MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

COORDINATING COMMITTEE IN-PERSON MEETING

AUGUST 17-18, 2011

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Agenda

Tab 1

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #3

Washington Marriot Wardman Park
2660 Woodley Road NW
Washington, DC

Dial: **888-551-9020**
Conference code: **9214777**

DAY 1 AGENDA: AUGUST 17, 2011

Meeting Objectives:

- *Refine draft measure selection criteria;*
- *Consider report drafts for Coordinating Committee reaction from Dual Eligible Beneficiaries, Clinician, and Ad Hoc Safety Workgroups;*
- *Review interim findings from PAC/LTC workgroup.*

8:30 am **Breakfast**

9:00 am **Welcome, Introductions, and Review of Meeting Objectives**
George Isham and Beth McGlynn, Committee Co-Chairs

9:15 am **Refine Draft Measure Selection Criteria**
Beth McGlynn
Connie Hwang, Vice President, Measure Applications Partnership
  - *Discussion and questions*
  - *Opportunity for public comment*

11:15 am **Themes across Workgroup Draft Reports**
George Isham
Tom Valuck, Senior Vice President, Strategic Partnerships
  - *Discussion and questions*

11:45 pm **Working Lunch**

12:15 pm **Dual Eligible Beneficiaries Quality Measurement Strategy**
George Isham
Alice Lind, Chair, Dual Eligible Beneficiaries Workgroup
  - *Dual Eligible Beneficiaries Workgroup draft for Coordinating Committee reaction*
  - *Discussion and questions*
  - *Opportunity for public comment*

2:15 pm	**Clinician Performance Measurement Coordination Strategy across Federal Programs** ***Beth McGlynn*** ***Mark McClellan, Chair, Clinician Workgroup*** • *Clinician Workgroup draft for Coordinating Committee reaction* • *Discussion and questions* • *Opportunity for public comment*
4:15 pm	**Summary of Day 1 and Look-Forward to Day 2** ***George Isham and Beth McGlynn***
4:30 pm	**Adjourn for the Day**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #2

DAY 2 AGENDA: AUGUST 18, 2011

8:00 am **Breakfast**

8:30 am **Welcome and Recap of Day 1**
George Isham and Beth McGlynn

9:00 am **Healthcare-Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers**
George Isham
Frank Opelka, Chair, Ad Hoc Safety Workgroup
- *Ad Hoc Safety Workgroup draft for Coordinating Committee reaction*
- *Discussion and questions*
- *Opportunity for public comment*

11:00 am **Break**

11:15 am **Post-Acute Care/Long Term Care Quality Measurement Strategy**
Beth McGlynn
Carol Raphael, Chair, Post-Acute/Long Term Care Workgroup
- *Review Post-Acute Care/Long Term Care Workgroup interim findings*
- *Discussion and questions*
- *Opportunity for public comment*

12:00 pm **Themes across Workgroup Draft Reports**
George Isham
- *Discussion and questions*

12:30 pm **Summation and Path Forward**
George Isham and Beth McGlynn

1:00 pm **Box Lunch/Adjourn**

Powerpoint Presentation

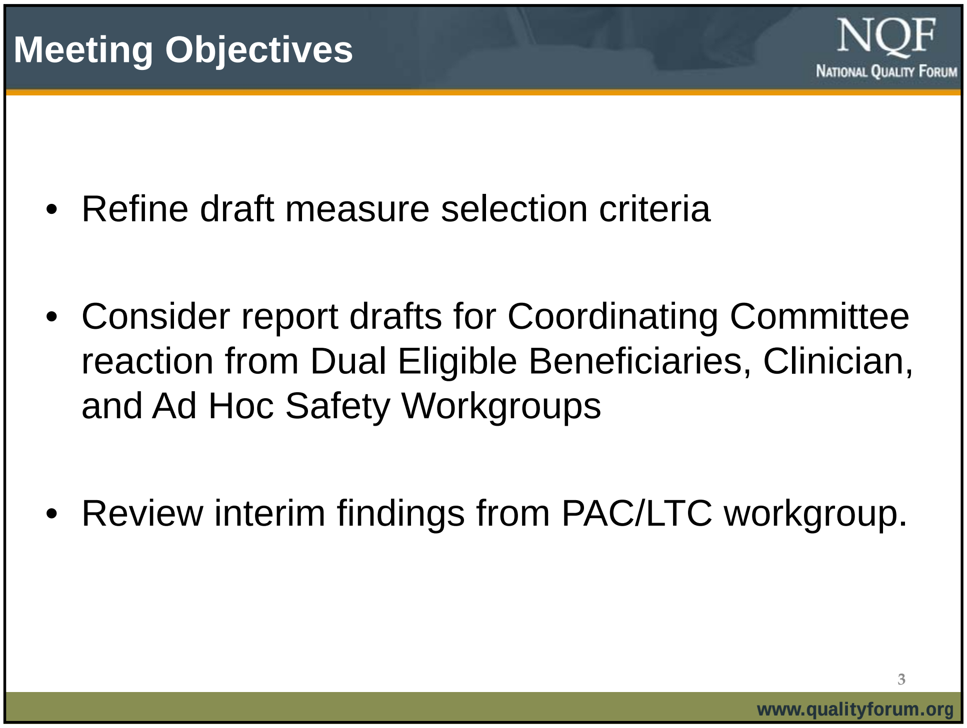
Tab 2

Measure Applications Partnership Coordinating Committee

In-Person Meeting #3

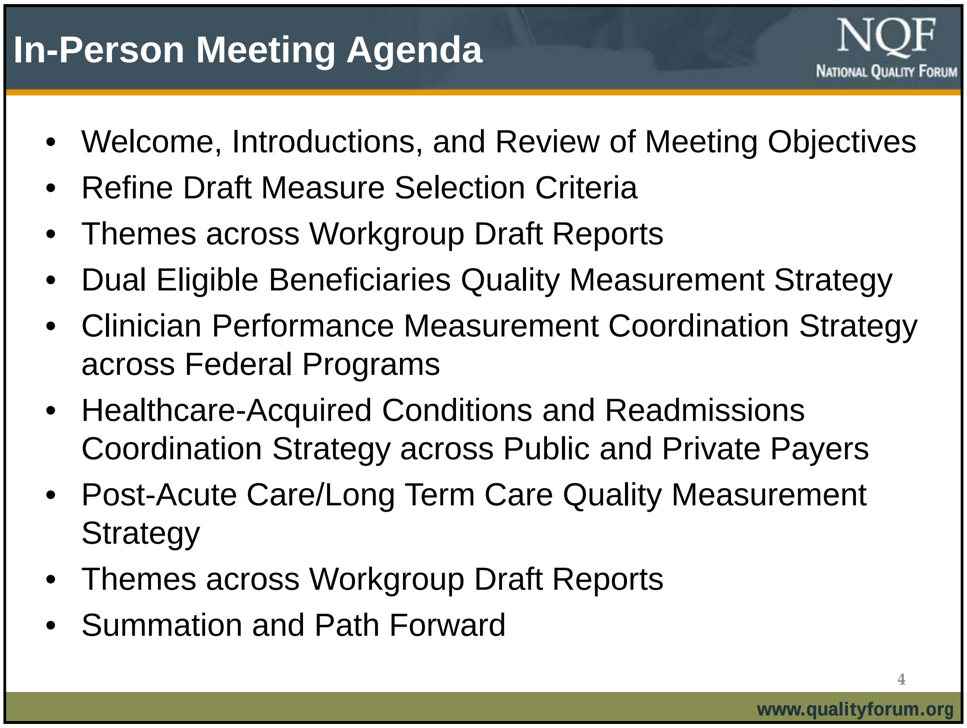
August 17-18, 2011
9:00 am – 5:00 pm ET

Welcome, Introductions, and Review of Meeting Objectives



Meeting Objectives

- Refine draft measure selection criteria
- Consider report drafts for Coordinating Committee reaction from Dual Eligible Beneficiaries, Clinician, and Ad Hoc Safety Workgroups
- Review interim findings from PAC/LTC workgroup.



In-Person Meeting Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- Refine Draft Measure Selection Criteria
- Themes across Workgroup Draft Reports
- Dual Eligible Beneficiaries Quality Measurement Strategy
- Clinician Performance Measurement Coordination Strategy across Federal Programs
- Healthcare-Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers
- Post-Acute Care/Long Term Care Quality Measurement Strategy
- Themes across Workgroup Draft Reports
- Summation and Path Forward

Refine Draft Measure Selection Criteria

MAP Coordinating Committee Charge

The charge of the Measure Applications Partnership Coordinating Committee is to:

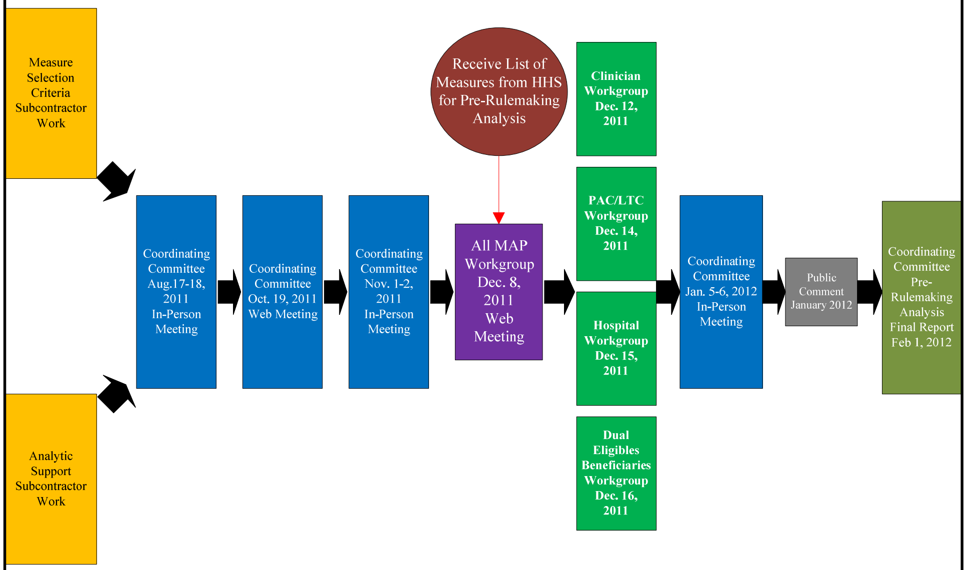
- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs;
- Advise HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers;
- Set the strategy for the two-tiered Partnership; and
- Give direction to and ensure alignment among the MAP advisory workgroups.

Measures to Be Implemented Through the Federal Rulemaking Process

Task Description	Deliverable	Timeline
Provide input to HHS on measures to be implemented through the federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the metrics for encouraging such improvement.	Final report containing Coordinating Committee framework for decision-making and proposed measures	Draft Report: January 2012 Final Report: February 1, 2012

Coordinating Committee with input from all workgroups

MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report



Measure Selection Criteria Subcontractor Work

Analytic Support Subcontractor Work

Coordinating Committee Aug.17-18, 2011 In-Person Meeting

Coordinating Committee Oct. 19, 2011 Web Meeting

Coordinating Committee Nov. 1-2, 2011 In-Person Meeting

Receive List of Measures from HHS for Pre-Rulemaking Analysis

All MAP Workgroup Dec. 8, 2011 Web Meeting

Clinician Workgroup Dec. 12, 2011

PAC/LTC Workgroup Dec. 14, 2011

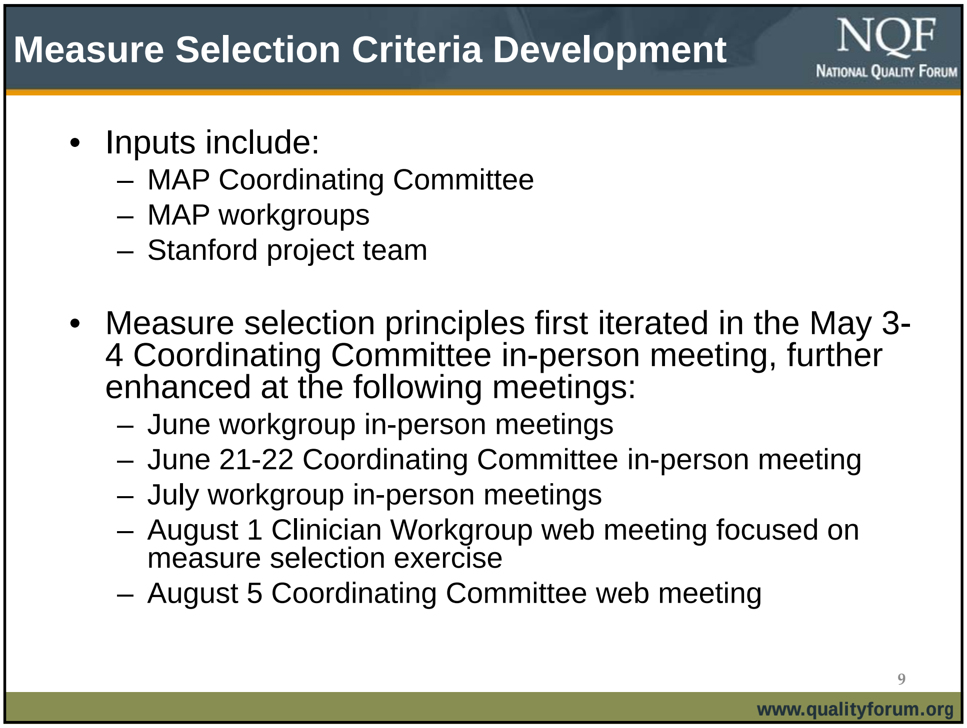
Hospital Workgroup Dec. 15, 2011

Dual Eligibles Beneficiaries Workgroup Dec. 16, 2011

Coordinating Committee Jan. 5-6, 2012 In-Person Meeting

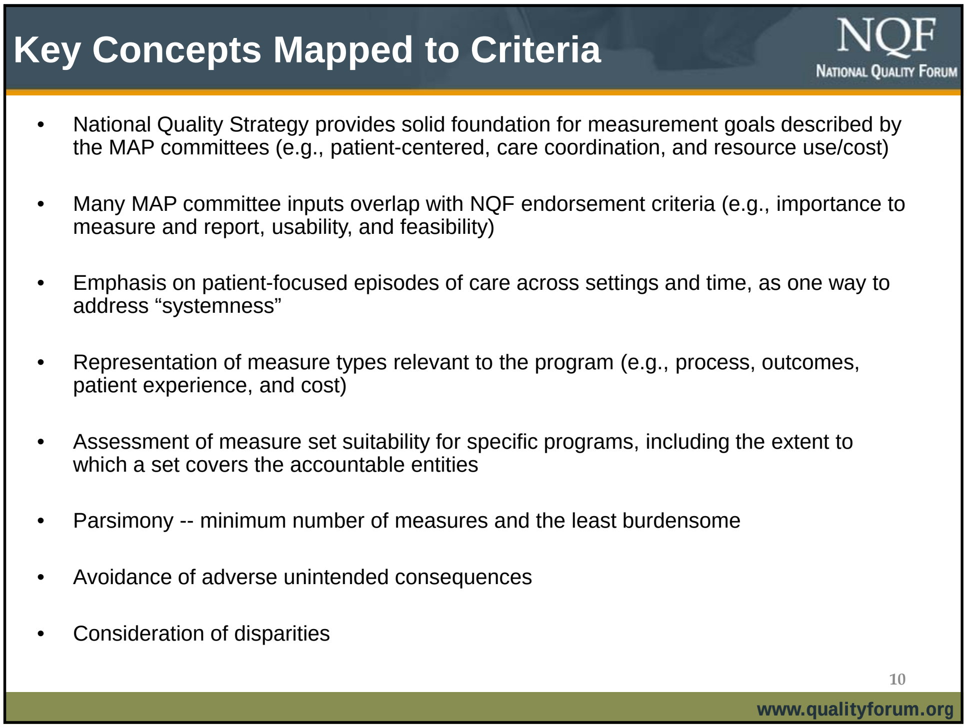
Public Comment January 2012

Coordinating Committee Pre-Rulemaking Analysis Final Report Feb 1, 2012



Measure Selection Criteria Development

- Inputs include:
  - MAP Coordinating Committee
  - MAP workgroups
  - Stanford project team
- Measure selection principles first iterated in the May 3-4 Coordinating Committee in-person meeting, further enhanced at the following meetings:
  - June workgroup in-person meetings
  - June 21-22 Coordinating Committee in-person meeting
  - July workgroup in-person meetings
  - August 1 Clinician Workgroup web meeting focused on measure selection exercise
  - August 5 Coordinating Committee web meeting



Key Concepts Mapped to Criteria

- National Quality Strategy provides solid foundation for measurement goals described by the MAP committees (e.g., patient-centered, care coordination, and resource use/cost)
- Many MAP committee inputs overlap with NQF endorsement criteria (e.g., importance to measure and report, usability, and feasibility)
- Emphasis on patient-focused episodes of care across settings and time, as one way to address “systemness”
- Representation of measure types relevant to the program (e.g., process, outcomes, patient experience, and cost)
- Assessment of measure set suitability for specific programs, including the extent to which a set covers the accountable entities
- Parsimony -- minimum number of measures and the least burdensome
- Avoidance of adverse unintended consequences
- Consideration of disparities

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Clinician Workgroup members evaluated, via a survey monkey tool, the physician value-based modifier proposed measure set – 62 quality measures
- Majority of respondents agree the MAP set-level measure selection criteria are a good starting place for assessing the adequacy of a measure set for a specific purpose
  - Strongly Agree – 30%
  - Agree – 50%
  - Disagree – 20%
  - Strongly Disagree – 0%

  N= 20, 71% response rate

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Addresses NQS Priorities, but concern with exact extent
- Addresses high-leverage opportunities, but should be defined beyond high-impact conditions
- Appropriate for all intended accountable entities, need better ways to assess or encourage "systemness" or shared accountability
- Criteria should have an appropriate mix of measure types not necessarily equal representation
- Parsimony, undesirable consequences, health care disparities criteria generally difficult to assess

August 5 Coordinating Committee web meeting

Discussion included the following points:

- Need to align measures to alleviate measurement burden and fragmented measurement efforts
- Consider alternative criteria rating systems (e.g., binary rating options) to avoid regression to the mean
- Clarify the meaning of parsimony to include concept of collection of burden not just the number of measures
- Measure selection criteria should consider specific applications
- Identification of measure gaps (e.g., measures for working-age population) and process for gap-filling
- Mapping of the input from the Stanford team to the measure selection criteria draft.

Measure Selection Criteria

Individual Measure Review

1. Measure addresses National Quality Strategy priorities and high-leverage measurement areas

2. Measure meets NQF endorsement criteria

3. Measure is applicable to multiple populations and providers

4. Measure enables longitudinal assessment of patient-focused episode of care

5. Measure is ready for implementation in the context of a specific program

6. Measures are proximal to outcomes

Merging of individual and set level criteria:

- No clear differentiation
- Objective to streamline the criteria
- All principles still represented

Measure Selection Criteria

NQF
National Quality Forum

Criterion #1

Measures within the set meet NQF endorsement criteria

Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF-endorsed but meet this threshold are expected to undergo review through the NQF endorsement process.)

Response option:
Yes/No: Measures within the measure set are NQF-endorsed or meet NQF endorsement criteria of being import to measure and report, scientifically acceptable, usable, and feasible

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Measure Selection Criteria

NQF
National Quality Forum

Criterion #2

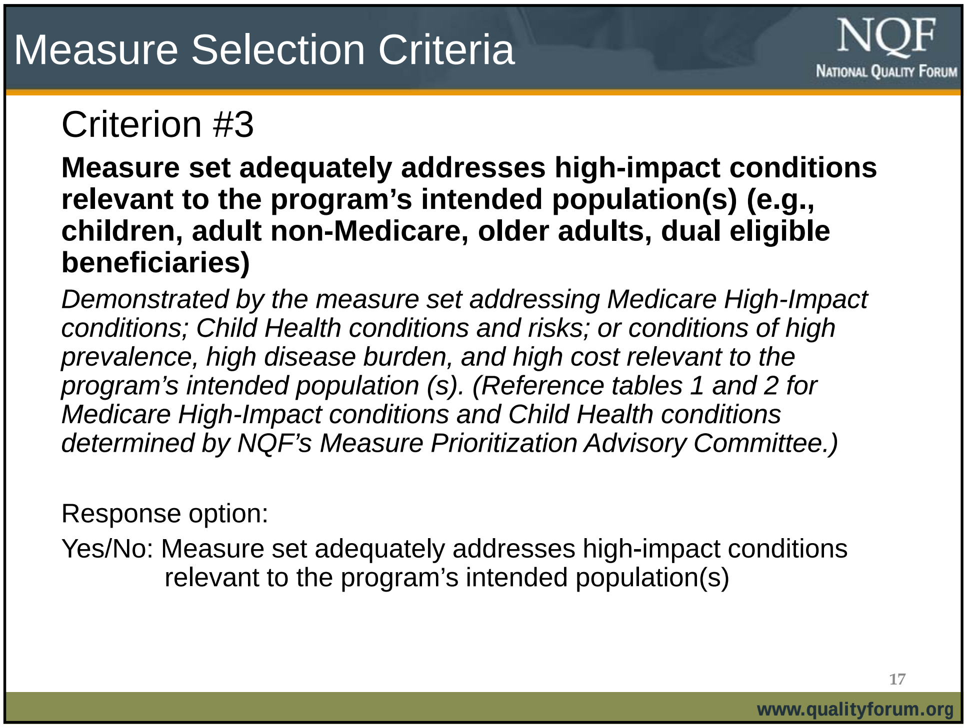
Measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	*Safer care*
Subcriterion 2.2	*Effective care coordination*
Subcriterion 2.3	*Prevention and treatment of leading causes of mortality*
Subcriterion 2.4	*Person and family centered care*
Subcriterion 2.5	*Supporting better health in communities*
Subcriterion 2.6	*Making care more affordable.*

Response option for each subcriterion:

Yes/No: NQS priority is adequately addressed in the measure set



Measure Selection Criteria

NQF NATIONAL QUALITY FORUM

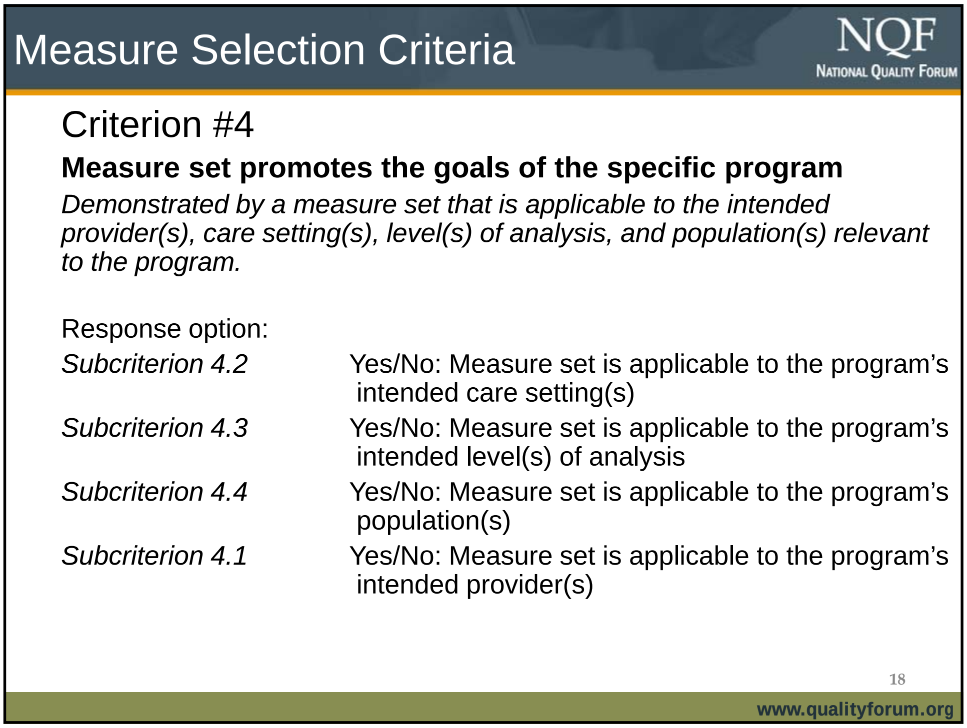
Criterion #3

Measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the measure set addressing Medicare High-Impact conditions; Child Health conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population (s). (Reference tables 1 and 2 for Medicare High-Impact conditions and Child Health conditions determined by NQF's Measure Prioritization Advisory Committee.)

Response option:

Yes/No: Measure set adequately addresses high-impact conditions relevant to the program's intended population(s)



Measure Selection Criteria

NQF NATIONAL QUALITY FORUM

Criterion #4

Measure set promotes the goals of the specific program

Demonstrated by a measure set that is applicable to the intended provider(s), care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option:

Subcriterion 4.2	Yes/No: Measure set is applicable to the program's intended care setting(s)
Subcriterion 4.3	Yes/No: Measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.4	Yes/No: Measure set is applicable to the program's population(s)
Subcriterion 4.1	Yes/No: Measure set is applicable to the program's intended provider(s)

Measure Selection Criteria

NQF
NATIONAL QUALITY FORUM

Criterion #5

Measure set includes an appropriate mix of measure types

Demonstrated by a measure set that includes an appropriate mix of process, outcome, patient experience, and cost/resource use measures necessary to achieve the goals of the program.

Response option:

Subcriterion 5.1	Yes/No: Outcome measures are adequately represented in the set
Subcriterion 5.2	Yes/No: Process measures with a strong link to outcomes are adequately represented in the set
Subcriterion 5.3	Yes/No: Patient experience measures are adequately represented in the set
Subcriterion 5.4	Yes/No: Cost/resource use measures are adequately represented in the set

Measure Selection Criteria

NQF
NATIONAL QUALITY FORUM

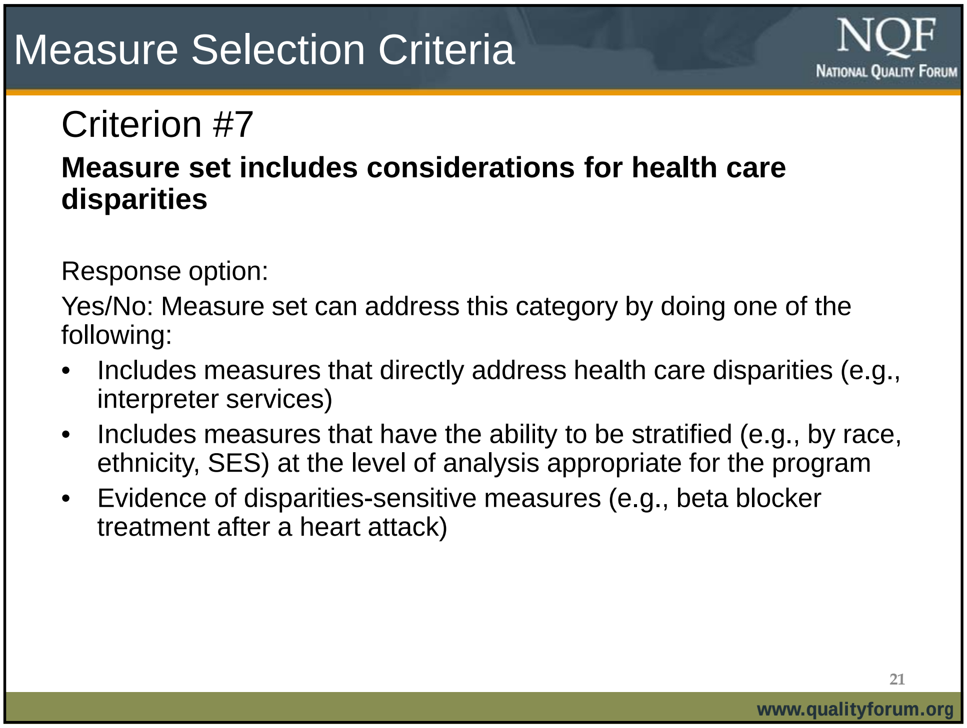
Criterion #6

Measure set enables measurement across the patient-focused episode of care

Demonstrated by assessment of the patient’s trajectory across providers, settings, and time.

Response option:

Subcriterion 6.1	Yes/No: Measures within the set are applicable across relevant providers
Subcriterion 6.2	Yes/No: Measures within the set are applicable across relevant settings
Subcriterion 6.3	Yes/No: Measure set adequately measures patient care across time



Measure Selection Criteria

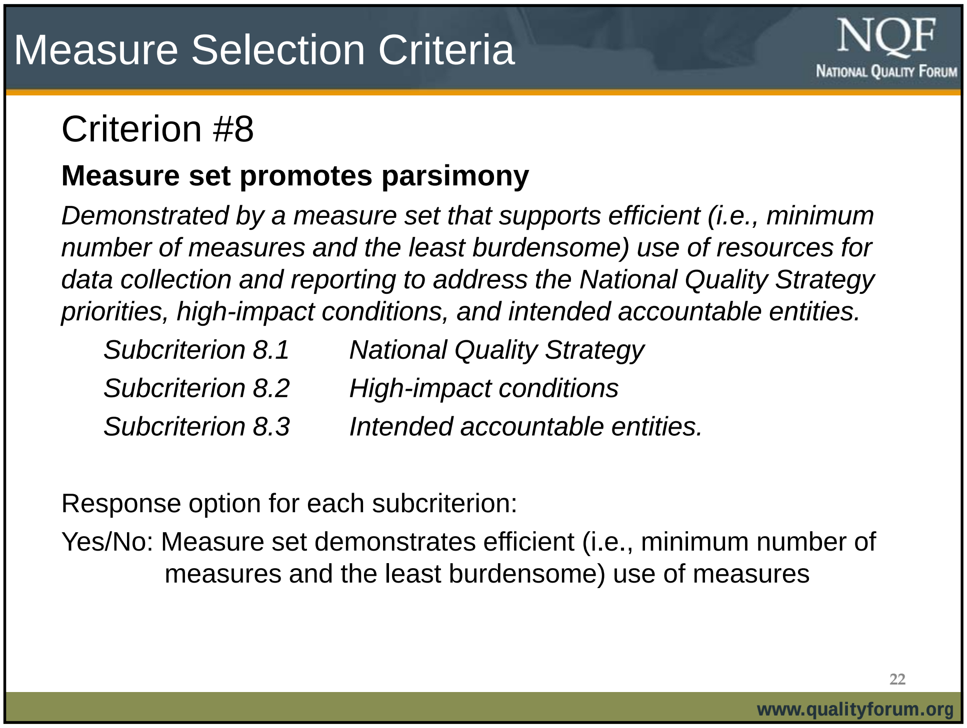
Criterion #7

Measure set includes considerations for health care disparities

Response option:

Yes/No: Measure set can address this category by doing one of the following:

- Includes measures that directly address health care disparities (e.g., interpreter services)
- Includes measures that have the ability to be stratified (e.g., by race, ethnicity, SES) at the level of analysis appropriate for the program
- Evidence of disparities-sensitive measures (e.g., beta blocker treatment after a heart attack)



Measure Selection Criteria

Criterion #8

Measure set promotes parsimony

Demonstrated by a measure set that supports efficient (i.e., minimum number of measures and the least burdensome) use of resources for data collection and reporting to address the National Quality Strategy priorities, high-impact conditions, and intended accountable entities.

Subcriterion 8.1	*National Quality Strategy*
Subcriterion 8.2	*High-impact conditions*
Subcriterion 8.3	*Intended accountable entities.*

Response option for each subcriterion:

Yes/No: Measure set demonstrates efficient (i.e., minimum number of measures and the least burdensome) use of measures

Measure Selection Criteria

Criterion #9

Measure set avoids adverse unintended consequences

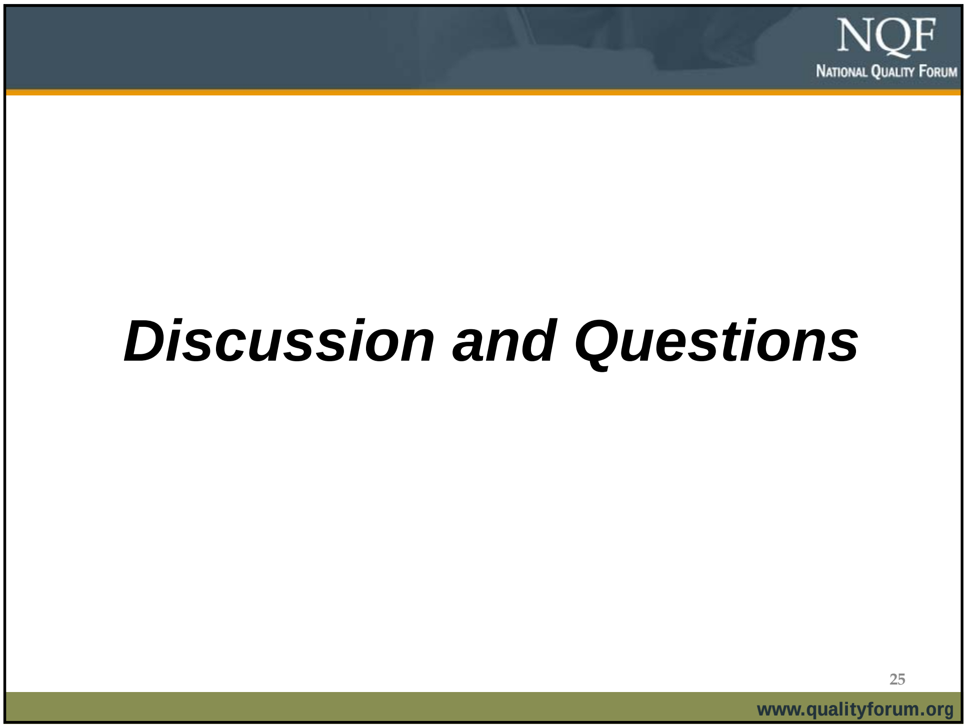
Demonstrated by a measure set in which the measures avoid or have a method for detecting adverse unintended consequences.

Response option:

Yes/No: Set includes measures that detect or monitor adverse unintended consequences (e.g., adverse selection, overtreatment, etc.)

Discussion Questions

- How can the criteria of disparities, adverse unintended consequences, and parsimony be further refined?
- How might the criteria be applied differentially to payment and public reporting programs?
- How to apply the concept of “adequate” through the operationalization of the criteria?



Discussion and Questions

Opportunity for Public Comment

Themes across Workgroup Draft Reports

Themes across Workgroup Draft Reports

Themes across Workgroup Draft Reports

- Measures and measurement issues
- Data sources and HIT implications
- Alignment
- Special considerations for dual eligible beneficiaries
- Pathway for improving measure application

Measures and Measurement Issues

- Promote “systemness,” “teamness,” shared accountability, coordination in delivery
- Address multiple levels of analysis
  - Cascading measures from national priorities to systems to groups to individuals
- Align across public and private sectors
- Useful to intended audiences
- Balance comprehensiveness and parsimony
- Potential for unintended consequences

Priority Measure Gap Areas

- Patient-reported measures (e.g., health risk assessment, functional status, experience of care, shared decision making)
- Coordination of care across multiple settings and providers, including the adequacy of community supports
- Assessment of care for patients with multiple comorbidities
- Physical and mental disabilities
- Disparities, cultural competency, language, health literacy
- Overuse
- Other cross-cutting measures

Data Source and HIT Implications

- Standardized data collection and transmission mechanism across public and private sectors
  - Library of data elements for all measures
- Types of data
  - Appropriateness of data source for specific measures, settings
  - Moving beyond claims data, incorporating patient self-reported and clinical data
- Data collection during the course of care to address burden and use for clinical decision support
- Promote HIT adoption, recognizing that HIT is not a short-term panacea
- Timeliness and transparency of data for use by consumers, purchasers, providers, and communities
- Availability of Medicare and Medicaid data to private sector

Alignment

- Frustration with misalignment mounting as reporting requirements increase
- Alignment of public and private sector initiatives including measures, data collection, and performance-based payment incentives
- Federal programmatic alignment issues
  - Data collection and transmission, feedback, and public reporting
  - Medicare/Medicaid alignment for dual eligible beneficiaries-across benefit structures, settings of care, and between health delivery system and community-based services and supports
- Need for core measure sets at various levels of analysis for various care providers

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Special Considerations for Dual Eligible Beneficiaries

- All dually eligible individuals are low-income but their clinical conditions and social circumstances are highly variable
- The population is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness
- More emphasis on a parsimonious measure set that relies on cross-cutting rather than condition-specific measures
- Disparities and unintended consequences are particularly important
- Availability of Medicare data for states

Pathway for Improving Measure Application

- Address measure gaps by supporting the development, testing, and endorsement of new measures
- Consider how to move from current to ideal state for each element of the coordination strategies
  - Identify core measure sets for specific purposes
  - Prioritize nearer-term achievable goals, while recognizing longer-term aspirational goals

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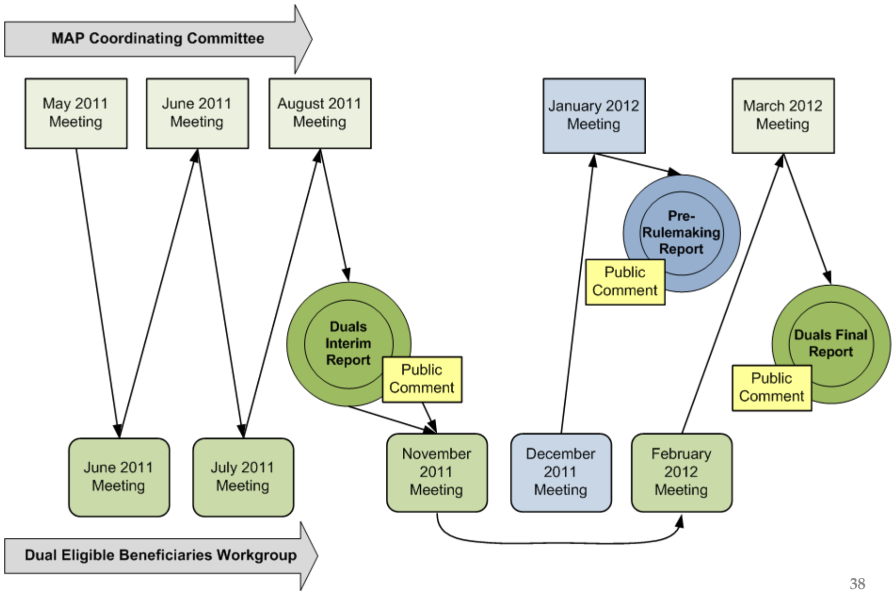
Dual Eligible Beneficiaries Quality Measurement Strategy

Dual Eligible Beneficiaries Workgroup Charge

To advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- Identify a core set of current measures that address the identified quality issues and apply to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

Flow of Information to Inform Reports



MAP Coordinating Committee

May 2011 Meeting

June 2011 Meeting

August 2011 Meeting

January 2012 Meeting

March 2012 Meeting

Pre-Rulemaking Report

Public Comment

Duals Interim Report

Public Comment

Duals Final Report

Public Comment

June 2011 Meeting

July 2011 Meeting

November 2011 Meeting

December 2011 Meeting

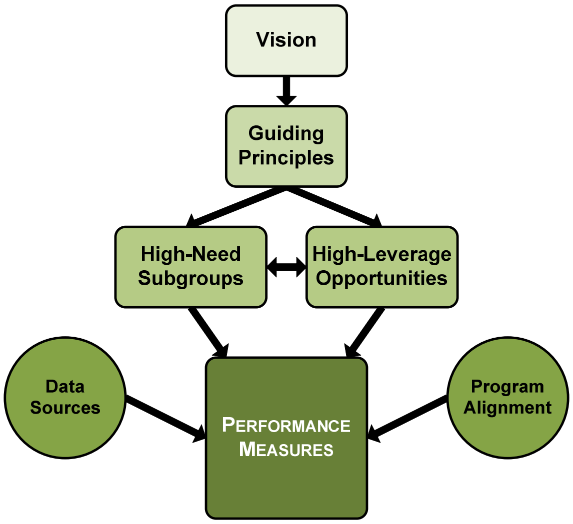
February 2012 Meeting

Dual Eligible Beneficiaries Workgroup

Guidance From Coordinating Committee

- **Guiding Principles for Performance Measurement Strategy**
  - Address “affordable care” aspect of National Quality Strategy (NQS)
  - Dysfunction that duals experience in the system is driven by lack of integration
  - Very small number of duals served in integrated delivery models; need measures that will work in current program parameters
- **High-Leverage Quality Improvement Opportunities**
  - As part of “better care” aspect of NQS, continue to ensure access to basic level of care/supports
  - Disease-specific quality measures for individuals with MCCs can be counterproductive
  - Monitor number of hospitalizations over the course of a year (not just readmissions)
  - Account for the different needs/wants of younger adults with disabilities regarding directing care and support services
  - Monitor medication adherence and intervene early if a problem is detected
  - Not enough to screen for mental health and substance abuse issues, must incorporate these factors into plan of care and follow up
  - Word usage: “multi-disciplinary” vs. “inter-professional”, “person and family-centered”

Strategic Approach to Quality Measurement



Vision for High-Quality Care

> In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain personal health goals.

The workgroup espouses the World Health Organization's definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Guiding Principles

- A person- and family-centered plan of care forms the foundation for the delivery of high-quality care and supports.
- The dually eligible population is a byproduct of payment policy, characterized more by its heterogeneity and diversity rather than any inherent similarity.
- Many shortfalls in the quality of care delivered to this population can be traced back to fragmentation of care delivery and payment between the Medicare and Medicaid programs. Fragmentation also damages ongoing efforts to promote efficient, affordable care.
- Measurement should drive clinical practice and provision of community supports toward desired models of integrated, coordinated care.
- The measurement strategy should encourage data exchange.
- It is necessary to clarify the level of analysis and specific use of a measurement strategy or measure set related to the care experience of dual eligible beneficiaries, as the appropriateness of specific measures are contingent upon their purpose.

High-Need Subgroups

Additive/Synergistic Effect

Limitations in one or more ADLs resulting from sensory and/or physical impairments

Mental health/substance use disorder

Cognitive impairment

Intellectual disability/developmental disability

Heavy disease burden from one condition (e.g., ESRD) or multiple chronic conditions

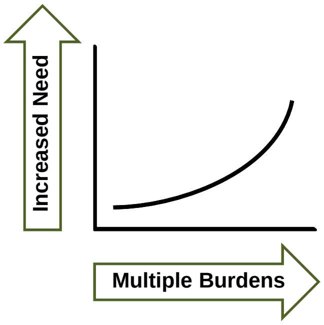
Pain

Residential care setting

Frail elderly

Recipient of Home and Community-Based Services (HCBS)

Social factors (e.g., low SES, homeless, racial/ethnic minority status, education level, cultural beliefs)



Service needs tend to increase along with the number of risk factors or categories that apply to an individual. The exact mathematical relationship is not known, and would vary by combination of factors, but evidence demonstrates it is not linear.

High-Leverage Opportunities: Quality of Life

- Focus on outcomes and capture individual's health-related goals, ability to have choice and autonomy, community participation, functional status, pain, and symptom control
- Structural measures related to elements that enhance quality of life (e.g., community-based services)

Illustrative Measure	Measure Type	Strengths	Weaknesses
Change in Daily Activity Function as Measured by the AM-PAC The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	Outcome	Broadly applicable across clinical conditions Functional status is a fundamental aspect of quality of life Oriented to outcomes Data for measure comes from EHR Promotes longitudinal measurement	Limited to post-acute care patients; many others in dual eligible population would benefit from regular assessment of daily activity function

High-Leverage Opportunities: Care Coordination

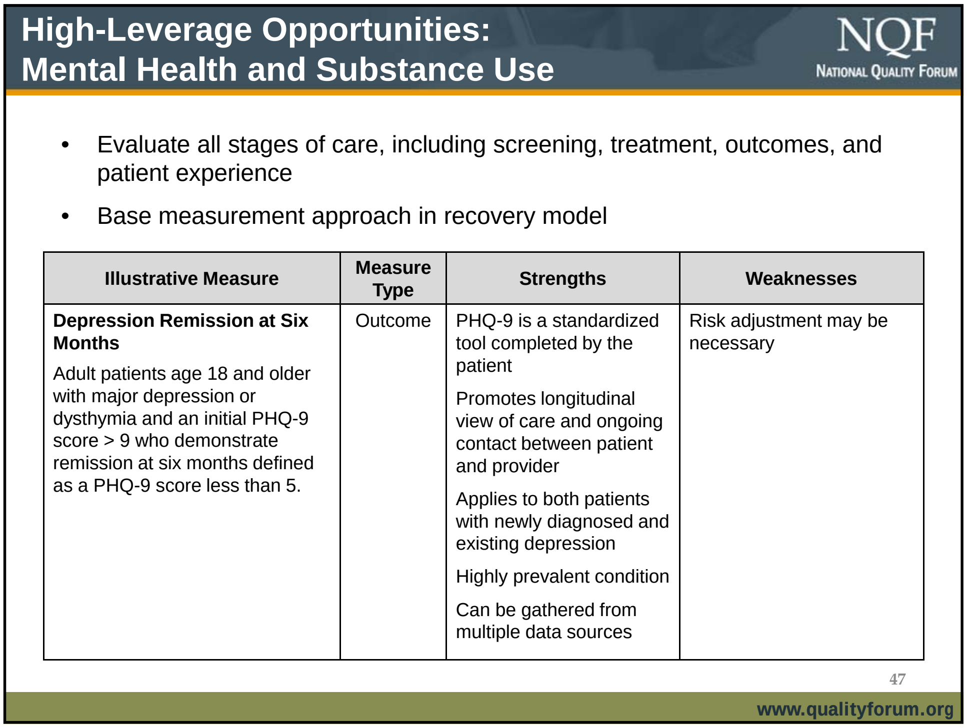
- Promote coordination across multiple dimensions: settings of care, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid programs
- Address medication management, access to an inter-professional care team, advance care planning, and palliative care

Illustrative Measure	Measure Type	Strengths	Weaknesses
3-Item Care Transition Measure (CTM-3) Uni-dimensional self-reported survey that measures the quality of preparation for a transition in care.	Patient Experience of Care	Captures the beneficiary's perspective Broadly applicable (not condition-specific or restricted by age)	Survey may not be in use as part of current process of care Many individuals may be unable to complete the survey themselves (due to limited English proficiency, cognitive impairment, et cetera)

High-Leverage Opportunities: Screening and Assessment

- Approach should be thorough and tailored to address the complex care needs of the population: food insecurity, drug and alcohol use, falls, underlying mental and cognitive conditions, HIV/AIDS, etc.
- Assess the home environment, availability of family and community supports, caregiver stress, and consideration of whether the care is in least restrictive setting

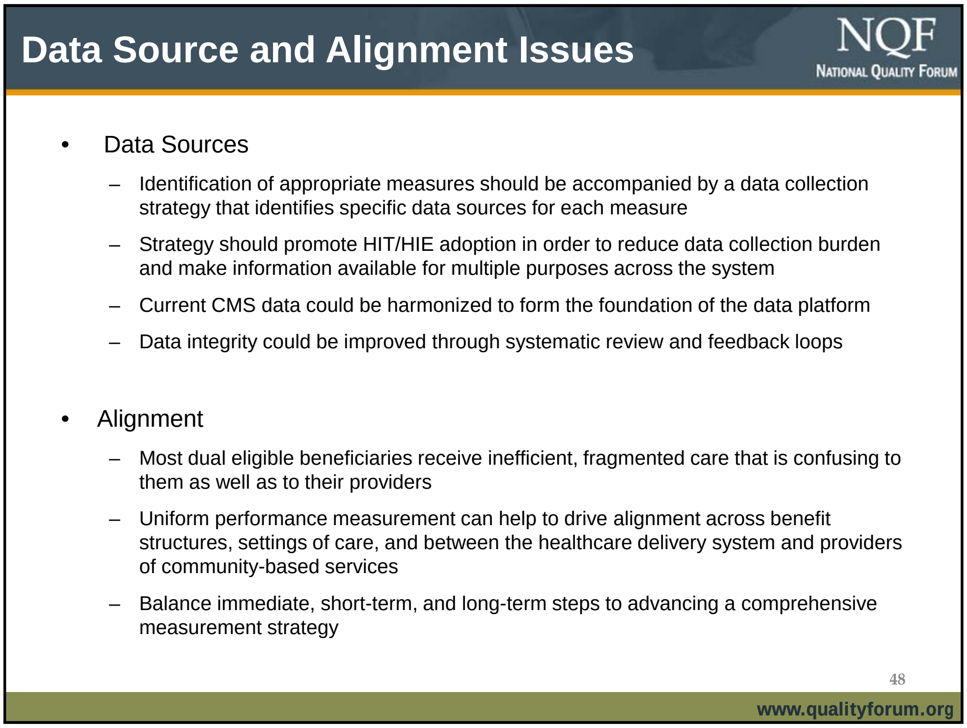
Illustrative Measure	Measure Type	Strengths	Weaknesses
Screening for fall risk Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	Process	Not specific to a clinical condition Important risk factor in the dual eligible population, particularly among older adults	Limited by age; others with limitations in mobility may be at risk for a fall Measure does not push provider to change plan of care based on results of the assessment, only to document that one was performed



High-Leverage Opportunities: Mental Health and Substance Use

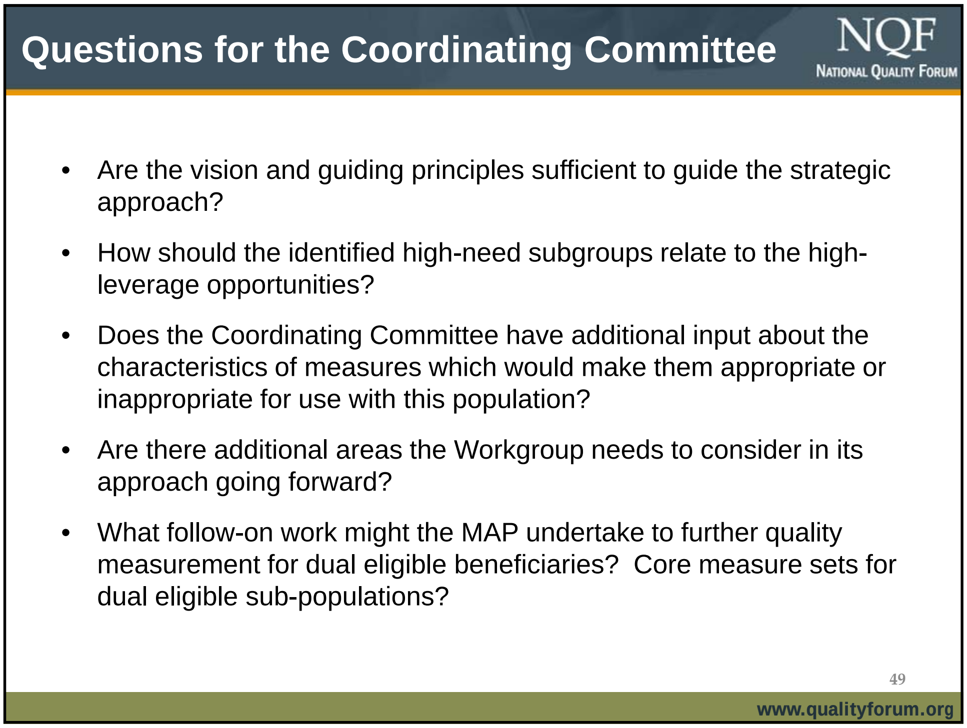
- Evaluate all stages of care, including screening, treatment, outcomes, and patient experience
- Base measurement approach in recovery model

Illustrative Measure	Measure Type	Strengths	Weaknesses
Depression Remission at Six Months Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5.	Outcome	PHQ-9 is a standardized tool completed by the patient Promotes longitudinal view of care and ongoing contact between patient and provider Applies to both patients with newly diagnosed and existing depression Highly prevalent condition Can be gathered from multiple data sources	Risk adjustment may be necessary



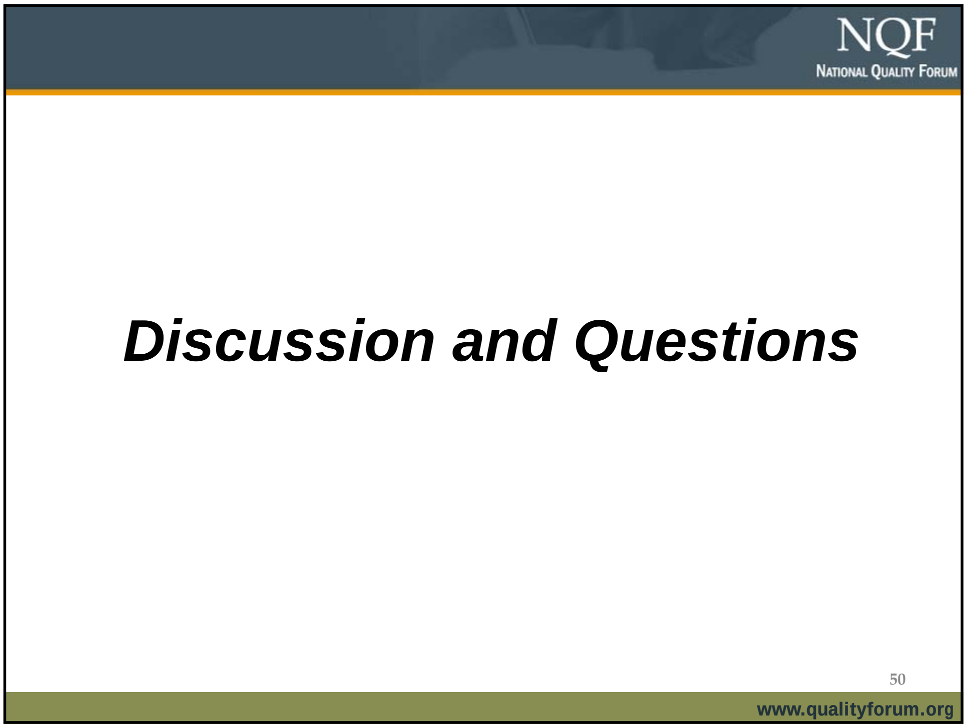
Data Source and Alignment Issues

- Data Sources
  - Identification of appropriate measures should be accompanied by a data collection strategy that identifies specific data sources for each measure
  - Strategy should promote HIT/HIE adoption in order to reduce data collection burden and make information available for multiple purposes across the system
  - Current CMS data could be harmonized to form the foundation of the data platform
  - Data integrity could be improved through systematic review and feedback loops
- Alignment
  - Most dual eligible beneficiaries receive inefficient, fragmented care that is confusing to them as well as to their providers
  - Uniform performance measurement can help to drive alignment across benefit structures, settings of care, and between the healthcare delivery system and providers of community-based services
  - Balance immediate, short-term, and long-term steps to advancing a comprehensive measurement strategy



Questions for the Coordinating Committee

- Are the vision and guiding principles sufficient to guide the strategic approach?
- How should the identified high-need subgroups relate to the high-leverage opportunities?
- Does the Coordinating Committee have additional input about the characteristics of measures which would make them appropriate or inappropriate for use with this population?
- Are there additional areas the Workgroup needs to consider in its approach going forward?
- What follow-on work might the MAP undertake to further quality measurement for dual eligible beneficiaries? Core measure sets for dual eligible sub-populations?



Discussion and Questions

Opportunity for Public Comment

Clinician Performance Measurement Coordination Strategy across Federal Programs

MAP Clinician Workgroup Charge

NQF
NATIONAL QUALITY FORUM

The charge of the MAP Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The workgroup will:

- Identify ideal characteristics of measure sets used to asses clinician performance, with a focus on:
  - Clinician measures needed across federal programs
  - Electronic data sources
  - Office setting
  - Cross cutting priorities from the NQS
  - Priority conditions
- Identify critical clinician measure development and endorsement gaps
- Develop a coordination strategy for clinical performance measurement including:
  - Alignment with other public and private initiatives
  - Health IT Implications
  - High level transition plan
- Provide input on measures to be implemented through the federal rulemaking process

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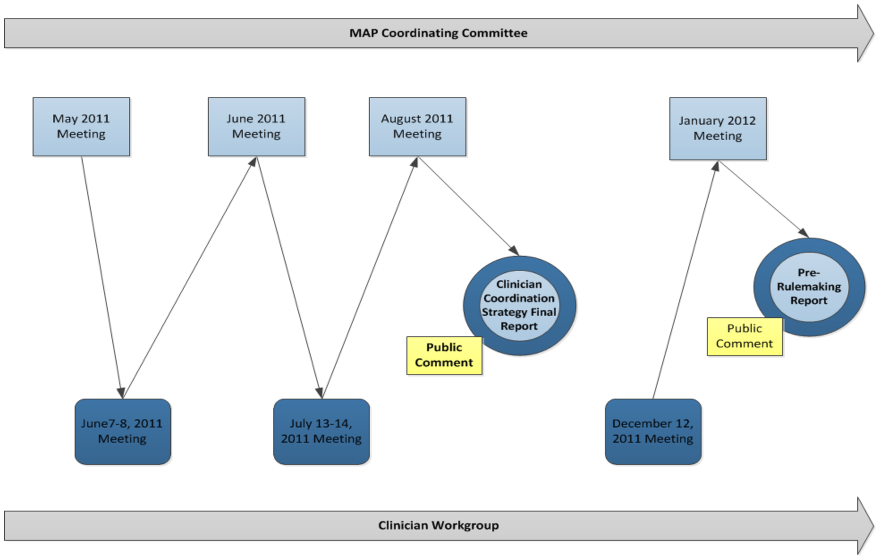
Clinician Workgroup Interaction with MAP Coordinating Committee

NQF
NATIONAL QUALITY FORUM



MAP Coordinating Committee

May 2011 Meeting

June 2011 Meeting

August 2011 Meeting

January 2012 Meeting

Clinician Coordination Strategy Final Report

Public Comment

Pre-Rulemaking Report

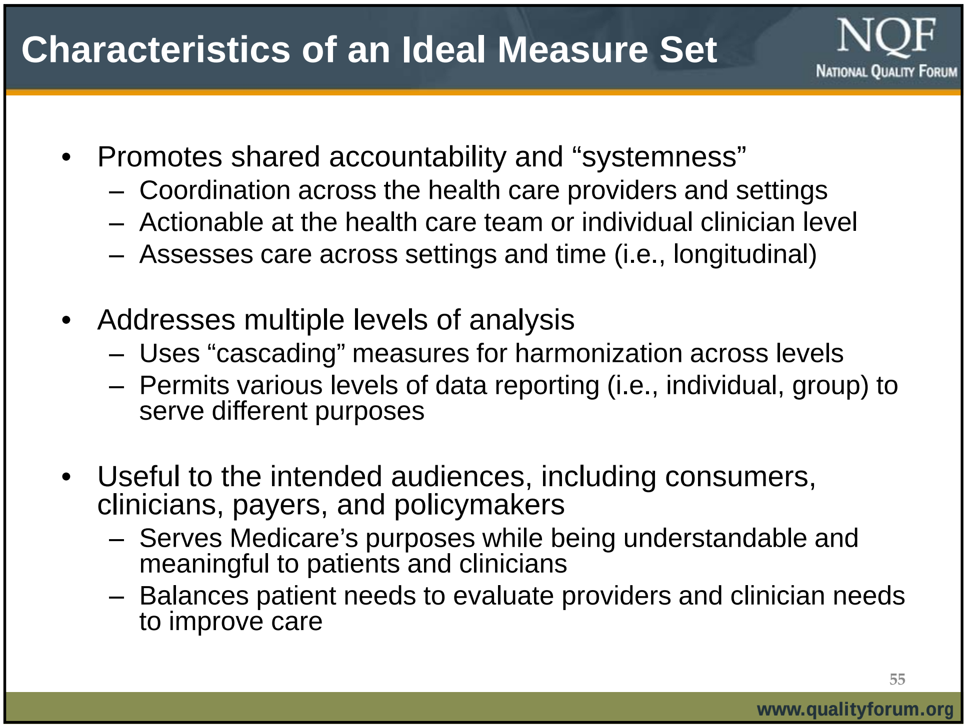
Public Comment

June7-8, 2011 Meeting

July 13-14, 2011 Meeting

December 12, 2011 Meeting

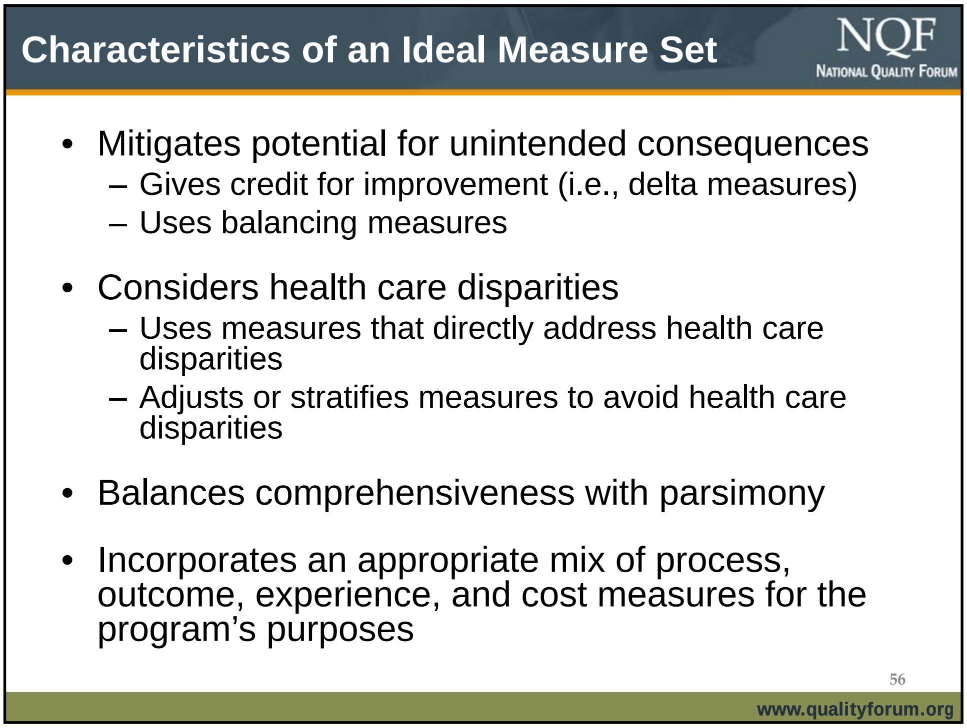
Clinician Workgroup



Characteristics of an Ideal Measure Set

NQF
NATIONAL QUALITY FORUM

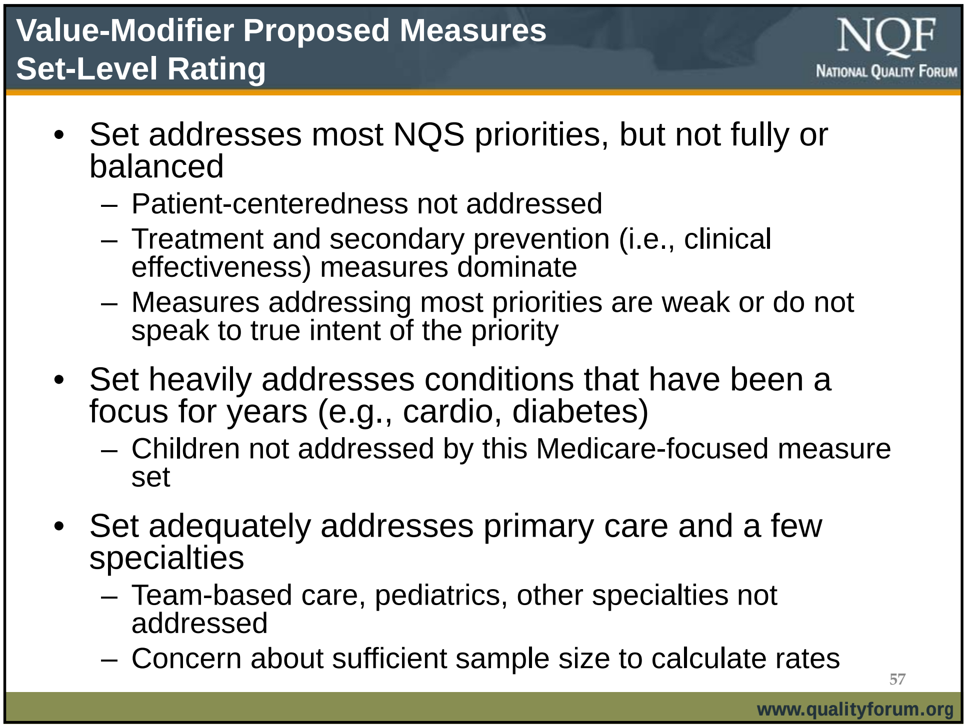
- Promotes shared accountability and “systemness”
  - Coordination across the health care providers and settings
  - Actionable at the health care team or individual clinician level
  - Assesses care across settings and time (i.e., longitudinal)
- Addresses multiple levels of analysis
  - Uses “cascading” measures for harmonization across levels
  - Permits various levels of data reporting (i.e., individual, group) to serve different purposes
- Useful to the intended audiences, including consumers, clinicians, payers, and policymakers
  - Serves Medicare’s purposes while being understandable and meaningful to patients and clinicians
  - Balances patient needs to evaluate providers and clinician needs to improve care



Characteristics of an Ideal Measure Set

NQF
NATIONAL QUALITY FORUM

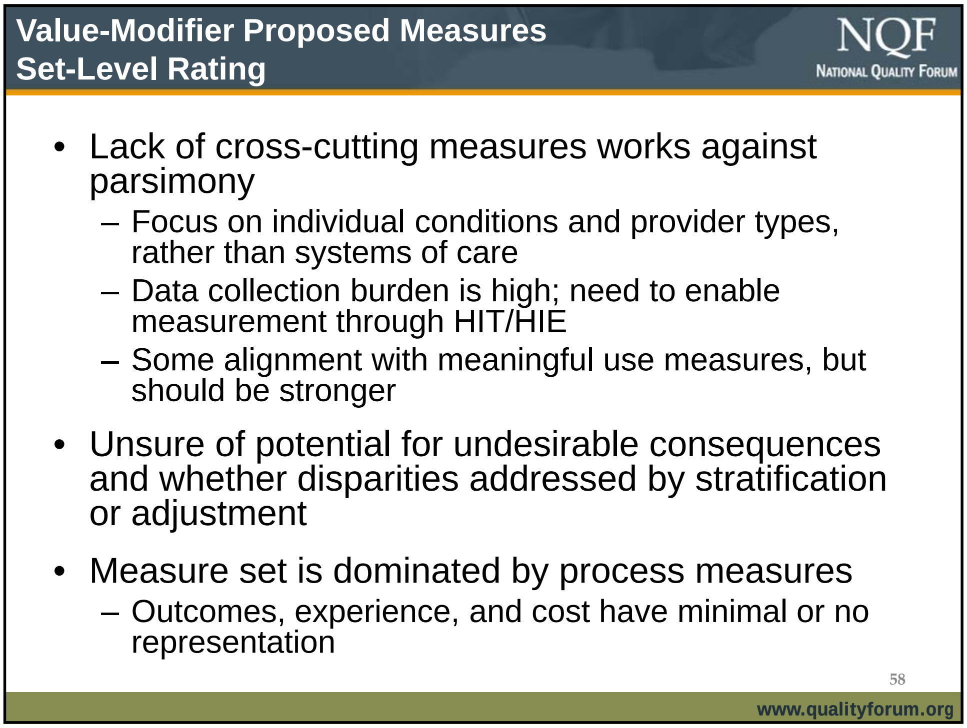
- Mitigates potential for unintended consequences
  - Gives credit for improvement (i.e., delta measures)
  - Uses balancing measures
- Considers health care disparities
  - Uses measures that directly address health care disparities
  - Adjusts or stratifies measures to avoid health care disparities
- Balances comprehensiveness with parsimony
- Incorporates an appropriate mix of process, outcome, experience, and cost measures for the program’s purposes



Value-Modifier Proposed Measures Set-Level Rating

NQF
NATIONAL QUALITY FORUM

- Set addresses most NQS priorities, but not fully or balanced
  - Patient-centeredness not addressed
  - Treatment and secondary prevention (i.e., clinical effectiveness) measures dominate
  - Measures addressing most priorities are weak or do not speak to true intent of the priority
- Set heavily addresses conditions that have been a focus for years (e.g., cardio, diabetes)
  - Children not addressed by this Medicare-focused measure set
- Set adequately addresses primary care and a few specialties
  - Team-based care, pediatrics, other specialties not addressed
  - Concern about sufficient sample size to calculate rates



Value-Modifier Proposed Measures Set-Level Rating

NQF
NATIONAL QUALITY FORUM

- Lack of cross-cutting measures works against parsimony
  - Focus on individual conditions and provider types, rather than systems of care
  - Data collection burden is high; need to enable measurement through HIT/HIE
  - Some alignment with meaningful use measures, but should be stronger
- Unsure of potential for undesirable consequences and whether disparities addressed by stratification or adjustment
- Measure set is dominated by process measures
  - Outcomes, experience, and cost have minimal or no representation

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Majority of respondents agree the MAP set-level measure selection criteria are a good starting place for assessing the adequacy of a measure set for a specific purpose
- Criteria would ideally better ascertain if a set contains the best or right measures to address a given criterion

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Addresses NQS Priorities
  - – Difficult determining how completely addressed
- Addresses high-leverage opportunities
  - – Different from high-leverage for improvement
  - – High-leverage should be defined beyond high-impact conditions
- Appropriate for all intended accountable entities
  - – Addressing all intended accountable entities may not encourage “systemness” or shared accountability

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Promotes parsimony
  - Many variables; generally difficult to assess
  - Requires an understanding of the universe of available measures
- Avoids undesirable consequences
  - Difficult to predict, as all measures have some potential for unintended consequences
  - Rating dependent on programmatic features, such as a plan to monitor

Experience Applying the Set-Level Criteria

NQF
NATIONAL QUALITY FORUM

- Contains a balance of type of measures
  - Equal representation is not necessarily the goal, rather addressing program priorities in parsimonious manner
- Includes considerations for health care disparities
  - Adequacy of adjustment difficult to assess
  - Stratification at individual clinician level may not be possible due to sample size

Data Platform Principles

1. A standardized measurement data collection and transmission process should be implemented across all Federal programs, and ultimately all payers (e.g., HIEs).

2. A library of all data elements needed for all measures (i.e., an inventory of all standardized data elements) should be defined and maintained. The data element library should be broad and deep enough to allow for innovation and flexibility in measurement.

3. The data platform should support patient-centered measurement, by enabling the collection of patient-reported data (both quantitative and qualitative) and the tracking of care across settings and over time.

Data Platform Principles

4. Data collection should occur at the individual clinician level, when analysis is appropriate at that level; data should also enable group level analysis.

5. Data collection should occur during the course of care, when possible, to minimize burden and maximize use in clinical decision making.

6. Processes such as clinician review of data and feedback loops should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications.

7. Timely feedback of measurement results is imperative to support improvement of care by clinicians and more informed decisions by consumers.

Priority Measure Gap Areas

- Patient-reported measures
  - Patient experience
  - Shared-decision making
  - Health risk assessment
  - Patient-reported outcomes (e.g., function, quality of life across the lifespan)
- Outcomes
- Care coordination
  - Across settings
  - Adequacy of community supports
- Assessment of multiple co-morbidities
- Physical and mental disabilities
- Cultural competency, language, health literacy
- Cost, overuse

Questions for the Coordinating Committee

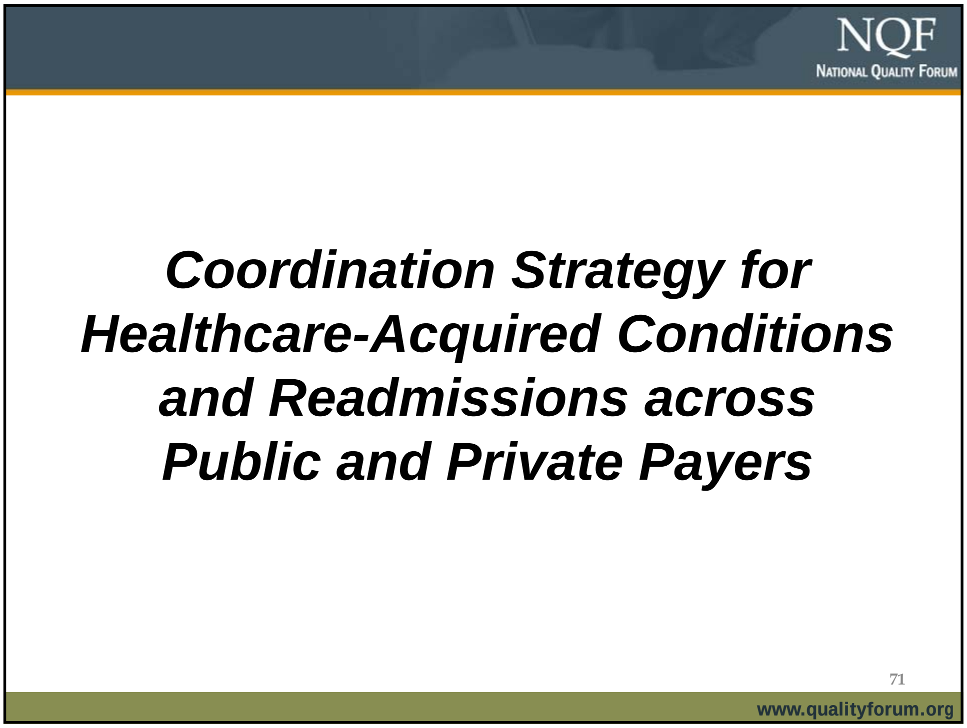
- Additional considerations for the clinician coordination strategy?
  - Characteristics of an ideal measure set?
  - Data platform principles?
  - Measure gap areas?
- Moving beyond identification of gaps?
  - How do we close the gaps?
  - Who are the key stakeholders that can facilitate closing the gaps?
  - Priorities for gap filling?
  - Future work for the MAP?

Discussion and Questions

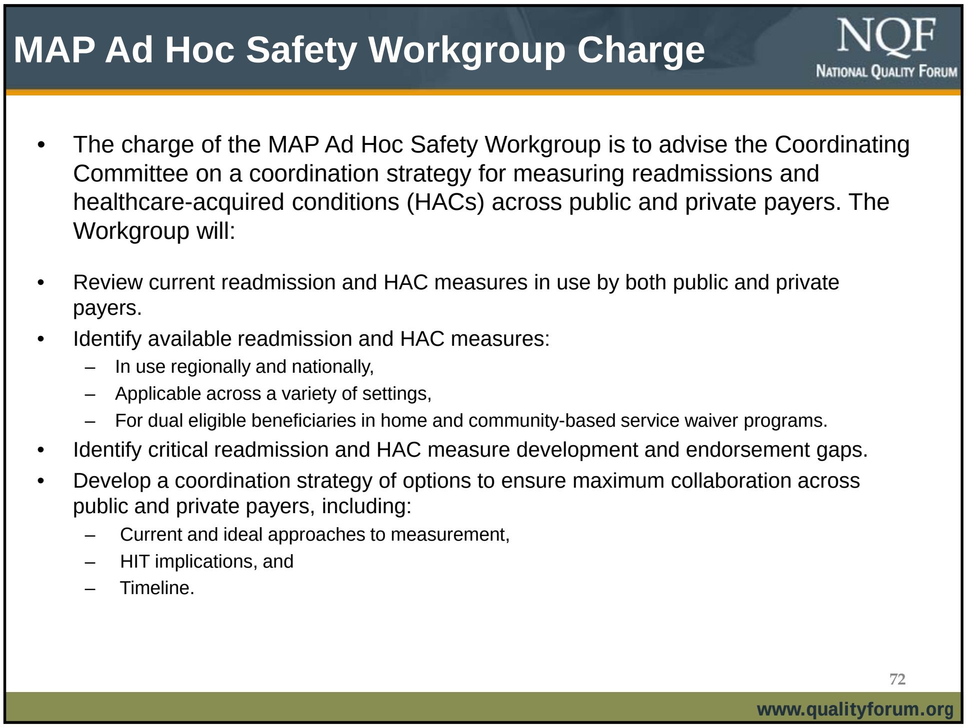
Opportunity for Public Comment

Summary of Day 1 and Look-Forward to Day 2

Welcome and Recap of Day 1



Coordination Strategy for Healthcare-Acquired Conditions and Readmissions across Public and Private Payers



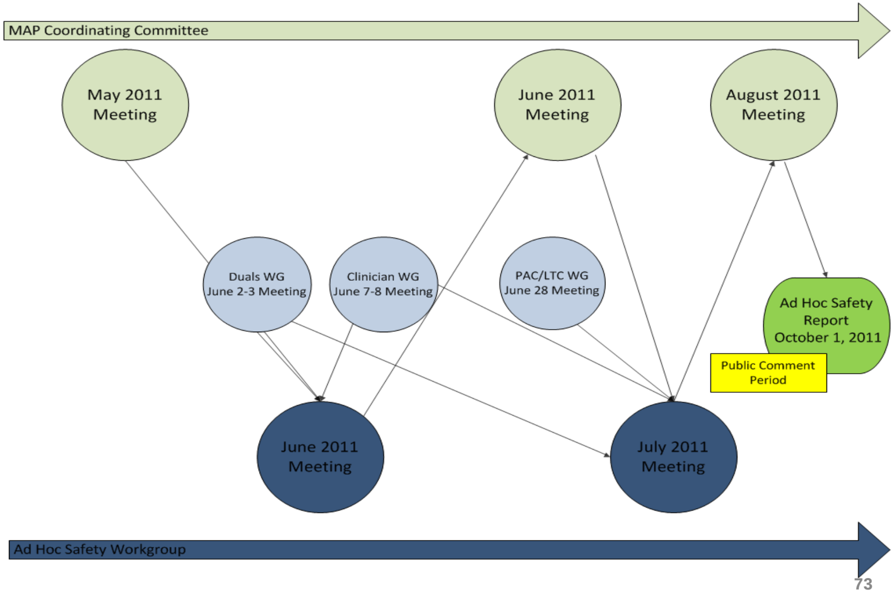
MAP Ad Hoc Safety Workgroup Charge

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

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

MAP Safety Workgroup Interaction with Coordinating Committee

NQF National Quality Forum



MAP Coordinating Committee

May 2011 Meeting

June 2011 Meeting

August 2011 Meeting

Duals WG June 2-3 Meeting

Clinician WG June 7-8 Meeting

PAC/LTC WG June 28 Meeting

Ad Hoc Safety Report October 1, 2011

Public Comment Period

June 2011 Meeting

July 2011 Meeting

Ad Hoc Safety Workgroup

NQF National Quality Forum

Guidance from the Coordinating Committee

Guidance from the Coordinating Committee

NQF
National Quality Forum

- Explore how patients can be activated to further engage in their care plans and to improve safety outcomes
- Encourage purchasers to use their leverage to promote payer alignment of measures and incentives
- Consider mechanisms to obtain multi-stakeholder engagement and commitment to coordination, particularly at the local/community level
- Learn from community and regional efforts to achieve alignment across multi-stakeholder efforts to improve quality and reduce cost
- Look beyond current models of care to drive improvement

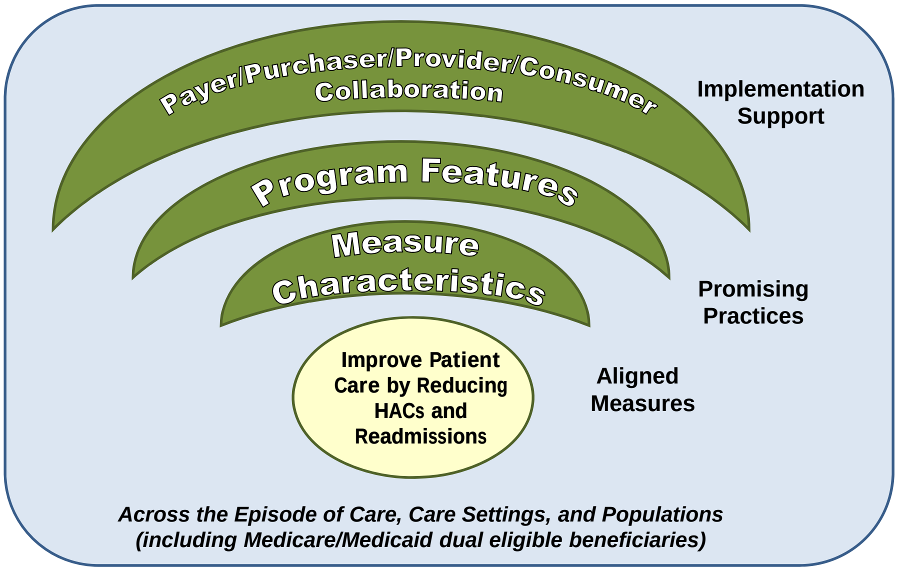
Guidance from the Coordinating Committee

NQF
National Quality Forum

- Ensure overall approach spans the continuum of care, not just hospitals
- Harmonize measures in use by private and public payers
- Use measures that are actionable by providers but also provide meaningful comparisons to patients, purchasers, and payers
- Consider preventable admissions while developing the strategy for readmissions
- Prioritize efficiency and resource use measures, as well as quality measures

Ad Hoc Safety Workgroup Recommendations

Dimensions of Payer Alignment



Payer/Purchaser/Provider/Consumer Collaboration

Implementation Support

Program Features

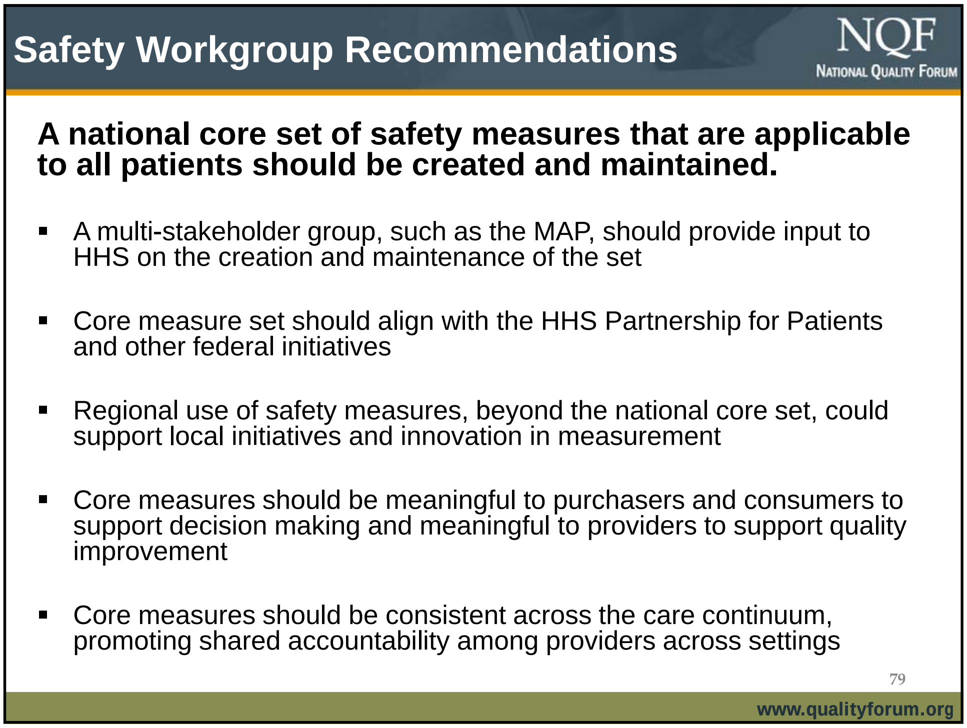
Promising Practices

Measure Characteristics

Aligned Measures

Improve Patient Care by Reducing HACs and Readmissions

Across the Episode of Care, Care Settings, and Populations (including Medicare/Medicaid dual eligible beneficiaries)

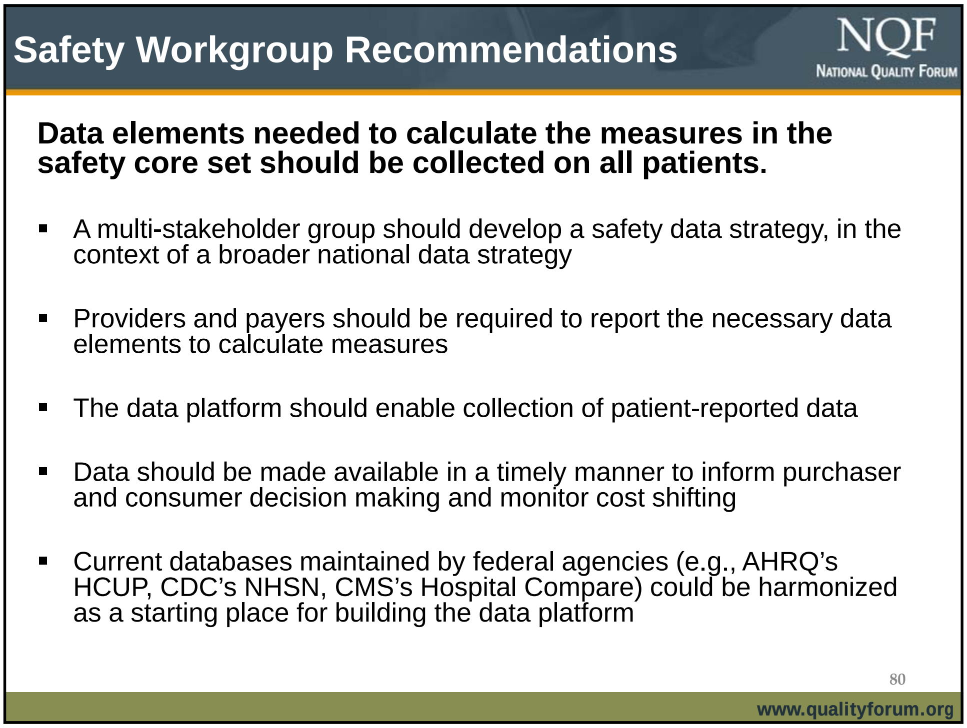


Safety Workgroup Recommendations

NQF
NATIONAL QUALITY FORUM

A national core set of safety measures that are applicable to all patients should be created and maintained.

- A multi-stakeholder group, such as the MAP, should provide input to HHS on the creation and maintenance of the set
- Core measure set should align with the HHS Partnership for Patients and other federal initiatives
- Regional use of safety measures, beyond the national core set, could support local initiatives and innovation in measurement
- Core measures should be meaningful to purchasers and consumers to support decision making and meaningful to providers to support quality improvement
- Core measures should be consistent across the care continuum, promoting shared accountability among providers across settings

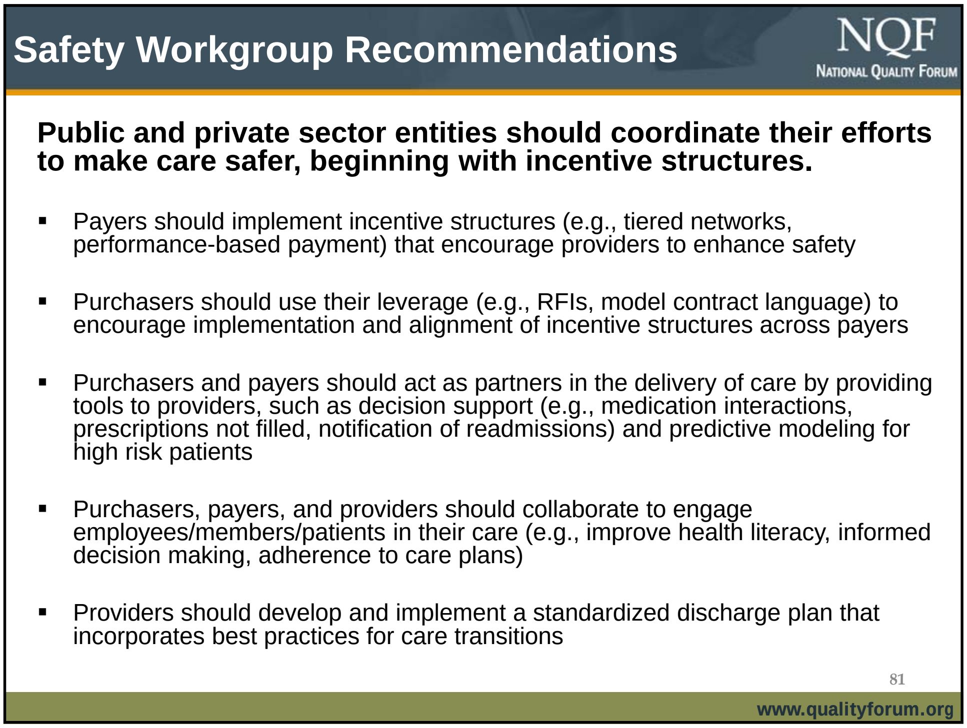


Safety Workgroup Recommendations

NQF
NATIONAL QUALITY FORUM

Data elements needed to calculate the measures in the safety core set should be collected on all patients.

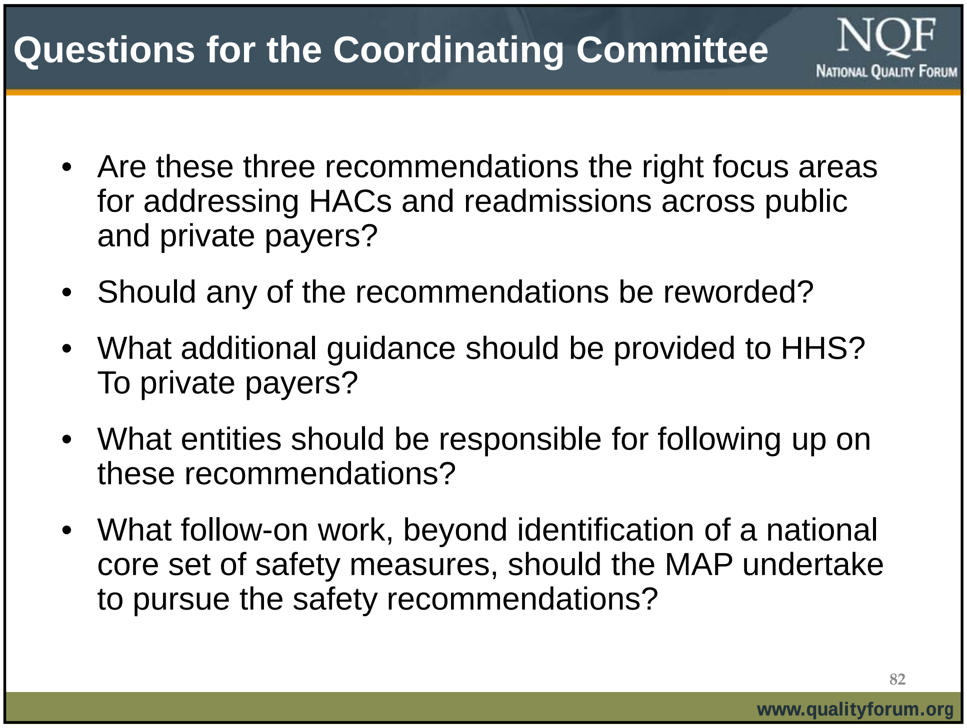
- A multi-stakeholder group should develop a safety data strategy, in the context of a broader national data strategy
- Providers and payers should be required to report the necessary data elements to calculate measures
- The data platform should enable collection of patient-reported data
- Data should be made available in a timely manner to inform purchaser and consumer decision making and monitor cost shifting
- Current databases maintained by federal agencies (e.g., AHRQ’s HCUP, CDC’s NHSN, CMS’s Hospital Compare) could be harmonized as a starting place for building the data platform



Safety Workgroup Recommendations

Public and private sector entities should coordinate their efforts to make care safer, beginning with incentive structures.

- Payers should implement incentive structures (e.g., tiered networks, performance-based payment) that encourage providers to enhance safety
- Purchasers should use their leverage (e.g., RFIs, model contract language) to encourage implementation and alignment of incentive structures across payers
- Purchasers and payers should act as partners in the delivery of care by providing tools to providers, such as decision support (e.g., medication interactions, prescriptions not filled, notification of readmissions) and predictive modeling for high risk patients
- Purchasers, payers, and providers should collaborate to engage employees/members/patients in their care (e.g., improve health literacy, informed decision making, adherence to care plans)
- Providers should develop and implement a standardized discharge plan that incorporates best practices for care transitions



Questions for the Coordinating Committee

- Are these three recommendations the right focus areas for addressing HACs and readmissions across public and private payers?
- Should any of the recommendations be reworded?
- What additional guidance should be provided to HHS? To private payers?
- What entities should be responsible for following up on these recommendations?
- What follow-on work, beyond identification of a national core set of safety measures, should the MAP undertake to pursue the safety recommendations?

Discussion and Questions

Opportunity for Public Comment

Coordination Strategy for Post-Acute Care/Long-Term Performance Measurement

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MAP Post-Acute Care/Long Term Care Workgroup Charge

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The Workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures
  - Identifying critical measure development and endorsement gaps
- Identify measures for quality reporting for hospice programs and facilities
- Provide input on measures to be implemented through the Federal rulemaking process that are applicable to post-acute settings

Coordination Strategy and Performance Measurement in PAC/LTC programs

Task Description	Deliverable	Timeline
Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012

PAC/LTC Workgroup will advise the Coordinating Committee

Considerations for All Workgroups

- How will the MAP ensure alignment of measures across settings, payers, and populations?
- What can each workgroup do to promote shared accountability?
- What are the key data source issues for each workgroup?
- How do we ensure that the MAP maintains a patient-centered approach?
- How do we ensure that measures and measurement strategies support and inform new delivery models, such as health homes and ACOs?
- What can each workgroup contribute to addressing the quality issues affecting dual eligible beneficiaries?

Review of PAC/LTC Workgroup Interim Findings

Elements of a Coordination Strategy

- Measures and measurement issues
  - Measure selection principles
  - Priority areas for measurement
  - Special considerations for dual eligible beneficiaries
  - Identification of measure gaps
- Data sources and HIT implications
- Alignment
- Pathway for improving measure application

Measure Selection Principles

Review of Coordinating Committee Selection Principles and Selection Criteria Strawperson. Measures contributing to a comprehensive set should:

- Address stages of illness, not just a single disease or care received in a single setting
- Assess care across providers, settings, and time to promote care coordination
- Be actionable by/attributable to clinicians, not just setting-specific
- Place strong emphasis on unintended consequences
- Incorporate patient outcomes and goal attainment
- Incorporate structural and process measures, which are necessary to target opportunities for improvement
- Considers cost and cost-shifting

Priority Areas for Measurement

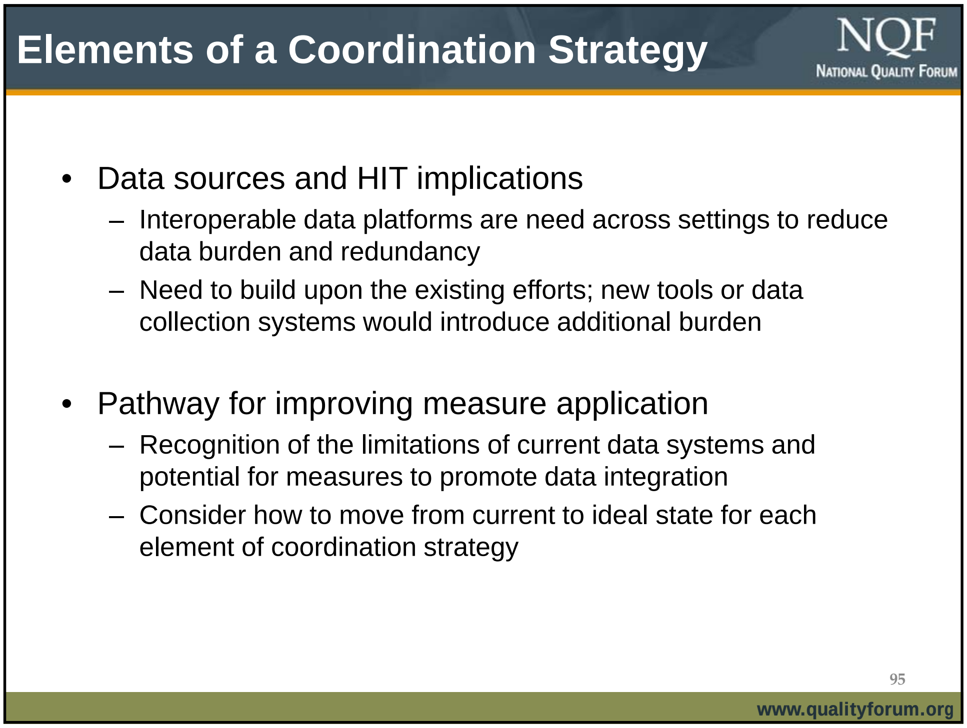
- **Function**
  - Patient factors such as ADLs and stage of illness
  - Helps define population subsets for measurement
- **Goal Attainment**
  - Goals of care may be different across settings (e.g., improvement, maintenance, palliation)
  - Patient and family should be engaged in determining the goals
- **Care coordination**
  - Across settings of care and providers
  - Assessing how the system coordinates care
- **Cost/Access**
  - Total cost and attention to cost-shifting
  - Patients access to additional social supports (e.g., home and community based services)
- *These areas are also critical to the dual-eligible beneficiaries population. Additional considerations for the duals include disparities, risk adjustment, and stratification.*

Identification of Measure Gaps

- Measures for cognitive impairment and mental health
- Measures addressing psychosocial and spiritual aspects of care
- Measures that assess clinician performance within site-delivered care

Alignment Considerations

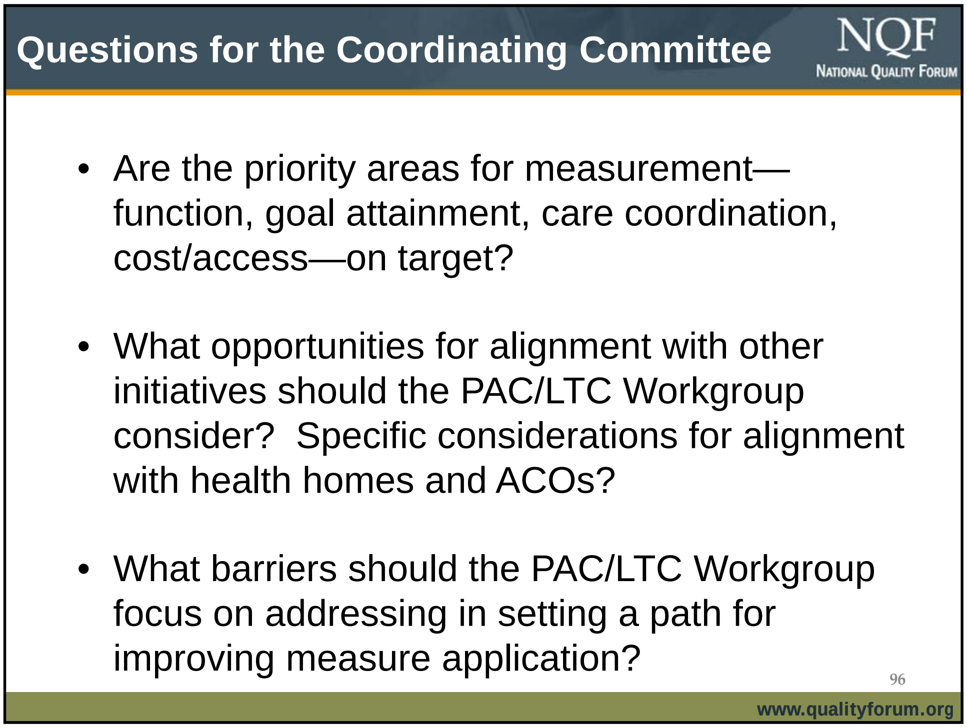
- **Balancing Standardization and Customization**
  - Distinct types of care (e.g., long stay vs. short stay) across post-acute care and long-term care settings
  - Multiple provider types and have varying payment structures (particularly differing requirements between Medicare and Medicaid)
  - Similar measure concepts should be standardized across settings; however, additional measures should address the unique qualities of each setting
- **Multi-level measurement**
  - Current measurement in post-acute care and long-term care settings is site-specific
  - Measurement should also be attributed to clinicians
  - Some areas of measurement should be assessed across both levels, while some areas may be attributed to only one level (e.g., assessing structural aspects at the setting level)



Elements of a Coordination Strategy

- Data sources and HIT implications
  - Interoperable data platforms are need across settings to reduce data burden and redundancy
  - Need to build upon the existing efforts; new tools or data collection systems would introduce additional burden

- Pathway for improving measure application
  - Recognition of the limitations of current data systems and potential for measures to promote data integration
  - Consider how to move from current to ideal state for each element of coordination strategy

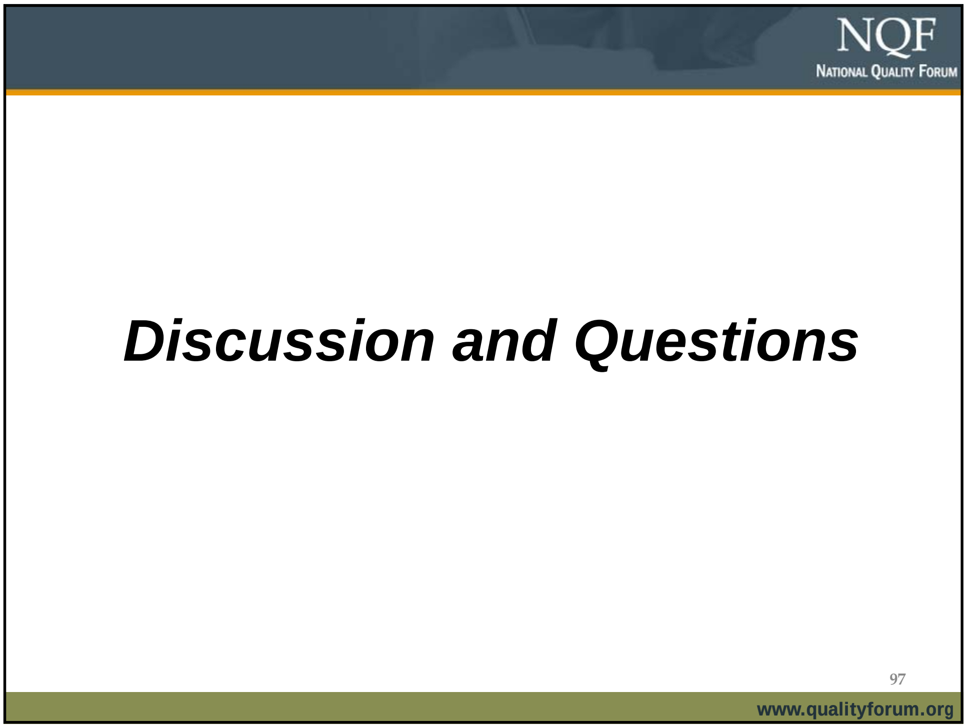


Questions for the Coordinating Committee

- Are the priority areas for measurement—function, goal attainment, care coordination, cost/access—on target?

- What opportunities for alignment with other initiatives should the PAC/LTC Workgroup consider? Specific considerations for alignment with health homes and ACOs?

- What barriers should the PAC/LTC Workgroup focus on addressing in setting a path for improving measure application?



Discussion and Questions

Opportunity for Public Comment

Themes across Workgroup Draft Reports

Summation and Path Forward

Committee Scope of Work and Timeline

NQF
NATIONAL QUALITY FORUM

October 19, 2011
- Convene a web meeting to adopt measure selection criteria.

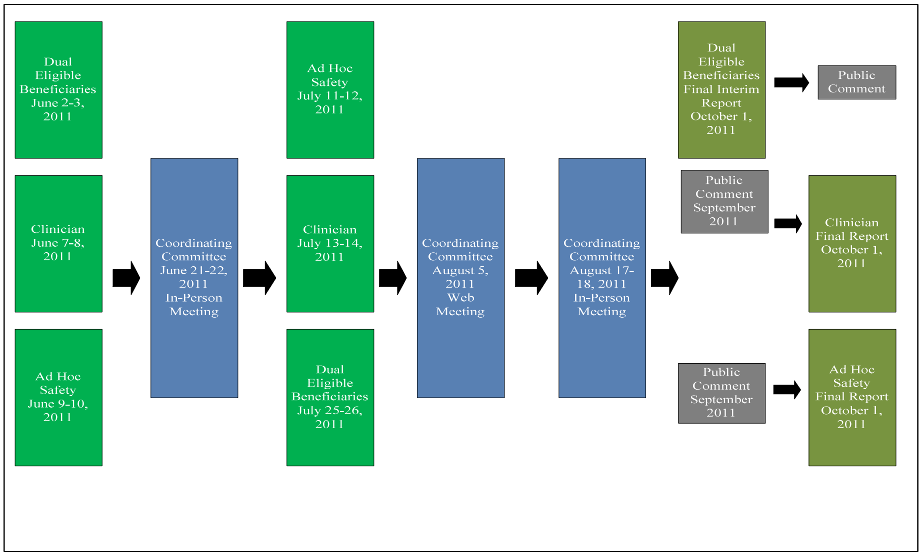
November 1-2, 2011
- Conduct an in-person meeting to review and finalize findings and recommendations from the Post-Acute Care/Long-Term Care Workgroup on a coordination strategy for quality reporting across post-acute care and long-term care settings; prepare for December 2011 pre-rulemaking analysis.

December 8, 2011
- Convene an ALL MAP web meeting to begin pre-rulemaking tasks.

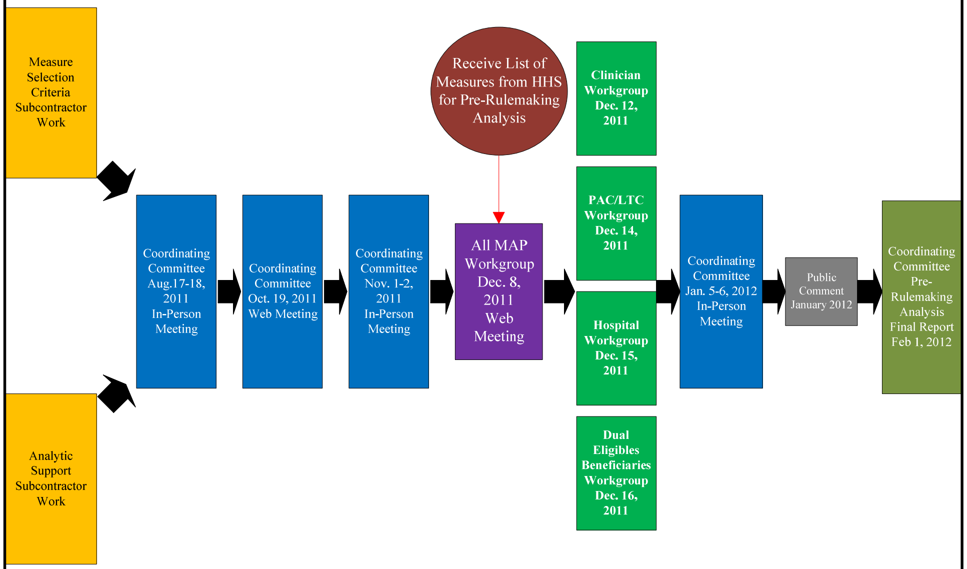
January 5-6, 2012
- Conduct an in-person meeting to finalize recommendation for the pre-rulemaking task.

MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports

NQF
NATIONAL QUALITY FORUM



MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report



Measure Selection Criteria Subcontractor Work

Analytic Support Subcontractor Work

Coordinating Committee Aug.17-18, 2011 In-Person Meeting

Coordinating Committee Oct. 19, 2011 Web Meeting

Coordinating Committee Nov. 1-2, 2011 In-Person Meeting

Receive List of Measures from HHS for Pre-Rulemaking Analysis

All MAP Workgroup Dec. 8, 2011 Web Meeting

Clinician Workgroup Dec. 12, 2011

PAC/LTC Workgroup Dec. 14, 2011

Hospital Workgroup Dec. 15, 2011

Dual Eligibles Beneficiaries Workgroup Dec. 16, 2011

Coordinating Committee Jan. 5-6, 2012 In-Person Meeting

Public Comment January 2012

Coordinating Committee Pre-Rulemaking Analysis Final Report Feb 1, 2012

MAP Meeting Schedule

Coordinating Committee Web Meeting #3:
October 19, 2011 2:00-4:00 pm EST

Coordinating Committee In-Person Meeting #4:
November 1-2, 2011 (Washington, DC)

ALL MAP Meeting #2
December 8, 2011 1:00-3:00 pm EST

Coordinating Committee In-Person Meeting #5
January 5-6, 2012 (Washington, DC)

Measure Selection Criteria

Tab 3

MAP “Working” Measure Selection Criteria

1. **Measures within the set meet NQF endorsement criteria**
Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF-endorsed but meet this threshold are expected to undergo review through the NQF endorsement process.)
Response option:
Yes/No: Measures within the measure set are NQF-endorsed or meet NQF endorsement criteria of being important to measure and report, scientifically acceptable, usable, and feasible

2. **Measure set adequately addresses each of the National Quality Strategy (NQS) priorities**
Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	*Safer care*
Subcriterion 2.2	*Effective care coordination*
Subcriterion 2.3	*Prevention and treatment of leading causes of mortality*
Subcriterion 2.4	*Person and family centered care*
Subcriterion 2.5	*Supporting better health in communities*
Subcriterion 2.6	*Making care more affordable.*

Response option for each subcriterion:
Yes/No: NQS priority is adequately addressed in the measure set

3. **Measure set adequately addresses high-impact conditions relevant to the program’s intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)**
Demonstrated by the measure set addressing Medicare High-Impact conditions; Child Health conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program’s intended population (s). (Reference tables 1 and 2 for Medicare High-Impact conditions and Child Health conditions determined by NQF’s Measure Prioritization Advisory Committee.)
Response option:
Yes/No: Measure set adequately addresses high-impact conditions relevant to the program’s intended population(s)

4. **Measure set promotes the goals of the specific program**
Demonstrated by a measure set that is applicable to the intended provider(s), care setting(s), level(s) of analysis, and population(s) relevant to the program.
Response option:

Subcriterion 4.1	Yes/No: Measure set is applicable to the program’s intended provider(s)
Subcriterion 4.2	Yes/No: Measure set is applicable to the program’s intended care setting(s)
Subcriterion 4.3	Yes/No: Measure set is applicable to the program’s intended level(s) of analysis
Subcriterion 4.4	Yes/No: Measure set is applicable to the program’s population(s)

5. **Measure set includes an appropriate mix of measure types**
Demonstrated by a measure set that includes an appropriate mix of process, outcome, patient experience, and cost/resource use measures necessary to achieve the goals of the program.
Response option:

Subcriterion 5.1	Yes/No: Outcome measures are adequately represented in the set
Subcriterion 5.2	Yes/No: Process measures with a strong link to outcomes are adequately represented in the set
Subcriterion 5.3	Yes/No: Patient experience measures are adequately represented in the set
Subcriterion 5.4	Yes/No: Cost/resource use measures are adequately represented in the set

6. **Measure set enables measurement across the patient-focused episode of care**

Demonstrated by assessment of the patient's trajectory across providers, settings, and time.

Response option:

Subcriterion 6.1	Yes/No: Measures within the set are applicable across relevant providers
Subcriterion 6.2	Yes/No: Measures within the set are applicable across relevant settings
Subcriterion 6.3	Yes/No: Measure set adequately measures patient care across time

7. **Measure set includes considerations for health care disparities**

Response option:

Yes/No: Measure set can address this category by doing one of the following:

- Includes measures that directly address health care disparities (e.g., interpreter services)
- Includes measures that have the ability to be stratified (e.g., by race, ethnicity, SES) at the level of analysis appropriate for the program
- Evidence of disparities-sensitive measures (e.g., beta blocker treatment after a heart attack)

8. **Measure set promotes parsimony**

Demonstrated by a measure set that supports efficient (i.e., minimum number of measures and the least burdensome) use of resources for data collection and reporting to address the National Quality Strategy priorities, high-impact conditions, and intended accountable entities.

Subcriterion 8.1	*National Quality Strategy*
Subcriterion 8.2	*High-impact conditions*
Subcriterion 8.3	*Intended accountable entities.*

Response option for each subcriterion:

Yes/No: Measure set demonstrates efficient (i.e., minimum number of measures and the least burdensome) use of measures

9. **Measure set avoids adverse unintended consequences**

Demonstrated by a measure set in which the measures avoid or have a method for detecting adverse unintended consequences.

Response option:

Yes/No: Set includes measures that detect or monitor adverse unintended consequences (e.g., adverse selection, overtreatment, etc.)

Table 1: National Quality Strategy Priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of developmental delays or behavioral problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression

8. Behavior or conduct problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental delay (diag.)
12. Environmental allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety problems
15. ADD/ADHD
16. Vision problems not corrected by glasses
17. Bone, joint or muscle problems
18. Migraine headaches
19. Food or digestive allergy
20. Hearing problems
21. Stuttering, stammering or other speech problems
22. Brain injury or concussion
23. Epilepsy or seizure disorder
24. Tourette Syndrome

Coordinating Committee Workgroup Reaction Drafts

Tab 4

NQF
NATIONAL QUALITY FORUM

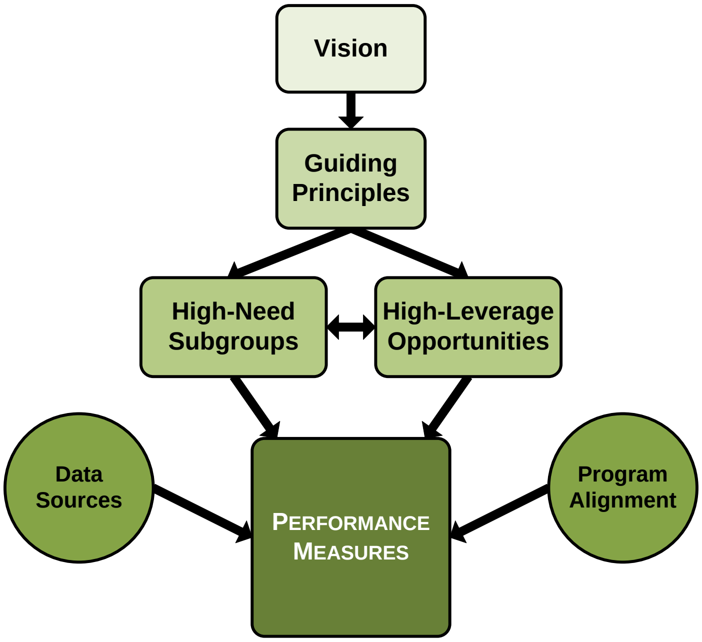
Measure Applications Partnership
Strategic Approach to Quality Measurement for Dual Eligible Beneficiaries
Coordinating Committee Reaction Draft

This work seeks to advance the National Quality Strategy's three-part aim of achieving better care, affordable care, and healthy people and communities for the population of individuals who are eligible for both Medicare and Medicaid. The MAP Dual Eligible Beneficiaries Workgroup has developed a strategic approach to performance measurement for the population comprised of:

- Vision for High-Quality Care
- Guiding Principles
- Identification of High-Need Subgroups
- High-Leverage Opportunities for Improvement through Measurement

The Workgroup also considered issues related to program alignment and data sources as a part of the approach. The strategic approach guides the Workgroup's task of identifying measures that are appropriate for use in assessing the quality of care delivered to dual eligible beneficiaries.

Strategic Approach to Quality Measurement for Dual Eligible Beneficiaries



Vision for High-Quality Care

In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain personal health goals.

To guide the strategic approach to performance measurement, the Workgroup espouses the World Health Organization's definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Guiding Principles

In considering how to achieve the desired vision, the Workgroup established the following principles to guide a measurement framework.

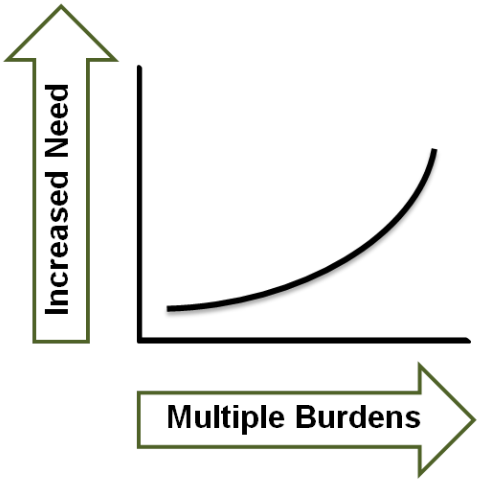
- A person- and family-centered plan of care forms the foundation for the delivery of high-quality care and supports.
    - The care planning process should support shared decisionmaking and assist the person receiving supports to define his/her own health goals, such as maintaining or improving function, palliation, longevity, or a combination of factors.
    - The measurement strategy must incorporate individuals' and families' assessment of the care experience and whether the plan of care was executed in accordance with their preferences.
- The dual eligible population is a byproduct of payment policy, characterized more by its heterogeneity and diversity rather than any inherent similarity.
    - All dual eligible individuals are low-income, but their clinical conditions and social circumstances are highly variable.
    - The group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness.
    - A parsimonious measure set would rely on cross-cutting rather than condition-specific measures in order to be broadly applicable.
- Many shortfalls in the quality of care delivered to this population can be traced back to fragmentation of care delivery and payment between the Medicare and Medicaid programs. Fragmentation also damages ongoing efforts to promote efficient, affordable care.
- Measurement should drive clinical practice and provision of community supports toward desired models of integrated, coordinated care.
    - To be culturally competent, care must be responsive to dimensions of race/ethnicity, age, functional status, language, level of health literacy, and accessibility of the environment for people with disability.
    - The measurement strategy must account for social factors, such as economic insecurity, the capacity of formal and informal caregivers, access to healthful food, appropriate housing, and transportation.
- The measurement strategy should encourage data exchange across providers through portable, interoperable electronic health records; a feedback loop to enable continuous improvement; as well as gathering information from and sharing information with the individual receiving care and his/her caregivers.
- It is necessary to clarify the level of analysis and specific use of a measurement strategy or measure set related to the care experience of dual eligible beneficiaries, because the appropriateness of specific measures are contingent upon their purpose.

  - For high-stakes applications such as payment and public reporting, the measures must be able to discriminate performance and enable accurate comparisons.
  - Risk adjustment and/or stratification may be employed, as appropriate, to mitigate potential unintended consequences (e.g., adverse selection, overuse).
  - Measure sets should contain the minimum number of measures to achieve the intended purpose and should minimize the burden of reporting.

High-Need Subgroups

In considering the performance measurement approach with the largest potential impact, Workgroup members further considered the heterogeneity of the population and the particularly intense needs of some subgroups. Deliberations suggested that there is not an established taxonomy for classifying the population. Rather, combinations of particular risk factors lead to high levels of need in an additive/synergistic manner. These risk factors, which exist in myriad combinations, include attributes of comorbidity, functionality, disability, and vulnerability:

- Limitations in one or more activities of daily living (ADLs) resulting from sensory and/or physical impairments
- Mental health/substance use disorder
- Cognitive impairment
- Intellectual disability/developmental disability
- Heavy disease burden from one condition (e.g., end state renal disease) or multiple chronic conditions
- Pain
- Residential care setting
- Frail elderly
- Recipient of Home and Community-Based Services (HCBS)
- Social factors (e.g., low socioeconomic status, homeless, racial/ethnic minority status, education level, cultural beliefs)



As depicted in the figure above, service needs tend to increase along with the number of risk factors or categories that apply to an individual. The exact mathematical relationship is not known, and would vary by combination of factors, but evidence demonstrates it is not linear.

Link to Affordability of Care

The dual eligible beneficiary population generally, and high-need subgroups specifically, heavily utilize healthcare and support services, incurring a disproportionate share of Medicare and Medicaid expenditures. The opportunity costs such as lost productivity and caregiver burden associated with high-need population subgroups are also significant. Patient complexity and intensity of service needs are related to the major cost drivers of emergency services, hospitalization, and institutionalization. In addition, disability is associated with direct spending on the conditions related to the disability as well as interaction with other conditions and the lower socioeconomic status of people with disabilities across the lifespan. Moreover, individuals with intellectual and developmental disabilities require services and supports throughout their lifetime.

Although specific strategies to deliver high-value care should be tailored to an individual's needs, the Workgroup offered a number of broad suggestions. For example, policies and programs should seek to enhance access to primary care medical homes and team-based care, reduce intensity of services and care settings where appropriate, and mobilize appropriate support resources for individuals who are less able to navigate the system for themselves.

High-Leverage Opportunities for Improvement Through Measurement

Countless opportunities exist to improve the quality of care delivered to dual eligible beneficiaries. In recognition that a measurement strategy should be parsimonious and focused on areas with substantial room for improvement, the Workgroup reached consensus on four domains where measurement could drive significant positive change. Those domains are quality of life, care coordination, screening and assessment, and mental health and substance use. The Workgroup concluded that, wherever possible, selection of measures to fit these areas should drive broad improvements in the delivery of healthcare and community supports by promoting shared accountability, addressing value along with quality, encouraging health information technology (HIT) uptake, and pushing toward longitudinal measurement.

Quality of Life

The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered care plan that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement. For example, in situations where an individual who is near the end of life has stated health-related goals oriented toward palliative care instead of heroic interventions, the measure strategy should accommodate that choice.

Measures in this care domain should focus on outcomes and capture multiple facets of quality of life, such as an individual's ability to have choice, autonomy, social connectedness, and the ability to participate in his/her community. In addition, it is vital to incorporate measures of functional status, particularly if they can be reported by the patient or caregiver and/or evaluated over time. The Workgroup also proposed considering measures related to comfort, pain management, and symptom control. In addition, structural measures can reflect the presence of elements that have the potential to enhance quality of life, such as the availability of HCBS and an individual's ability to self-direct those services.

Care Coordination

Care coordination is a vital feature of high-quality care for dual eligible beneficiaries. Measures in this domain should promote coordination across multiple dimensions, such as across care settings, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid program benefit structures. In order to ensure adequate care coordination, measures should address desired components of medication management, access to an inter-professional care team, advance care planning, and palliative care. A thorough approach to care coordination would also measure patient engagement and relevant factors (e.g., symptom control) in the span between encounters with the health system.

Screening and Assessment

Approaches to screening and assessment should be thorough and tailored to address the complex care needs of the dual eligible beneficiary population. Many measures related to routine clinical preventive screenings, for example, were seen as necessary but not sufficient for this group. The screening and assessment process should go beyond the basics in order to account for factors that particularly affect vulnerable populations such as food insecurity, drug and alcohol use, falls, underlying mental and cognitive conditions, and HIV/AIDS. Measures in this domain should promote assessment of the home environment, availability of family and community supports, caregiver stress, and consideration of whether the individual is receiving care in the most appropriate, least restrictive setting. After screening and assessment is complete, the results should be incorporated into an individual’s care plan.

Mental Health and Substance Use

Mental health conditions such as depression are highly prevalent in the dual eligible population overall. Other serious conditions such as schizophrenia are less common but heavily concentrated in the dual eligible population less than 65 years old. Substance use disorders are also commonplace. Measures in this domain should evaluate all stages of care, including screening, treatment, outcomes, and patient experience. Approaches to both treatment and performance measurement should be grounded in the recovery model.

Illustrative Measures

The table below provides a brief summation of potential strengths and weaknesses of using existing performance measures in the strategic approach to performance measurement. The Workgroup did not attempt to assemble a measure set. Instead, members discussed the characteristics of desired measures, rationale for their use, and how to identify those which would be the most reflective of the unique care experience of dual eligible beneficiaries. Two illustrative measures are provided for each of the four high-leverage measurement domains.

Existing Performance Measures	Measure Type	Strengths	Weaknesses
Quality of Life Measure: Urinary Incontinence Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.	Process	Important issue in the dual eligible population, especially compared to more routine preventive screenings Incontinence is a major driver of institutionalization Promotes longitudinal view across measurement year	Limited by both gender and age Measure does not push provider to change care plan based on results of the assessment, only to document that one was performed Incontinence is an important but narrow aspect of an individual's quality of life Not proximal to outcome
Quality of Life Measure: Change in Daily Activity Function as Measured by the AM-PAC The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified that consists of functional tasks that cover the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	Outcome	Broadly applicable across clinical conditions Functional status is a fundamental aspect of quality of life Oriented to outcomes Data for measure comes from electronic health record (EHR) Promotes longitudinal measurement	Limited to post-acute care patients; many others in dual eligible population would benefit from regular assessment of daily activity function
Care Coordination Measure: 3-Item Care Transition Measure (CTM-3) Uni-dimensional self-reported survey that measures the quality of preparation for a transition in care.	Patient Experience of Care	Captures the beneficiary's perspective Broadly applicable (not condition-specific or age-restricted)	Survey may not be in use as part of current process of care Many individuals may be unable to complete the survey themselves (because of limited English proficiency, cognitive impairment, etc.)

Existing Performance Measures	Measure Type	Strengths	Weaknesses
Care Coordination Measure: Proportion of Patients with a Chronic Condition That Have Potentially Avoidable Complication During a Calendar Year Percentage of adult population aged 18-65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus, Congestive Heart Failure, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disease, or Asthma, were followed for one year, and had one or more potentially avoidable complications.	Outcome	Crosses conditions Applies to all care settings Oriented to outcomes Promotes the provision of safer healthcare Promotes longitudinal view across measurement year	Limited by age Limited to six conditions
Screening and Assessment Measure: Screening for Fall Risk Percentage of patients aged 65 years and older who were screened for fall risk (two or more falls in the past year or any fall with injury in the past year) at least once within 12 months	Process	Not specific to a clinical condition Important risk factor in the dual eligible population, particularly among older adults	Limited by age; others with limitations in mobility may be at risk for a fall Measure does not push provider to change care plan based on results of the assessment, only to document that one was performed
Screening and Assessment Measure: Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	Process	Assessment is paired with an intervention Promotes longitudinal view across the two-year measurement window Not limited by age or other clinical condition	Does not measure the success of the cessation intervention

Existing Performance Measures	Measure Type	Strengths	Weaknesses
Mental Health and Substance Use Measure: Depression Remission at Six Months Adult patients aged 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5.	Outcome	PHQ-9 is a standardized tool completed by the patient Promotes longitudinal view of care and ongoing contact between patient and provider Applies to both patients with newly diagnosed and existing depression Highly prevalent condition Can be gathered from multiple data sources	Risk adjustment may be necessary
Mental Health and Substance Use Measure: Follow-up After Hospitalization for Mental Illness Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	Process	Crosses mental health conditions Promotes follow-up care at a vulnerable time Proposed Medicaid Adult Core measure Can be reported at many levels (clinician, facility, health plan, integrated delivery system, population)	Follow-up conducted by phone would not fulfill the measure requirement Only applicable to portion of dual eligible population with serious mental illness

Data Sources

The limited data generated by existing approaches is inadequate to inform policymakers and other stakeholders about the quality of healthcare and community supports provided to dual eligible beneficiaries. The identification of appropriate measures should be accompanied by a data collection strategy that identifies one or more specific data sources for each measure in order to generate the information required to calculate them.

A data collection strategy should promote electronic data sources and HIT/HIE (health information exchange) adoption in order to reduce the burden of data collection and make information readily available for multiple purposes across the system. Although it would be necessary to precisely define the necessary data elements and the desired structure, current Medicare and Medicaid data collected by the Centers for Medicare & Medicaid Services (CMS) could be harmonized to form the foundation of the data platform. Data integrity, a problem highlighted by the Workgroup, could be improved through systematic review and feedback loops.

Although data source issues will be explored more fully in a later phase of this effort, the Workgroup has identified the following issues in its initial discussion:

- Data elements should include individual characteristics, community/environmental characteristics, clinical characteristics, and health-related experience.
- Administrative claims are a needed data source, particularly for measures that draw on pharmacy data, but would likely need to be accompanied by other information.
- Patient-reported data may be particularly important for this population because it enables assessment of health risks, quality of life, functional status, and patient experience relative to an individual’s plan of care.
- Leveraging HIEs, data warehouses, and aggregation tools to bring together clinical and non-clinical information from multiple data sources (e.g., EHR, claims, beneficiary-reported, Health Resources and Services Administration’s area resource file) could benefit both measurement and practice.
    - When presented to providers with decision support, this information can assist in delivering appropriate care that is responsive to an individual’s social and environmental context.
    - HIEs can also enable sharing a single plan of care between healthcare providers, home- and community-based support providers, and other services.
    - Interoperability and bidirectional flows of information enable better care coordination across providers, making sure that vulnerable individuals do not fall between the cracks
- Clarification of the desired unit of analysis is a precursor to identifying a parsimonious set of measures and establishing a corresponding data collection strategy. It will be important to clearly message the intention and desired use of measures in order to demonstrate value to those reporting the data.
- The Workgroup acknowledges and supports ongoing efforts within CMS to make Medicare and Medicaid data more available and useful to states. Lessons learned from that process should inform the data collection strategy and be applied to additional

challenges, such as the lack of CMS data on dual eligible beneficiaries who are enrolled in managed care plans.

Alignment

A small percentage of dual eligible beneficiaries are served through integrated models of care such as the Program for All-Inclusive Care for the Elderly (PACE), but the vast majority of the population receives care that is fragmented by payer source. Medicare is the primary payer for most acute care services, while Medicaid is the primary payer for most long-term care services. Both Medicare and Medicaid can be delivered through a fee-for-service model or a managed care model. Moreover, some states carve out behavioral health and other services. A single beneficiary may be enrolled in three (or more) health plans with different benefit structures, provider networks, policies, and procedures. This fragmentation is confusing to beneficiaries and providers, inefficient, and makes it impossible for a single entity to be held accountable for delivering high-quality care.

Current Medicare and Medicaid measurement activities include dual eligible beneficiaries, but the population has not been stratified or separately evaluated in a systematic fashion to date. The Medicare program has many ongoing measurement activities, most of which are specific to a provider type or setting of care. National measurement in the Medicaid program is just getting under way. CMS has sought public comment on a list of potential core measures of adult healthcare to be voluntarily reported by state Medicaid programs. The Workgroup recommended that states report measures related to alcohol misuse, hospital readmissions, follow-up after hospitalization for mental illness, management of schizophrenia, and patient experience of care in a manner that would allow for identification of dual eligible beneficiaries.

As a part of a larger policy alignment strategy, uniform performance measurement can help to drive alignment across benefit structures, settings of care, and begin to bridge the divide between the healthcare delivery system and community-based supports and services.
The Workgroup’s strategic approach to performance measurement goes far beyond current Medicare and Medicaid reporting requirements. It will be necessary to balance immediate, short-term, and long-term steps to advancing a comprehensive measurement strategy. For example, asking states to separately report selected Medicaid performance measures for dual eligible beneficiaries can take place in the near term, while other measures would need significantly more time to be developed, tested, and codified.

Next Phase of Work

Following submission of these interim findings, the Workgroup will continue its work related to identifying measures appropriate for use with the dual eligible population. The Workgroup will consider gaps in currently available measures and potential modifications to existing measures, and may propose new measure concepts for further development. A final report with the MAP’s input on improving the quality of care delivered to individuals who are eligible for both Medicare and Medicaid is due to the Department of Health and Human Services on June 1, 2012.

Measure Applications Partnership
Coordination Strategy for Clinician Performance Measurement
Coordinating Committee Reaction Draft

The clinician performance measurement coordination strategy aims to enhance alignment across federal programs with a focus on four key areas:

- Aligning measures and data sources to reduce duplication and burden;
- Characterizing an ideal measure set to promote common goals across programs;
- Defining common data sources and highlighting health information technology (HIT) implications so that data can be collected once and used for multiple purposes; and
- Determining a pathway for improving measure application to meet the needs of all relevant programs.

Alignment

Multiple federal programs involve clinician performance measurement. The differing goals and structures of these programs create alignment issues that can cause undue burden for clinicians and groups participating in multiple programs and confusion for those who use performance improvement information for decision making. The federal programs for clinician performance measurement are briefly described below:

- *The Physician Quality Reporting System* (PQRS) provides incentive payments to eligible professionals who satisfactorily report data on quality measures (selected from among 240 measures) for covered services furnished to Medicare beneficiaries.[i]
- *The Medicare and Medicaid EHR Meaningful Use Incentive Program* (EHR-MU) provides incentive payments to eligible professionals (as well as eligible hospitals) for the “meaningful use” of certified electronic health record (EHR) technology to enhance quality, safety, and effectiveness of care.[ii]
- *The E-Prescribing Incentive Program* (ERx) provides incentive payments to eligible professionals who are successful electronic prescribers.[iii]
- *The Physician Resource Use Measurement and Reporting (RUR) Program*, which will be incorporated into the Physician Feedback/Value-Modifier Program, currently provides confidential feedback reports to physicians and other medical professionals. These reports gauge the resource use and quality of care provided to patients in comparison to the peer groups practicing in the same specialty.[iv]
- *The Physician Compare website* currently serves as a healthcare professional directory, but will be enhanced to provide performance information in the future.

Clinicians who participate in the PQRS, EHR-MU, and ERx incentive programs face measure and data alignment issues that make participation burdensome and confusing. The misalignment of programs induces duplication of efforts and burden which increasingly taxes clinicians’ limited resources and time available for quality measurement. These alignment issues need to be resolved for the current programs and to prepare for the Physician Compare and Value-Modifier programs that will depend on data generated from the current programs. Alignment issues include different data sources (e.g., claims, EHRs) and reporting periods for the same measure resulting in different specifications across programs; separate reporting mechanisms for the same measure (e.g., submission of data for PQRS and submission of rates for EHR-MU); and inconsistency in allowing a group reporting option. Given these alignment issues, a measure that overlaps programs may have up to seven different reporting options that vary by data sources, specifications, and reporting periods.

There is broad recognition that the need for alignment of clinician performance measurement programs extends beyond the federal programs to private sector initiatives. Addressing federal program alignment issues creates opportunities to align broadly with private sector initiatives. For example, PQRS now gives credit for Medical Specialty Board Maintenance of Certification (MOC), and several certification boards have incorporated a PQRS reporting option into their MOC programs. To further the goal of alignment across public and private sector programs, the coordination strategy final report (due October 1, 2011) will consider the measurement and data source recommendations in light of public and private sector initiatives like medical homes and accountable care organizations (ACOs).

Characteristics of an Ideal Measure Set

After reviewing clinician performance measures currently in use and building on measure selection principles developed by the MAP Coordinating Committee, the Workgroup identified the following characteristics of an ideal measure set:

- Measure sets should promote **shared accountability and "systemness."** Patients should receive care in a seamless delivery system in which there is communication and coordination across settings and clinicians are jointly held accountable for patient care. The healthcare team or an individual clinician should be able to influence the result of the measure (i.e., **actionable**), and the measure should assess care across settings and time (i.e., **longitudinal**).
- Measure sets should address multiple **levels of analysis**, using "cascading" measures to harmonize across levels. Clinician performance measurement programs may permit different levels of data reporting (i.e., individual, group) to serve different purposes. Group level analysis promotes shared accountability, while individual level analysis promotes individual accountability.
- Measure sets should be **useful to the intended audiences**, including consumers, clinicians, payers, and policymakers. Measures should serve not only Medicare's purposes, but the results of measures must also be understandable and meaningful to patients and clinicians. Balance should be achieved between patient needs to evaluate providers with clinician needs to improve care.
- Consideration should be given to the potential for **unintended consequences** from measurement. Depending on the type of measure selected, risk adjustment or stratification may be needed to recognize the complexity of certain subpopulations and to avoid incentives for "cherry picking," while not adjusting away disparities. Two measurement approaches can address unintended consequences: giving credit for improvement (i.e., delta measures) and selecting balancing measures (e.g., access measures).
- Measure sets should include considerations for healthcare **disparities** to understand and address the unique needs of vulnerable populations, including the Medicare-Medicaid dual-eligible population. Healthcare disparities can be addressed by either including measures that directly address healthcare disparities or stratifying measures to elicit potential healthcare disparities.
- Measure sets should **balance comprehensiveness with parsimony**, recognizing that few measures will address all of the measure selection principles.
- Measure sets should include **appropriate representation among types of measures—**process, outcome, experience, and cost measures.

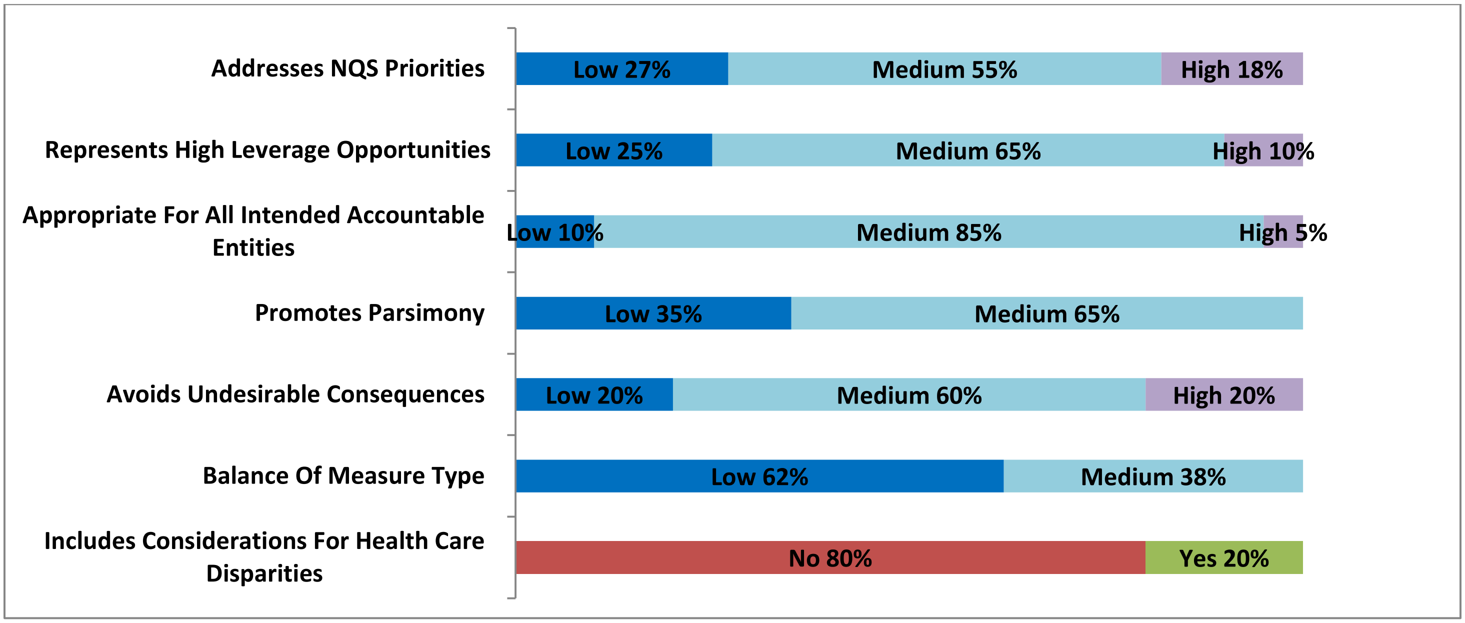
Evaluating the CMS Value-Based Payment Modifier Proposed Measure Set

The Clinician Workgroup evaluated the proposed measure set for the Physician Value-Based Payment Modifier (Value-Modifier), which was published in the 2012 Medicare Physician Fee Schedule Proposed Rule. The Value-Modifier program was selected for review because it applies to both individual and group levels of analysis and because of its significance as the initial set of measures for the value-modifier program, which will be the first performance-based payment program to be applied to all physicians participating in Medicare.

For this exercise, the Clinician Workgroup used the draft set-level measure selection criteria below that were derived from the Coordinating Committee measure selection criteria principles and the Workgroup's characteristics of an ideal measure set:

1. Measure set provides a comprehensive view of quality – assesses the extent to which a measure set **addresses all of the National Quality Strategy (NQS) priorities** (effective communication and care coordination, person- and family-centered care, making quality care more affordable, enable healthy living, make care safer, prevention and treatment of leading causes of mortality)
2. Measure set provides a comprehensive view of quality – assesses the extent to which a measure set **addresses high-leverage opportunities identified for the intended accountable entities**
3. Measure set is appropriate for all intended accountable entities – assesses the extent to which a measure set is **applicable to the intended providers, care settings, and levels of analysis relevant to the program**
4. Measure set promotes parsimony – assesses the extent to which a measure set supports efficient use of resources for data collection, measurement, and reporting through the **smallest number of measures needed** to address the NQS, high leverage opportunities, and all intended accountable entities
5. Measure set avoids undesirable consequences – assesses the extent to which a measure set **avoids undesirable consequences or has a method for detecting** undesirable consequences
6. Measure set has an appropriate representation of measure types – assesses the extent to which a measure set **includes clinical process, outcomes, patient experience, and cost measures**
7. Measure set includes considerations for healthcare disparities – assesses if a measure set **either includes measures that directly address healthcare disparities or includes measures that have been tested for stratification** (by race, ethnicity, socioeconomic status) at the level of analysis appropriate for the program

The extent to which the Workgroup found each criterion in the draft set-level criteria to be met by the proposed Value-Modifier measure set is reflected in the graph below:



The Workgroup members provided the following rationale in support of their responses:

- The Value-Modifier proposed measure set addresses most NQS priorities, but does not necessarily effectively or equitably across priorities. Patient-centeredness is not addressed, while treatment and secondary prevention (i.e., clinical effectiveness) measures dominate.
- The measure set heavily addresses conditions that have been a focus for years, such as cardiovascular conditions and diabetes. Less consideration is given to other high-leverage opportunities for improvement, such as care coordination measures that cut across conditions.
- The measure set is appropriate for individual clinicians and groups of clinicians, though focused on primary care. Team-based care, pediatrics (by design for this Medicare program), and most specialties are not addressed. Some measures may not have sufficient sample size to calculate rates for individual clinicians.
- The lack of measures that cross conditions and specialties works against parsimony for the set. Focus on systems of care beyond specific conditions would help achieve parsimony. The alignment with EHR-MU measures should be stronger.
- Attention to unintended consequences is important, as all measures have the potential for unintended consequences. However, the group found it difficult to assess the measure set for potential unintended consequences and disparities, given the information in the proposed rule.
- The measure set is dominated by process measures. Outcomes, experience, and cost have minimal or no representation, though cost of care measures will ultimately be a part of the Value-Modifier.
- For comprehensiveness, the measure set has gaps in the areas of patient preferences, patient experience, functional status, quality of life, care coordination, mental and behavioral health, and affordability and overuse.

Experience Using Measure Selection Criteria

The Clinician Workgroup members found the set-level measure selection criteria to be a useful qualitative tool to iteratively assess the adequacy of a measure set for a specific purpose, though the criteria would ideally better ascertain if a set contains the best or right measures to address a given criterion. The Clinician Workgroup provided feedback on their experience using each individual criterion:

- Nearly all measures can loosely address some aspect of the NQS priorities, but it is difficult to determine if a measure set addresses the true goals and intent of the NQS priorities.
- High-leverage should be defined beyond high-impact conditions to capture opportunities for improvement that cross conditions.
- Evaluating if a measure set is appropriate for all intended accountable entities was viewed as important by the group. However, simply including measures that are applicable to all intended accountable entities does not necessarily encourage collaboration and coordination across the system.
- Determining if a measure set meets all of the other criteria in a parsimonious manner was challenging for the group to assess. Evaluation of whether the measure set contains the minimum number of measures necessary requires an understanding of the universe of available measures.
- While it is important to consider if a measure set avoids undesirable consequences, it is difficult to predict as all measures have some potential for unintended consequences. Undesirable consequences may best be addressed through programmatic features, such as monitoring and mitigation strategies.
- Representation of process, outcomes, experience, and cost measures is important. However, appropriate use for the specific program, rather than equal representation of measure types, is the goal. For example, a single experience of care measure may be adequate for a measure set.
- Addressing healthcare disparities should be a priority. This criterion is difficult to assess as it depends on adequacy of risk adjustment or use of stratification, which may not be feasible at the individual clinician level due to sample size.

Data Sources and HIT Implications

The Clinician Workgroup discussed the need for the coordination strategy to promote standard electronic data sources and HIT adoption to reduce data collection burden so that clinicians can eventually collect data once and used it for multiple programs and purposes. At the same time, the group recognized that HIT will not immediately or totally relieve the burden of reporting. Accordingly, the Clinician Workgroup adopted the following data platform principles:

1. **A standardized measurement data collection and transmission process should be implemented across all federal programs, and ultimately all payers.** A unified process across all public and private payers would significantly reduce provider burden. Health Information Exchanges are an example of a mechanism that promotes standardization.
2. **A library of all data elements needed for all measures (i.e., an inventory of all standardized data elements) should be defined and maintained. The data element library should be broad and deep enough to allow for innovation and flexibility in measurement.** The data elements collected should include all information needed to calculate measures, including data elements that could support risk adjustment and stratification. As no individual source of data is sufficient for quality measurement, the data elements may be generated from multiple sources of data including, but not limited to claims, pharmacy data, lab or other clinical results, registries, or EHRs.
3. **The data platform should support patient-centered measurement, by enabling the collection of patient-reported data (both quantitative and qualitative) and the tracking of care across settings and over time.** Additionally, use of patient identifiers, along with mechanisms to ensure patient confidentiality, would enable patient-centered measurement across providers, payers, and time.

4. **Data collection should occur at the individual clinician level, when analysis is appropriate at that level; data should also enable group level analysis.** Individual level analysis can help consumers make decisions in selecting clinicians; while group level analysis promotes team accountability.
5. **Data collection should occur during the course of care, when possible.** Data collection burden should be minimized by capturing data as a part of workflow. Data should be available for use in clinical decision making.
6. **Processes such as clinician review of data and feedback loops should be implemented.** Clinician review and feedback can help ensure data integrity and inform continuous improvement of data validity and measure specifications.
7. **Timely feedback of measurement results is imperative to support improvement of care by clinicians and more informed decisions by consumers.** Timeliness standards that minimize the lag time from data collection, to analysis, to reporting should be adopted.

In operationalizing these principles, certain considerations will need to be taken into account:

- The timeline for progressing from the current state to ideal state.
- Incorporating cost data elements into the data element library.
- Privacy, confidentiality, ownership, and access to data.
- Distribution of implementation costs.

Pathway for Improving Measure Application

Considering the extent to which clinician performance measures currently in use address the characteristics of an ideal measure set, the Workgroup members raised priority measure gap areas throughout their deliberations. One of the prominent gap areas is measures that address the patient perspective by incorporating patient-reported data. Patient-reported measures include measures of patient experience, the patient's role in shared decision making about care goals, functional status and quality of life, and assessment of health risk. Another priority gap area is care coordination measures, specifically the coordination of care across multiple settings and providers and the adequacy of community supports. Additional gap areas include measures that support the assessment of multiple comorbidities; physical and mental disabilities; cultural competency, language, and health literacy; and overuse.

It is imperative to address the measure gaps through federal and private support for the development, testing, and endorsement of these measure concepts. The NQS priorities should guide gap-filling priorities. The data platform must support new approaches to measurement, such as patient-reported measures. The impact of measure application should be evaluated for continuous improvement. These steps are captured below in a pathway for improving measure application:

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[i] Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). *Physician Quality Reporting System (PQRS)*. Baltimore, MD: CMS, 2011. Available at http://www.cms.gov/pqrs/01_overview.asp?. Last accessed August 2011.

[ii] CMS. *EHR Meaningful Use Incentive Program*. Baltimore, MD: CMS, 2011. Available at https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage. Last accessed August 2011.

[iii] CMS. *E-Prescribing Incentive Program (ERx)*. Baltimore, MD: CMS, 2011. Available at http://www.cms.gov/ERXincentive/. Last accessed August 2011.

[iv] CMS. *Physician Feedback Value-Based Modifier Program*. Baltimore, MD: CMS, 2011. Available at http://www.cms.gov/PhysicianFeedbackProgram/. Last accessed August 2011.

NQF
NATIONAL QUALITY FORUM

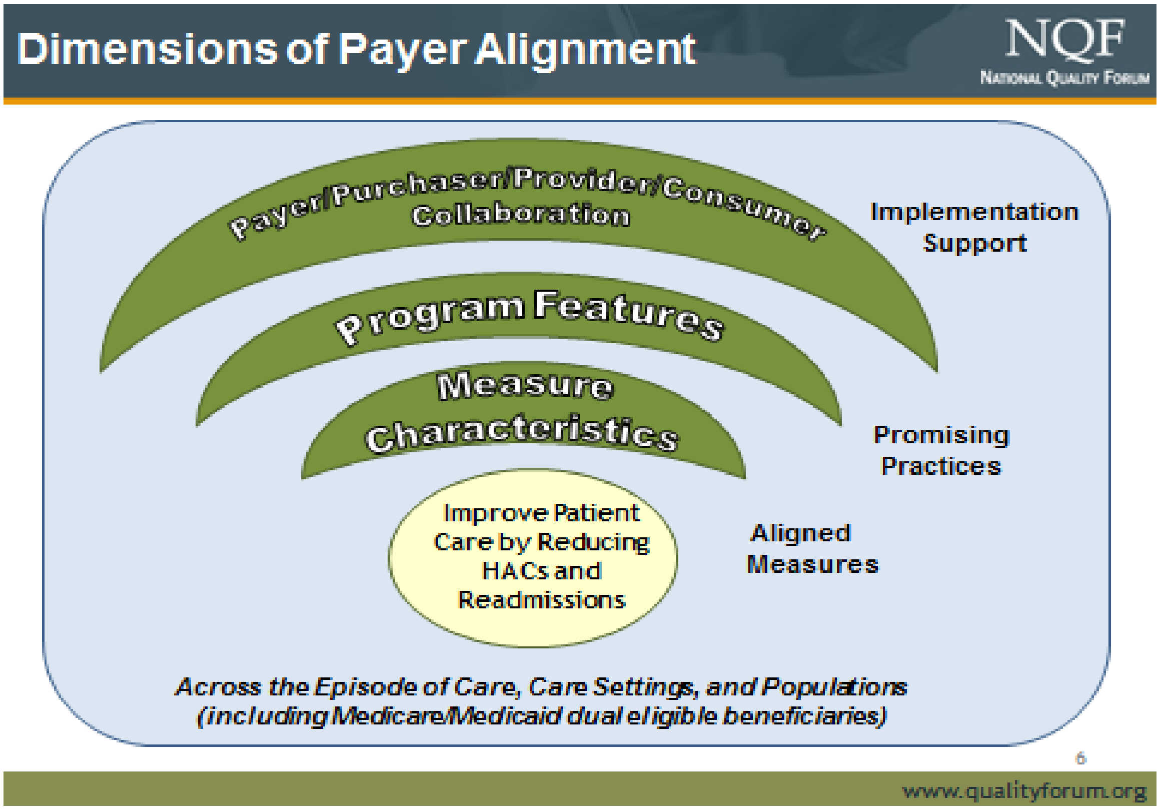
Measure Applications Partnership
Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers
Coordinating Committee Reaction Draft

Background

The charge of the Measure Applications Partnership (MAP) Ad Hoc Safety Workgroup is to advise the MAP Coordinating Committee on a coordination strategy for addressing readmissions and healthcare-acquired conditions (HACs) across public and private payers. The Workgroup charge is not to recommend selection of specific measures; rather, the charge is to identify opportunities for alignment across public and private payers to reduce these events.

The Safety Workgroup is comprised of members of the MAP Hospital Workgroup at its core as well as additional payers and purchasers from the Coordinating Committee and the three other workgroups: Clinician, Post-Acute Care/Long-Term Care, and Dual Eligible Beneficiaries.

Consistent with all MAP work, the Ad Hoc Safety Workgroup was guided by the National Quality Strategy. The Workgroup also focused attention on the HHS Partnership for Patients national safety initiative. A conceptual model (below) depicting the dimensions of payer alignment was developed to assist the Workgroup in their deliberations.



Dimensions of Payer Alignment

NQF
National Quality Forum

Payer/Purchaser/Provider/Consumer Collaboration

Implementation Support

Program Features

Promising Practices

Measure Characteristics

Aligned Measures

Improve Patient Care by Reducing HACs and Readmissions

Across the Episode of Care, Care Settings, and Populations (including Medicare/Medicaid dual eligible beneficiaries)

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This model evolved over the course of the work, as the Workgroup honed in on specific aspects of both the ultimate aim (improve patient care by reducing HACs and readmissions) and the specific means to reach it— aligning measures, finding promising practices among both the public and private sectors, and aligning all of the key stakeholders in collaboration, recognizing that each plays a significant role in improving patient care.

Due in part to the unique make-up and charge of the MAP Ad Hoc Safety Workgroup, it has worked closely with the other workgroups and the Coordinating Committee to provide and receive input. The recommendations that follow take into consideration the input of all three of the other workgroups. The Safety Workgroup also completed a survey exercise in follow up to their July in-person meeting, in which the overall recommendations for coordination among public and private efforts to reduce healthcare-acquired conditions and readmissions were refined and affirmed.

Recommendations to the Coordinating Committee

The MAP Safety Workgroup identified three focus areas for aligning public and private efforts to reduce healthcare-acquired conditions and readmissions: measures, data, and specific coordination strategies.

Recommendation #1: A national core set of safety measures that are applicable to all patients should be created and maintained.

As the Safety Workgroup discussed the coordination of public and private payer strategies to reduce healthcare-acquired conditions and readmissions, the need for all-patient, all-payer measurement to ensure consistency, allow comparison, and reduce the burden on providers was identified. Current misaligned measurement efforts confuse consumer and purchaser decisionmaking and fail to drive substantial quality improvement because they frequently give variable results and only provide partial information. Furthermore, inconsistency across public and private payer safety programs increases provider burden of reporting and diverts resources from their improvement efforts. To address this need, the Workgroup recommended the development of a national core set of safety measures that are applicable to all patients. The Workgroup strongly agreed that this core measure set should cross the lifespan regardless of payer, to include pediatric, neonatal, obstetrical, and behavioral healthcare.

Alignment with federal initiatives was recognized as a key feature of the safety measure set. The set should reflect the National Quality Strategy and firmly support the national priorities and goals. The Workgroup agreed with aligning the measure set with the Partnership for Patients and other federal programs, but recommended that the set not be limited by those initiatives. It is also important to look beyond federal initiatives to align with private sector approaches. The Workgroup felt the core safety measure set should be identified in partnership with CMS, but stressed that the measure set needs to be applicable to all patients, not just patients eligible for Medicare.

One of the highest priorities for the national safety measure set is the measures should be simple and meaningful to purchasers and consumers to support decisionmaking, as well as useful to providers to support quality improvement. The core measure set must include measures that provide clear and understandable information so that purchasers and consumers can make informed decisions about their healthcare. Additionally, the measure set needs to include measures with information that providers can use to make necessary changes to clinical practice to improve patient safety.

Toward the goal of a unified safety measure set, the core measures should be consistent across the care continuum, promoting shared accountability among providers across settings. Creating a healthcare system that supports shared accountability is essential to improving patient outcomes and reducing HACs and readmissions. Only when providers are using consistent measures, regardless of setting, will progress be made toward this end. Along with the strong support for consistent safety measures across settings, the Workgroup recognized that the measures should support adequate access to care and not exacerbate disparities in care.

The Workgroup members recognized that a national core set would allow for standardization and comparison, but need not hamper successful work already being done at the regional level. Use of measures in addition to those in the core safety measure set can support ongoing local initiatives as well as innovation in measurement. The Workgroup cautioned that, in such cases, the use of additional measures should not increase the data collection and reporting burden significantly, and proposed that these measures should address specific issues not included in the core set to prevent additional burden or confusion.

Since the creation of a national core safety measure set would have a broad impact, the Workgroup agreed that a multi-stakeholder group, such as the MAP, should provide input to HHS on the creation and maintenance of the set. Input from a multi-stakeholder group to HHS on the selection of the measure set would ensure that the perspectives of all involved parties are considered and would create greater buy-in from all stakeholders. The multi-stakeholder group must be balanced and represent at least payers, consumers, purchasers, and providers. Individuals with specific expertise in measurement and quality improvement should also be included as members of this group.

Recommendation #2: Data elements needed to calculate the measures in the safety core set should be collected on all patients.

After a national core set of safety measures is defined, data will be needed to calculate the measures for all patients in the most efficient manner possible. The Workgroup agreed that a national safety data strategy is essential for coordination of quality measurement and improvement efforts related to HACs and readmissions. The data strategy would be anchored on a unified data platform for collection of standardized quality data of all types, including safety data. To create access to data, the Workgroup agreed that providers and payers have a responsibility to report the necessary data elements so that measures can be calculated. However, the Safety Workgroup strongly cautioned that this process needs to be simple and consistent, and should not create additional administrative burden. Ultimately, the data strategy should reduce reporting burden.

As a starting place for the data platform, the Workgroup recommended that the reporting processes for current databases maintained by federal agencies (e.g. Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project, Centers for Disease Control and Prevention's National Healthcare Safety Network, Centers for Medicare & Medicaid Services' Hospital Compare) could be harmonized. This would reduce reporting burden as well as begin a robust and standardized data platform. Another key recommendation was that the data platform should enable collection of patient-reported information.

The Workgroup agreed it is critical that safety information be made available to purchasers and consumers in a timely manner to inform decisionmaking for provider selection. Information about healthcare-acquired conditions and readmission supports purchaser contracting decisions and consumers' decisions about where to seek care. Availability of information can also assist in monitoring whether changing payment or delivery models are achieving their goals or exacerbating problems such as cost-shifting.

The overarching theme of transparency was prominent throughout the meetings of the Safety Workgroup. While different stakeholders expressed unique needs with regard to uses of data—providers need data for quality improvement, purchasers need data to make decisions about value, consumers need data to select providers— all would benefit from a national data strategy, a data platform, and access to safety performance measure information across all patients, regardless of payer.

Recommendation #3: Public and private sector entities should coordinate their efforts to make care safer, beginning with incentive structures.

The Safety Workgroup agreed that in order to achieve significant improvement in patient safety, the public and private sectors need to coordinate their safety efforts. As noted above, this includes agreement on a national core set of safety measures and a standardized approach for capturing and reporting patient safety performance. Beyond these two recommendations, the Workgroup further recommends that patient safety information be leveraged to support coordinated incentive structures and other uses.

There was agreement among the members of the Workgroup that both public and private payers should implement incentive structures that encourage providers to improve patient safety, such as performance-based payment and tiered networks. It is important to establish consistency in the use of incentives while allowing enough space for innovation and new model development. The use of incentive structures needs to account for the unique role of safety net providers in serving vulnerable populations, so as not to penalize unfairly these organizations and the individuals they serve.

The roles of the other stakeholder groups, beyond public and private payers, were heavily emphasized for the coordination of efforts toward improving patient safety. Consistent and sustained reductions in HACs and readmissions will not occur unless purchasers, consumers, communities, and providers actively support new approaches to healthcare delivery. Purchasers have a strong role in this effort by leveraging their purchasing power to encourage implementation and alignment of incentive structures across payers. This can be done through standardized requests for information and contract language that signal to payers the need for improved patient safety across healthcare settings.

Additionally, both purchasers and payers should consider expanding their roles to become more active partners in the delivery of care. Though providers and patients remain primary in determining what care is provided and how, payers are well positioned to offer additional tools to providers. These include notifications regarding readmissions, as well as direct enrollee outreach concerning potential medication interactions, prescriptions not being filled, and participation in disease management programs. Payers can also share predictive modeling information with providers that identifies high risk patients. Beyond the traditional role of providers as the source for all patient education, purchasers, payers, and communities can collaborate with providers to engage employees/members/patients in their care by improving health literacy, informed decisionmaking, and adherence to care plans. Providing resources to patients from multiple avenues will help ensure that patients fully understand the role that they should play in maintaining their health and determining their healthcare needs.

A specific tactic identified by the Workgroup for improving patient safety, particularly as it relates to reductions in readmissions, was to develop and implement a standardized discharge plan that incorporates best practices for care transitions. There is value for patients and providers in having standardized elements on all discharge forms across care settings. In this way, the discharge paperwork can also support continuation of the care plan established in the prior setting of care. It is important to note that the Workgroup did not believe that the discharge plan had to be in a standard format across the nation, but that it should include a specific set of core components. This would support the consistency desired for transitions between settings, while also allowing for customization to account for unique differences among populations.