NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership

Post-Acute Care/Long-Term Care Workgroup In-Person Meeting Agenda

December 10, 2013

National Quality Forum Conference Center

1030 15th Street NW, 9th Floor, Washington, DC 20005

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com.
- Under "Enter a Meeting" type in the meeting number: **628272.**
- In the "Display Name" field, type in your first and last names and click "Enter Meeting."

Teleconference

- Dial (888) 802-7237 for workgroup members or (877) 303-9138 for public participants; use conference ID code: **98490814** to access the audio platform.

Meeting Objectives:

- Review and provide input on currently finalized program measure sets for federal programs applicable to PAC/LTC settings
- Review and provide input on measures under consideration for federal programs applicable to PAC/LTC settings
- Identify high-priority measure gaps for each program measure set
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

8:30 am	**Breakfast**
9:00 am	**Welcome, Review Meeting Objectives, and Pre-Rulemaking Approach** *Carol Raphael, Workgroup Chair* *Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF*
9:20 am	**Pre-Rulemaking Input on Inpatient Rehabilitation Facility Quality Reporting Program Measure Set**

- Provide recommendations on measures under consideration and finalized measures
- Identify high priority areas for measurement

10:00 am **Pre-Rulemaking Input on Long-Term Care Hospital Quality Reporting Program Measure Set**

- Provide recommendations on measures under consideration and finalized measures
- Identify high priority areas for measurement

10:20 am **Pre-Rulemaking Input on End Stage Renal Disease Quality Incentive Program Measure Set**
Robyn Nishimi and Kathleen Lester, Kidney Care Partners
Reactors:
Andrew Narva, National Institutes of Health
Constance Anderson, Northwest Kidney Centers
Joseph Vassalotti, National Kidney Foundation

- Provide recommendations on measures under consideration and finalized measures
- Identify high priority areas for measurement

11:45 am **Opportunity for Public Comment**

12:00 pm **Lunch**

12:45 pm **Input on Alignment Issues across PAC/LTC Programs**

12:45-1:00 pm Continuity Assessment Record and Evaluation (CARE) tool Demonstration and Implications for Use across PAC/LTC Programs
Tara McMullen and Stella Mandl, CMS

1:00-1:30 pm Gaps in Assessing Cost across PAC/LTC Settings

1:30-2:00 pm Admission/readmission measures for use in PAC/LTC settings
Joel Andress, CMS

2:00 pm **Pre-Rulemaking Input on Home Health Quality Reporting Program Measure Set**

- Provide recommendations on measures under consideration and finalized measures
- Identify high priority areas for measurement

2:30 pm **Pre-Rulemaking Input on Hospice Quality Reporting Program and Palliative Care Measures for Hospital Quality Measurement Programs**
Reactor:
Sean Morrison, Subject Matter Expert, palliative Care; member of MAP Hospital Workgroup

- Identify high priority areas for measurement
- Update on CMS Hospice Experience of Care Survey
- Recommendations across settings

3:00 pm **Pre-Rulemaking Input on Nursing Home Quality Initiative Program**
Alex LaBerge, CMS

- Nursing Home Value-Based Purchasing demonstration and implementation plans
- Identify high priority areas for measurement and provide input on future direction of the program

3:30 pm **Opportunity for Public Comment**

3:45 pm **Summary of Day**

4:00 pm **Adjourn**

NATIONAL QUALITY FORUM

Post-Acute Care/Long-Term Care Workgroup
Pre-Rulemaking Meeting Discussion Guide

Meeting Objectives:

- Review and provide input on currently finalized program measure sets for federal programs applicable to PAC/LTC settings
- Review and provide input on measures under consideration for federal programs applicable to PAC/LTC settings
- Identify high-priority measure gaps for each program measure set
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

Time	Issue/Question	Considerations
9:00am	**Welcome, Review Meeting Objectives, and Pre-Rulemaking Approach**	
9:20am	**Pre-Rulemaking Input on Inpatient Rehabilitation Facility Quality Reporting Program Measure Set (Tab #1)**	
	1. Review program summary and currently finalized program measure set	The finalized set includes 5 measures: • 4 out of 5 measures in the program measure set are NQF-endorsed. • The measure set addresses the NQS aim of better care and the NQS priority of patient safety. The priorities of patient and family engagement, community and population health, and making care more affordable are not addressed. • The measure set addresses 3 MAP PAC/LTC core measure concepts: infection rates, pressure ulcers, and avoidable admissions. The set does not address other core measure concepts relevant to this setting. • The measure set includes outcome and process measures. The set lacks structure and cost measures. • The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences. • None of the measures is disparities-sensitive or addresses cultural competency.

Time	Issue/Question	Considerations
		• 4 measures in the set are used in other federal programs. 1 measure is used in private programs. 2 measures are in 1-2 MAP families of measures.
	2. One measure under consideration is NQF-endorsed and addresses the MAP PAC/LTC core measure concept of falls	• NQF #0674 Percent of Residents Experiencing One or More Falls with Major Injury (Row #2) o Included in MAP duals and safety family of measures o Endorsed for Nursing Home/Skilled Nursing Facility; not endorsed for Inpatient Rehabilitation Facility o Use in federal programs: ▪ Currently finalized in Long-term Care Hospital Quality Reporting Program and Nursing Home Quality Initiative and Nursing Home Compare
	3. Two measures under consideration are NQF- endorsed and address the MAP PAC/LTC core measure concept of infection rates	• NQF #1716 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (Row #3) o Included in MAP safety family of measures o Endorsed for multiple setting including Inpatient Rehabilitation Facility o Use in federal programs: ▪ Currently finalized in Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, and Long-Term Care Hospital Quality Reporting o Use in private programs: ▪ AmeriHealth Mercy Family of Companies; Wellpoint • NQF #1717 National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (Row #4) o Included in MAP safety family of measures o Endorsed for multiple setting including Inpatient Rehabilitation Facility o Use in federal programs: ▪ Currently finalized in Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, and Long-Term Care Hospital Quality Reporting

Time	Issue/Question	Considerations
		○ Use in private programs: ▪ AmeriHealth Mercy Family of Companies; Wellpoint
	4. One measure under consideration is NQF-endorsed and addresses the MAP PAC/LTC core measure concept of experience with care	• NQF #0676 Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) (Row #5) ○ Endorsed for use in skilled nursing facilities; not endorsed for Inpatient Rehabilitation Facility ○ Patient-reported outcome measure ○ Use in federal programs: ▪ Currently finalized in Nursing Home Quality Initiative and Nursing Home Compare
	5. Four measures under consideration are not NQF-endorsed and address the MAP PAC/LTC core measure concept of functional and cognitive status assessment	These measures are intermediate outcome measures; being tested; data will be collected through IRF-PAI. • Functional Outcome Measure: Change in Mobility Score (Row #6) ○ Estimates the risk-adjusted mean change in mobility function between admission and discharge ○ MAP had previously supported the direction of this measure noting that it addresses a core measure concept but is still under development and needs to be tested • Functional Outcome Measure: Change in Self-Care Score (Row #7) ○ Estimates the risk-adjusted mean change in self-care function between admission and discharge ○ MAP has previously supported the direction of this measure noting that it addresses a core measure concept but is still under development and needs to be tested • Functional Outcome Measure: Discharge Mobility Score (Row #8) ○ The percent of patients who meet or exceed an expected discharge mobility score • Functional Outcome Measure: Discharge Self-Care Score (Row #9) ○ The percent of patients who meet or exceed an expected discharge self-care score
	6. Identify priority measure gaps	• MAP had previously noted that the measure set could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and the safety

Time	Issue/Question	Considerations
		issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and *C. difficile*. • Additional core concepts missing from the set are: o Advanced care planning and treatment o Adverse drug events o Establishment of patient/family/caregiver goals o Experience of care o Shared decision-making o Transition planning • The set does not include cost measures or address the NQS aim of affordable care. • Several NQF-endorsed measures for this setting address gaps: o NQF #0326 Advance Care Plan (Row #10) ▪ Included in MAP care coordination, hospice and palliative care, and dual families of measures ▪ Disparities-sensitive measure o NQF #0726 Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services (Row #11) ▪ Included in MAP care coordination family of measure o NQF #0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (Row #12) ▪ Included in MAP safety and dual families of measures ▪ Disparities- sensitive measure o NQF #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)(Row #13) ▪ Included in MAP care coordination and hospice and palliative care family of measures o NQF #1919 Cultural Competency Implementation Measure (Row #14)
10:00 am	**Pre-Rulemaking Input on Long-Term Care Hospital Quality Reporting Program Measure Set (Tab #2)**	
	1. Review program summary and currently finalized program measure set	The finalized set includes 9 measures: • The majority of the finalized measures are NQF-endorsed. • The measure set addresses the NQS aim of better care, specifically the priorities

Time	Issue/Question	Considerations
		of prevention and treatment of leading causes of mortality, patient safety, and effective communication and care coordination. • The measure set addresses the MAP PAC/LTC core measure concepts of avoidable admissions, infection rates, falls, and pressure ulcers. The measure set lacks measures addressing person- and family- centered care. • The measure set has 2 process and 7 outcome measures. The set lacks structure and cost measures. • The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences. • None of the measures are disparities sensitive or addresses cultural competency. • Most of the finalized measures are being used in 1 or more additional federal programs and/or private sector programs; 6 of them are included in a MAP family of measures.
	2. Two measures under consideration are not NQF-endorsed and address the MAP PAC/LTC core measure concept of functional and cognitive assessment	• Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function (Row #2) o Measure is being tested; data will be collected through the LTCH CARE Data Set • Functional Outcome Measure: change in mobility among patients requiring ventilator support (Row #3) o Change in mobility score between admission and discharge among patients requiring ventilator support at admission o Measure is being tested; data will be collected through the LTCH CARE Data Set
	3. One measure under consideration is not NQF-endorsed and addresses the NQS priority of making care safer	• Ventilator-Associated Event (Row #4) o The measures are 2 Standardized Incidence Ratios (SIR) for healthcare-associated, ventilator-associated events (VAEs) among adult patients, >=18 years old, in acute and long-term acute care hospitals and inpatient rehabilitation facilities, receiving conventional mechanical ventilator support for >=3 calendar days. Persons receiving rescue mechanical ventilation therapies are excluded. The 2 SIRS are for: 1. Ventilator-Associated Conditions (VAC) 2. Infection-related Ventilator-Associated Complications (IVAC)

Time	Issue/Question	Considerations
		o Measure is fully developed; data will be collected through NHSN
	4. Identify priority measure gaps	• MAP had previously noted that the measure set lacks the PAC/LTC core measure concepts including cognitive status assessment (e.g. dementia identification), advance care planning and treatment, and inappropriate medication use (e.g., use of antipsychotic medications). • Additional core concept missing from the set are: o Establishment of patient/family/caregiver goals o Shared decision-making o Adverse drug events o Transition planning o Advance care planning and treatment o Mental health • The set does not include cost measures or address the NQS aim of affordable care • An NQF-endorsed measure for this setting that addresses the mental health gap: o NQF #0726 Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services (Row #5) ▪ Included in MAP care coordination family of measure
10:20 am	**Pre-Rulemaking Input on End Stage Renal Disease Quality Incentive Program (Tab #3)**	
	1. Review program summary and currently finalized program measure set	The finalized set includes 15 measures: • 7 out of 15 measures in the program measure set are NQF-endorsed. • The measure set addresses the NQS aim of better care, specifically the priorities of effective clinical care and person and caregiver-centered experience and patient safety. • The measure set addresses the MAP PAC/LTC core measure concept of infection rates and experience of care. The set does not address cross-cutting concepts such as advance care planning, care coordination, and patient engagement. • The measure set is comprised of outcome, intermediate outcome, process, and structure measures. • The measure set does not include follow-up care, transition planning, or

Time	Issue/Question	Considerations
		measures that support shared decision making and patient preferences. • None of the measures is disparities-sensitive or addresses cultural competency. • Two measures are used in private programs.
	2. Discussion of measurement challenges for ESRD Facilities	*Presentation by Robyn Nishimi and Kathleen Lester, Kidney Care Partners*
	3. High level summary of measures under consideration	• 21 measures are under consideration for the ESRD QIP: o 7 measures under consideration are NQF-endorsed. o 6 measures are used in federal program. o 3 measures are used in private programs. o 4 measures are included in the MAP families of measures. *Reactors:* *Andrew Narva, National Institutes of Health* *Constance Anderson, Northwest Kidney Centers* *Joseph Vassalotti, National Kidney Foundation*
	4. Two measures under consideration are NQF-endorsed and address the MAP PAC/LTC core measure concept of establishment of patient/family/caregiver goals	• NQF #0029 Counseling on Physical Activity in Older Adults – a. Discussing Physical Activity, b. Advising Physical Activity (Row #2) o Patient reported outcome measure o Endorsed for multiple settings including dialysis facilities o Use in federal programs: ▪ Currently finalized in Medicare Part C Plan Rating o Use in private programs: ▪ Wellpoint; HEDIS • NQF #0260 Assessment of Health-related Quality of Life (Physical & Mental Functioning) (Row #3) o In 2012 pre-rulemaking report, MAP had suggested the inclusion of the measures into the program measure set as an initial step to addressing patient goals and preferences. o Patient reported outcome measure o Measure is not used in any programs

Time	Issue/Question	Considerations
		o Endorsed for dialysis facilities
	5. One measure under consideration is NQF-endorsed and addresses the NQS priority of community/population health	• NQF #0004 Initiation and Engagement of Alcohol and other Drug Dependence Treatment (Row #4) o Included in MAP duals family of measures o Not endorsed for this setting o Use in federal programs: ▪ Currently finalized in Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use (EHR Incentive Program) Eligible Professionals; Physician Quality Reporting System (PQRS) o Use in private programs: ▪ HEDIS
	6. One measure under consideration is NQF-endorsed and addresses the MAP PAC/LTC core measure concept of mental health	• NQF #0418 Screening for Clinical Depression (Row #5) o Included in MAP duals family of measures o Not endorsed for this setting o Use in federal programs: ▪ Currently finalized in Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use (EHR Incentive Program) Eligible Professionals; Medicare Shared Savings Program; Physician Feedback; Physician Quality Reporting System (PQRS); HRSA o Use in private programs: ▪ Bridges to Excellence
	7. One measure under consideration is NQF-endorsed and addresses the MAP PAC/LTC core measure concept of experience of care	• NQF #0420 Pain Assessment and Follow-Up (Row #6) o Included in MAP duals family of measures o Not endorsed for this setting o Patient reported outcome measure o Use in federal programs: ▪ Currently finalized in Physician Feedback and Physician Quality Reporting System (PQRS)

Time	Issue/Question	Considerations
	8. Two measures under consideration are NQF-endorsed and address the MAP PAC/LTC core measure concept of infection rates	• NQF #0393 Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia (Row #7) o Not endorsed for this setting o Use in federal programs: ▪ Currently finalized in Physician Quality Reporting System (PQRS) • NQF #0431 Influenza Vaccination Coverage Among Healthcare Personnel (Row #8) o Included in MAP safety family of measures o Endorsed for multiple facilities including Dialysis Facility o Use in federal programs: ▪ Currently finalized in Ambulatory Surgical Center Quality Reporting; Hospital Inpatient Quality Reporting, Inpatient Rehabilitation Facilities Quality Reporting; and Long-Term Care Hospital Quality Reporting
	9. Six measures under consideration are not NQF-endorsed and address the MAP PAC/LTC core measure concept of infection rates	• Pneumococcal Vaccination Measure (PCV13) (Row #9) o Draft: Percentage of ESRD patients ≥ 5 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who have ever received a PCV13 pneumococcal vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication. o Measure is being specified • ESRD Vaccination - Pneumococcal Vaccination (PPSV23) (Row #10) o Draft: Percentage of ESRD patients ≥ 2 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who either had an up-to-date PPSV23 vaccine status or received PPSV23 vaccination during the reporting period, were offered but declined the vaccination, or were determined to have a medical contraindication. o Measure is being specified • Full-Season Influenza Vaccination (ESRD Patients) (Row #11) o Draft: Percentage of ESRD patients ≥ 6 months of age on October 1 and on chronic dialysis ≥ 30 days in a facility at any point between October 1 and

Time	Issue/Question	Considerations
		March 31 who either received an influenza vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication. o Measure is being specified • ESRD Vaccination - Timely Influenza Vaccination (Row #12) o Draft: Percentage of ESRD patients ≥ 6 months of age on October 1 and on chronic dialysis ≥ 30 days in a facility at any point between October 1 and December 31 who either received an influenza vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication. o Measure is being specified • Hepatitis B vaccine coverage in hemodialysis patients (Row #13) o Percentage of hemodialysis patients who have ever received three or more doses of hepatitis B vaccine o Measure is not NQF-endorsed but is fully developed • ESRD Vaccination – Lifetime Pneumococcal Vaccination (Row #14) o Percentage of ESRD patients ≥ 2 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who either have ever received a pneumococcal vaccination (PPSV23 or PCV13), were offered and declined the vaccination, or were determined to have a medical contraindication. o Measure is being specified
	10. Two measures under consideration are not NQF-endorsed and address the pediatric ESRD population	• Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V (Row #15) o The percent of pediatric peritoneal dialysis patient-months with Kt/V greater than or equal to 1.8 (dialytic + residual) during the six month reporting period. o Outcome measure being specified • Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V (Row #16) o Percent of pediatric peritoneal dialysis patient-months with Kt/V measured at least once in a six-month period o Process measure being specified; not yet tested

Time	Issue/Question	Considerations
	11. One measure under consideration is not NQF-endorsed and addresses the MAP PAC/LTC core measure concept of establishment of patient/family/caregiver goals	• Percentage of Dialysis Patients with Dietary Counseling (Row #17) o Percentage of all hemodialysis and peritoneal dialysis patients included in the sample for analysis with dietary counseling of the patient and/or caregiver on appropriate phosphorus sources and content as part of an overall healthy nutrition plan at least once within six-months o Process measure being specified
	12. Four measures under consideration are not NQF-endorsed and address the ESRD program statutory requirements	*Volume Control* • Ultrafiltration Rate (UFR) (Row #18) o Percent of patients with a UFR greater than 10 ml/kg/hr o Process measure being specified *Dialysis Adequacy* • Surface Area Normalized Kt/V (Row #19) o Percent of adult HD patients in a facility with all necessary data elements reported to calculate the weekly SAN Kt/V, on a monthly basis o Process measure being specified • Standardized Kt/V (Row #20) o Percent of adult HD patients in a facility with all necessary data elements reported to calculate the weekly Standard kt/V, on a monthly basis o Process measure being specified *Bone mineral Metabolism* • Measurement of Plasma PTH Concentration (Row #21) o Percentage of all peritoneal dialysis and hemodialysis patients included in the sample for analysis with plasma PTH measured, together with documentation of the specific PTH assay utilized, at least once within a 3 month period o Process measure being specified
	13. One measure under consideration is not NQF-endorsed and addresses the	• Comorbidity Reporting (Row # 22) o Annual reporting in CROWNWeb of patients who have one or more of any

Time	Issue/Question	Considerations
	NQS priority of making care safer	of the 24 qualifying comorbidities, or "none of the above" o This measure may assist in calculating performance on the following NQF-endorsed measures: ▪ NQF #0369 Dialysis Facility Risk-adjusted Standardized Mortality Ratio • MAP supported this measure in the 2013 pre-rulemaking report noting that mortality is an important outcome for patients; however, the measure should be linked to structural and process measures ▪ NQF #1463 Standardized Hospitalization Ratio for Admissions • MAP supported the direction of this measure noting a consolidated, evidence-based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings. The measure should be appropriately risk adjusted to accommodate variations in population.
	14. Identify priority measure gaps	• MAP had previously noted that the core measure concepts not addressed in this measure set include advance care planning, care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression. • MAP had also recommended exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care. • The set does not include cost measures or address the NQS aim of affordable care. • An NQF-endorsed measure for this setting that addresses cultural competency: o NQF #1919 Cultural Competency Implementation Measure (Row #23) ▪ Measure is NQF-endorsed for multiple settings including dialysis facilities
11:45 am	**Opportunity for Public Comment**	

Time	Issue/Question	Considerations
12:00 pm	**Lunch**	
12:45 pm	**Input on Alignment Issues across PAC/LTC Programs (Tab #4)**	
12:45 pm	***Continuity Assessment Record and Evaluation (CARE) tool Demonstration and Implications for Use across PAC/LTC Settings (Tab #4a)***	
	1. Update on the CARE tool	*Presentation by Tara McMullen and Stella Mandl, CMS*
1:00 pm	***Gaps in Assessing Cost across PAC/LTC Settings (Tab #4b)***	
	1. Discussion of cost measures for use in PAC/LTC settings	• How should access to care be assessed across PAC/LTC settings? • What are the main drivers of cost in PAC/LTC settings, and how can they be measured and improved? • How can cost measurement promote shared accountability among settings? • What clinical quality measures should be linked with cost measures to assess efficiency in PAC/LTC settings?
1:30 pm	***Admission/Readmission Measures for Use in PAC/LTC Settings (Tab #4c)***	
	1. Update on the development of admission/readmission measures for use in PAC/LTC settings	*Presentation by Joel Andress, CMS*
	2. Discussion of admissions/readmissions measures for use in PAC/LTC settings	• What barriers inhibit alignment of readmission measures across settings? • What options are there to overcome these barriers? • What factors should be considered in a risk adjustment approach? SES, disease severity, other? • How can we utilize readmission measurement to promote shared accountability across settings?
2:00 pm	**Pre-Rulemaking Input on Home Health Quality Reporting Program Measure Set (Tab #5)**	
	1. Review program summary and currently finalized program measure	The finalized set includes 84 measures: • The majority of measures in the set are not NQF-endorsed.

Time	Issue/Question	Considerations
	set	• The measure set addresses the NQS aim of better care and healthy people and communities. Specifically the priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination, and patient and family engagement are addressed. The priority of making care affordable is not addressed. • The measure set addresses 10 core measure concepts. • The set includes process, outcome, and patient experience of care measures. The set does not include structure or cost measures. • The measure set addresses follow-up care, transition planning, and establishment of patient goals. The set does not include measures that support shared decision making and patient preferences. • 2 of the measures are disparities sensitive. • In the CY 2014 Home Health Rule, CMS removed 17 measures to bring the set to 84. The process measures that were stratified by episode were removed.
	2. HHS has asked MAP to provide input on two finalized measures that are not NQF-endorsed and address admissions/readmissions	These measures were recently finalized for the HHQR program. MAP is asked to provide input on the revised specifications. The risk adjustment model had not yet been developed last December when the MAP previously reviewed the measures. CMS has developed a hierarchical risk adjustment model that incorporates five categories of risk factors, including (i) prior care setting, (ii) age and sex interactions, (iii) health status, (iv) end stage renal disease (ESRD) and disability status, and (v) interaction terms between one set of the health status covariates. • Rehospitalization During the First 30 Days of Home Health (Row #2) o Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay. • Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (Row #3) o Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute

Time	Issue/Question	Considerations
		care hospital during the 30 days following the start of the home health stay.
	3. One measure under consideration is not NQF-endorsed and addresses the MAP PAC/LTC core measure concept of mental health	• Depression Screening Conducted and Follow-Up Plan Documented (Row #4) o Measure set includes one other measure addressing depression: Depression Interventions Implemented During All Episodes of Care o This measure could enable measurement of person- and family-centered care and services o Measure is being specified
	4. One measure under consideration is not NQF-endorsed and addresses the MAP PAC/LTC core measure concept of pressure ulcers	• New or Worsened Pressure Ulcers (Row #5) o Measure set includes seven other measures addressing pressure ulcers: ▪ Discharged to the Community with an Unhealed Stage II Pressure Ulcer ▪ Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented During All Episodes Of Care ▪ Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care ▪ Pressure Ulcer Prevention Implemented During All Episodes of Care ▪ Pressure Ulcer Risk Assessment Conducted ▪ Increase in number of pressure ulcers ▪ Pressure Ulcer Prevention and Care o Measure is being specified
	5. Identify priority measure gaps	• The program measure set does not address the following PAC/LTC core concepts: o Advanced care planning and treatment ▪ NQF endorsed measures that are endorsed for the home health setting and could fill this gap include: • NQF# 0326 Advance Care Plan (Row #6) • NQF #1632 CARE - Consumer Assessments and Reports of End of Life (Row #7) o Inappropriate medicine use o Shared decision-making • The set does not include cost measures or address the NQS aim of affordable care.

Time	Issue/Question	Considerations
	6. Input on future direction of the program	• What are key issues that should be addressed in future revisions of OASIS? • How can the HHQR program be better aligned with other PAC/LTC quality reporting programs? • What are other key considerations for the future direction of the HHQR program?
2:30 pm	**Pre-Rulemaking Input on Hospice Quality Reporting Program (Tab #6)**	
	1. Review program summary and currently finalized program measure set	The finalized set includes 10 measures. 2 measures, Participation in a Quality Assessment Performance Improvement Program and NQF #0209 Comfortable Dying, have been finalized for removal from the set in FY 2015 reporting. The following evaluation excludes these 2 measures slated for future removal. • All of the measures are endorsed, with the exception of the Hospice Experience of Care Survey that CMS is building. • The measure set addresses the aim of better care, specifically the priorities of person- and family-centered care and effective communication and care coordination. • The measure set addresses person-centered care at end of life, but could be enhanced by measures addressing shared decision making, timely referral to hospice, the caregiver's role, and advance care planning. • All of the measures in this set are process measures. • There are 5 palliative and pain screening/assessment measures. 3 of the measures are patient reported outcome measures. The measure set could be enhanced by measures addressing the family and caregiver's role and shared decision making. • 4 of the measures are disparities sensitive. None of the measures addresses cultural competency. • Three measures are included in the MAP Safety Family of Measures. None of the measures is used in other programs.

Time	Issue/Question	Considerations
	2. Identify priority measure gaps	• MAP had previously noted that the measure set failed to address several core measure concepts, including pain, goal attainment, patient engagement, care coordination, and depression • An NQF endorsed measure that is endorsed for the hospice and could fill gaps: o # 1919 Cultural Competency Implementation Measure (Row #3) ▪ Endorsed for multiple settings, including hospice, hospital, long-term care, nursing home, dialysis facility, and skilled nursing facility ▪ Addresses culturally appropriate care high-leverage opportunity identified by workgroup in the Hospice Family of Measures ▪ This measure was not available when the Hospice Family of Measures was created (it was endorsed August 2012), which is why it does not appear in the family • MAP also recommended that the measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice. • The set does not include cost measures or address the NQS aim of affordable care.
	3. Update on CMS Hospice Experience Survey	
	4. Recommendations across settings	The MAP Hospital Workgroup has recognized a need for more palliative care measures in the Inpatient Quality Reporting Program and the PPS Exempt Cancer Hospital Quality Reporting Program. What recommendations would this workgroup like to make to increase alignment across these settings? Please refer to the PCHQR and IQR program measure sets. Measures in the Hospice Quality Reporting Program to consider: • # 1641 Hospice and Palliative Care – Treatment Preferences (Row #11) o Included in 2012 Hospice Family of Measures o Disparities sensitive o Endorsed for hospice and hospital/acute care facility • #1634 Hospice and Palliative Care – Pain Screening (paired with 1637)(Row #7) o Included in the MAP Hospice and Palliative Care Family of Measures

Time	Issue/Question	Considerations
		o Measure description: Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/palliative care initial encounter. o Included in the MAP Safety Family of Measures o Endorsed for Hospice, Hospital/Acute Care Facility o Measure is sensitive to known disparities in healthcare • #1637 Hospice and Palliative Care – Pain Assessment (paired with 1634)(Row #8) o Included in the MAP Hospice and Palliative Care Family of Measures o Measure description: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. o Included in the MAP Safety Family of Measures o Endorsed for Hospice, Hospital/Acute Care Facility o Measure is sensitive to known disparities in healthcare Additional measures potentially appropriate for the PCHQR program measure set: • # 0326 Advance Care Plan (Row #2) o Included in the MAP Hospice Family of Measures o Endorsed for multiple settings, including hospital o Addresses advanced care planning gap identified by workgroup • # 1919 Cultural Competency Implementation Measure (Row #3) o Endorsed for multiple settings, including hospital o Addresses culturally appropriate care high-leverage opportunity identified by workgroup in the Hospice Family of Measures o This measure was not available when the Hospice Family of Measures was created (it was endorsed August 2012), which is why it does not appear in the family *Reactor:* *Sean Morrison, Subject Matter Expert, Palliative Care; member of MAP Hospital Workgroup*
3:00 pm	**Pre-Rulemaking Input on Nursing Home Quality Initiative Program (Tab #7)**	

Time	Issue/Question	Considerations

	1. Review program summary and currently finalized program measure set	The finalized set includes 26 measures:
		• More than half of measures (16) in the set are NQF-endorsed.
		• The measure set addresses the NQS aim of better care.
		  o The priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination are addressed.
		  o The priorities of patient and family engagement and making care affordable are not addressed.
		• The measure set addresses resident health and quality of life.
		• The measure set addresses several MAP PAC/LTC core measure concepts—falls, functional and cognitive status assessment, inappropriate medication use, infection rates, mental health, and pressure ulcers.
		• The set includes process, outcome, and structure measures.
		• The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
		• 1 measure is disparities-sensitive.
		• 2 measures are used in other federal programs. Additionally, all measures are collected through MDS, a required assessment for home health patients, which reduces reporting burden.

	2. Nursing Home Value-Based Purchasing demonstration and implementation plan	*Presentation by Alex LaBerge, CMS*

	3. Identify priority measure gaps	• The program measure set does not address the following PAC/LTC core concepts:
		  o Advanced care planning and treatment
		  o Adverse drug events
		  o Avoidable admissions
		  o Establishment of patient/family/caregiver goals
		  o Experience of care
		  o Shared decision-making
		• The set does not include patient experience of care or cost measures.
		  o The gap in patient experience could be addressed by:

Time	Issue/Question	Considerations
		▪ NQF #0693 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument (Row #2) ▪ NQF #0692 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument (Row #3)
	4. Input on future direction of the program	• What are key issues that should be addressed in future revisions of MDS? • How can the NHQI program be better aligned with other PAC/LTC quality reporting programs? • What are other key considerations for the future direction of the NHQI program?
3:30 pm	**Opportunity for Public Comment**	
3:45 pm	**Summary of Day**	
4:00 pm	**Adjourn**	

NATIONAL QUALITY FORUM

Affordability Measures for Post-Acute Care and Long-Term Care Settings

In its Post-Acute Care/Long-Term Care Measure Coordination Strategy, MAP identified "Cost/Access" as one of the highest measurement priorities for these settings. Measures addressing cost and access highlight areas where resources are overused or underused and elucidate total cost and cost-shifting across settings. MAP noted that measures assessing patient access to social supports such as home- and community- based services should be a focus, as well as measures that can highlight significant drivers of cost, such as avoidable admissions, readmissions, and emergency department visits. Special consideration should be given to the limited resources of dual eligible beneficiaries, as these individuals may not have access to a usual source of care and may rely more heavily on community supports.

Last year, MAP supported the direction of one cost measure under consideration, Medicare Spending Per Beneficiary, for the Long-Term Care Hospital Quality Reporting program, noting that the measure under consideration would exclude LTCHs because the measure methodology excludes hospitals whose average inpatient length of stay exceeds 25 days. MAP recommended that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings.

Recently, MAP convened an Affordability Task Force to begin developing an affordability family of measures. Specifically, this group will develop a consensus-based definition of affordability, identify high-leverage opportunities for improvement and measurement, and create a family of available measures and gaps.

Recognizing that cost measures remain a gap across PAC/LTC settings, we would like your input on how cost should best be addressed in PAC/LTC settings. Please consider the following discussion questions:

- How should access to care be assessed across PAC/LTC settings?
- What are the main drivers of cost in PAC/LTC settings, and how can they be measured and improved?
- How can cost measurement promote shared accountability among settings?
- What clinical quality measures should be linked with cost measures to assess efficiency in PAC/LTC settings?

The following are NQF-endorsed cost and resource use measures that could be applied to PAC-LTC settings.

Measure Title	Measure Description	Endorsed Settings
NQF #1558 Relative Resource Use for People with Cardiovascular Conditions	The risk-adjusted relative resource use by health plan members with specific cardiovascular conditions during the measurement year.	Inpatient Rehabilitation Facility
NQF #1560 Relative Resource Use for People with Asthma	The risk-adjusted relative resource use by health plan members with asthma during the measurement year.	Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
NQF #1561 Relative Resource Use for People with COPD	The risk-adjusted relative resource use by health plan members with COPD during the measurement year.	Nursing Home/Skilled Nursing Facility
NQF # 1598 Total Resource use Population-based PMPM index	The Resource Use Index (RUI) is a risk adjusted measure of the frequency	Dialysis Facility, Home Health, Hospice, Inpatient Rehabilitation

	and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	Facility, Nursing Home/Skilled Nursing Facility
NQF #1604 Total cost of care population-based PMPM Index	Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	Dialysis Facility, Home Health, Hospice, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
NQF #1609 ETG Based Hip/Knee Replacement cost of care measure	The measure focuses on resources used to deliver episodes of care for patients who have undergone a Hip/Knee Replacement.	Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation
NQF #1611 ETG Based Pneumonia cost of care measure	The measure focuses on resources used to deliver episodes of care for patients with pneumonia.	Home Health, Hospice, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility

Cost and Resource Use Background

NQF's Cost and Resource Use Consensus Development Project is an ongoing effort to evaluate resource use measures for NQF endorsement. The initial phase of the project sought to understand resource use measures and identify the important attributes to consider in their evaluation. This project generated the NQF Resource Use Measure Evaluation Criteria. Additionally, this project established key definitions for resource use:

> **Resource Use:** Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters). A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.
>
> **Efficiency:** The resource use (or cost) associated with a specific level of performance with respect to the other five Institute of Medicine (IOM) aims of quality: safety, timeliness, effectiveness, equity, and patient-centeredness. Time is sometimes used to define efficiency when determining efficiency of throughput processes or applying time-driven activity based costing methods.

Finally, this project highlighted key considerations for resource use and cost measures:

- Efficiency measurement approaches should be patient-centered, building on previous efforts such as the NQF Patient-Centered Episodes of Care (EOC) Efficiency Framework.
- NQF supports using and reporting resource use measures in the context of quality performance, preferably outcome measures. Using resource use measures independent of quality measures does not provide an accurate assessment of efficiency or value and may lead to adverse unintended consequences.
- Given the diverse perspectives on cost and resource use measurement, it is important to know the purpose and perspectives these measures represent when evaluating the measures for endorsement.

Admission/Readmission Measures for Use in Post-Acute Care and Long-Term Care Settings

MAP has identified avoidable admissions as a PAC/LTC core concept and recommended that measures addressing avoidable admissions and readmissions be included in PAC/LTC quality measurement programs. While identifying a Care Coordination Family of Measures, MAP developed a Guidance Document for the Selection of Avoidable Admission and Readmission Measures, in which MAP provided implementation principles:

- Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination.
- All-cause and condition-specific measures of avoidable admissions and readmissions are both important.
- Monitoring by program implementers is necessary to understand and mitigate potential unintended consequences.
- Risk adjustment is necessary for fair comparisons of readmission rates.
- Readmission measures should exclude planned readmissions.

Additionally, the MAP Dual Eligible Beneficiaries Workgroup has emphasized the high importance of preventing all types of admissions and readmissions because of the negative impact transitions have on individuals. This is particularly important for individuals receiving long-term supports in the community or who reside in nursing facilities.

In its 2013 Pre-Rulemaking Report, MAP emphasized the need to align measurement among PAC/LTC settings as well as between PAC/LTC and acute care settings, such as hospitals. Aligning measurement between PAC/LTC and acute care settings could promote shared accountability across the care continuum. MAP suggested that shared accountability be considered when utilizing results from admission and readmission measures so that providers are not unfairly penalized. However, MAP emphasized that alignment must be balanced with consideration for the heterogeneity of patient needs across settings, noting that admission and readmission measures should be standardized across settings, yet customized to address the unique needs of the heterogeneous PAC/LTC population.

MAP has continually emphasized the need for care transition measures in PAC/LTC performance measurement programs. While the current setting-specific admission and readmission measures in use address this need, MAP has recommended a more parsimonious approach, utilizing fewer measures to address readmissions across settings. However, MAP cautioned that attention would need to be given to defining the index event (e.g., acute hospital admission versus LTCH admission) so that the measure can serve multiple settings. In PAC/LTC settings, measures of avoidable admissions and readmissions are currently included in the Long Term Care Hospital Quality Reporting program, Inpatient Rehabilitation Facility Quality Reporting program, and Home Health Quality Reporting programs. To measure readmissions in acute care settings, both condition-specific and all-cause readmission measures are included in the Inpatient Quality Reporting program.

The PAC/LTC Workgroup is asked to provide guidance on aligning admission/readmission measures across PAC/LTC settings and between PAC/LTC and acute care settings. Please consider the following discussion questions.

- What barriers inhibit alignment of readmission measures across settings?
- What options are there to overcome these barriers?
- What factors should be considered in a risk adjustment approach? SES, disease severity, other?
- How can we utilize readmission measurement to promote shared accountability across settings?

Inpatient Rehabilitation Facility Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Inpatient Rehabilitation Facilities

Statutory Mandate:

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge. [1]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP found the program measure set too limited and noted that it could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and *C. difficile*.
- MAP supported the direction of two measures that address CAUTI and *C. difficile*, in addition to supporting three immunization measures.
- MAP supported the direction of three functional status outcome measures and one avoidable admissions measure, noting that the measures are important but still in development.
- MAP did not support one CLABSI measure, which has a low incidence in this setting.

---

[1] FY 2012 IRF PPS final rule The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Four out of five measures in the program measure set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care and the NQS priority of patient safety. The priorities of patient and family engagement, community and population health, and making care more affordable are not addressed.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses three MAP PAC/LTC core measure concepts — infection rates, pressure ulcers, and avoidable admissions. The set does not address other core measure concepts relevant to this setting.
4. Program measure set includes an appropriate mix of measure types	The measure set includes outcome and process measures. The set lacks structure and cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures is disparities-sensitive or addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Four measures in the set are used in other federal programs. One measure is used in private programs. Two measures are in one or two MAP Families of measures.

[1] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

[2] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

Long-Term Care Hospital Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.[1] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Long-Term Care Hospitals

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).[3]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP noted that many measures under consideration would support alignment with other settings; however, measures should be tested in LTCHs to determine if they are feasible for implementation.
- MAP supported the direction of one cost measure, noting that the measure under consideration would exclude LTCHs because the measure methodology excludes hospitals whose average inpatient length of stay exceeds 25 days. MAP recommends that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings.

---

[1] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/

[2] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/

[3] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

- MAP did not support four measures under consideration that did not address PAC/LTC core concepts or had lost NQF endorsement.
- Measures should address the PAC/LTC core measures not currently addressed in the measure set including cognitive status assessment (e.g. dementia identification), advance care planning and treatment, and inappropriate medication use (e.g., use of antipsychotic medications).

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of the finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, and communication and care coordination.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses the MAP PAC/LTC coe measure concepts of avoidable admissions, infection rates, falls, and pressure ulcers. The measure set lacks measures addressing person- and family-centered care.
4. Program measure set includes an appropriate mix of measure types	The measure set has two process and seven outcome measures. The set lacks structure and cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures are disparities sensitive or addresses cultural competency.

7. Program measure set promotes parsimony and alignment	Most of the finalized measures are being used in one or more additional federal programs and/or private sector programs; six of them are included in a MAP family of measures.

End Stage Renal Disease Quality Incentive Program

Program Type:

Pay for Performance, Public Reporting

Incentive Structure:

Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.[1] Performance is reported on the Dialysis Facility Compare website.

Care Settings Included:

Dialysis Providers/Facilities

Statutory Mandate:

The ESRD Quality Incentive Program (QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as "value-based purchasing") model quality incentive program.[2]

Statutory Requirements for Measures:

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. [3]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the only measure under consideration that addresses a cross-cutting topic, NQF # 0258 CAHPS In-Center Hemodialysis Survey, in alignment with its previous recommendation that the measure set expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination.
- Recognizing that the program is statutorily required to include measures of dialysis adequacy, MAP supported 11 measures under consideration that are clinically focused.
- MAP supported the direction of an additional 9 clinically focused measures under consideration, because the measures would address statutory requirements but they are undergoing development and need to be brought forward for NQF endorsement.
- MAP did not support 1 measure under consideration because its NQF endorsement has been removed.
- MAP recommended exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.
- The core measure concepts not addressed in this measure set include advance care planning, care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Seven out of fifteen measures in the program measure set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of effective clinical care and person and caregiver-centered experience and patient safety.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses the MAP PAC/LTC core measure concept of infection rates and experience of care. The set does not address cross-cutting concepts such as advance care planning, care coordination, and patient engagement.
4. Program measure set includes an appropriate mix of measure types	The measure set is comprised of outcome, intermediate outcome, process, and structure measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures is disparities-sensitive and addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Two measures are used in private programs.

[1] Federal Register. Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers. https://www.federalregister.gov/articles/2012/07/11/2012-16566/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and

[2] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[3]Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Home Health Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[2] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[3] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

Care Settings Included:

Medicare-certified home health agencies

Statutory Mandate:

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

Statutory Requirements for Measures:

None.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures under consideration for the Home Health Quality Reporting Program. MAP supported the direction of both because they address the PAC/LTC core concept of avoidable admissions. MAP recognized the importance of reducing rehospitalizations and ED visits but noted that these measures should replace or be harmonized with currently finalized measures addressing hospitalizations and ED visits in order to reduce redundancy in the set.
- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of measures in the set are not NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care and healthy people and communities. Specifically the priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination, and patient and family engagement are addressed. The priority of making care affordable is not addressed.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses 10 core measure concepts.
4. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and patient experience of care measures. The set does not include structure or cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses follow-up care,transition planning, establishment of patient goals. The set does not include measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	Two of the measures are disparities sensitive.
7. Program measure set promotes parsimony and alignment	There are 84 measures finalized for HHQR. In the CY 2014 Home Health Rule CMS removed 17 process measures that were stratified by episode with the goal of simplifing the reporting process.

[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.

[2] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2011.

[3] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.

Hospice Quality Reporting Program

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.[1] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [2]

Care Settings Included:

Multiple; hospice care can be provided in inpatient and outpatient settings.

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.[3]

Statutory Requirements for Measures:

None.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures currently finalized for the program measure set and seven measures under consideration; they supported all of these measures since they were all included in the 2012 MAP Hospice and Palliative Care Coordination Strategy.
- MAP recommended that other measures in the MAP Hospice Family of Measures be added to the measure set; specifically, NQF #1647 Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss.
- MAP noted that the measure set failed to address several core measure concepts, including pain, goal attainment, patient engagement, care coordination, and depression
- MAP also recommended that the measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	All of the measures are endorsed, with the exception of the Hospice Experience of Care Survey that CMS is building.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the aim of better care, specifically the priorities of person- and family-centered care and effective communication and care coordination.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses person- centered care at end of life, but could be enhanced by measures addressing shared decision making, timely referral to hospice, the caregiver's role, and advance care planning.
4. Program measure set includes an appropriate mix of measure types	All of the measures in this set are process measures.
5. Program measure set enables measurement of person- and family-centered care and services	There are five palliative and pain screening/assessment measures. Three of the measures are patient reported outcome measures. The measure set could be enhanced by measures addressing the family and caregiver's role and shared decision making.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	Four of the measures are disparities sensitive. None of the measures addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Three measures are included in the Safety Family of Measures. None of the measures are used in other programs.

[1] Ibid
[2] CMS. Hospice Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html

[3] Ibid

Nursing Home Quality Initiative and Nursing Home Compare

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1]

Care Settings Included:

Medicare- or Medicaid-certified nursing facilities

Statutory Mandate:

The 1987 Omnibus Budget Reconciliation Act mandated the development of a nursing home resident assessment instrument.

Statutory Requirements for Measures:

OBRA mandated the inclusion of the domains of resident health and quality of life in the resident assessment instrument.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the direction of 2 measures that address the PAC/LTC core concept of inappropriate medication use, noting that the measures should have as few exclusions as possible and monitoring should be incorporated into program implementation to detect unintended consequences. MAP noted the need for measures that address the overall improvement of dementia care and cautioned that focus on reducing inappropriate use of one class of medication may lead to inappropriate use of other medication classes.
- MAP also supported the direction of two measures addressing avoidable admissions, a core measure concept. MAP recognized the importance of measuring readmissions in the nursing home setting but would prefer fewer measures to address readmissions across settings.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	More than half of measures (16) in the set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care. Specifically the priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination are addressed. The priorities of patient and family engagement and making care affordable are not addressed.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses resident health and quality of life. Additionally, the measure set addresses several MAP PAC/LTC core measure concepts—falls, functional and cognitive status assessment, inappropriate medication use, infection rates, mental health, and pressure ulcers.
4. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and structure measures. The set does not include patient experience of care or cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	One measure in the set is disparities-sensitive.
7. Program measure set promotes parsimony and alignment	Two measures in the set are used in other federal programs. Additionally, all measures are collected through MDS, a required assessment for home health patients, which reduces reporting burden.

[1] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.

MAP MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

NATIONAL QUALITY FORUM

MAP Previously Identified Measure Gaps

This document provides a synthesis of previously identified measure gaps compiled from all prior MAP reports. The gaps are grouped by NQS priority.

Safety

- Composite measure of most significant Serious Reportable Events

Healthcare-Associated Infections

- Ventilator-associated events for acute care, post-acute care, long-term care hospitals and home health settings
- Pediatric population: special considerations for ventilator-associated events and C. difficile
- Infection measures reported as rates, rather than ratios (more meaningful to consumers)
- Sepsis (healthcare-acquired and community-acquired) incidence, early detection, monitoring, and failure to rescue related to sepsis
- Post-discharge follow-up on infections in ambulatory settings
- Vancomycin Resistant Enterococci (VRE) measures (e.g., positive blood cultures, appropriate antibiotic use)

Medication and Infusion Safety

- Adverse drug events
    - Injury/mortality related to inappropriate drug management
    - Total number of adverse drug events that occur within all settings (including administration of wrong medication or wrong dosage and drug-allergy or drug-drug interactions)
- Inappropriate medication use
    - Polypharmacy and use of unnecessary medications for all ages, especially high-risk medications
    - Antibiotic use for sinusitis
    - Use of sedatives, hypnotics, atypical-antipsychotics, pain medications (consideration for individuals with dementia, Alzheimer's, or residing in long-term care settings)
- Medication management
    - Patient-reported measures of understanding medications (purpose, dosage, side effects, etc.)
    - Medication documentation, including appropriate prescribing and comprehensive medication review
    - Persistence of medications (patients taking medications) for secondary prevention of cardiovascular conditions
    - Role of community pharmacist or home health provider in medication reconciliation
- Blood incompatibility

Perioperative/Procedural Safety

- Air embolism
- Anesthesia events (inter-operative myocardial infarction, corneal abrasion, broken tooth, etc.)
- Perioperative respiratory events, blood loss, and unnecessary transfusion
- Altered mental status in perioperative period

Venous Thromboembolism

- VTE outcome measures for ambulatory surgical centers and post-acute care/long-term care settings

- Adherence to VTE medications, monitoring of therapeutic levels, medication side effects, and recurrence

Falls and Immobility

- Standard definition of falls across settings to avoid potential confusion related to two different fall rates
- Structural measures of staff availability to ambulate and reposition patients, including home care providers and home health aides

Obstetrical Adverse Events

- Obstetrical adverse event index
- Measures using National Health Safety Network (NHSN) definitions for infections in newborns

Pain Management

- Effectiveness of pain management paired with patient experience and balanced by overuse/misuse monitoring
- Assessment of depression with pain

Patient & Family Engagement

Person-Centered Communication

- Information provided at appropriate times
- Information is aligned with patient preferences
- Patient understanding of information, not just receiving information (considerations for cultural sensitivity, ethnicity, language, religion, multiple chronic conditions, frailty, disability, medical complexity)
- Outreach to non-compliant patients

Shared Decision-Making and Care Planning

- Person-centered care plan, created early in the care process, with identified goals for all people
- Integration of patient/family values in care planning
- Plan agreed to by the patient and provider and given to patient, including advanced care plan
- Plan shared among all providers seeing the patient (integrated); multidisciplinary
- Identified primary provider responsible for the care plan
- Fidelity to care plan and attainment of goals
    - Treatment consistent with advanced care plan
- Social care planning addressing social, practical, and legal needs of patient and caregivers
- Grief and bereavement care planning

Advanced Illness Care

- Symptom management (nausea, shortness of breath, nutrition)
- Comfort at end of life

Patient-Reported Measures

- Functional status
    - Particularly for individuals with multiple chronic conditions
    - Optimal functioning (e.g., improving when possible, maintaining, managing decline)
- Pain and symptom management
- Health-related quality of life
- Patient activation/engagement

Healthy Living

- Life enjoyment
- Community inclusion/participation for people with long-term services and supports needs
- Sense of control/autonomy/self-determination
- Safety risk assessment

Care Coordination

Communication

- Sharing information across settings
    - Address both the sending and receiving of adequate information
    - Sharing medical records (including advance directives) across all providers
    - Documented consent for care coordination
    - Coordination between inpatient psychiatric care and alcohol/substance abuse treatment
- Effective and timely communication (e.g., provider-to-patient/family, provider-to-provider)
    - Survey/composite measure of provider perspective of care coordination
- Comprehensive care coordination survey that looks across episode and settings (includes all ages; recognizes accountability of the multidisciplinary team)

Care Transitions

- Measures of patient transition to next provider/site of care across all settings, beyond hospital transitions (e.g., primary care to specialty care, clinician to community pharmacist, nursing home to home health) as well as transitions to community services
- Timely communication of discharge information to all parties (e.g., caregiver, primary care physician)
- Transition planning
    - Outcome measures for after care
    - Primary care follow-up after discharge measures (e.g., patients keeping follow-up appointments)
    - Access to needed social supports

System and Infrastructure Support

- Interoperability of EHRs to enhance communication
- Measures of "systemness," including accountable care organizations and patient-centered medical homes
- Structures to connect health systems and benefits (e.g., coordinating Medicare and Medicaid benefits, connecting to long-term supports and services)

Avoidable Admissions and Readmissions

- Shared accountability and attribution across the continuum
- Community role; patient's ability to connect to available resources

Affordability

- Ability to obtain follow-up care
- Utilization benchmarking (e.g., outpatient/ED/nursing facility)
- Consideration of total cost of care, including patient out of pocket cost
- Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, procedures
- Chemotherapy appropriateness, including dosing
- Avoiding unnecessary end-of-life care
- Use of radiographic imaging in the pediatric population

Prevention and Treatment for the Leading Causes of Mortality

Primary and Secondary Prevention

- Lipid control
- Outcomes of smoking cessation interventions
- Lifestyle management (e.g., physical activity/exercise, diet/nutrition)
- Cardiometabolic risk
- Modify Prevention Quality Indicators (PQI) measures to assess accountable care organizations; modify population to include all patients with the disease (if applicable)

Cancer

- Cancer- and stage-specific survival as well as patient-reported measures
- Complications such as febrile neutropenia and surgical site infection
- Transplants: bone marrow and peripheral stem cells
- Staging measures for lung, prostate, and gynecological cancers
- Marker/drug combination measures for marker-specific therapies, performance status of patients undergoing oncologic therapy/pre-therapy assessment
- Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
- Pediatric measures, including hematologic cancers and transitions to adult care

Cardiovascular Conditions

- Appropriateness of coronary artery bypass graft and PCI at the provider and system levels of analysis
- Early identification of heart failure decompensation
- ACE/ARB, beta blocker, statin persistence (patients taking medications) for ischemic heart disease

Depression

- Suicide risk assessment for any type of depression diagnosis
- Assessment and referral for substance use
- Medication adherence and persistence for all behavioral health conditions

Diabetes

- Measures addressing glycemic control for complex patients (e.g., geriatric population, multiple chronic conditions) at the clinician, facility, and system levels of analysis
- Pediatric glycemic control
- Sequelae of diabetes

Musculoskeletal

- Evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings

MAP Decision Categories

	MAP Decision (standardized options)	Decision Description	MAP Rationale (suggested options)	MAP Findings (open text)
Measures Under Consideration	Support	Indicates measures under consideration that should be added to the program measure set during the current rulemaking cycle.	• NQF-endorsed measure • Addresses National Quality Strategy aim or priority not adequately addressed in program measure set • Addresses program goals/requirements • Addresses a measure type not adequately represented in the program measure set • Promotes person- and family-centered care • Provides considerations for healthcare disparities and cultural competency • Promotes parsimony • Promotes alignment across programs, settings, and public and private sector efforts • Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries • Included in a MAP family of measures	*MAP findings will highlight additional considerations raised by the group.*
	Do Not Support	Indicates measures that are not recommended for inclusion in the program measure set.	• Measure does not adequately address any current needs of the program • A finalized measure addresses a similar topic and better addresses the needs of the program • A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • Measure previously submitted for endorsement and was not endorsed	*MAP findings will highlight additional considerations raised by the group.*
	Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s).	• Not ready for implementation; measure concept is promising but requires modification or further development • Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; data sources do not align with program's data sources • Not ready for implementation; measure needs further experience or testing before being used in the program	*MAP findings will highlight the contingent factors that should be met before a measure is included in the program.* For example: • Guidance on modifications • Description of how the measure concept will add value when fully developed and NQF-endorsed

				• Additional programmatic considerations, such as needing at least 1 year of results before implementation in other programs
Finalized Measures	**Decision Category**	**Decision Description**	**Rationale Category**	**Rationale Description**
	Remove	Indicates measures that should be removed from a program measure set.	• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program and promotes alignment	*MAP findings will indicate the timing of removal.*

ROSTER FOR THE MAP POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

CHAIR (VOTING)
Carol Raphael, MPA

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder Kauserud, PT
American Occupational Therapy Association	Pamela Roberts, PhD, OTR/L, SCFES, CPHQ, FAOTA
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
American Society of Consultant Pharmacists	Jennifer Thomas, PharmD
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kidney Care Partners	Allen Nissenson, MD, FACP, FASN, FNKF
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health & Services	Dianna Reely
Service Employees International Union	Charissa Raynor
Visiting Nurses Association of America	Margaret Terry, PhD, RN

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Clinician/Nephrology	Louis H. Diamond, MBChB, FCP (SA), FACP, FHIMSS
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	Marc Leib, MD, JD
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	
Agency for Healthcare Research and Quality (AHRQ)	D.E.B. Potter, MS
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

BIOS FOR THE MAP POST-ACUTE CARE / LONG-TERM CARE WORKGROUP

CHAIR (VOTING)

Carol Raphael, MPA

Carol Raphael, MPA, is President and Chief Executive Officer of Visiting Nurse Service of New York, the largest nonprofit home health agency in the United States. She oversees VNSNY's comprehensive programs in post-acute care, long-term care, hospice and palliative care, rehabilitation and mental health as well as its health plans for dually eligible Medicare and Medicaid beneficiaries. Ms. Raphael developed the Center for Home Care Policy and Research, which conducts policy-relevant research focusing on the management and quality of home and community-based services. Previously, Ms. Raphael held positions as Director of Operations Management at Mt. Sinai Medical Center and Executive Deputy Commissioner of the Human Resources Administration in charge of the Medicaid and Public Assistance programs in New York City. Between 1999 and 2005, Ms. Raphael was a member of MedPAC. She served on the New York State Hospital Review and Planning Council for 12 years (1992-2004) and chaired its Fiscal Policy Committee. She chairs the New York eHealth Collaborative and was a member of the IOM's Committee to Study the Future Health Care Workforce for Older Americans, which issued its report in April 2008. She is on the Boards of AARP, Pace University, and the Continuing Care Leadership Coalition. She is a member of the Harvard School of Public Health's Health Policy Management Executive Council, the Markle Foundation Connecting for Health Steering Group, Atlantic Philanthropies Geriatrics Practice Scholars Program, and Henry Schein Company Medical Advisory Board, the Jonas Center for Excellence in Nursing Advisory Board, NYU College of Nursing Advisory Board, and the New York City Health and Mental Hygiene Advisory Council. She was a member of the Lifetime Excellus Board from 2002-2010. She has authored papers and presentations on post-acute, long-term and end-of-life care and co-edited the book Home Based Care for a New Century. Ms. Raphael has an M.P.A. from Harvard University's Kennedy School of Government, and was a Visiting Fellow at the Kings Fund in the United Kingdom. Ms. Raphael was recently listed in Crain's New York Business 50 Most Powerful Women in New York City.

ORGANIZATIONAL MEMBERS (VOTING)

AETNA

Randall Krakauer, MD

Dr. Randall Krakauer graduated from Albany Medical College in 1972 and is Board Certified in Internal Medicine and Rheumatology. He received training in Internal Medicine at the University of Minnesota Hospitals and in Rheumatology at the National Institutes of Health and Massachusetts General Hospital/Harvard Medical School, and received an MBA from Rutgers. He is a fellow of the American College of Physicians and the American College of Rheumatology and Professor of Medicine at Seton Hall University Graduate School of Medicine. He is past chairman of the American College of Managed Care Medicine. Dr. Krakauer has more than 30 years of experience in medicine and medical management, has held senior medical management positions in several major organizations. He is author of many publications on Medical Management, Advanced Care Management and Collaborative

Medical Management. He is responsible for medical management planning and implementation nationally for Aetna Medicare members, including program development and administration.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Suzanne Snyder Kauserud, PT

Suzanne Snyder Kauserud is a Vice President at Carolinas Rehabilitation and Administrator of a 90 bed freestanding Inpatient Rehabilitation Hospital. Carolinas Rehabilitation owns or manages over a 180 inpatient rehabilitation beds in Charlotte, North Carolina as well as over 14 outpatient therapy and physician clinics. Suzanne is a Fellow in the American College of Healthcare Executives and holds a Master's degree in Business Administration, Bachelors in Physical Therapy and a Certification in Healthcare Management. In 2009 Suzanne expanded her ability to impact the lives of patients and the rehab community by becoming a member of the AMRPA Board of Directors. In her role at Carolinas Rehabilitation Suzanne is responsible for oversight of IRF PAI data collection/transmission, utilization management, utilization review, Medicare appeals, insurance authorizations, medical necessity documentation and quality outcomes reporting. Suzanne was instrumental in the creation and continuation of the EQUADR^{SM} (Exchanged Quality Data for Rehabilitation) Network a Patient Safety Organization, established to share quality outcomes amongst rehabilitation providers and define the most appropriate quality indicators for the inpatient rehabilitation setting. She has helped to shape quality measures for the inpatient rehabilitation field through her work as co-chair of the American Medical Rehabilitation Providers Association's (AMRPA) Quality Committee and participation on technical expert panels for MedPAC and CMS. Suzanne is a Commission on Accreditation of Rehabilitation Facilities (CARF) surveyor and coordinates the CARF readiness of Carolinas Rehabilitation.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Pamela Roberts, PhD, MSHA, OTR/L, SCFES, FAOTA, CPHQ

Pamela Roberts is the manager of Rehabilitation and Neuropsychology at Cedars-Sinai Medical Center in Los Angeles, California. Dr. Roberts has worked throughout the continuum of care as a clinician, administrator, educator, and researcher. She has been instrumental in developing and implementing programs including quality metrics for rehabilitation and has been involved in technical expert panels for rehabilitation and post-acute care and is a certified professional in healthcare quality (CPHQ). Dr. Roberts teaches at the University of Southern California Occupational Science and Occupational Therapy Program and is a Commission on Accreditation of Rehabilitation Facilities (CARF) surveyor. She is involved in the American Congress of Rehabilitation Medicine (ACRM) and is on the Executive Committee for the Stroke Interdisciplinary Special Interest Group, serves on multiple committees for the American Occupational Therapy Association, Vice Chair of the Accreditation Council for Occupational Therapy Education (ACOTE), past chair of the California Hospital Association Center for Medical Rehabilitation Services, and currently serves on the California Hospital Association Post-Acute Care advisory board. Dr. Roberts has degrees in occupational therapy from Washington University in St. Louis, master's degree in health administration for the California State University-Northridge, and a doctor of philosophy in health sciences from Touro University International.

AMERICAN PHYSICAL THERAPY ASSOCIATION

Roger Herr, PT, MPA, COS-C

Roger Herr, PT, MPA, COS-C is an elected Director on the Board of the American Physical Therapy Association (APTA), the national nonprofit membership organization of physical therapists based in Alexandria, VA. Roger's activities in APTA have focused on geriatrics, home care and the post-acute care

data sets. Roger has worked in seven settings of care, with the majority in post-acute care focused in home health and hospice. He has served as a clinician, manager, director and external site visitor for accreditation. Currently, Roger has a day job as a Strategic Advisor with OCS HomeCare, a Seattle based division of National Research Company (NRC), a publically traded organization. Roger has degrees in biological science in physical therapy from Temple University in Philadelphia and a master's degree in public administration – health care management from New York University.

AMERICAN SOCIETY OF CONSULTANT PHARMACISTS

Jennifer Thomas, PharmD

Jennifer K. Thomas, PharmD, is the Manager, Pharmacy Services for the Quality Improvement Organizations (QIOs), Delmarva Foundation for Medical Care in Maryland and Delmarva Foundation of the District of Columbia. Her current role is project lead and coordinator of the QIOs current drug safety project, reducing adverse drug events in high risk populations. Jennifer also works collaboratively with the care transitions, healthcare acquired infections, and nursing home teams in the QIO. Jennifer's practice experience includes: critical care/infectious diseases pharmacy specialist in both community and community/teaching hospitals; homecare infusion pharmacy, and as a Medical Technologist with over 10 years of clinical laboratory/microbiology experience. Dr. Thomas is a Clinical Assistant Professor, of the University of Maryland, School of Pharmacy, and for Notre Dame University of Maryland School of Pharmacy, experiential programs. She is an active member of several professional pharmacy state and national organizations (MPhA, APhA, MSHP, ASHP, MD-ASCP, ASCP, Pharmacy Quality Alliance). She served as MSHP President and Secretary as well as Chair of the Antimicrobial Stewardship and Emergency Preparedness Committee. She had served as an MPhA Board of Trustee and is currently a member of the Professional Development Committee. She is a current member of the PQA medication safety workgroup and was a member of the 2010 CMS Medication Measures Technical Expert Panel (MMTEP). She is also the pharmacist representative to the Maryland Statewide Advisory Commission on Immunizations (MSACI). Jennifer received her doctor of pharmacy degree from Auburn University. She completed an ASHP accredited general practice residency and a post-doctoral fellowship in infectious diseases pharmacodynamics/ pharmacokinetics at the Clinical Pharmacokinetics Laboratory, in Buffalo, New York.

FAMILY CAREGIVER ALLIANCE

Kathleen Kelly, MPA

Kathleen Kelly is the Executive Director of Family Caregiver Alliance and the National Center on Caregiving. Ms. Kelly has over 30 years of experience in program and state system development regarding integration of family caregivers within health and social service systems. Ms. Kelly has overseen the development of state service programs, consumer information systems, caregiver data reporting, and numerous research projects. She has advocated for family caregivers in public policy, service development, professional staff development and the media.

HEALTHINSIGHT

Juliana Preston, MPA

Juliana Preston is the Vice President of Utah Operations for HealthInsight. Ms. Preston is responsible for leading the organization's quality improvement division in Utah. As the leader of the quality improvement initiatives, she oversees the management of the Medicare quality improvement contract work and other quality improvement related contracts in Utah. Ms. Preston has extensive experience working with nursing homes. She has developed numerous workshops and seminars including root

cause analysis, healthcare quality improvement, human factors science, and resident-centered care. In addition to her experience at HealthInsight, she has held various positions during her career in long-term care including Certified Nursing Assistant, Admissions & Marketing Coordinator. Ms. Preston graduated from Oregon State University in 1998 with a Bachelor's of Science degree with an emphasis in Long Term Care and minor in Business Administration. In 2003, she obtained her Master's degree in Public Administration from the University of Utah with an emphasis in Health Policy.

KIDNEY CARE PARTNERS

Allen Nissenson, MD, FACP, FASN, FNKF

Allen R. Nissenson, MD, FACP is Chief Medical Officer of DaVita Healthcare Partners, Inc. and an Emeritus Professor of Medicine at the David Geffen School of Medicine at UCLA, where he served as Director of the Dialysis Program and Associate Dean. Dr. Nissenson also serves as the Editor-in-Chief of NephLink, the online physician community for kidney care, enabling the physician community to connect, engage, and collaborate in improving patient care and clinical outcomes. Dr. Nissenson is a former President of the Renal Physicians Association and served on the RPA Board of Directors as a special advisor to the President. Dr. Nissenson is Immediate Past President of the Southern California End-Stage Renal Disease (ESRD) Network. Dr. Nissenson served as a Robert Wood Johnson Health Policy Fellow of the Institute of Medicine in 1994-5, working in the office of the late Senator Paul Wellstone. Dr. Nissenson is the author of two dialysis textbooks, both in their fourth editions and was the founding Editor-in-Chief of Advances in Renal Replacement Therapy, an official journal of the National Kidney Foundation. He recently completed service as Editor-in-Chief of Hemodialysis International the official journal of the International Society for Hemodialysis, as well as Medscape Nephrology, an innovative website focused on nephrology. He has over 650 publications in the field of nephrology, dialysis, anemia management, and health care delivery and policy. Among his numerous honors are the 2007 Lifetime Achievement Award in Hemodialysis presented by the University of Missouri on behalf of the Annual Dialysis Conference, the President's Award of the National Kidney Foundation and the 2011 Medal of Excellence Award of the Association of American Kidney Patients.

KINDRED HEALTHCARE

Sean Muldoon, MD

Sean R. Muldoon, MD, MPH, FCCP was named SVP and Chief Medical Officer for the hospital division, effective January, 2004. Dr. Muldoon has been with Kindred since 1994, first as medical director of Kindred Hospital - North Florida and most recently as Chief Medical Officer for the division. Sean holds degrees in Chemical Engineering from the University of Illinois and Northwestern, as well as in Medicine and Public Health from the University of Illinois. He is board certified in Internal Medicine, Pulmonary Disease and Preventive Medicine.

NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE

Lisa Tripp, JD

Lisa Tripp is an Assistant Professor at Atlanta's John Marshall Law School, Atlanta Georgia. She teaches Health Care Law, Torts and Remedies. Professor Tripp practiced health care law and commercial litigation prior to joining the faculty of Atlanta's John Marshall Law School in 2006. As an attorney for the U.S. Department of Health and Human Services (HHS), Professor Tripp focused primarily on long term care enforcement. She litigated many cases involving physical and sexual abuse, elopements, falls, neglect and substandard quality of care. Professor Tripp currently serves on the Governing Board of The National Consumer Voice for Quality Long-Term Care and is a Member of the Emory University

Institutional Review Board. She has served on health quality measurement committees and panels for the National Quality Forum and the Medicare Payment Advisory Commission (MedPAC). Professor Tripp received her law degree, with honors, from George Washington University Law School, in Washington, D.C.

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

Carol Spence, PhD

Carol Spence, PhD, is Director of Research and Quality at NHPCO, and is responsible for NHPCO performance measurement development and implementation activities and in addition to all other NHPCO research and quality activities. Carol has many years of clinical experience as a hospice nurse. She served on the National Board for Certification of Hospice and Palliative Nurses for six years and is past chair of the Examination Development Committee for the certification examination for advanced practice hospice and palliative nurses. She has experience in research design, plus developing, implementing, and managing field research projects. Carol holds a doctoral degree from the University of Maryland and holds a Master of Science degree in mental health nursing.

NATIONAL TRANSITIONS OF CARE COALITION

James Lett II, MD, CMD

Dr. Lett received his medical degree from the University of Kentucky, College of Medicine in 1974, and completed a Family Practice residency. He is certified by the American Board of Family Practice with a Certificate in Added Qualifications in Geriatrics and is a Certified Medical Director (CMD). He has practice experience in office, hospital and the long term care continuum. He has written about geriatric, long-term care and care transition subjects, and given multiple presentations around the country on these issues. Dr. Lett is a member of the American Medical Directors Association (AMDA), a 7,000-member long-term care physician group and is a past president in 2003-2004. He has held multiple positions and memberships in local, state and national medical organizations. He served as a member of the CMS workgroup to revise F-Tag 329: Unnecessary Drugs chaired a joint national effort that created a long-term care medication toolkit for patient safety, and chaired a national workgroup to create a Clinical Practice Guideline for Care Transitions in the Long-Term Care Continuum. He was Senior Medical Director for Quality for Lumetra, the Quality Improvement Organization for California until assuming the role of Chief Medical Officer of Long-Term Care for the California Prison Health Care Services in October 2008. He is currently Medical Director for Charles E. Smith Life Communities, a multi-level care campus located in Rockville, MD.

PROVIDENCE HEALTH & SERVICES

Dianna Reely

Dianna Reely, Providence Senior and Community Services VP Quality and Informatics has over 30 years of healthcare leadership experience including roles as Vice President of Quality at Overlake Hospital Medical Center, a 357 bed hospital and currently at Providence Health and Services in the Senior and Community Services division. Providence Senior and Community Services include home health, hospice, skilled nursing facility, assisted living, home infusion and pharmacy and senior housing services. Dianna lead her hospital organization as early adopters through the IHI 100,000 lives campaign and implementation of Joint Commission core measures. Dianna has also served as Chief Experience Officer and has spent over 10 years leading efforts that have improved the patient experience in a variety of settings. Dianna's educational background includes certifications in Health Information Management, Quality and Healthcare Compliance.

SERVICE EMPLOYEES INTERNATIONAL UNION

Charissa Raynor

Charissa is Executive Director of the SEIU Healthcare NW Training Partnership and Health Benefits Trust. The Training Partnership is the largest nonprofit school of its kind in the nation providing training and workforce development services to more than 40,000 long-term care workers annually while the Health Benefits Trust provides smartly designed health benefits coverage to nearly 14,000 long-term care workers in Washington and Montana. Charissa provides overall leadership and strategic direction to these two inter-related organizations building on more than 10 years of experience in the health care field including administration, research, and policy work. She is also a Registered Nurse with experience in public health, long-term care, and primary care settings. Previously, Charissa held positions with SEIU Healthcare 775NW, the University of Hawaii at Manoa School of Nursing, and the Institute for the Future of Aging Services. She holds a Master's degree in health services administration. Charissa is a board member of the Puget Sound Health Alliance and a member of the U.S. Secretary of Labor's Advisory Committee on Apprenticeship.

VISITING NURSES ASSOCIATIONS OF AMERICA

Margaret (Peg) Terry, PhD, RN

Margaret Terry oversees the quality, risk management, compliance programs as well as technology and specialty programs throughout the Visiting Nurse Association (VNA) and MedStar Health Infusion (MHI). As part of her role in quality, she is responsible for the agencies' compliance with the standards of The Joint Commission, CMS and State licensure. Her role also includes performance improvement activities as well as the evaluation and tracking of outcomes and processes for home care including the evaluation of the patient's experience. Her other responsibilities include oversight for the Immunization and Wellness program at the VNA. Dr. Terry is the Chair of the Professional Technical Advisory Committee at the Joint Commission for the home care group and a member of the Home Health Quality Improvement (HHQI) National Campaign Executive Steering Committee for 2010. Over the years, Terry has served as president of the Capitol Home Care Association, and a board member for the Maryland National Capital Home Care Association and the National Home Care Association. Additionally, she participated on National Quality Forum's (NQF) Steering Committee on National Consensus Standards for Additional Home Health Measures (2008), the NQF's Advisory committee on Harmonization of Immunization Standards for health care organizations (2008) and the NQF's panel of the Safety Technical Advisory Panel for the National Consensus Standards for Therapeutic Drug Management Quality (2007). Prior to coming to VNA, Terry was president and chief executive officer for Home Care Partners, Inc. a non-profit providing personal care to residents in the Washington DC area. Preceding this position, she was an assistant professor in the School of Nursing in the graduate division at Catholic University. Dr. Terry earned a doctorate from the University of Maryland at Baltimore examining clinical outcomes in home care. Terry holds a Master of Science in Nursing with a Community Health Concentration from Boston University and a Bachelor of Science in Nursing from the State University of New York. She also has participated in several research studies at the VNA and recently published an article titled a "Feasibility Study of Home Care Wound Management Using Tele-monitoring" in the journal Advances in Skin and Wound Care.

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

CLINICIAN/NEPHROLOGY

Louis H. Diamond, MBChB, FCP, (SA), FACP, FHIMSS

Louis H. Diamond, MBChB, FCP (SA), FACP, FHIMSS, is the President of Quality in Health Care Advisory Group, LLC (QHC). He is an expert in the use of methodologies for measuring and improving quality and also involved in the development of public policy through projects focused on patient safety, health system financing, physician payment reform, quality measurement and reporting, and performance improvement. He currently serves as the following: Chair, Physician Engagement Committee, Health Information Management Systems Society; Member, Leadership Network, National Quality Forum (NQF); Member, Measurement Application Partnership Post-Acute Workgroup, NQF; Vice Chair, End-Stage Renal Disease Network, (A QIO for the ESRD program Board; Delegate for the Renal Physicians Association to the American Medical Association House of Delegates; Member, National Priorities Partnership representing the Healthcare Information and Management Systems Society; Member, Board of Trustees, American College of Medical Quality; and Board Member, Quality Insights Holdings. He previously held leadership positions at a variety of healthcare organizations including: Chair, Strategic Directions Subcommittee, Physician Consortium for Performance Improvement; Chair, Policy Steering Committee, eHealth Initiative (eHI); Chair, Quality Safety and Outcomes Committee, Healthcare Information and Management Systems Society (HIMSS); Chair, Quality, Measurement and Research Council, NQF; President, Renal Physicians Association; Board of Directors, National Patient Safety Foundation; President, Medical Society of D.C.; Board of Trustees, American Society of Internal Medicine; President, American College of Medical Quality and Chair, Physician Engagement Committee, HIMSS as of July 2013. In addition, Dr. Diamond served as a Robert Wood Johnson Health Policy Fellow; Vice President and Medical Director, Thomson Reuters Healthcare; Professor of Medicine, Chair, Georgetown Department of Medicine and Dean for Medical Affairs, at D. C. General Hospital; Research Fellow, Renal Metabolic Unit and Assistant professor of Medicine, Cape Town School of Medicine and Groote Schuur Hospital. Dr. Diamond is a graduate of the University of Cape Town Medical School, South Africa; Fellow, American College of Physicians; and Fellow, College of Physicians, South Africa and Fellow American College of Physicians.

CLINICIAN/NURSING

Charlene Harrington, PhD, RN, FAAN

Charlene Harrington, Ph.D., RN, FAAN has been a professor at the University of California San Francisco since 1980 where she has specialized in long term care policy and research. She was elected to the IOM in 1996, and served on various IOM committees. In 2002, she and a team of researchers designed a model California long term care consumer information system website funded by the California Health Care Foundation and she continues to maintain and expand the site. Since 1994, she has been collecting and analyzing trend data on Medicaid home and community based service programs and policies, currently funded by the Kaiser Family Foundation. In 2003, she became the principal investigator of a five-year $4.5 million national Center for Personal Assistance Services funded by the National Institute on Disability and Rehabilitation Research, which has just been refunded for (2008-2013). She has testified before the US Senate Special Committee on Aging, and has written more than 200 articles and chapters and co-edited five books while lecturing widely in the U.S.

CARE COORDINATION

Gerri Lamb, PhD

Dr. Gerri Lamb is an Associate Professor at Arizona State University in Phoenix, Arizona. She holds joint appointments in the College of Nursing and Health Innovation and the Herberger Institute for Design and the Arts where she teaches in the interprofessional graduate programs in Leadership in Healthcare Innovation and Health and Healing Environments. Dr. Lamb is well-known for her leadership and research on care coordination, case management, and transitional care. She has presented many papers and published extensively on processes and outcomes of care across service settings. Her funded research has focused on hospital care coordination and adverse outcomes associated with transfers between hospitals and post-acute and long-term care settings. She is a member of the research team that developed and tested the INTERACT program for reducing hospital transfers of nursing home residents. Her most recent grant work funded by the Josiah Macy Jr Foundation is focused on interprofessional education and practice in primary care. Dr. Lamb has chaired and/or participated in a number of national quality and safety initiatives. She co-chaired both of the National Quality Forum's Steering Committees on Care Coordination. She also co-chaired the American Academy of Nursing's Expert Panel on Quality and currently represents the Academy on the board of the Nursing Alliance for Quality Care. She serves as a member of the Physician Consortium on Performance Improvement's Measurement Advisory Committee and the American Board of Internal Medicine's Product Oversight Committee.

CLINICIAN/GERIATRICS

Bruce Leff, MD

Dr. Leff is Professor of Medicine at the Johns Hopkins University School of Medicine, and holds a Joint Appointment in the Department of Health Policy and Management at the Johns Hopkins University Bloomberg School of Public Health. He is the Director of the Program in Geriatric Health Services Research and the Co-Director of the Elder House Call Program, in the Division of Geriatric Medicine at the Johns Hopkins. His principal areas of research relate to home care and the development, evaluation, and dissemination of novel models of care for older adults, including the Hospital at Home model of care (www.hospitalathome.org), guided care (www.guidedcare.org), geriatric service line models (www.med-ic.org), and medical house call practices (www.iahnow.org). In addition, his research interests extend to issues related to the care of patients with multiple chronic conditions, guideline development, performance measurement, quality indicators, and case-mix issues. Dr. Leff cares for patients in the acute, ambulatory, and home settings. He practices in the home, ambulatory, hospital, nursing home, skilled nursing facility, rehabilitation, and PACE settings. He is the Associate Director of the Medicine Clerkship at the Johns Hopkins University School of Medicine and has received numerous awards for his teaching and mentorship. He is a member of the Board of Regents of the American College of Physicians, President of the American Academy of Home Care Physicians, and is a Fellow of InterRAI.

STATE MEDICAID

Marc L. Leib, MD, JD

In his position Dr. Leib's duties include developing medical policies, determining coverage criteria for new procedures, overseeing quality assurance and improvement activities, investigating member and provider complaints, evaluating regulatory requirements, and assuring that the approximately one million AHCCCS members receive appropriate medical services. Dr. Leib practiced anesthesia in Tucson, AZ for approximately two decades and was very active in the medical community, serving as president

of both the Arizona Society of Anesthesiologists and the Arizona Medical Association. He later attended law school and subsequently practiced health care law at a large firm in Washington, D.C., concentrating on Medicare regulatory affairs and Health Insurance Portability and Accountability Act (HIPAA) issues.

MEASURE METHODOLOGIST

Debra Saliba, MD, MPH

Debra Saliba, MD, MPH, is the Anna & Harry Borun Chair in Geriatrics at the David Geffen School of Medicine at UCLA and is the director of the UCLA/JH Borun Center for Geronotological Research. She is also a geriatrician with the VA GRECC and a Senior Natural Scientist at RAND. Dr. Saliba's research has focused on creating tools and knowledge that can be applied to improving quality of care and quality of life for vulnerable older adults across the care continuum. Her research has addressed the hospitalization of vulnerable older adults, assessment of functional status and co-morbidity, patient safety, quality measurement, pressure ulcers, falls, pain, home accessibility, and the prediction of functional limitation and mortality. Dr. Saliba recently led the national revision of the Minimum Data Set for Nursing Homes (MDS 3.0) for the Centers for Medicare & Medicaid Services and VA HSR&D. In this large multi-state project, Dr. Saliba led a national consortium of researchers and used both qualitative and quantitative methods to improve item reliability, validity and efficiency for this national program. Gains were also seen in facility staff satisfaction with the MDS assessment. Dr. Saliba's research in quality of care and vulnerable populations has received awards from the Journal of American Medical Directors Association, VA Health Services Research & Development, and the American Geriatrics Society. She is a member of the Board of Directors of the California Association of Long Term Care Medicine and of the American Geriatrics Society.

HEALTH IT

Thomas von Sternberg, MD

Tom von Sternberg, MD, is the associate medical director of Geriatrics, HomeCare and Hospice. He has been practicing as a geriatrician for 27 years. He is also involved in helping to supervise HealthPartners Case and Disease Management Services. Dr. von Sternberg is medical director of clinical care for Post-acute, long term care and assisted living at HealthPartners. He is medical director of HealthPartners Dual Eligible FIDESNP program. He is the co-chair of the American Geriatric Society Quality performance measurement committee. He is a past chair and active member of the State of Minnesota Health Services Advisory council. Dr. von Sternberg participates on the Joint Commission's Technical Advisory Council for long term care. He also has an appointment of associate clinical faculty at the University of Minnesota Department of Family Medicine and Community Health.

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

D.E.B. Potter, MS

D.E.B. Potter is a Senior Survey Statistician, in the Center for Financing, Access and Cost Trends (CFACT), Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). Her work focuses on improving the measurement of the long-term care (LTC) and disabled populations at the national level. Efforts include data collection and instrument design; measuring use, financing and quality of health care; and estimation issues involving people with disabilities that use

institutional, sub-acute and home and community-based services (HCBS). In 2002, she (with others) received HHS Secretary's Award "for developing and implementing a strategy to provide information the Department needs to improve long-term care." She currently serves as Co-Lead, AHRQ's LTC Program, and is responsible for AHRQ's Assisted Living Initiative and the Medicaid HCBS quality measures project.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Shari Ling, MD

Dr. Shari M. Ling is currently the Centers for Medicare and Medicaid Services (CMS), Deputy Chief Medical Officer serving in the Office of Clinical Standards and Quality (OCSQ), responsible for assisting the CMS Chief Medical Officer in the Agency's pursuit of higher quality health care, healthier populations, and lower cost through quality improvement. Dr. Ling's long-standing focus is on the achievement of meaningful health outcomes through delivery of high quality beneficiary-centered care across all care settings, with a special interest in the care of persons with multiple chronic conditions and functional limitations, and reducing health disparities. Dr. Ling has served as the lead coordinator and facilitator of the OCSQ Measures Forum. Dr. Ling represents CMS on the Health and Human Services (HHS) Multiple Chronic Conditions workgroup, and the National Quality Forum Measures Application Partnership – Post-acute Care/Long-term Care workgroup, and chairs the Measures and Data sources sub-workgroup for the HHS Action Plan for Healthcare Associated Infection (HAI) Prevention in Long-term Care facilities. Dr. Ling also serves as the clinical sub-group lead for the HHS National Alzheimer's Project Act. Dr. Ling is a Geriatrician and Rheumatologist who received her medical training at Georgetown University School of Medicine where she graduated as a member of the Alpha Omega Alpha Honor Society. Dr. Ling received her clinical training in Internal Medicine and Rheumatology at Georgetown University Medical Center, and completing Geriatric Medicine studies at Johns Hopkins University., remaining on faculty at Johns Hopkins for 5 years, after which she joined the Intramural Research Program of the National Institutes of Health at the National Institute on Aging as a Staff Clinician for 8 years studying human aging and age-associated chronic diseases with attention to musculoskeletal conditions and mobility function. Dr. Ling continues to serve as a part-time faculty member in the Division of Geriatric Medicine and Gerontology at Johns Hopkins University School of Medicine, and in the Division of Rheumatology, Allergy and Clinical Immunology at the University of Mary-land. Dr. Ling volunteers at the Veterans Administration Medical Center in Baltimore. She is a Gerontologist who received her training in Direct Service from the Ethel Percy Andrus Gerontology Center, at the University of Southern California, and served as the co-director of the Andrus Older Adult Counseling Center.

VETERANS HEALTH ADMINISTRATION (VHA)

Scott Shreve, MD

Dr. Scott Shreve is the National Director of Hospice and Palliative Care Program for the Department of Veterans Affairs. He is responsible for all policy, program development, staff education and quality assurance for palliative and hospice care provided or purchased for enrolled Veterans. Dr. Shreve leads the implementation and oversight of the Comprehensive End-of-Life Care Initiative, a 3 year program to change the culture of care for Veterans at end of life and to ensure reliable access to quality end of life care. Clinically, Dr. Shreve commits half of his time to front line care of Veterans as the Medical Director and teaching attending at a 17 bed inpatient Hospice and Palliative Care Unit at the Lebanon VA Medical Center in Central Pennsylvania. Dr. Shreve is an Associate Professor of Clinical Medical at The Pennsylvania State University and has been awarded the Internal Medicine Distinguished Teaching

Award in 2007 and 2009. Dr. Shreve has board certifications in Internal Medicine, Geriatrics and in Hospice and Palliative Care. Prior to medical school, Scott was a corporate banker.

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)

George J. Isham, MD, MS

George Isham, M.D., M.S. is the chief health officer for HealthPartners. He is responsible for the improvement of health and quality of care as well as HealthPartners' research and education programs. Dr. Isham currently chairs the Institute of Medicine (IOM) Roundtable on Health Literacy. He also chaired the IOM Committees on Identifying Priority Areas for Quality Improvement and The State of the USA Health Indicators. He has served as a member of the IOM committee on The Future of the Public's Health and the subcommittees on the Environment for Committee on Quality in Health Care which authored the reports To Err is Human and Crossing the Quality Chasm. He has served on the subcommittee on performance measures for the committee charged with redesigning health insurance benefits, payment and performance improvement programs for Medicare and was a member of the IOM Board on Population Health and Public Health Policy. Dr. Isham was founding co-chair of and is currently a member of the National Committee on Quality Assurance's committee on performance measurement which oversees the Health Employer Data Information Set (HEDIS) and currently co-chairs the National Quality Forum's advisory committee on prioritization of quality measures for Medicare. Before his current position, he was medical director of MedCenters health Plan in Minneapolis and In the late 1980s he was executive director of University Health Care, an organization affiliated with the University of Wisconsin-Madison.

Elizabeth A. McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the Director of Kaiser Permanente's Center for Effectiveness and Safety Research (CESR). She is responsible for the strategic direction and scientific oversight of CESR, a virtual center designed to improve the health and well-being of Kaiser's 9 million members and the public by conducting comparative effectiveness and safety research and implementing findings in policy and practice. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness, quality and efficiency of health care delivery. She has conducted research in the U.S. and in other countries. Dr. McGlynn has also led major initiatives to evaluate health reform options under consideration at the federal and state levels. Dr. McGlynn is a member of the Institute of Medicine. She serves as the Secretary and Treasurer of the American Board of Internal Medicine Foundation Board of Trustees. She is on the Board of AcademyHealth and the Institute of Medicine Board of Health Care Services. She chairs the Scientific Advisory Group for the Institute for Healthcare Improvement. She co-chairs the Coordinating Committee for the National Quality Forum's Measures Application Partnership. She serves on the editorial boards for *Health Services Research* and *The Milbank Quarterly* and is a regular reviewer for many leading journals. Dr. McGlynn received her B.A. in international political economy from The Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her Ph.D. in public policy analysis from the Pardee RAND Graduate School.

NATIONAL QUALITY FORUM STAFF

Thomas B. Valuck, MD, JD, MHSA

Thomas B. Valuck, MD, JD, is Senior Vice President, Strategic Partnerships, at the National Quality Forum (NQF). Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through use of performance information for public reporting, payment incentives, accreditation and certification, and systems improvement. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Aisha Pittman, MPH

Aisha T. Pittman, MPH, is a Senior Director, Strategic Partnerships, at the National Quality Forum (NQF). Miss Pittman leads the Clinician Workgroup and the Post-Acute Care/Long-Term Care Workgroup of the Measure Applications Partnership (MAP). Additionally, Ms. Pittman led an effort devoted to achieving consensus on a measurement framework for assessing the efficiency of care provided to individuals with multiple chronic conditions. Ms. Pittman comes to NQF from the Maryland Health Care Commission (MHCC) where she was Chief of Health Plan Quality and Performance; responsible for state efforts to monitor commercial health plan quality and address racial and ethnic disparities in health care. Prior to MHCC, Ms. Pittman spent five years at the National Committee for Quality Assurance (NCQA) where she was responsible for developing performance measures and evaluation approaches, with a focus on the geriatric population and Medicare Special Needs Plans. Ms. Pittman has a bachelor of science in Biology, a Bachelor of Arts in Psychology, and a Masters in Public Health all from The George Washington University. Ms. Pittman was recognized with GWU's School of Public Health and Health Services Excellence in Health Policy Award.

Mitra Ghazinour, MPP

Mitra Ghazinour, MPP, is a project manager, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization with the mission to build consensus on national priorities and goals for performance improvement and endorse national consensus standards for measuring and publicly reporting on performance. Ms. Ghazinour is currently supporting the work of the NQF Measure Applications Partnership (MAP) Clinician and Post-Acute/Long-Term Care (PAC/LTC) workgroups. Prior to working at NQF, she was a research analyst III at Optimal Solutions Group, LLC, serving as the audit team leader for the Evaluation & Oversight (E&O) of Qualified Independent Contractors (QIC) project. Her

responsibilities as audit team leader included serving as a point of contact for QIC and CMS, conducting interviews with QIC staff, reviewing case files, facilitating debriefings and meetings, and writing evaluation reports. Ms. Ghazinour also served as the project manager for the Website Monitoring of Part D Benefits project, providing project management as well as technical support. Additionally, she provided research expertise for several key projects during her employment at IMPAQ International, LLC. In the project, Development of Medicare Part C and Part D Monitoring Methods for CMS, Ms. Ghazinour assisted with the collaboration between CMS and IMPAQ on a broad effort to review, analyze, and develop methods and measures to enhance the current tools CMS uses to monitor Medicare Advantage (Part C) and Prescription Drug (Part D) programs. In another effort to support CMS, Ms. Ghazinour coordinated the tasks within the National Balancing Contractor (NBIC) project which entailed developing a set of national indicators to assess states' efforts to balance their long-term support system between institutional and community-based supports, including the characteristics associated with improved quality of life for individuals. She also provided analytic support for the development of the report on the Medicare advantage value-based purchasing programs as part of her work on the Quality Improvement Program for Medicare Advantage Plans project at IMPAQ. Ms. Ghazinour has a Master's degree in Public Policy and a bachelor's degree in Health Administration and Policy Program (Magna Cum Laude) from the University of Maryland, Baltimore County (UMBC).

Erin O'Rourke

Erin O'Rourke is a Project Manager in the Strategic Partnerships department at the National Quality Forum. Ms. O'Rourke staffs the NQF-convened Measure Applications Partnership (MAP), supporting an expert workgroup focused on measuring and improving the quality of care delivered in hospitals and post-acute and long-term care settings. Prior to joining NQF Ms. O'Rourke worked in Outcomes Research at United BioSource Corporation. While at UBC, she worked to develop patient-reported outcome measures and evaluate their measurement qualities. Additionally, she also worked on studies to evaluate symptoms, measure health-related quality of life, and evaluate treatment satisfaction and patient preference. Before working with UBC, Ms. O'Rourke began her career with The Foundation for Informed Medical Decision Making, a non-profit organization working to promote shared decision-making and patient engagement where she was responsible for supporting the Foundation's research efforts. Ms. O'Rourke has a bachelor of science in Health Care Management and Policy from Georgetown University.

Y. Alexandra Ogungbemi

Alexandra Ogungbemi is an Administrative Assistant in Strategic Partnerships, at the National Quality Forum (NQF). Ms. Ogungbemi contributes to the Clinician, Dual Eligible Beneficiaries, and Post-Acute Care/Long-Term Care Workgroups, as well as various task forces of the Measure Applications Partnership (MAP). Post-graduation, she spent 2 years managing the Administrative side of Cignet Healthcare, a multi-specialty physician's practice in Southern Maryland, before joining NQF. Ms. Ogungbemi has a Bachelor of Science in Health Services Administration from The Ohio University and has plans to extend her post-graduate education in the field of Health and Family Law.