based shared accountability measures of person- and family- centered care, and recommended measures to assess the quality of collaboration in respecting patients' goals for advanced illness care.

Care Planning and Delivery

Patient-centered goals should drive longitudinal care planning as well as the delivery of care, and should be informed by patients' overall health status, and their values and preferences for care—what they would like to achieve, and how they would like their care to support them. For instance, a measure in the CAHPS Patient-Centered Medical Home (PCMH) Item Set Survey asks patients whether anyone in the provider's office talked with them about specific goals for their health. It is also important to note that measures need to stretch beyond assessing whether individual's needs and preferences are considered in care planning and include whether their goals are being met.

Care integration is critical to the successful implementation of care plans, and can only occur when information flows easily between care teams, particularly during hands-offs and transitions. The updated HCAHPS survey includes the *3-Item Care Transition Measure (CTM-3)* as a patient-reported indicator of preparation for self-care for adult patients discharged from hospitals. MAP also supported three NQF-endorsed measures for this priority area, including *NQF #1641 Hospice and Palliative Care Treatment Preferences* to assess whether patient preferences are elicited and recorded*, NQF #1626 Patients Admitted to ICU who have Care Preferences Documented,* and *NQF #0647 Transition Records with Specified Elements Received by Discharged Patients*.

Access to Support

Access in the broadest sense includes how quickly appointments can be made as well as timely and easy access to needed information—whether in person, telephonically, or online—to support patients in managing their own care. Access also needs to account for family caregivers, who play a critical role in delivering care. Therefore, they need support and education to help their loved ones while maintaining balance in their personal lives. Many CAHPS measures address support for patients yet do not address the needs of family

caregivers. Therefore, MAP supported a measure that is not NQF-endorsed, *Dementia: Caregiver Education and Support*, noting that although limited to a specific condition, it addresses a growing population. Future measures should evaluate support for all family caregivers.

Quality of Life

An optimal quality of life represents an ideal outcome—and one which the aforementioned areas should support. MAP emphasized the importance of measures of behavioral, physical, social, emotional, and spiritual well-being; interventions designed to improve or maintain physical and cognitive functioning; alleviation of symptom and symptom burden (e.g., pain, fatigue, dyspnea, mood); and minimization of treatment burden on patients, families, and caregivers.

Overall, MAP favored patient-reported outcomes for this measurement area, and acknowledged opportunities in the CAHPS instruments to emphasize aspects of quality of life such as pain management. MAP recommended several additional measures to assess and address depression, including NQF-endorsed measures *#0710/#0711/#0712 Depression Remission at Twelve and Six Months and Depression Utilization of the PHQ-9 Tool.* These performance measures track improvement over time for people over 18 with a diagnosis of major depression or dysthymia using the PHQ-9 tool and have been widely used across settings. MAP also recommended NQF-endorsed *#0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan* to include a measure applicable to adolescents and adults aged 12 years and older. One public comment supported MAP's recommendations to include the above depression measures in the family and noted the importance of a follow-up measure to support measure #0418.

MAP recommended three outcome measures used in the Home Health Outcome and Assessment Information Set (OASIS) to assess improvement in patient mobility, pain interfering with activity, and management of oral medications as a foray into assessing quality of life. Although limited to a single setting at this time, these measures assess functional status regardless of diagnosis and most importantly offer an assessment of a change in function. Other measures that hold promise and may be considered—but that MAP did not specifically recommend at this time—include NQF-endorsed measures #0423, 0424, 0425, 0426, and 0427, which assess a change in functional status for specific musculoskeletal diagnoses.

MAP supported NQF-endorsed measure *#0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment,* emphasizing the importance of managing pain, particularly for persons with advanced illness. This measure is currently removed from the hospice program, but is being used in ambulatory settings. MAP noted the absence of an appropriate measure for addressing pain unrelated to the dying process, and discussed NQF-endorsed measure *#0420 Pain Assessment and Follow-Up* at length. In the end, MAP felt this measure was too broadly applied to be meaningful and thus stressed the need for a better, more focused measure. Lastly, MAP identified the evaluation of treatment burden as an important gap area in need of further exploration.

Prominent Gaps in Person-Centered Care Performance Measures

Although the CAHPS survey instruments address many of the high-leverage opportunities identified by MAP, they do not sufficiently address each of the measure areas comprehensively. In particular, the availability of measures to address issues of quality of life remains quite low. In the home health and nursing home settings, CAHPS measures begin to assess issues related to quality of life, but across the board, much more work is needed in this area. Tools to assess patient-reported outcomes, such as the National Institutes of Health's Patient Reported Outcomes Measurement Information System (PROMIS)—which measures

patient-reported health status for physical, behavioral, and social well-being—offer a launching pad for the development of performance measures to fill remaining gaps and should be considered a high priority for measurement in the near term. As part of the gap-filling efforts, the **NQF Prioritizing Measure Gaps: Person-Centered Care and Outcomes Committee** has developed a framework to envision ideal person- and family-centered care which is not constrained by current care delivery models and has made short- and intermediate-term recommendations to measure performance and progress on ideal person- and family- centered care.

Several public comments agreed with the focus on patient-reported outcomes for future measure development, with one recommendation to study and replicate existing measurement approaches (e.g., the National Core Indicators™ and The Council on Quality and Leadership's Personal Outcome Measures®). One public comment agreed with the importance of addressing patient experience of care and quality of life, but noted that measurement should not overlook good process measures in favor of patient-reported outcomes. Simple measures of pain and symptom assessment may provide a good baseline against which progress can be measured. Finally, the importance of capturing the experiences of very sick and frail individuals needs to be addressed. Measures must be developed to determine whether goals of care are being elicited for these individuals and whether quality of life indicators are being assessed and addressed, regardless of the person's ability to participate in surveys.

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APPENDIX A:
Approach to Identifying Families of Measures

MAP convened time-limited task forces, drawn from the membership of the MAP Coordinating Committee and four advisory workgroups, to advise the MAP Coordinating Committee on measure families for specific content areas (see Appendix F for the Coordinating Committee roster). Currently MAP has convened task forces to develop families of measures focusing on affordability, population health, and person- and family-centered care (see Appendices G, H, and I, respectively, for task force rosters). Previously, MAP convened task forces to develop families of measures related to safety, care coordination, cardiovascular disease, diabetes, cancer care, dual eligible beneficiaries, and hospice care.

MAP developed a five-step process to identify a family of measures, illustrated in the graphic on the next page, with some task forces using a slightly modified approach described in its corresponding section. Additionally, MAP solicited public feedback on its recommendations during a three-week commenting period.

The task forces convened via web meetings and in-person meetings to identify each family—the Population Health and Person- and Family-Centered Care task forces each held 1 web meeting and 1 one-day, in-person meeting, while the Affordability task force held 2 web meetings and 1 two-day in-person meeting. In addition to the meetings, the Population Health task force also conducted a post-meeting follow-up survey of task force members to verify the high-leverage opportunity topics and measures. All MAP meetings are open to members of the public; the agendas and materials for the task force and Coordinating Committee meetings can be found on the NQF website.

Scan for Currently Available and Pipeline Measures That Address the High-Leverage Opportunities

To begin, MAP scanned for available measures that could address the high-leverage opportunities. The environmental scan included the NQF-endorsed portfolio of measures, measures used in federal programs (including current measures and measures under consideration during MAP pre-rulemaking deliberations), and measures used in other public- and private-sector efforts (e.g., eValue8, Million Hearts Campaign, IHA P4P, Bridges to Excellence, other purchaser and value-based purchasing programs, recognition programs, and Board certification programs).

Identify Measures for Each High-Leverage Opportunity

Next, the task forces selected measures appropriate for assessing each high-leverage opportunity. Where appropriate, MAP used the Measure Selection Criteria as a general guide for considering factors such as: 1) how measures address relevant care settings, populations, and levels of analysis; 2) whether measures are harmonized across settings, populations, levels of analysis; 3) appropriate types of measures, including outcome, process, and structure measures; and 4) attention to parsimony, with the intent of identifying only the most important measures for driving change.

When developing a family of measures, MAP may note where currently available NQF-endorsed measures do not adequately address the high-leverage opportunities. Finally, MAP considered issues such as disparities and the needs of vulnerable populations.

Identify Measure Gaps and Limitations, Such as Implementation Barriers

When selecting available measures for each family, MAP identified the high-leverage improvement opportunities that lack adequate performance measures. When gaps were identified, it explored ways to promote gap-filling. In some cases, MAP generated potential measure concepts that could be developed to fill these gaps, as well as recommendations to measure developers for potentially modifying existing measures that do not adequately address the high-leverage opportunities but are currently considered the best alternative. MAP recognizes that modifications to existing measures require resources to develop, test, and submit the modified measures for NQF endorsement. The deliberations also explored implementation barriers such as limitations of available data and the challenges of attributing accountability for system wide issues impacting affordability, person- and family-centered care, and population health.

FIGURE A1. GRAPHICAL DESCRIPTION OF THE PROCESS FOR DEVELOPING A MAP FAMILY OF MEASURES

1 Scan universe of measures (>1,600 measures)
NQF-endorsed portfolio of measures, measures used in federal programs (current and previous measures under consideration), and other public-private sector programs (e.g., Million Hearts, eValue8, IHA).

2 Identify measures for high-leverage opportunities
Staff identified potential measures for the families based on the task forces' discussions about high-leverage opportunities for the different measurement areas.

3 Undergo initial staff review
Staff used the MAP Measure Selection Criteria as a guide for selecting measures. Staff focused on measures that span the patient-focused episode of care and, when appropriate, used the Institute of Medicine's overarching criteria for choosing clinical priority areas (i.e., Impact, Improvability, Inclusiveness).

4 Conduct initial task force review
The task forces reviewed the staff measure suggestions through an online survey.

5 Hold in-person task force meetings
During in-person meetings, the task forces met to identify measures for inclusion in the family as well as measurement gaps, methodological challenges and data availability, and implementation issues. The task forces focused on whether the families addressed relevant care settings, populations, and levels of analysis; how to align or harmonize measures where possible; providing appropriate types of measures (outcome, process, and structure); and encouraging parsimony.

APPENDIX B:
Alignment Table

Measures Included in Three or More MAP Families

NQF #	Measure Title	Families*
0005	CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	CC; Duals; PFCC
0006	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	CC; Duals; PFCC
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	CC; Duals; PFCC
0018	Controlling High Blood Pressure	CV; Diabetes; Pop Health
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	CV; Diabetes; Duals
0097	Medication Reconciliation	Affordability; Duals; Hospice
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Affordability; Cancer; Safety
0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Affordability; Cancer; Safety
0166	HCAHPS	CC; Duals; PFCC
0171	Acute care hospitalization (risk-adjusted)	Affordability; CC; Hospice
0173	Emergency Department Use without Hospitalization	Affordability; CC; Hospice
0208	Family Evaluation of Hospice Care	Cancer; CC; Hospice
0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Cancer; Duals; Hospice; PFCC; Safety
0216	Proportion admitted to hospice for less than 3 days	Affordability; CC; Hospice
0258	CAHPS In-Center Hemodialysis Survey	CC; Duals; PFCC
0326	Advance Care Plan	CC; Duals; Hospice
0418	Screening for Clinical Depression	Duals; PFCC; Pop Health
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Affordability; CV; Diabetes; Duals; Pop Health
0517	CAHPS® Home Health Care Survey	CC; Duals; PFCC
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	CC; Duals; Hospice; PFCC
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	CC; Duals; Hospice
0691	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument	CC; Duals; PFCC

NQF #	Measure Title	Families*
0692	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	CC; Duals; PFCC
0693	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument	CC; Duals; PFCC
1598	Total Resource Use Population-based PMPM Index	Affordability; CV; Diabetes
1604	Total Cost of Care Population-based PMPM Index	Affordability; CV; Diabetes
1626	Patients Admitted to ICU who Have Care Preferences Documented	CC; Duals; Hospice; PFCC
1632	CARE - Consumer Assessments and Reports of End of Life	CC; Duals; Hospice
1641	Hospice and Palliative Care – Treatment Preferences	Duals; Hospice; PFCC
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	CC; Duals; PFCC
1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Affordability; CC; Duals

*CC = Care Coordination; CV = Cardiovascular; PFCC = Person- and Family-Centered Care

APPENDIX C:
Affordability Tables

TABLE C1. MEASURES OF AFFORDABILITY: CURRENTLY ENDORSED MEASURES, SHORT-TERM OPPORTUNITIES FOR DEVELOPING MEASURES, AND LONGER-TERM VISION FOR ASSESSMENT

Short-term development opportunities represent measures that are currently in use or could be developed from current mechanisms and submitted for NQF-endorsement. Long-term development opportunities represent gaps where further measure development is needed.

Category	High-Leverage Opportunity	Currently Endorsed Measures	Short-Term Development Opportunities	Long-Term Development Opportunities
Direct Measurements of Affordability	Total Spending – All stakeholders	• NQF #1604 Total Cost of Care Population-based PMPM Index	• Total cost of care measures from national surveys: – Medical Expenditure Panel Survey • National Health Expenditure Accounts • Per capita total cost for attributed patients	• Converging macro/ national total cost data with provider-/setting-/ service area-specific/ patient-/third-party payer- total cost • Employer spending on employee health benefits
	Spending by condition, episode, or intervention	• NQF #1609 ETG Based HIP/KNEE REPLACEMENT cost of care measure • NQF #1611 ETG Based PNEUMONIA cost of care measure	• Minnesota Community Measurement cost per procedure episode grouper measures	• Managing chronic conditions (diabetes, arthritis, cardiovascular, some mental conditions, COPD, asthma, • Cancer care • Gastrointestinal condition care • Vulnerable populations (multi-morbidity with functional or cognitive impairment, frail elderly, or disabled) • Maternity (mother and baby) care • Trauma care
	Spending by the Patient	*No NQF-endorsed measures selected or available*	• Total out of pocket costs (synced with ACA definition of affordable care) – Data could be derived from MEPS or Consumer Expenditure Survey	• Premiums • Deductibles • Out of pocket costs • Healthcare costs as percent of income • Indirect costs (loss of wages, loss of function) • Disparities in access and affordability with regards to socioeconomic stats, race, and ethnicity, and geography • Access to specialists and community resources • Cost as a barrier to care

Category	High-Leverage Opportunity	Currently Endorsed Measures	Short-Term Development Opportunities	Long-Term Development Opportunities
Direct Measurements of Affordability (continued)	Utilization	• NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB) • NQF #1598 Total Resource Use Population-based PMPM Index • NQF #1557 Relative Resource Use for People with Diabetes (RDI) • NQF #1558 Relative Resource Use for People with Cardiovascular Conditions • NQF #1560 Relative Resource Use for People with Asthma	• Radiology utilization • Utilization of outpatient care for priority conditions	• Addressing intense needs for care and support of medically complex populations (i.e., dual eligible beneficiaries, individuals with multiple chronic conditions, frail elders, and disabled) • Targeted utilization measures for most common conditions
	Prices	*Opportunity for measure development*	• Medicare Part D Drug Pricing Measures • Overall price index (such as derived from total cost of care methodology)	• Structural measure on price transparency • Average differences in prices
Drivers of Affordability	Overuse/ Underuse/ Appropriateness	• NQF #0052 Use of Imaging Studies for Low Back Pain • NQF #0554 Medication Reconciliation Post-Discharge (MRP) • NQF #0036 Use of appropriate medications for people with asthma (ASM) • NQF# 0058 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis • NQF #0309[a] Back Pain: Appropriate Use of Epidural Steroid Injections • NQF #0553 Care for Older Adults (COA) – Medication Review • NQF #0471 PC-02 Cesarean Section • NQF# 0654 Acute Otitis Externa: Systemic antimicrobial therapy – Avoidance of inappropriate use • NQF #0657 Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use • NQF# 0002 Appropriate Testing for Children With Pharyngitis (CWP) • NQF #0469 PC-01 Elective Delivery	• Measures derived from Choosing Wisely	• Unwarranted maternity care interventions (C-section) • End of life care including inappropriate non-palliative services at the end of life • Cancer care • Shared decisionmaking • Appropriate Imaging: – Mammography recall – Minimal cancer detection ratios – Headache – Low back pain • Orthopedics – Back surgery for low back pain • Appropriate medication therapy – ADHD – Antipsychotics • Medication adherence – Asthma – Diabetes • Unnecessary overuse of antibiotics
	Efficient Use of Services, Providers, and Settings	• NQF #0173 Emergency Department Use without Hospitalization • NQF #0216 Proportion admitted to hospice for less than 3 days • NQF #0215 Proportion not admitted to hospice	• AHRQ ambulatory sensitive conditions measures • Availability of lower cost alternatives • Site of services measures	• Issues of access to lower intensity care – Focus on achieving equivalent outcomes • Access and use of palliative care, including hospice • Use of higher cost drug or device when a lower cost alternative achieves equivalent outcomes

Category	High-Leverage Opportunity	Currently Endorsed Measures	Short-Term Development Opportunities	Long-Term Development Opportunities
Drivers of Affordability (continued)	Person- and Family-Centered Care[b]	*Opportunity for measure development*	• Shared decisionmaking • Patient activation: knowledge skills & ability to follow • Patient reported outcome measures	• through with treatment plan • Measure of lost productivity (i.e. school days missed, work days missed) • Connection to community services • Health literacy • Ensuring that care accords with treatment plan
	Errors and complications[b]	• NQF #0138 National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure • NQF #0139 National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure • NQF #0363 Foreign Body Left During Procedure (PSI 5) • NQF #0267 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant • NQF #0376[a] Incidence of Potentially Preventable Venous Thromboembolism • NQF #0140[a] Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients • NQF #0201 Pressure ulcer prevalence (hospital acquired) • NQF #0181 Increase in number of pressure ulcers • NQF# 0530 Mortality for Selected Conditions (Composite Measure) • NQF# 0531 Patient Safety for Selected Indicators (Composite Measure) • NQF #0532 Pediatric Patient Safety for Selected Indicators (Composite Measure) • NQF #0500 Severe Sepsis and Shock: Management Bundle (Composite Measure)	• Composite measures (*Global trigger All harm index, Premier Administrative Harm Measurement Tool, Leapfrog Safety score)*	• Diagnostic errors • Medication errors • Patient reported outcome measure of harm • Culture of safety

Category	High-Leverage Opportunity	Currently Endorsed Measures	Short-Term Development Opportunities	Long-Term Development Opportunities
Drivers of Affordability (continued)	Lack of care coordination[b]	• NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) • NQF #0171 Acute care hospitalization (risk-adjusted) • NQF #0335 PICU Unplanned Readmission Rate • NQF# 0505 Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. • NQF# 0506 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization • NQF # 1768 Plan All-Cause Readmissions (PCR) • ACO 9 – NQF#0275 – Chronic obstructive pulmonary disease (PQI 5) • ACO 10 – NQF#0277 – Heart Failure Admission Rate (PQI 8) • ACO 12 – NQF#0097 – Medication Reconciliation • ACO 13 – NQF#0101 – Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	• ACO 8 – Risk Standardized, All Condition Readmissions (adapted from NQF #1789) • ACO 11 – Percent of PCPs who Qualified for EHR Incentive Payment • Common assessment tool such as the CARE tool. • Access to telemedicine	• Patient-reported outcome of care coordination • Reduce duplicative services (i.e imaging or lab test) • Measure of care coordination for primary care, cancer care, EOL • Measure of care coordination with community (especially community organizations, like fire depts.)
	Prevention and Wellness[b]	• NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up • NQF #2020: Adult Current Smoking Prevalence • NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		• Smoking cessation • Obesity (Diet and Exercise) • Alcohol and drug abuse • Immunization • Behavioral health • Recommended and effective screenings (cancer, depression) • Disease Management • Follow up care • Overall health risk

A number of public comments were received on the measures selected for the Affordability Family. One commenter noted that NQF#1789 should not be included in the family until it is expanded to include psychiatric patients. One commenter was not supportive of including NQF#1557, #1558, and #1560 because of concerns about the usability of these measures. One commenter was not supportive of including NQF #0036 because of the challenges of using administrative data and an inability to track performance by stage of disease as defined by clinical guidelines. One commenter was not supportive of including NQF #2020 because of concerns about the reliability and validity of patient responses across different populations.

TABLE C2. RATIONALE FOR MEASURE SELECTION FOR EACH OPPORTUNITY AREA

Category	High-Leverage Opportunity	Measurement Selection Rationale
Direct Measurements of Affordability	Total Spending – All stakeholders	• There are few measures that track total spending, and further work is needed to understand total healthcare spending at different levels, including population, system, group, and individual provider level.
	Spending by condition, episode, or intervention	• For this opportunity, the group considered major episodes, conditions, and interventions that have a significant impact on costs, with a particular focus on episodes where consumers could shop between multiple options.
	Spending by the Patient	The task force sought measures that captured out of pocket spending by patients, although the group did not identify any endorsed measures in this area.
	Utilization	• The task force focused on the conditions that accounted for the leading causes of preventable death or the conditions associated with highest healthcare spending.[1,2] The task force further refined this list based on the conditions that could be improved with current clinical capabilities.
	Prices	There are not current outcome measures for prices, and future measures should focus on price transparency.
Drivers of Affordability	Overuse/Underuse/ Appropriateness	• The task force focused on a parsimonious set of appropriateness measures in priority areas that drive costs, balancing a focused set on important topics against systematic, consistent measurement of appropriateness. • The task force recognized that specific benchmarks are not possible in all cases, and that shared decisionmaking offers an opportunity to determine appropriateness based on individual patient's goals and needs.
	Efficient Use of Services, Providers, and Settings	• For this category, the group considered areas where alternatives existed at different prices but that achieved equivalent outcomes. • The deliberations also focused on improving care quality for patients near the end of life, and ensuring that these patients have the services they need.
	Person- and Family-Centered Care[b]	For this measurement area, the group considered the measures selected for the patient and family centered care family, with a focus on metrics that affect affordability.
	Errors and complications[b]	• For this measurement area, the group considered the measures selected for the safety family, with a focus on metrics that have the greatest impact on affordability. • For the future, the task force wanted to composite measures that reflect a safe environment, as opposed to specific metrics that assess relatively rare events.
	Lack of care coordination[b]	• For this measurement area, the group considered the measures selected for the care coordination family, with a focus on outcomes from poor care coordination that have the greatest cost implications.
	Prevention and Wellness[b]	• For many preventive services, there is unclear evidence whether they affect long-term cost. • The task force focused on measures that assess conditions associated with the highest healthcare costs, recognizing that these conditions have extensive direct and indirect costs.

a Measure is no longer NQF endorsed.

b The MAP Affordability Taskforce sought to align with the work of the MAP Safety, Care Coordination, Population Health, and Person- and Family-Centered Care task forces. The Affordability Taskforce focused on identifying cost drivers from the high-leverage opportunities, measures, and gaps identified by those groups.

ENDNOTES

1 Yoon PW, Bastian B, Anderson RN. Potentially preventable deaths from the five leading causes of death — United States, 2008–2010. MMWR Morb Mortal Wkly R*ep. 2014;63(17);369-374.*

2 Agency for Healthcare Research and Quality Medical Expenditure Panel Survey website. Table 3. http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=1&subcomponent=0&tableSeries=2&year=-1&SearchMethod=1&Action=Search. Last accessed May 2014.

APPENDIX D:
Population Health Tables

Final Population Health Family of Measures by Topic Area

Topic Area	Measures*
Access to Healthcare	1. NQF #0719 Children Who Receive Effective Care Coordination of Healthcare Services When Needed 2. LHI 1.1: Percent of persons under age 65 years with health (medical) insurance
Chronic Illness	1. NQF #0728 Asthma Admission Rate (pediatric) 2. NQF #0018 Controlling High Blood Pressure 3. NQF #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Clinical Preventive Services	1. NQF #1959 Human Papillomavirus Vaccine for Female Adolescents 2. NQF #0034 Colorectal Cancer Screening 3. NQF #0041 Influenza Immunization 4. NQF #0617 High Risk for Pneumococcal Disease – Pneumococcal Vaccination 5. NQF #1407 Immunizations by 13 years of age 6. NQF #0032 Cervical Cancer Screening 7. NQF #0038 Childhood Immunization Status 8. NQF #0043 Pneumonia vaccination status for older adults 9. NQF #0431 Influenza vaccination coverage among healthcare personnel 10. LHI IID-8: Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines
Community Safety	1. NQF #0720 Children Who Live in Communities Perceived as Safe 2. County Health Rankings: Violent Crime 3. NQF #0721 Children Who Attend Schools Perceived as Safe 4. LHI IVP-1.1 Fatal Injuries
Family & Social Support	1. County Health Rankings: Children in single-parent households 2. County Health Rankings: Inadequate social support
Maternal/Child Health	1. NQF #0717 Number of School Days Children Miss Due to Illness 2. NQF #1517 Prenatal and Postpartum Care (PPC) 3. NQF #1448 Developmental Screening in the First Three Years of Life 4. NQF #0278 Low Birth Weight Rate (PQI 9) 5. NQF #1392 Well-Child Visits in the First 15 Months of Life 6. NQF #1516 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 7. NQF #1332 Children Who Receive Preventive Medical Visits 8. NQF #1391 Frequency of Ongoing Prenatal Care (FPC)

Topic Area	Measures*
Mental Health	1. NQF #1401 Maternal Depression Screening 2. LHI: Suicides (MHMD-1) 3. NQF #0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan 4. NQF #1394 Depression Screening By 13 years of age 5. NQF #1515 Depression Screening By 18 Years of Age
Nutrition, Physical Activity and Obesity	1. NQF #1348 Children Age 6-17 Years who Engage in Weekly Physical Activity 2. NQF #1349 Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI) 3. NQF #0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up 4. LHI: Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle strengthening activity (PA-2.4) 5. LHI: Adults who are obese (NWS-9)
Oral Health	1. NQF #1388 Annual Dental Visit 2. NQF #1335 Children Who Have Dental Decay or Cavities 3. NQF #1419 Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers 4. NQF #1334 Children Who Received Preventive Dental Care 5. LHI: Persons aged 2 years and older who used the oral healthcare system in past 12 months (OH-7)
Physical Environment	1. County Health Rankings: Drinking water violations 2. LHI: Air Quality Index (AQI) exceeding 100 (EH-1)
Reproductive and Sexual Health	1. LHI: Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months (FP-7.1)
Social Determinants	1. County Health Rankings: Severe housing problems 2. County Health Rankings: Children in poverty 3. County Health Rankings: Unemployment 4. County Health Rankings: High School graduation
Substance Abuse	1. NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 2. LHI (SA-13.1): Adolescents (12-17 years old) using alcohol or any illicit drugs during the past 30 days
Tobacco/Smoking	1. NQF #2020 Adult Current Smoking Prevalence 2. LHI (TU-1.1): Adults who are current cigarette smokers 3. NQF #1346 Children Who Are Exposed to Secondhand Smoke Inside Home 4. LHI (TU-2.2): Adolescents who smoked cigarettes in the past 30 days

* Measures are listed in order of prioritization within each topic area per task force member responses on the post-meeting survey. NQF measures were all endorsed as of April 9, 2014. LHI = Leading Health Indicator.

APPENDIX E:
Person- and Family-Centered Care Family of Measures Tables

Table E1 includes the measures selected for the person- and family-centered care family as well as a sample of CAHPS surveys for illustrative purposes. Table E2 includes a crosswalk of all the pertinent CAHPS survey tools at the measure level to the priority areas.

TABLE E1. PERSON- AND FAMILY-CENTERED CARE MEASURES BY TOPIC AREA

Topic Area	Measures
Interpersonal relationships	CAHPS Survey Instruments, for example: *NQF #0005 CAHPS Clinician & Group* *• Provider communication* *NQF #0258 CAHPS In-Center Hemodialysis Survey Core Composites* *• Nephrologists' Communication and Caring*
Patient and family engagement	CAHPS survey instruments, for example: *NQF #0009 CAHPS Item Set for Children with Chronic Conditions* *• Parents' Experiences with Shared Decision-making* *#693 CAHPS Nursing Home Family Survey - Nursing Home* *• Nursing Home Provides Information/ Encourages Family Involvement (in Care)*
Care planning and delivery	NQF #0647 Transition Record with Specified Elements Received by Discharged Patients NQF #1641 Hospice and Palliative Care Treatment Preferences NQF #1626 Patients Admitted to ICU Who Have Care Preferences Documented CAHPS survey instruments, for example: *NQF #0166 CAHPS Hospital Survey* *• 3-Item Care Transition Measure (CTM-3)* *NQF #0009 CAHPS Item Set for Children with Chronic Conditions* *• Parents' Experiences with Coordination of Their Child's Care*
Access to support	Dementia: Caregiver Education and Support (not endorsed) CAHPS survey instruments, for example: *NQF #1902 CAHPS Item Set for Addressing Health Literacy* *• Disease self-management*
Quality of life	NQF #0418 Screening for Clinical Depression NQF #0710/0711/0712 Depression: Utilization of the PHQ-9 Tool and Remission at 6 & 12 Months NQF #0167 Improvement in Ambulation/Locomotion NQF #0177 Improvement in Pain Interfering with Activity NQF #0176 Improvement in Management of Oral Medications NQF #0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment CAHPS survey instruments, for example: *CAHPS Patient-Centered Medical Home (PCMH) Item Set (Not Endorsed)* *• Providers Pay Attention to Your Mental or Emotional Health (Adult only)*

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Access to care *Getting Needed Care *Getting Care Quickly				yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Most recent visit				yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Provider communication with child	yes			yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Provider communication	yes			yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Development	yes			yes	yes
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Prevention	yes			yes	yes
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Clerks and receptionists at provider's office	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Health status					yes
0005 CAHPS Clinician & Group (Updated June 2012)	Core Items in Adult 12-Month and Visit Surveys 2.0 and the Child 12-Month Survey 2.0	Mental and emotional health status					yes
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	After hours care				yes	

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Being informed about appointment start	yes			yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Chronic conditions				yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Communication with providers	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Cost of care (prescriptions)	yes			yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Cultural competence	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Health improvement	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Health information technology				yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Health literacy	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Health promotion and education	yes				yes
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Patient-centered medical home (PCMH)	yes			yes	yes
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Shared decisionmaking	yes	yes			
0005 CAHPS Clinician & Group (Updated June 2012)	Adult Supplemental Items	Your care from specialists in the last 12 months	yes			yes	
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Screening items for children with chronic conditions				yes	yes
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Provider communication with child	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Provider communication	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Provider thoroughness				yes	

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Patient-Centered Medical Home Item Set	yes			yes	yes
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Prescription medicines	yes				
0005 CAHPS Clinician & Group (Updated June 2012)	Child Supplemental Items	Shared decisionmaking	yes	yes			
0258 CAHPS In-Center Hemodialysis Survey Core Composites (Updated December 2007)	Dialysis Facility	Nephrologists' Communication and Caring	yes				
0258 CAHPS In-Center Hemodialysis Survey Core Composites (Updated December 2007)	Dialysis Facility	Quality of Dialysis Center Care and Operations	yes			yes	yes
0258 CAHPS In-Center Hemodialysis Survey Core Composites (Updated December 2007)	Dialysis Facility	Providing Information to Patients	yes	yes		yes	
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Communication with Nurses	yes				
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Communication with Doctors	yes				
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Responsiveness of Hospital Staff				yes	yes
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Cleanliness of the Hospital Environment				yes	yes
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Quietness of the Hospital Environment	yes				
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Pain Management				yes	yes
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Communication about Medicines	yes				
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	Discharge Information			yes	yes	

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0166 CAHPS Hospital Survey (Updated January 2008)	Hospital/Acute Care Facility	An updated HCHAPS would include the 3-Item Care Transition Measure (CTM-3) (which is now required by CMS as part of the HCAPS reporting)	yes		yes		
0517 CAHPS Home Health Care Survey (Updated May 2009)	Home Health	Patient Care	yes			yes	
0517 CAHPS Home Health Care Survey (Updated May 2009)	Home Health	Communication with Health Care Providers and Agency Staff	yes			yes	
0517 CAHPS Home Health Care Survey (Updated May 2009)	Home Health	Specific Care Issues Related to Pain and Medication	yes			yes	yes
0006 CAHPS Health Plan Survey, Version 5.0 (Updated May 2012)	Core Items (Medicaid and commercial)	Access to care: *Getting Needed Care *Getting Care Quickly				yes	
0006 CAHPS Health Plan Survey, Version 5.0 (Updated May 2012)	Core Items (Medicaid and commercial)	How well doctors communicate	yes				
0006 CAHPS Health Plan Survey, Version 5.0 (Updated May 2012)	Core Items (Medicaid and commercial)	Plan administration	yes				
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences with Prescription Medicines				yes	
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences Getting Specialized Services for Their Child				yes	
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences with the Child's Personal Doctor or Nurse	yes				yes
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences with Shared Decision-making	yes	yes			

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences with Getting Needed Information about Their Child's Care	yes				
0009 CAHPS Item Set for Children with Chronic Conditions 4.0 Version (Updated July 2008)	Ambulatory Care	Parents' Experiences with Coordination of Their Child's Care			yes		
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	Information To Help You Prepare For Surgery	yes				
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	How Well Surgeon Communicates With Patients Before Surgery	yes				
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	Surgeon's Attentiveness on Day of Surgery	yes				
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	Information To Help You Recover From Surgery	yes			yes	yes
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	How Well Surgeon Communicates With Patients After Surgery	yes				
1741 CAHPS Surgical Care Survey (Updated December 2011)	Ambulatory Care; Hospital/Acute Care Facility	Helpful, Courteous, and Respectful Staff at Surgeon's Office	yes				
1904 CAHPS Cultural Competence Item Set (Updated May 2012)	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Patient-provider communication	yes				
1904 CAHPS Cultural Competence Item Set (Updated May 2012)	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Complementary and alternative medicine				yes	
1904 CAHPS Cultural Competence Item Set (Updated May 2012)	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Experiences of discrimination due to race/ethnicity, insurance, or language	yes				

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
1904 CAHPS Cultural Competence Item Set (Updated May 2012)	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Experiences leading to trust or distrust, including level of trust, caring, and truth-telling	yes				
1904 CAHPS Cultural Competence Item Set (Updated May 2012)	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Interpreter services		yes		yes	
1902 CAHPS Item Set for Addressing Health Literacy (Updated May 2012)	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Communication with provider	yes				
1902 CAHPS Item Set for Addressing Health Literacy (Updated May 2012)	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Disease self-management	yes			yes	
1902 CAHPS Item Set for Addressing Health Literacy (Updated May 2012)	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Communication about medicines	yes			yes	
1902 CAHPS Item Set for Addressing Health Literacy (Updated May 2012)	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Communication about test results	yes				
1902 CAHPS Item Set for Addressing Health Literacy (Updated May 2012)	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Communication about forms	yes				
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Visit to doctor				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Being examined on the examination table				yes	

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Getting weighed at the doctor's office				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Difficulty moving around the restroom				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Pain					yes
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Fatigue					yes
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Getting physical and occupational therapy				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Getting speech therapy				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Getting mobility equipment repaired				yes	
CAHPS Item Set for People with Mobility Impairments (Updated June 2008)	Supplemental Item Set to the Health Plan Survey	Getting or replacing mobility equipment				yes	
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Providers Pay Attention to Your Mental or Emotional Health (Adult only)					yes
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Providers Support you in Taking Care of your Own Health	yes	yes			

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Providers Discuss Medication Decisions (Adult only)	yes	yes			
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Access to Care				yes	
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Attention to Care from Other Providers	yes		yes		
CAHPS Patient-Centered Medical Home (PCMH) Item Set	Clinician & Group (C&G) PCMH Survey (Version 5 of the C&G Survey)	Information about Care and Appointments	yes			yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Getting treatment quickly				yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	How well clinicians communicate	yes	yes			
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Getting treatment and information from the plan or MBHO	yes			yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO CAHPS Behavioral Health for MCO or MBHO	Perceived improvement			yes		yes
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Information about treatment options	yes			yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Seen within 15 minutes of appointment time				yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Told about side effects of medication	yes	yes			

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Talk about Including family and friends	yes	yes	yes		
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Given as much information as wanted to manage condition		yes	yes	yes	
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Given information about rights as a patient	yes				
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Patients feels that he or she could refuse a specific type of treatment	yes	yes	yes		
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Confident about privacy of treatment information	yes				
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Care responsive to cultural needs	yes	yes			yes
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Amount helped by treatment			yes		yes
0008 Experience of Care and Health Outcomes (ECHO) Survey 3.0 (2004)	CAHPS Behavioral Health for MCO or MBHO	Plan provides information about how to get treatment after benefits are used up				yes	
0693 CAHPS Nursing Home Family Survey (2011)	Nursing Home/Skilled Nursing Facility	Meeting Basic Needs: Help with Eating, Drinking, and Toileting	yes			yes	yes
0693 CAHPS Nursing Home Family Survey (2011)	Nursing Home/Skilled Nursing Facility	Nurses/Aides' Kindness/Respect Towards Resident	yes				
0693 CAHPS Nursing Home Family Survey (2011)	Nursing Home/Skilled Nursing Facility	Nursing Home Provides Information/ Encourages Respondent (Family) Involvement (In Care)	yes	yes		yes	
0693 CAHPS Nursing Home Family Survey (2011)	Nursing Home/Skilled Nursing Facility	Nursing Home Staffing, Care of Belongings, and Cleanliness				yes	

TABLE E2. CROSSWALK OF CAHPS SURVEYS AT THE MEASURE LEVEL TO THE PRIORITY AREAS (continued)

NQF #/Survey Name and Version # or Date	Type and/or Setting	Measure (Name of composite or individual measure)	Person- and Family-Centered Care High Priority Topics				
			Interpersonal Relationships	Patient and Family Engagement	Care Planning and Delivery	Access to Support	Quality of Life
0691 & 0692 CAHPS Nursing Home Resident Surveys: Discharged Resident and Long-Stay Resident Instruments (slight wording changes between instruments)	Nursing Home/Skilled Nursing Facility	Environment	yes			yes	yes
0691 & 0692 CAHPS Nursing Home Resident Surveys: Discharged Resident and Long-Stay Resident Instruments (slight wording changes between instruments)	Nursing Home/Skilled Nursing Facility	Care	yes			yes	yes
0691 & 0692 CAHPS Nursing Home Resident Surveys: Discharged Resident and Long-Stay Resident Instruments (slight wording changes between instruments)	Nursing Home/Skilled Nursing Facility	Communication and Respect	yes				
0691 & 0692 CAHPS Nursing Home Resident Surveys: Discharged Resident and Long-Stay Resident Instruments (slight wording changes between instruments)	Nursing Home/Skilled Nursing Facility	Autonomy		yes			yes
0691 & 0692 CAHPS Nursing Home Resident Surveys: Discharged Resident and Long-Stay Resident Instruments (slight wording changes between instruments)	Nursing Home/Skilled Nursing Facility	Activities					yes

APPENDIX F:
Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX G:
Roster for the MAP Affordability Task Force

CHAIR (VOTING)
Mark McClellan, MD, PhD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AdvaMed	Steven Brotman, MD, JD
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
America's Health Insurance Plans	Aparna Higgins, MA
American College of Radiology	David Seidenwurm, MD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Hospital Association	Richard Umbdenstock, FACHE
American Medical Association	Carl Sirio, MD
American Society of Consultant Pharmacists	Jennifer Thomas, PharmD
Association of American Medical Colleges	Joanne Conroy, MD
Blue Cross Blue Shield of Massachusetts	Wei Ying, MD, MS, MBA
Kindred Healthcare	Sean Muldoon, MD, MPH, FCCP
Minnesota Community Measurement	Beth Averbeck, MD
Mothers Against Medical Error	Helen Haskell, MA
Pacific Business Group on Health	David Hopkins, PhD
Pharmaceutical Research and Manufacturers of America	Christopher Dezii, RN, MBA, CPHQ
Visiting Nurses Association of America	Margaret Terry, PhD, RN

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Care Coordination	Gerri Lamb, PhD
Emergency Medical Services	James Dunford, MD
Measure Methodologist	Dolores Yanagihara, MPH
Palliative Care	Sean Morrison, MD
Population Health	Eugene Nelson, MPH, DSc
State Policy	Dolores Mitchell, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Centers for Medicare & Medicaid Services (CMS)	Kate Goodrich, MD
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

APPENDIX H:
Roster for the MAP Population Health Task Force

CHAIR (VOTING)
Bobbie Berkowitz, PhD, RN, CNAA, FAAN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
American Academy of Nurse Practitioners	Diane Padden, PhD, CRNP, FAANP
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Speech-Language-Hearing Association	Robert C. Mullen, MPH
Blue Cross Blue Shield of Massachusetts	Wei Ying, MD, MS, MBA
Building Services 32BJ Health Fund	Barbara Caress
Connecticut Children's Medical Center	Andrea Benin, MD
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Kaiser Permanente	Amy Compton-Phillips, MD
LeadingAge	Cheryl Phillips, MD, AGSF
Minnesota Community Measurement	Christine Norton, MA
St. Louis Area Business Health Coalition	Karen Roth, RN, MBA, CPA

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disparities	Luther T. Clark, MD
Health IT	Dana Alexander, RN, MSN, MBA
Mental Health	Rhonda Robinson Beale, MD
Nursing	Gail Stuart, PhD, RN
Rural Health	Ira Moscovice, PhD
Substance Abuse	Mady Chalk, MSW, PhD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Pamela Owens, PhD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Health Resources and Services Administration (HRSA)	Samantha Meklir, MPP
Veterans Health Administration (VHA)	Scott Shreve, MD

CDP/NPP LIAISON (NON-VOTING)	REPRESENTATIVES
Association of State and Territorial Health Officers	Paul Jarris, MD, MBA

APPENDIX I:
Roster for the MAP Person- and Family-Centered Care Task Force

CO-CHAIRS (VOTING)
Gail Hunt
Rhonda Anderson, RN, DNSc, FAAN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Aetna	Randall Krakauer, MD
American Nurses Association	Marla J. Weston, PhD, RN
Center for Patient Partnerships	Rachel Grob, PhD
Consumers Union	Lisa McGiffert
March of Dimes	Cynthia Pellegrini
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Partnership for Women and Families	Alison Shippy
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP
The Alliance	Cheryl A. DeMars

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Clinician/Geriatrics	Bruce Leff, MD
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Measure Methodologist	Debra Saliba, MD, MPH
Palliative Care	Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN
Patient Experience	Jack Fowler, Jr., PhD
Post-Acute Care/Home Health/Hospice	Carol Raphael, MPA
Shared Decisionmaking	Karen Sepucha, PhD
Surgical Care	Eric B. Whitacre, MD, FACS
Team-Based Care	Ronald Stock, MD, MA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	D.E.B. Potter, MS
Centers for Medicare & Medicaid Services (CMS)	Chisara N. Asomugha, MD, MSPH, FAAP

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
National Committee for Quality Assurance	Sarah Scholle, DrPH, MPH
The Joint Commission	Sharon Sprenger, MPA, RHIA, CPHQ

APPENDIX J:
Public Comments

Section 1: Advancing Measurement in Priority Areas: Cross-Cutting Themes

America's Health Insurance Plans
Carmella Bocchino

We are supportive of the cross-cutting themes as presented in the report. We also recommend clarifying which themes may be more or less relevant for different subpopulations.

American College of Medical Quality & IPO 4 Health
Donald Casey

Any measure that is to be considered for the priority areas mentioned should be presented and evaluated in terms of its actual impact on patient outcomes. For example, a measure that is publicly reported should demonstrate through its use an actual causative impact on patient outcomes. If there is only a hypothetical and/or unproven association with a given outcome, then how/if actual causation is demonstrated should also be presented. The actual cost to the agent (e.g. federal or state agency) that is publicly reporting the measure should also be quantified in real terms on an ongoing basis. Further, there should be measurable evidence of how/if stakeholders (especially consumers) use such measure to evaluate their own healthcare and make effective choices that have measurable impact on cost and quality. Adding these steps to the consensus development process will help NQF and "end users" to prioritize a parsimonious set of the most cost-beneficial measures.

Children's Hospital Association
Ellen Schwalenstocker

The Children's Hospital Association recommends one addition to the third sentence of the last paragraph on page 5. We recommend this sentence read as follows. "However, measure availability is uneven, with some limited numbers available for several important priorities and subpopulations. As noted under general comments, we recommend including a high level description of the method used to identify the measures selected for the various families, perhaps between the second and third paragraphs of the section entitled "Families of Measures: Tool for Assessing Progress." The Children's Hospital Association strongly supports structures for measure development (such as a measure incubator) to link measurement expertise with necessary resources for creating metrics mentioned in this section.

CHSLI
Eileen Esposito

It is admirable to see the synergy of the measures with meaningful use and PQRS measures. Indicators such as tobacco screening and cessation counseling also impact population health and PFCC, and medication reconciliation is a key indicator in the continuum of care/transition management of patients and should be included in those MAP families.

Consortium for Citizens with Disabilities
E. Clarke Ross

pg 4 & 15 - Reinforce draft theme 3 - attention should also be given to health disparities and unique needs of subpopulations. pg 16 - reinforce not neglecting vulnerable subpopulations including persons with disabilities. pg 17 - reinforce focus on behavioral, social, & environmental factors

Highmark
Christine Pozar

Working from the premise that healthcare access is most accepted if it is affordable, adaptable and local; patients tend to focus on their own needs rather than a broader scope such as reported through national data (Hospital Compare, etc.) and therefore do not

readily utilize information if it is not directly related to them or their family. Bottom line cost of care is something that is necessary however healthcare professionals must understand that individual healthcare needs when they arise especially urgently, require immediate attention so the consumer's ability to "shop" for affordable healthcare interventions are not always feasible. Pre-published costs at the point of service would better serve the consumer than individually researched price comparison.

National Association of Social Workers
Joan Zlotnik

Pages 4 and 5, Common Themes and Key Themes: The second and third points are somewhat confusing. Read in isolation, the second point implies that the available measures are stronger and broader than they actually are. Yet, the report makes clear that sufficient measures do not exist for some priority areas. As stated in the third point of the common themes, though, this concept seems to contradict the second point. Adding to the beginning of the third point a transitional word or phrase such as However, Nonetheless, or At the same time would link the second and third points and convey both concepts more clearly.

Section 2: Affordability Family of Measures

America's Health Insurance Plans
Carmella Bocchino

Assessing affordability requires the total cost of care at different levels of the health care system (e.g. episode, individual provider, community, and national levels) for different stakeholders (e.g. individuals, employers, government programs). It is also important to account for variation across markets and purchasers (e.g. individuals, exchanges, employers, government programs), as well as the total and marginal benefit associated with health care interventions. Data collection and measurement efforts must also account for the shift in the health care market toward more coordinated, integrated models of care that use a prospective, population-based payment model and do not maintain cost data in the form of individual claims. In such models, information on the total cost of care is more meaningful than unit-based pricing and utilization data.

We recommend including an accountability feature that identifies the stakeholder or entity accountable for each measure (e.g. provider, facility, health plan, etc.). We also recommend including the VTE measures reported on Hospital Compare to the Error and Complications high-leverage opportunity category listed in the report. We are not supportive of the inclusion of the following measures into the Affordability Family and offer measure specific comments:

#1557, #1558, and #1560: Relative resource use measures can be useful to assess utilization patterns, but are not particularly useful or meaningful to consumers to assess efficiency and should not be used for public reporting. These measures do not directly address out of pocket or total costs specific to the condition. These measures are also limited as they focus only on specific conditions (e.g. diabetes, cardiovascular conditions, and asthma) and consumers need information on total costs of care. We recommend that the usability of these measure to end users be further examined before included in the family of measures. Additionally, issues with the current measure specifications need to be further examined such as exclusion of some but not all high cost diagnoses (e.g. cancer and HIV).

#0036: Classification of asthma using administrative data poses challenges and does not allow for tracking of performance by stage of disease as defined by clinical guidelines. As EHR data become available, it will be important to include clinically defined asthma stages and ensuring appropriate care by stage. Also since a single prescription can ensure compliance, this measure does not track how well asthma is managed for a patient.

#2020: Given that this measure is based on patient reported data, we are concerned with the validity and accuracy of patient responses across different populations. It is unclear whether testing data reveal any systematic biases in responses for different

populations and if responses have been validated for accuracy as part of measure testing.

American College of Medical Quality & IPO 4 Health

Donald Casey

ACMQ agrees with the principles set forth in this section of the report. We wish to add an additional specific high-leverage opportunity on page 12, that of the use of new and emerging healthcare technologies. This could apply to drugs, devices, therapeutic modalities, delivery innovations or information technology. The public is constantly inundated with stories of success with such before there is actual compelling evidence of efficacy. "Centers of Excellence" often capitalize on this uncertainty and promote interventions with unproven benefit. On the other hand, insurers sometimes deny payment for new discoveries that show dramatic promise over existing treatments. A method for explicitly measuring and monitoring the costs, affordability and benefits of new technologies has yet to be developed.

American Psychiatric Association

Samantha Sugarman

Measure #1789, utilized within the Measures of Affordability section of the report, continues to exclude "Admissions for primary psychiatric disease" based on the rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals." Per the Pre-voting Consensus Report the measure steward, CMS, was asked to "incorporate psychiatric patients into their measure because of possible implications of the readmission rates for patients with comorbid psychiatric disorders. CMS agreed to evaluate the impact of including patients with psychiatric conditions in the medicine cohort or creating a sixth cohort." Due to the large population it will exclude, we continue to feel that it should be removed from this measure family until updates are made.

Children's Hospital Association

Ellen Schwalenstocker

In the table of measures, it might also be helpful to define what short-term and long-term development opportunities mean. For example, several of the short-term opportunities appear to draw from mechanisms in place. Is the thinking that more testing and experience is needed before measures are widely adopted for use in various initiatives?

CHSLI

Eileen Esposito

The affordability measures are important measures but it is often difficult to obtain total cost of care data from the provider-side when there are multiple cost accounting systems that need to be queried. In the physician practice arena, the spending by condition, episode, or intervention will likely be the most valuable of the indicators as this is the one we can impact using evidence-based guidelines and good benchmark/comparative data.

GlaxoSmithKline

Deborah Fritz

GlaxoSmithKline is pleased to see the focus MAP has put on addressing Families of Measures and encourages MAP's continued efforts to define a "family" of aligned measures that includes available measures and measure gaps that span programs, care settings, and levels of analysis related to the National Quality Strategy (NQS). Regarding Affordability, we strongly agree with the Task Force approach to "affordability" as a concept that changes based on the stakeholder and their particular point of view and the drivers of affordability. Patient perspective and the patient's ability to access care is the most appropriate perspective. Drivers such as benefit design and out-of-pocket costs should be considered. While we agree with the approach described, we are disappointed with the list of measures that are cost and resource use-type measures in the absence of quality considerations. This does not provide an accurate assessment of value and may lead to adverse consequences including reduced access to appropriate care.

In addition, such utilization and cost measures are not patient-centered and do not consider the patient's point of view. We strongly support development of measures that incorporate the patient's perspective on affordability and that can demonstrate the linkage between quality, resource use and cost.

PhRMA

Jennifer Van Meter

PhRMA appreciates the MAP Affordability Task Force's recognition in the report that "affordability" is a concept that changes based on the stakeholder's perception. We support the examination of affordability as well as the drivers of affordability. We also appreciate that the project emphasized the importance of the patient perspective and the patient's ability to access care; we believe that affordability is best evaluated from the patient perspective, which incorporates benefit design, rather than focusing only on cost or resource use-type measures. To that end, we support the report narrative. However, we note that measures directed at patient-centered affordability are not available, as indicated in the report. Thus, in absence of those measures, the family of measures centers its direct measurement on cost and resource use, which is void of patient perspective, despite the project's emphasis on its importance. We encourage development of measures that incorporate the patient's perspective on affordability.

Additionally, previous NQF and MAP reports have stated support for use and reporting of resource use measures in the context of quality performance, preferably outcomes, and measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences. PhRMA urges continued development and refinement of these measures to ensure that a proper linkage between quality and resource use measures is made.

Section 3: Population Health Family of Measures

America's Health Insurance Plans

Carmella Bocchino

We are supportive of the topic areas selected to address key aspects of population health and commend the committee on including social determinants of health. We also recommend adding categories for physical and behavioral determinants of health. Additionally, some of the proposed measures do not seem to relate to population health such as children who receive effective care coordination of healthcare services when needed.

We are not supportive of the inclusion of the following measures into the Population Health Family of Measures and offer measure specific comments:

#1394 Depression Screening by 13 Years of Age & #1515 Depression Screening by 18 years of Age: These measures lack a sufficient level of evidence, are not suitable for quality improvement or are questionable regarding their ability to improve health outcomes. In some cases, these measures may be overly burdensome to providers and caregivers to collect, as they will require medical chart abstraction.

#1419 Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers: Data collection for this measure may be a challenge across different health plans' products. Not all health plans cover this particular service, so availability of data to calculate this measure may be an issue. For example, children's dental visits are often bundled services and are billed as one service on administrative claims forms. In order to assess if the dental preventive services are specifically delivered, the physician would have to document this in the medical record. It is also more appropriate to track fluoride varnish in the context of the well child visit and not limit it to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations.

American College of Medical Quality

Valeriya V. Kettelhut

1. The report provided a definition for population health: "Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the

group."21" In epidemiologic terms, it is an aggregate level of measurement based on the individual level data. Because of this, the report pointed out that one of the challenges is the availability of data and variety of data sources for generating comparable results. Local communities will encounter this issue when making decisions which measurements they can use in their communities.

- I think that developing a variety of measurements for advancing population health should not be precluded by this barrier. Instead, the best practices and innovations should be captured in a form of new measurements and listed for the others. This would help communities to adopt those measurements they can agree upon and develop needed infrastructure for data generation. Also, different stakeholders from the same community can mutually utilize the data for different purposes to increase a community ROI.

2. Another issue discussed in the report is "whether measures should apply to the entire population, or if measures should be targeted to various subpopulations" and "how to best capture health inequities". The decision proposed was that "measure results should be stratified when relevant, with targeted assessments to consider subpopulations where needed".

- I agree with this approach because it is difficult to decide in advance which subgroups attribute to specific outcomes: the subgroups may change over time depending on many factors, e.g. changing demographics, environmental changes, etc. Sub-group analysis should be secondary to the entire population analysis. The longitudinal population data will show changes in a composition of different sub-groups or changes in different health outcomes with prevalence and incidence data.

3. "Health inequalities" is a complex social term: any health outcome should have a specific definition, rationale, and indicators of "health inequality". Then, these definitions should become a subject for next round of endorsement. The experts in basic science should be part of the measure developer group to inform the developers to what extent biological factors can affect health outcomes.

4. "The lack of well-established measures for certain subpopulations, such as the elderly or individuals with a disability: For instance, it may be difficult to meaningfully measure physical activity for individuals with severe intellectual or physical limitations without accounting for the particular adaptations needed by these individuals to readily obtain exercise."

5. This concern relates to understanding of what would be expected for different sub-populations in terms of specific health status: it could be defined "healthy population" "espoused population" and "affected population". And then based on this categorization, different "expected" outcomes, behaviors, and other events could be identified through analysis of each sub-group.

6. Finally, the report indicated that "relatively few measures available" in this family of measurements and that "consensus was established that more and better measures are needed to effectively address population health".

7. The outlined "four use cases", such as federal programs for healthcare providers, ACOs, community health need assessment, and public health, seem to reflect a high level structure. I think these use cases do not reflect the complexity of the measurements. The report did indicate that the population measurements are divided for clinical vs. public health settings: my question is this necessary to determine the "owners" of the measurements or "implementers"? It seems that the list of use cases is not comprehensive.

8. I would also suggest to consider some of the measurement that reflect the external drivers of unhealthy behaviors such as new technologies (e.g. time spent on videogames, an exposure to a violent content), or the drivers of healthy behaviors (e.g. number of hours for physical education in schools) vs. output of these drives (e.g. percent of children engaged in after-school physical activity). I believe there are plenty of existing "social" measures of health" (e.g. prevalence of single mothers, prevalence of teen mothers). Some other examples would be "e.g., prevalence of DUIs, misdemeanors among different age groups, expulsions for schools, etc."

9. In conclusion, I believe that population measures are based on the individual measures. By developing

specific requirements for individual measures, it would be easier for generating the reliable population measures through de-identified data.

American College of Medical Quality & IPO 4 Health
Donald Casey

On page 18: Don't believe that Obesity and Low Birthweight are appropriate just for ACOs. These are public health measures as well and could conceivably be applied to the other 3 domains. "Co-Accountability" should be stressed with measurement of issues such as these with wide-ranging implications.

American Psychiatric Association
Samantha Sugarman

We strongly support the inclusion of Mental Health, Substance Use Disorders, and Tobacco/Smoking as specific topic areas within the Population Health Family. It would be advantageous to view the specifications of the non-NQF endorsed measure listed in the Mental Health Section "20 LHI: Suicides (MHMD-1)" so that we may weigh in on the inclusion of this measure. We also recommend the presence of a greater number of adult measures within this section.

Children's Hospital Association
Ellen Schwalenstocker

The Children's Hospital Association agrees with the key themes highlighted for this family of measures, particularly the importance of measuring upstream determinants and attention to disparities. A "one size fits all approach" to measurement will not be sufficient to advancing healthier people and communities. We strongly agree with the need for attention to unique needs of subpopulations, including children. The table listing currently endorsed and short- and long-term development opportunities presented with the Affordability Family of Measures presents a very useful framework, and we would encourage a similar approach with the Population Health Family of Measures. The ability to measure the effects of care (including preventive, acute and chronic care) on long term population health and costs is an important topic for long-term development.

CHSLI
Eileen Esposito

This is a very useful set of measures and most can be captured thru a variety of documentation methods.

Depression screening is an important measure however the availability of behavioral health services to support positive screenings is very limited. I think it is unrealistic to have providers routinely screen if they have little or no options for referral.

Under the substance abuse section, I think the LHI indicator should not be limited to adolescents. Drug and alcohol use are important issues in the adult population as well and adults would benefit from routine screening.

Consortium for Citizens with Disabilities
E. Clarke Ross

Rely on Census Bureau American Community Survey six disability questions and add two additional questions - see June 15 AAHD-AUCD letter submitted to 7 NQF staff including Adams-Leavens-Weissburg. Additions - accommodation, understanding, communicating, personal assistance. See letter for details

Regarding pg 19 difficulty measuring - see June 15 AAHD-AUCD letter submitted to 7 NQF staff including Adams-Leavens-Weissburg for details. Discuss with CDC funded Special Olympics and CDC funded National Center on Health, Physical Activity, and Disability to learn adaptations currently used. June 15 letter provides severe physical disability adaptations.

We appreciate pg 19 inclusion of "home and community living" as a measure topic.

Highmark
Christine Pozar

Actionable behavioral and mental health issues have long been ignored or omitted because they do take significant time for providers to address. The long term impact may be greater than medical issues and cross more populations.

Because known dental health issues also impact broader populations and many disease related

illnesses can be directly related to poor dental health issues, both of these measures should be considered for inclusion.

National Association of Social Workers
Joan Zlotnik

Page 19: NASW concurs with the need for measures to address the social and physical environmental determinants of health, as proposed by the task force in the last paragraph. However, we note the absence of economic security, which is critical to health care access and outcomes. We strongly encourage NQF to consider this social determinant in its continued work on population health.

St. Louis Area Business Health Coalition
Karen Roth

On behalf of the payer community, I support the topic area of clinical preventive service measures for the MAP Population Health Family of Measures. In an effort to create a parsimonious set of measures, I suggest deleting Leading Health Indicator, LHI IID-8: Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines. The reasoning behind this suggestion is that LHI IID-8 does not include all of the vaccines recommended under CDC guidelines for children in this age group. It also appears to be duplicative of NQF #0038.

On behalf of the payer community, I support the topic area of Tobacco/Smoking for the MAP Population Health Family of Measures. In an effort to create a parsimonious set of measures, I suggest deleting Leading Health Indicator, LHI (TU- 1.1): Adults who are current cigarette smokers. The reasoning behind this suggestion is that LHI (TU- 1.1) appears to be duplicative of and data collection via survey does not appear to be as frequent as NQF #2020. Including both measures in the set could produce conflicting and confusing results.

Section 4: Person- and Family-Centered Care Family of Measures

America's Health Insurance Plans
Carmella Bocchino

We are supportive of measuring patient and family-centered care including patient-reported outcomes.

American Nurses Association
Maureen Dailey

The Person/Family Centered Care (PFCC) report section did an excellent job of capturing the key insights from the PFCC Task Force. On p. 23, bullet one, it is important to add "goals" to read "needs… and goals are addressed". Also, on p. 24 in both the Engagement and Care Planning and Delivery (CP&D) sections, the importance of integrating patient-centered goals (choices) identified in shared decision making to actually drive the longitudinal care planning and delivery should be made explicit.

On p.24 in paragraph 2 in the Engagement section, the importance of full integration of "advance care planning" preferences was captured. The Task Force members also had rich discussion regarding the importance of patient and family engagement in populations with multiple chronic conditions including identification of patient-centered goals and decision-making regarding their care. In the CP&D section on p.24, paragraph 1, it is important to note that measures need to go beyond assessing if their needs and preferences were considered in care planning to include whether their goals are being met using PROMs and other metrics. Team-based evaluation measures should be considered to evaluate the quality of inter-professional team-based care in advanced illness care. Reliable and valid tools such as the Collaboration and Satisfaction About Care Decisions (Baggs, 1994) exist and are now used in a shorter version to reduce burden. Evaluating the quality team-based collaboration in respecting patients' goals for advanced illness care is important to improve the support by inter-professional team of patient/families in the decision-making. High performing inter-professional teams and data collected from these teams are both essential to a learning health system.

On p.24, the importance of communication and care provided in transition of care is addressed. During

the Task Force discussions, the importance of the RNs component of HCAHPS was identified since the nurse section of HCAHPS (questions 1-4) have been found by RAND (Elliot, et al., 2009) to be the most important in determining a hospital's overall HCAHPS grade. Also, a Press Ganey study (2013) identified the "Communication with Nurses" as a "rising tide measure" among the eight HCAHPS dimensions of care. A rising tide measure is one whose change and trajectory in performance is correlated with multiple measures. This effect is important to understand when identifying and improving high-impact metrics to evaluate the quality of care and devising performance improvement strategies because, as the score of a rising tide measure increases, the scores of the associated measures are likely to rise as well. Organizations are identifying best practices to improve communication by nurses, the proximal caregiver.

Resources to Reference

The publications by the Nursing Alliance for Quality Care (NAQC), Guiding Principles for Patient Engagement and Fostering Patient and Family Engagement: Nursing's Critical Roles, were discussed in the Task Force deliberations. Linking these NAQC publications in the report may be helpful to the readers as a resource. Additionally, the NQF report Critical Paths for Creating Data Platforms: Care Coordination (2012) was identified as important resource to inform structures necessary for PFCC, including care planning and intervention driven by patient/family-centered goals.

Measure Gaps

The Engagement section (p. 24) and gap description (p. 25-26) did not address the concept of self-care efficacy or activation. It is important to engage patients and families to interact more effectively with the health care system, to better self-manage, to identify the onset of acute exacerbations and take effective action, etc. to prevent avoidable adverse events (e.g., avoidable admissions, readmissions, complications related to illness advancement related to ineffective self-care). There are tools in the public domain being used to evaluate the outcomes of education and other interventions, such as the "self-efficacy for chronic illness" tool (Lorig et al., 1996), which may be effective across populations with chronic illnesses across payers. The persistent gaps in team-based, shared accountability measures of PFCC and engagement with attribution should also be added to the gap section. These metrics are important to ascertain the best mix of clinicians with the right staffing that yields the best outcomes for populations needing preventative, chronic illness, and end of life care. Organizations from multiple disciplines have been working on a paper to address clinician-patient shared accountability in measurement. Although these metrics require complex methodology to develop, closing the gap in these team-based measures in key priority areas such as PFCC/Engagement, care coordination, and safety are essential to achieve the tri-part aim in the National Quality Strategy. Additionally, meaningful measures that assess if targeted interventions are provided to underserved populations to reduce disparities are important.

American Psychiatric Association
Samantha Sugarman

The APA is pleased that the Quality of Life topic area includes a screening for clinical depression and multiple depression-outcomes measures. It is of value, however, to include a follow-up measure to support the measure #418: Screening for Clinical Depression.

Center to Advance Palliative Care
Emily Warner

p. 20, 25. CAPC agrees with the importance of soliciting patients goals for care, and for addressing patient experience of care and quality of life. However, measurement should not focus solely on patient-reported outcomes. Outcome measurement is a laudable goal, but process measures are also crucial to moving toward a system that assesses and addresses quality of life, and available process measures should not be overlooked in favor of PRO measures. Simple measures of whether pain and symptoms were assessed, and whether social and emotional issues were assessed, will help provide baselines against which progress can be measured. Further, many patient-reported measures, including the CAHPS family of surveys, fail to capture the experiences of very sick individuals—individuals too

sick to fill out surveys and who are at significant risk of poor care due to their extensive contact with the health system and often poor ability to advocate for themselves. We must measure whether goals of care are being elicited for these individuals, and whether quality of life indicators are being assessed and addressed, even if (especially if) the patient is too sick to participate in surveys. This should be accomplished both through process measures and through family-reported outcomes measures.

Appendix E1. The following measures are also measures of PFCC and should be marked as such:

- Family Evaluation of Hospice Care
- Advance Care plan
- Patients admitted to ICU who have care preferences documented
- Consumer Assessments and Reports of End of Life

Children's Hospital Association
Ellen Schwalenstocker

The Children's Hospital Association agrees with the focus on patient-reported outcomes for future measure development. We also believe that quality of life issues, including symptom and treatment burden (including burden on families) are important foci for this family of measures. As with our comments under the Population Health Family of Measures, we believe it would be valuable to present both currently endorsed measures and topics for short- and long-term development as was done with the Affordability Family of Measures.

Consortium for Citizens with Disabilities
E. Clarke Ross

pg 20 - commend focus on holistic view of care; considering the individual's goals-needs-preferences. Reinforce that each person and their family be engaged as partners in their care, using a shared decision-making process.

pg 21 - absolutely delighted to see: one single term cannot apply to all individuals in all situations and task force agreed to use the word person as an overarching term to encompass health and healthcare needs of all individuals, regardless of age, setting, health status

pg 21 and pg 23 - given concerns with NCQA approach as discussed in the NQF duals eligible workgroup - delighted to see that term centered care centers on the person's priorities and goals and delighted with importance of measures that assess individual needs, preferences, and values - importance of respect and dignity - measurement should be through the person's eyes to assess interactions

Existing measurement approaches should be studies and replicated in pilot adapted formats - as discussed in the NQF duals workgroup - National Core Indicators and CQL personal outcomes measures for persons with intellectual disability; NCI pilot by NASUAD for physical disability & aging in GA, MN, OH; independent consumer and family nonprofit consumer experience efforts in MD-MA-PA-WI for persons with serious mental illness.

National Association of Social Workers
Joan Zlotnik

Page 22: The task force revised the definition of person- and family-centered care as follows: "...that is centered around a person's goals via collaborative partnerships among individuals, their families (as defined by each individual), and providers of care...." Rationale: The addition of a person's goals makes clear that the collaborative partnerships exist to promote each patient's goals. Defined family may be interpreted as family defined by law or a health care organization, which may not match a patient's definition of family.

The task force also stressed the importance of incorporating medical evidence within the definition, although (as noted on p. 23) the measures do not address that aspect of care. NASW suggests the following wording, deliberately broadening medical evidence to evidence: "...and providers of care. In addition to being evidence based, person- and family-centered care supports health and well-being..."

Page 23: NASW strongly supports the guiding principles for selecting measures. The third and fourth points are helpful in elucidating the task force's decision-making process.

Page 24, Interpersonal Relationships: NASW

strongly supports the language about cultural and linguistic responsiveness in paragraph 1. At the same time, we suggest that the phrase even if from a different culture or background be deleted. Given the multitudinous aspects of culture (including, but not limited to, race, ethnicity, and national origin; migration background, degree of acculturation, and documentation status; socioeconomic class; age; gender, gender identity, and gender expression; sexual orientation; family status; spiritual, religious, and political belief or affiliation; physical, psychiatric, and cognitive ability; and literacy, including health, behavioral health, and financial literacy), it is clear that no two people share the exact same culture, even within a family. Thus, every health care practitioner must treat every interaction with every patient and family as a cross-cultural interaction. In contrast, the phrase even if from a different culture or background implies that cultural and linguistic competence only need be drawn upon in certain situations, rather than an overall approach that infuses every aspect of practice. We suggest the following wording: "Cultural and linguistic responsiveness can also assess whether patients and families feel that their culture and language are respected, that they are treated in a dignified manner, and that care is congruent with their values." (For additional information, please refer to the NASW Indicators for the Achievement of the NASW Standards for Cultural Competence in Social Work Practice, available at www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf)

Page 24, Patient and Family Engagement: The second paragraph reflects some, but not all, of the task force discussion on May 12. Thus, NASW suggests adding the following sentence to the end of the paragraph: "Specifically, the task force emphasized that advance care planning is a dynamic process that includes ongoing discussion, documentation, reassessment, and modification of patients' values, short- and long-term goals of care, and potential benefits and risks of various treatment options."

Page 25, Quality of Life: The draft report omits mention of the task force's lengthy consideration of the NQF-endorsed measure #0420 Pain Assessment and Follow-Up. NASW suggests adding to the third paragraph text along the lines: "At the same time, the task force noted the absence of an appropriate measure for addressing pain unrelated to the dying process. The task force discussed NQF-endorsed measure #0420 Pain Assessment and Follow-Up but felt it was too broadly applied to be meaningful. Thus, the task force excluded the measure from the person- and family-centered care family of measures, while stressing the need for a better measure. NASW encourages inclusion of text to this effect in the NQF report.

Page 47, Care planning and delivery topic area: NASW's understanding was that the task force supported inclusion of NQF-endorsed measure #1626 Patients Admitted to ICU Who Have Care Preferences Documented, despite agreeing to exclude NQF-endorsed measure #0326 Advance Care Plan. Inclusion of measure #1626 would not eliminate the need for a separate, more comprehensive measure on advance care planning, as addressed on p. 24 (Patient and Family Engagement).

Section 5: General Comments

American College of Medical Quality & IPO 4 Health
Donald Casey

Unfortunately, this report only lists "Errors and Complications" that are focused on inpatient settings. There should be more attention given to dealing with this set of issues across patient care boundaries, including those that occur as a result of "non-medical" issues (e.g. MRSA acquisition in health clubs). Focusing on "Errors and Complications" that are "POA" (Present on Admission) is also a topic that needs further development and understanding as well as a better defined accountability.

On page 22 in Table 2, there should also be emphasis on improving a patient's understanding of illness, better self-managent and personal responsibility, including a good understanding of a given measure and the impact of these patient-centered

accountabilities on the improvement of the measure at the microsystem and population health levels. Evidence exists that many health care consumers either don't care about cost or don't believe it's their responsibility to worry about cost.

American Psychiatric Association
Samantha Sugarman

The American Psychiatric Association agrees that the inclusion of measure families will allow stakeholders to more efficiently choose appropriate measurement tools which will help save money and reduce the confusion when interpreting measurement results.

Children's Hospital Association
Ellen Schwalenstocker

The Children's Hospital Association appreciates the opportunity to comment on the draft report. In general, we find the concept of identifying families of measures to be a very useful one, and we support many of the themes discussed in the report. We believe the report could be strengthened by including additional context at its beginning. For example, we recommend including a high level summary of why the work to develop this report was undertaken in the Executive Summary. In addition, we recommend adding an overview of the methodology that was used to identify the recommended measures in both the Executive Summary and the section on Advancing Measurement in Priority Areas: Cross-Cutting Themes. To the extent possible, we also suggesting making each section of the report as consistent with the others as possible. For example, the Venn diagram included as Figure 2 in the Population Health Family of Measures discussion, the rationale for measure selection in the Affordability Family of Measures (Table C2) and the illustration of measures applied to use cases in the Population Health Family of Measures provide helpful context to those not involved in the development of the report and would be valuable additions to each of the three families of measures presented. Further discussion of related current NQF projects would also be useful. It might also be helpful to restate the National Quality Strategy aims and priorities as they apply to each of the families of measures in the introductory paragraphs of those sections.

Finally, we would suggest that there be more discussion around how the families of measures fit together. The inter-relationship between the aims of affordable care, better care and population health is a strength of the National Quality Strategy, but also poses challenges in terms of identifying parsimonious sets of measures. Perhaps some thought could be given to identifying primary and secondary homes for measures. For example, the care coordination measures under the affordability family might best fit under the family and person-centered measures as a primary home. We recognize that this is draft report representing work in progress and that some of these suggestions may already be planned for incorporation.

National Association of Social Workers
Joan Zlotnik

The term clinical is used multiple times throughout the report, with two distinct connotations: (a) health care (e.g., clinical settings vs. community or public health settings on pp. 4, 15, 17, and 18; clinical care at the bottom of p. 6 and on p. 15; clinical information at the bottom of p. 13) and (b) a broad range of health care practitioner activities (e.g., clinical processes at the bottom of p. 5 and clinically focused measures on p. 18). In other instances, the meaning is unclear (e.g., clinical preventive services on pp. 15 and 17; which may refer solely to medical care or to a team-based preventive care approach, including social work). At the same time, not every health care service is clinical. For example, some health care social workers provide clinical services (generally defined by both CMS and state licensure boards as the assessment and psychotherapeutic treatment of mental health conditions), while others provide case management and other nonclinical services. Because the term clinical holds different meanings for various disciplines, and because each discipline offers a unique and valuable clinical contribution to the health care team, NASW encourages NQF to reexamine its use of the term clinical in this report. Depending on the context, alternatives include health care, medical, or practitioner.

NASW also encourages NQF to reconsider its use of the term family of measures. This term may be confusing, given the inclusion of measures addressing family members' involvement in health care. Thus, NASW encourages NQF to identify a term other than family to would describe a set of related measures.

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NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org