MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

For

IN-PERSON MEETING OF THE POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

JUNE 28, 2011

Measure Applications Partnership (MAP)

Post-Acute Care/Long-Term Care Workgroup

In-Person Meeting #1

June 28, 2011

Welcome and Review of Meeting Objectives

Meeting Objectives

- Review charge of the MAP PAC-LTC Workgroup, role within MAP, and a plan to complete the tasks
- Establish guiding principles for a coordination strategy for performance measurement across PAC/LTC settings
- Provide input on the coordination of healthcare-acquired condition and hospital readmission measurement across public and private payers

Meeting Agenda

- Welcome, review of meeting objectives, and opening remarks
- Introductions and disclosures of interests
- MAP functions
- Guiding frameworks and workgroup charge
- Post-acute care and long-term care settings and performance measurement
- Opportunities for alignment across PAC-LTC settings
- Defining the elements of a PAC-LTC performance measurement coordination strategy
  - Measure Selection Criteria
  - Data source and HIT implications
  - Special considerations for Medicare/Medicaid dual-eligible beneficiaries
- PAC-LTC Workgroup input to the Safety Workgroup
- Summary
- Adjourn

Introductions and Disclosures of Interests

Post-Acute Care/ Long-Term Care Workgroup Membership

Chair	Carol Raphael, MPA

Organizational Members	Representatives
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
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 and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurse Associations of America	Emilie Deady, RN, MSN, MGA

Post-Acute Care/ Long-Term Care Workgroup Membership

Subject Matter Experts	Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
	Care Coordination	Gerri Lamb, PhD
	Clinician/Geriatrics	Bruce Leff, MD
	State Medicaid	Mary Anne Lindeblad, MPH
	Measure Methodologist	Debra Saliba, MD, MPH
	Health IT	Thomas von Sternberg, MD

Federal Government Members	Agency for Healthcare Research and Quality	**Representatives**	Judy Sangl, ScD
	Centers for Medicare & Medicaid Services		Shari Ling, MD
	Veterans Health Administration		Scott Shreve, MD

Coordinating Committee Co-Chairs	George Isham, MD, MS
	Beth McGlynn, PhD, MPP

MAP Function

Process and Purpose of Input to the Coordinating Committee

Statutory Authority

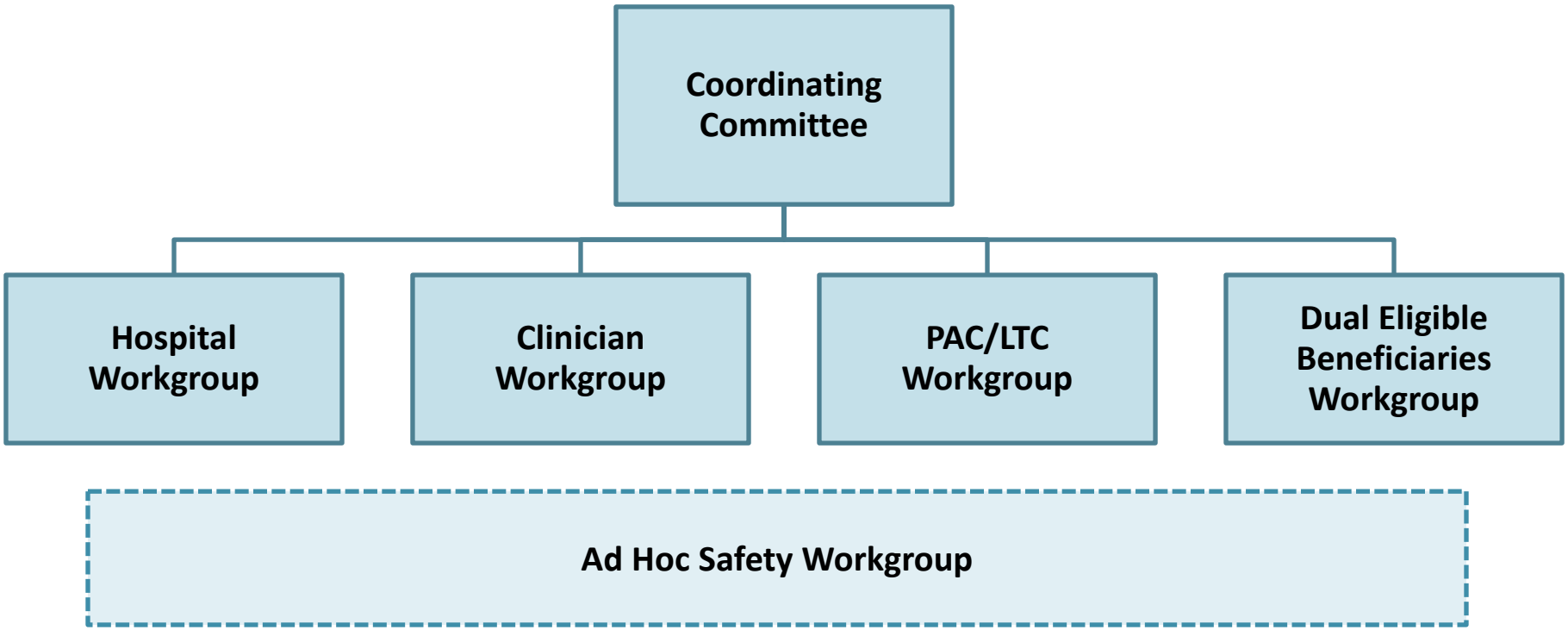
Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (NQF) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, performance-based payment, and other programs.

HR 3590 § 3014, amending the Social Security Act (PHSA) by adding § 1890(b)(7)

Function

- Provide input to HHS/CMS on the selection of available measures for public reporting and performance-based payment programs
- Identify gaps for measure development and endorsement
- Encourage alignment of public and private sector programs and across settings

MAP Two-Tiered Structure



MAP Coordinating Committee Charge

The charge of the MAP Coordinating Committee is to:

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

MAP Member Responsibilities and Communications Policies and Support

MAP Policies and Support

- Member responsibilities
- Communications policies and support
  - Template press release
  - Frequently asked questions
  - NQF Communications staff

Workgroup Member Terms

- While NQF's current scope of work with HHS lasts through June 2012; MAP's work is expected to continue.
  - Specific tasks will change over time
  - The workgroup structure is designed to be flexible and groups may shift to align with evolving priorities
- The terms for MAP members are for three years.
- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw.
- There are equal numbers of 1-, 2-, and 3-year terms.
- Members whose terms expire are eligible to re-nominate themselves during the open Call for Nominations.
- There is no term limit for MAP members at this time.

Membership Terms

Chair	Term Length
Carol Raphael, MPA	

Organizational Members	Term Length
Aetna	
American Medical Rehabilitation Providers Association	
American Physical Therapy Association	
Family Caregiver Alliance	
HealthInsight	
Kindred Healthcare	
National Consumer Voice for Quality Long-Term Care	
National Hospice and Palliative Care Organization	
National Transitions of Care Coalition	
Providence Health and Services	
Service Employees International Union	
Visiting Nurse Associations of America	

Subject Matter Experts	Term Length
Charlene Harrington, PhD, RN, FAAN	
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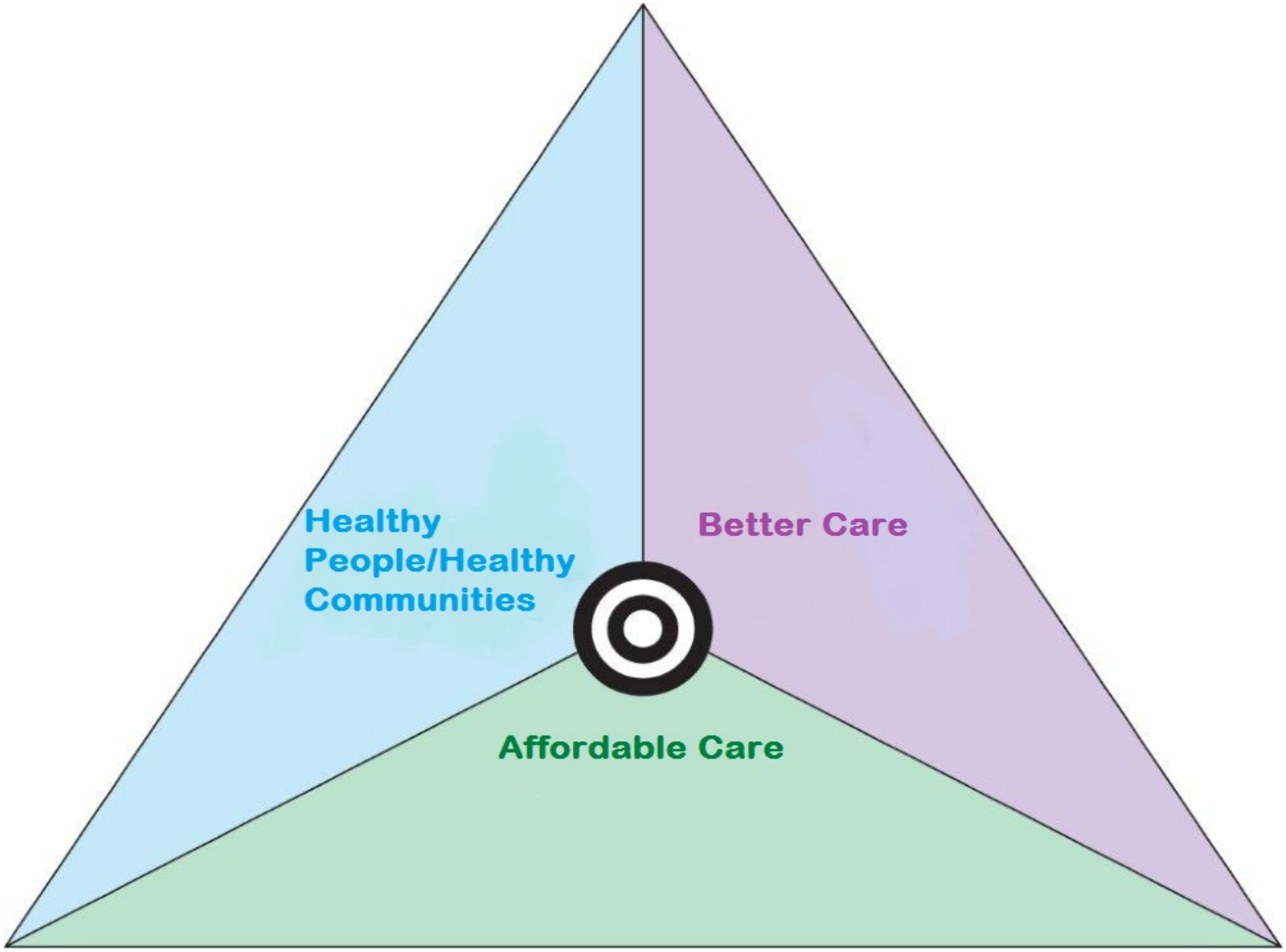
Debra Saliba, MD, MPH	
Thomas von Sternberg, MD	

Federal Government Members	Term Length
Agency for Healthcare Research and Quality	
Centers for Medicare & Medicaid Services	
Veterans Health Administration	

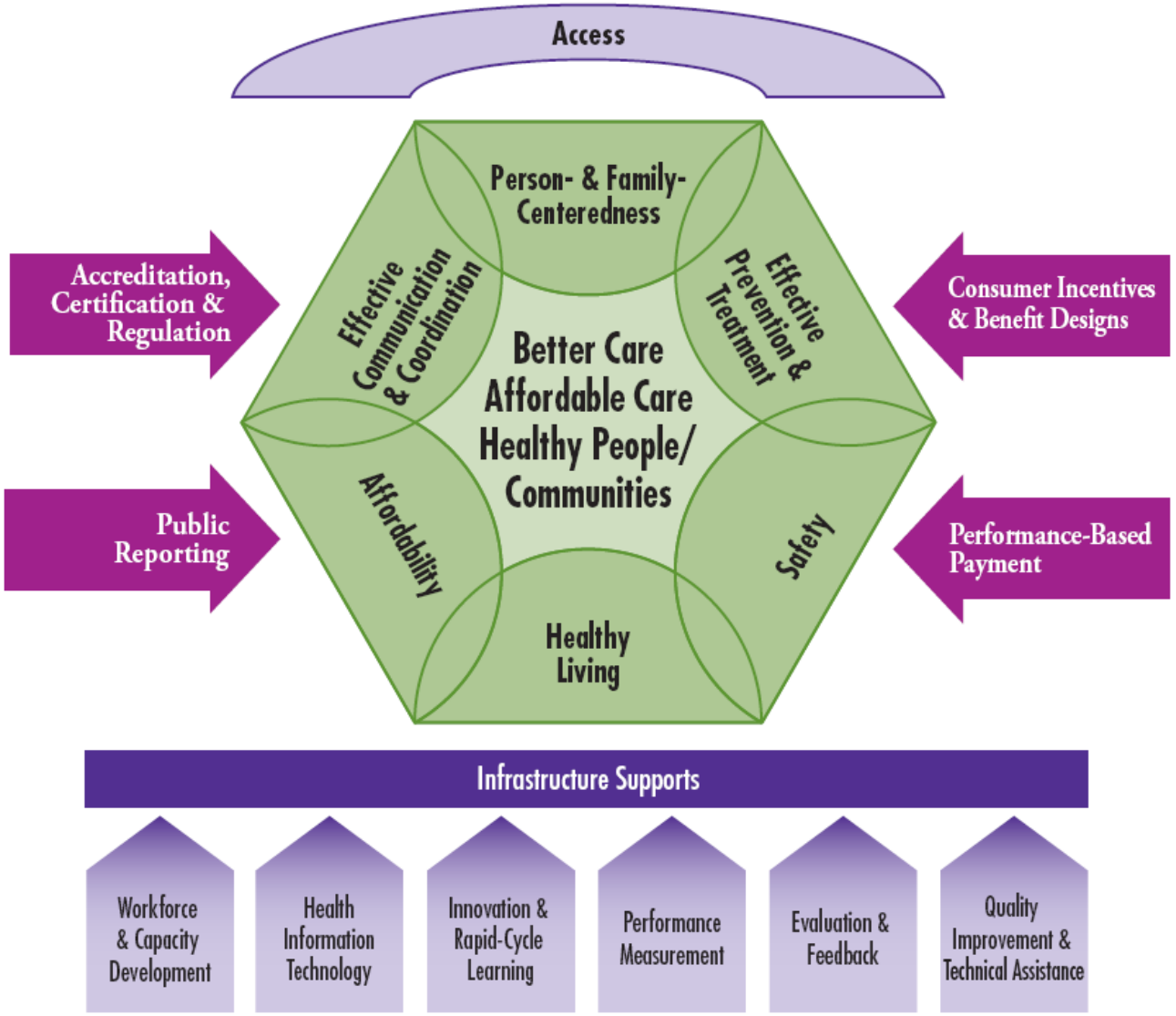
Discussion and Questions

Guiding Frameworks and Workgroup Charge

HHS Aims for the National Quality Strategy



HHS National Quality Strategy



Principles for the National Quality Strategy

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1. Person-centeredness and family engagement

2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage.

3. Eliminating disparities in care

4. Aligning the efforts of public and private sectors

5. Quality improvement

6. Consistent national standards

7. Primary care will become a bigger focus

8. Coordination will be enhanced

9. Integration of care delivery

10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them will be encouraged.

High-Impact Conditions

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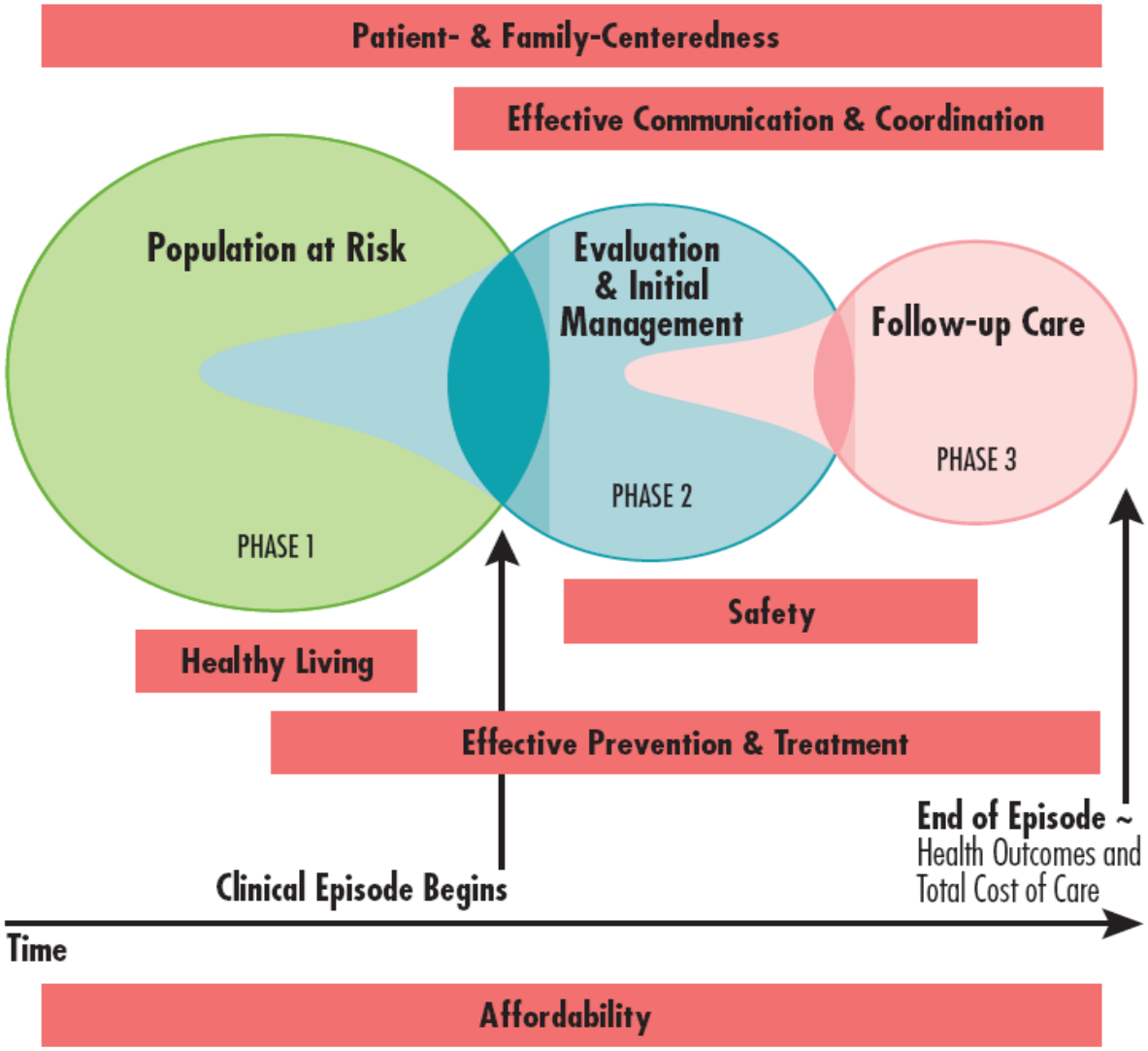
Medicare Conditions

	Condition	Votes
1.	Major Depression	30
2.	Congestive Heart Failure	25
3.	Ischemic Heart Disease	24
4.	Diabetes	24
5.	Stroke/Transient Ischemic Attack	24
6.	Alzheimer's Disease	22
7.	Breast Cancer	20
8.	Chronic Obstructive Pulmonary Disease	15
9.	Acute Myocardial Infarction	14
10.	Colorectal Cancer	14
11.	Hip/Pelvic Fracture	8
12.	Chronic Renal Disease	7
13.	Prostate Cancer	6
14.	Rheumatoid Arthritis/Osteoarthritis	6
15.	Atrial Fibrillation	5
16.	Lung Cancer	2
17.	Cataract	1
18.	Osteoporosis	1
19.	Glaucoma	0
20.	Endometrial Cancer	0

Child Health Conditions and Risks

Condition and Risk	Votes
Tobacco Use	29
Overweight/Obese (≥85th percentile BMI for age)	27
Risk of developmental delays or behavioral problems	20
Oral Health	19
Diabetes	17
Asthma	14
Depression	13
Behavior or conduct problems	13
Chronic Ear Infections (3 or more in the past year)	9
Autism, Asperger's, PDD, ASD	8
Developmental delay (diag.)	6
Environmental allergies (hay fever, respiratory or skin allergies)	4
Learning Disability	4
Anxiety problems	3
ADD/ADHD	1
Vision problems not corrected by glasses	1
Bone, joint or muscle problems	1
Migraine headaches	0
Food or digestive allergy	0
Hearing problems	0
Stuttering, stammering or other speech problems	0
Brain injury or concussion	0
Epilepsy or seizure disorder	0
Tourette Syndrome	0

Patient-Focused Episodes of Care Model



MAP Decision-Making Framework

- Overarching principle:
  - The aims and priorities of the National Quality Strategy (NQS) will provide the foundation for MAP decision making.

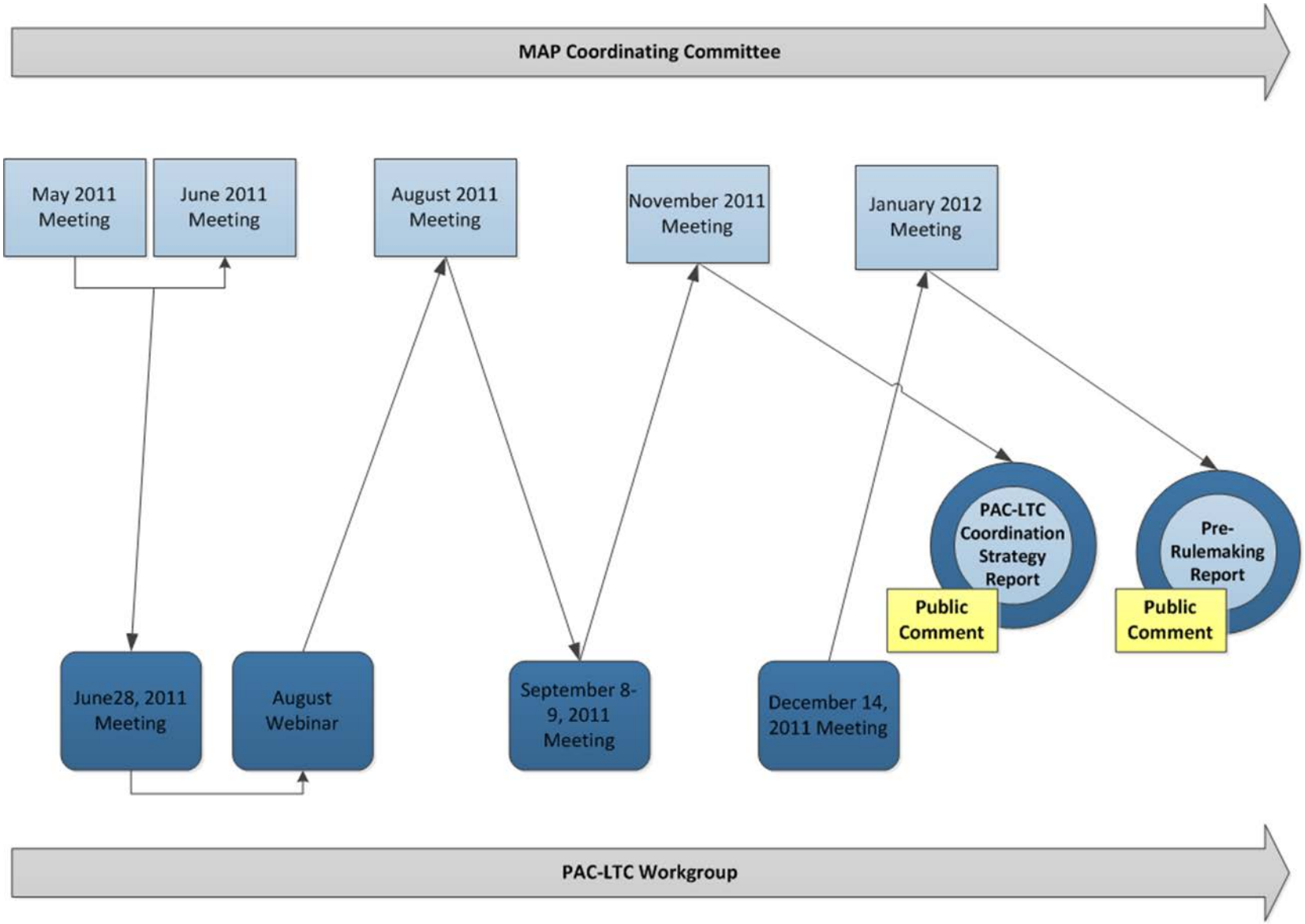
- Additional factors for consideration:
  - The two dimensional framework for performance measurement—NQS priorities and high-impact conditions—will provide focus.
  - The patient-focused episodes of care model will reinforce patient-centered measurement across settings and time.
  - HHS Multiple Chronic Conditions Framework.
  - Attention to equity across the NQS priorities.
  - Connection to financing and delivery models and broader context (e.g., ACOs).

Workgroup Charge

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

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

Workgroup Interaction with Coordinating Committee



Upcoming Work & Timeline

August 2011

- Convene a web meeting to discuss the decision-making criteria and framework developed by the Coordinating Committee

Coordinating Committee Meeting – August 17-18

Sep 8-9, 2011

- Conduct second in-person meeting to discuss the coordination strategy for PAC-LTC performance measurement

Coordinating Committee Meeting – November 1-2

Dec 14, 2011

- Convene third in-person meeting to react to proposed measures

Coordinating Committee Meeting – January 2012

Feb 1, 2012

- Final report due to HHS from the MAP Coordinating Committee regarding the PAC-LTC coordination strategy

Discussion and Questions

Opportunity for Public Comment

PAC-LTC Settings and Performance Measurement

Overview of PAC-LTC Settings and Quality Performance Programs

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- Post-Acute Care
  - Skilled Nursing Facilities (SNF)
  - Inpatient Rehabilitation Facilities (IRF)
  - Long-term Care Hospitals (LTCHs)
  - Home Health Care
- Hospice
- End Stage Renal Disease (ESRD) Facilities

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Post-Acute Care

Program/Quality Initiative	Quality Performance Assessment Domain
Post-Acute Care Payment Reform Initiative – This initiative is aimed to standardize patient assessment information among PAC settings and to employ these data to guide payment policy in the Medicare program.	Data will be collected using the CARE tool, which is an internet-based uniform patient assessment instrument that will measure the health and functional status of Medicare acute discharges and measure changes in severity and other outcome for Medicare PAC patients. The four major domains include: • Medical • Functional • Cognitive impairments • Social/environmental factors

Skilled Nursing Facilities/Nursing Homes

Program/Quality Initiative	Quality Performance Assessment Domain
Minimum Data Set (MDS) – MDS is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes.	The tool contains items that assess physical, psychological, and psychosocial functioning.
CAHPS nursing home surveys – The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to support the assessment of consumer's experiences with healthcare.	The surveys include long-stay resident and discharged resident instruments. • The long-stay resident instrument is designed to be administered in person and has been endorsed by the NQF. • The discharged resident instrument is designed to be administered by mail and has been endorsed by NQF on a provisional basis, pending final analyses of reporting composites. Both instruments include the following domains: environment, care, communication and respect, autonomy, and activities.
Nursing Home Compare – the website provides consumers, their families, and caregivers with information on the quality of care nursing homes offer.	• Health inspections- ratings are based on the number, scope, and severity of deficiencies identified during annual surveys and findings from complaint investigations, as well as the number of revisits to ensure that deficiencies have been resolved. • Staffing- ratings are based on two measures: RN hours per resident day and total staffing per resident day. • Quality measures (QMs)- ratings are based on performance of QMs developed from MDS-based indicators and include 7 long-stay and 3 short-stay measures.

Skilled Nursing Facilities/Nursing Homes

Program/Quality Initiative	Quality Performance Assessment Domain
Quality Indicator Survey (QIS)- The QIS is a computer assisted long-term care survey process used by selected state survey agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the federal requirements.	The areas of assessment include: • Review residents medical records to identify residents who were at risk for specified conditions and review diagnoses and medication. • Conduct resident interview which includes questions about pressure ulcers, urinary incontinence, nutrition, choices, and activities. • Perform resident observations such as ADL-choice, dining, and behavioral observations.
Medicare Quality Improvement Organization (QIO) Care Transitions Theme – The care transition theme involves 14 QIOs and focuses on improving coordination across the continuum of care.	CMS will measure the rate of 30-day hospital readmissions in the Care Transitions communities.

LTCHs, IRFs, and Hospice Program

Program/Quality Initiative	Quality Performance Assessment Domain
Quality Measurement Reporting Program- According to the section 3004 of the ACA, CMS is required to establish quality reporting programs for LTCHS, IRFs, and hospice programs, which in turn, require providers to submit data on quality measures to receive annual payment update, starting for fiscal year 2014 and each year thereafter.	CMS envisions the implementation of high priority, site-specific, and cross-setting quality measures for LTCHs, IRFs, and hospices that are valid, meaningful, feasible to collect, and that address symptom management, patient preferences, and avoidable adverse events.
Inpatient Rehabilitation Facility- Patient Assessment Instrument (IRF-PAI)- To administer the prospective payment system for IRFs, CMS requires each facility to electronically transmit a patient assessment instrument for each IRF stay to CMS's National Assessment Collection Database.	IRF-PAI data items address the physical, cognitive, functional, and functional, and psychosocial status of patients.

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Home Health Care

Program/Quality Initiative	Quality Performance Assessment Domain
Outcome and Assessment Information Set (OASIS) – The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is proposed to be an integral part of the revised Conditions of Participation for Medicare-certified home health agencies (HHAs).	The OASIS includes six major domains: • Sociodemographic • Environmental • Support system • Health status • Functional status Additionally, selected health service utilization items are included.
Home Health Compare- Home Health Compare provides information in regard to the quality of care provided by "Medicare-certified" HHAs throughout the U.S.	Domains of the quality measurement include: • Managing daily activities • Managing pain and treating symptoms • Treating wounds and preventing pressure sores • Preventing harm • Preventing unplanned hospital care

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End Stage Renal Disease (ESRD) Facilities

Program/Quality Initiative	Quality Performance Assessment Domain
Dialysis Facility Compare (DFC)- the tool assists patients and their family members and professionals to review and compare facility characteristics and quality of care offered in these facilities.	The quality measures used in the DFC include the following: • Percent of patients who had enough wastes removed from their blood during dialysis • Percent of patients who have their anemia under control • Patient survival rate
End-stage Renal Disease Quality Incentive Program (ESRD QIP)- The program is the first pay-for-performance program in a Medicare prospective payment system aimed to improve the quality of care for beneficiaries by changing the way dialysis facilities in the ESRD program are reimbursed.	The ESRD QIP focuses on three core measures: • Two measures covering anemia management • One measure capturing hemodialysis adequacy
Quality Assessment and Performance Improvement (QAPI)- Each dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program and also demonstrate evidence of its improvement to CMS.	The program must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors.

Discussion and Questions

Opportunities for Alignment Across Post-Acute Care and Long-Term Care Settings

PAC/LTC Alignment

- Given that the goals of care for patients in post-acute and long-term care settings and levels of care are different, what do you see as the key challenges to align measures across PAC/LTC settings?
- Do any of the existing instruments or measures sets help facilitate alignment across settings?
- How can we promote alignment with quality efforts in other settings (hospitals, ambulatory clinical care)?
- What are the key challenges to align private and public sectors?
- What community (regional/state/local) PAC/LTC quality efforts can inform our coordination strategy?

Discussion and Questions

Opportunity for Public Comment

Defining the Elements of a PAC-LTC Performance Measurement Coordination Strategy

Elements of a Coordination Strategy

- Measure selection principles
  - Selecting measures for specific uses (i.e., public reporting and payment reform)
  - Identifying gaps
  - Addressing value (i.e., quality and cost)
- Data source and health IT implications
  - Burden of measurement/data collection mechanisms
  - Levels of analysis (i.e., group practice vs. individual)
  - Progression toward e-measures and interoperable data platforms
- Special considerations for Medicare/Medicaid dual eligible beneficiaries

Elements of a Coordination Strategy

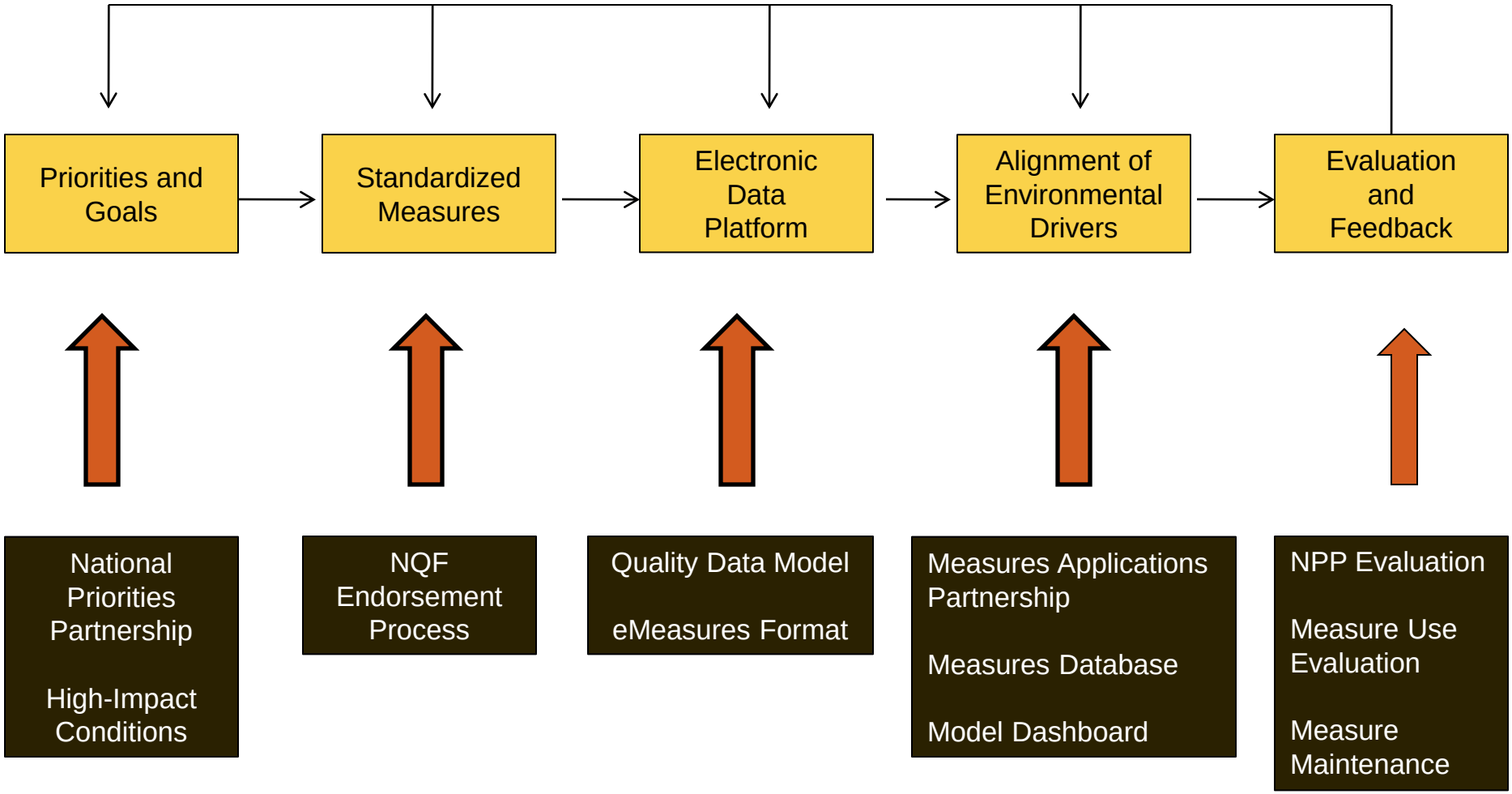
- Alignment with other settings and other public/private initiatives including new payment and delivery models
  - Capture key concepts from Workgroup deliberations
  - Coordinating Committee will discuss alignment themes across all workgroups
- Path for improving measure application
  - Consider how to move from current to ideal in each element of coordination strategy

Discussion and Questions

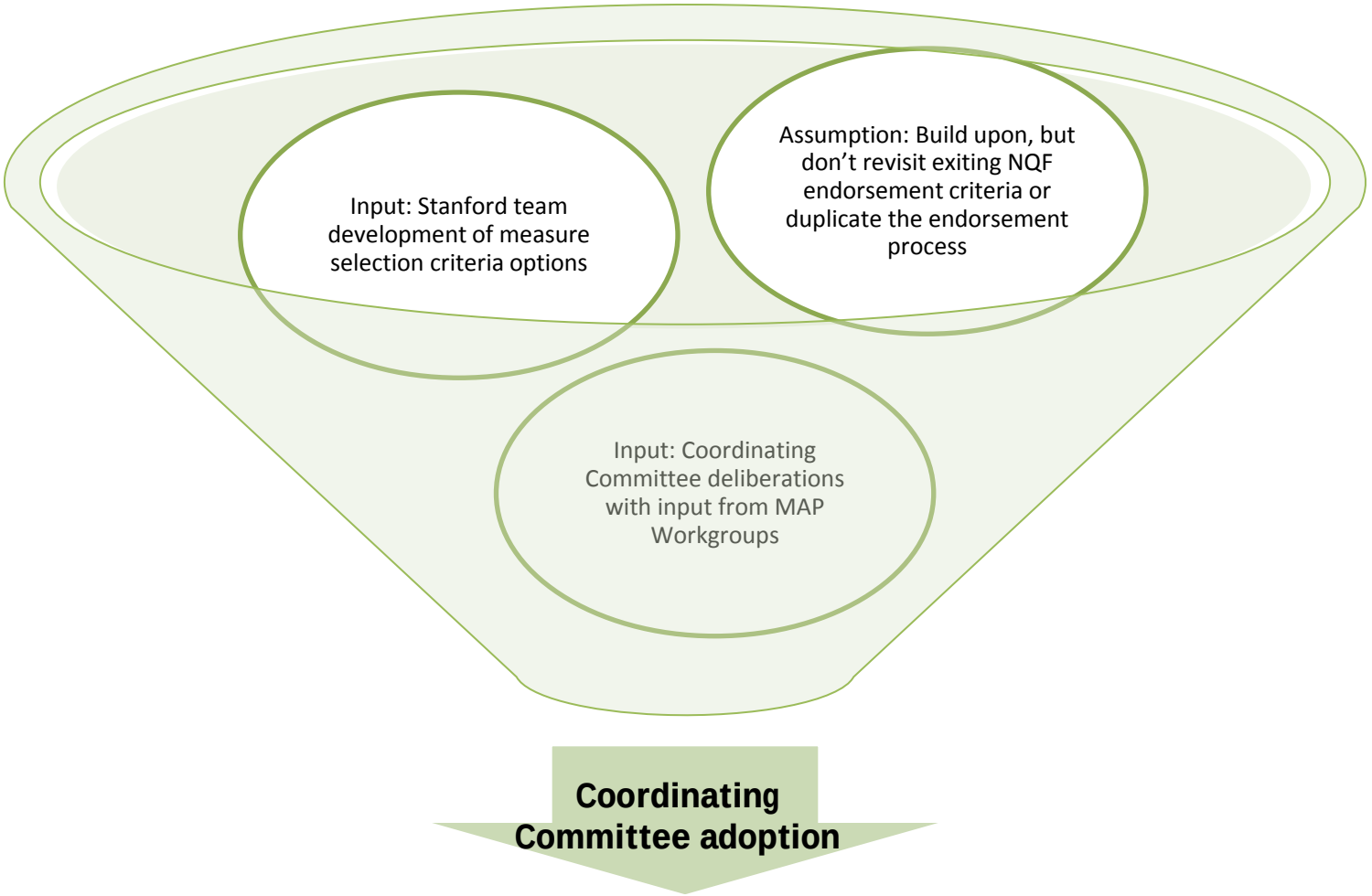
Opportunity for Public Comment

Measure Selection Principles

Quality Measurement Enterprise



Measure Selection Criteria Development



Measure Selection Principles from May 3-4 Coordinating Committee Meeting

- Promotes "systemness" and joint accountability
  - Promotes shared decision making and care coordination
  - Addresses various levels of accountability
- Addresses the patient perspective
  - Helps consumers make rational judgments
  - Incorporates patient preference and patient experience
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
    - Resource use, efficiency, appropriateness
- Promotes adoption of health IT
- Promotes parsimony
  - Applicability to multiple providers, settings, clinicians

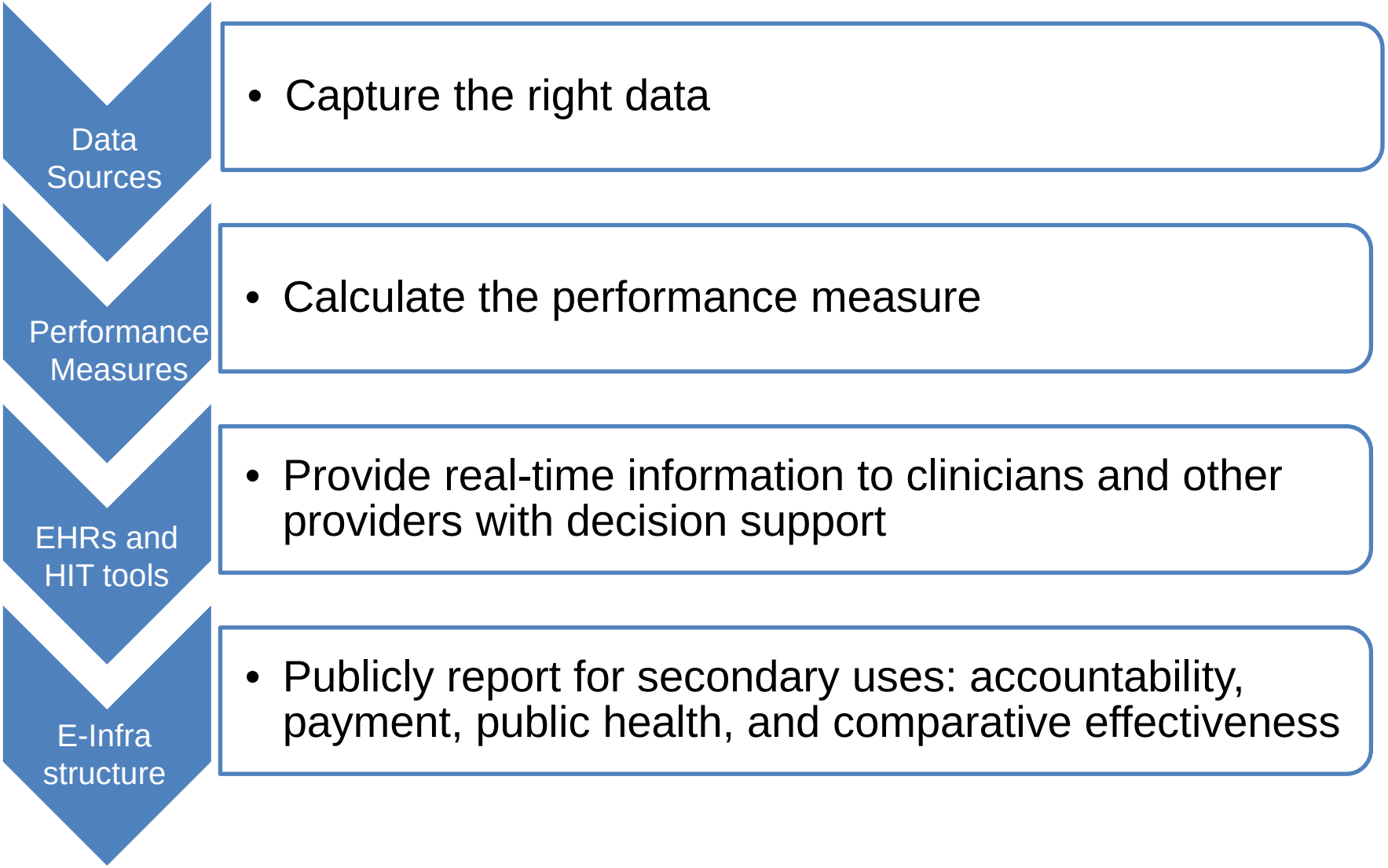
The results of the Coordinating Committee June 21-22 Measure Selection Criteria development activities will be provided during the meeting

Discussion and Questions

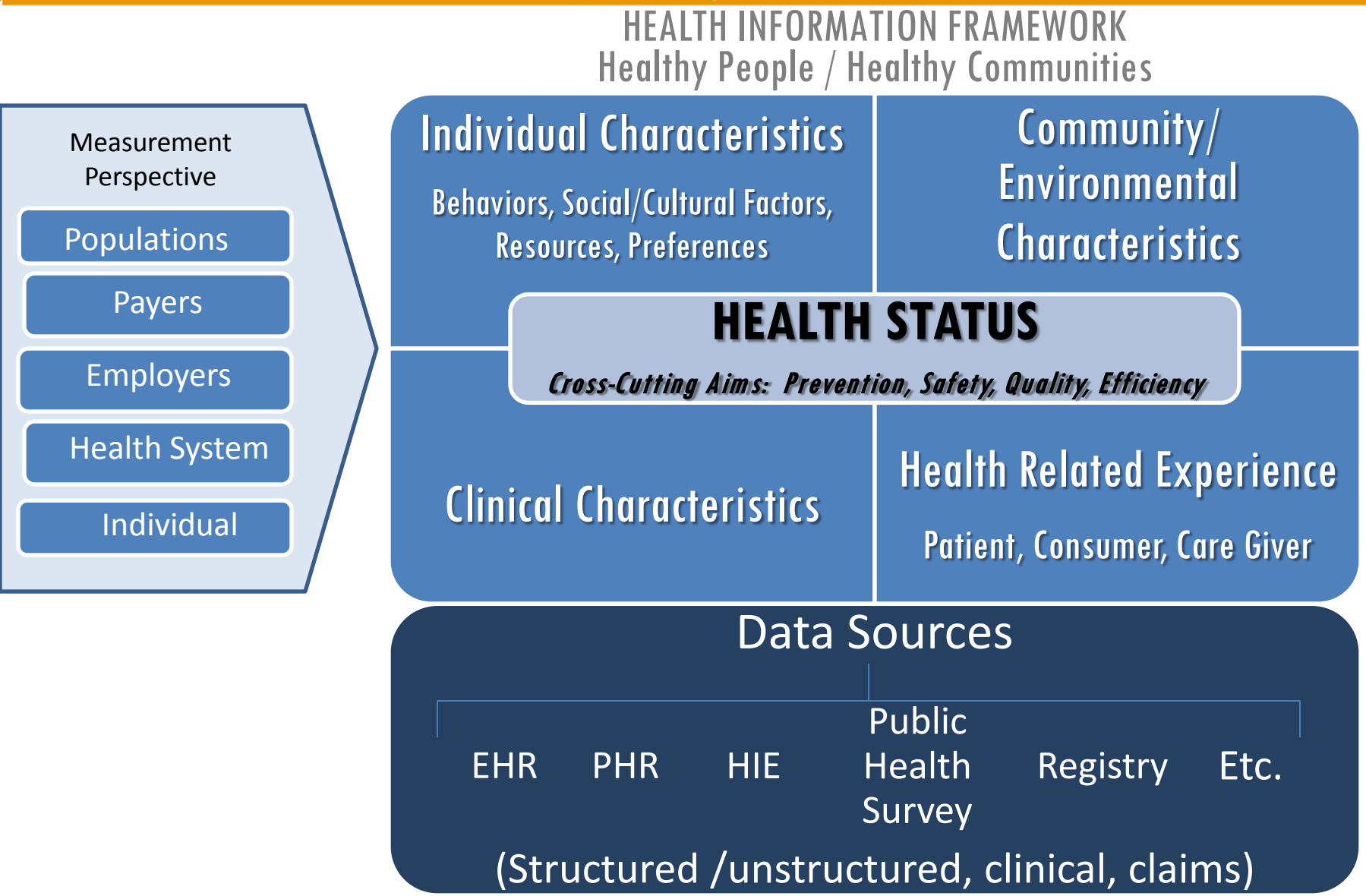
Opportunity for Public Comment

Data Sources and HIT Implications

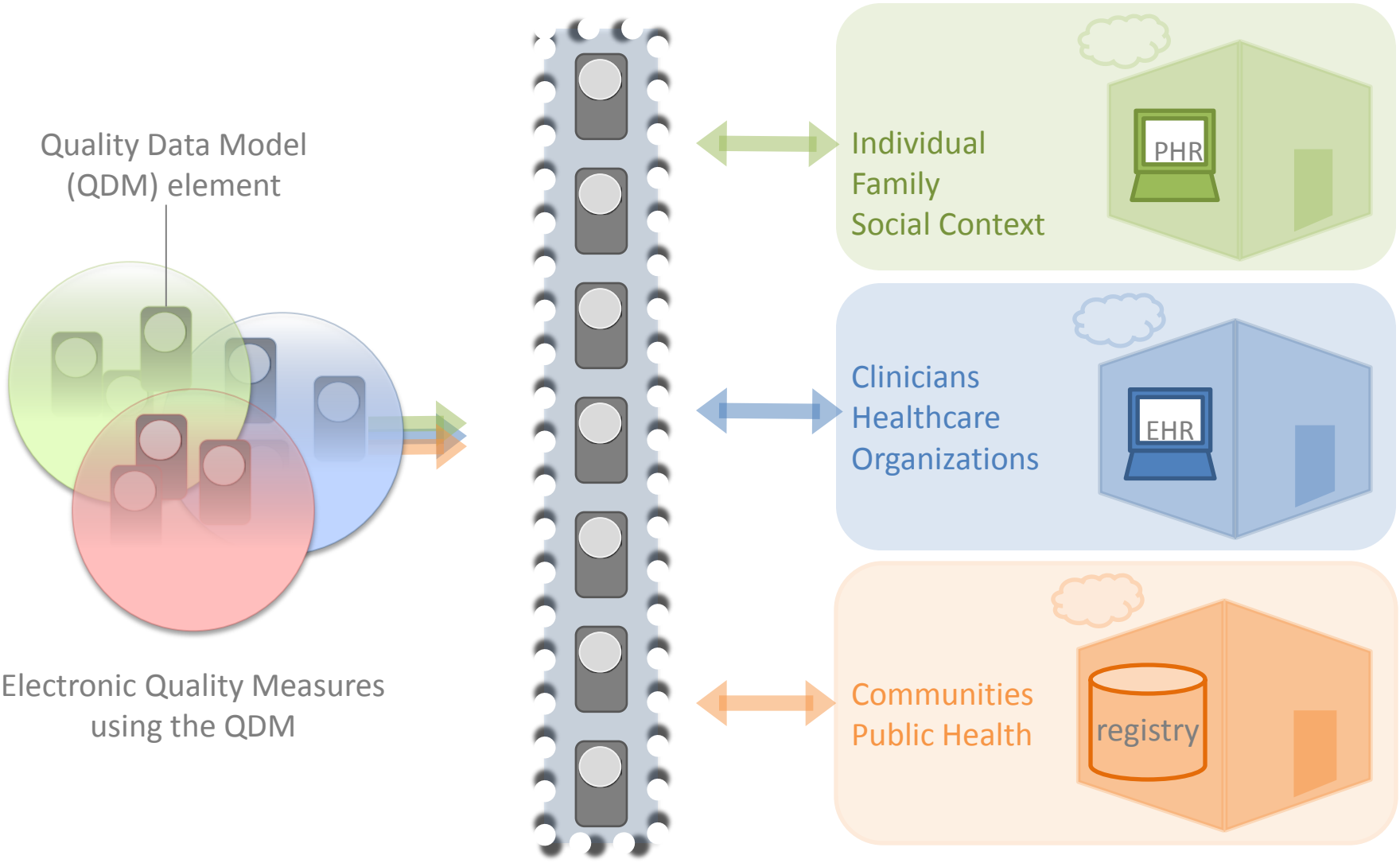
Data, Measurement, and Health IT are Inextricably Linked



Performance Measures and Information Requirements Will Change Over Time



Quality Data Model is Working to Define the Data



NQF is Helping Build the Necessary Electronic Infrastructure

Capture Data → Calculate Performance Measures → Real-Time Info to Clinician → Publicly Report

What (data/information) is available in an EHR that I can use to create my measure?

Quality Data Model

How can I say what I want/need to say so that all readers will interpret it the same way?

How can I create my measure so that an EHR and the average clinician can each understand it?

Example: Medication Adherence (Current)

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Patient

Measures:
- Patient-reported outcomes
- Experience of care (CAHPS)
- Shared decision making

Data Sources:
- PHRs
- Registry
- Clinical records
- Surveys

Pharmacy

Measures:
- Medication adherence
- Medication reconciliation

Data sources:
- Claims

Payer

Measures:
- Medication adherence
- Medication reconciliation
- Drug-disease interactions

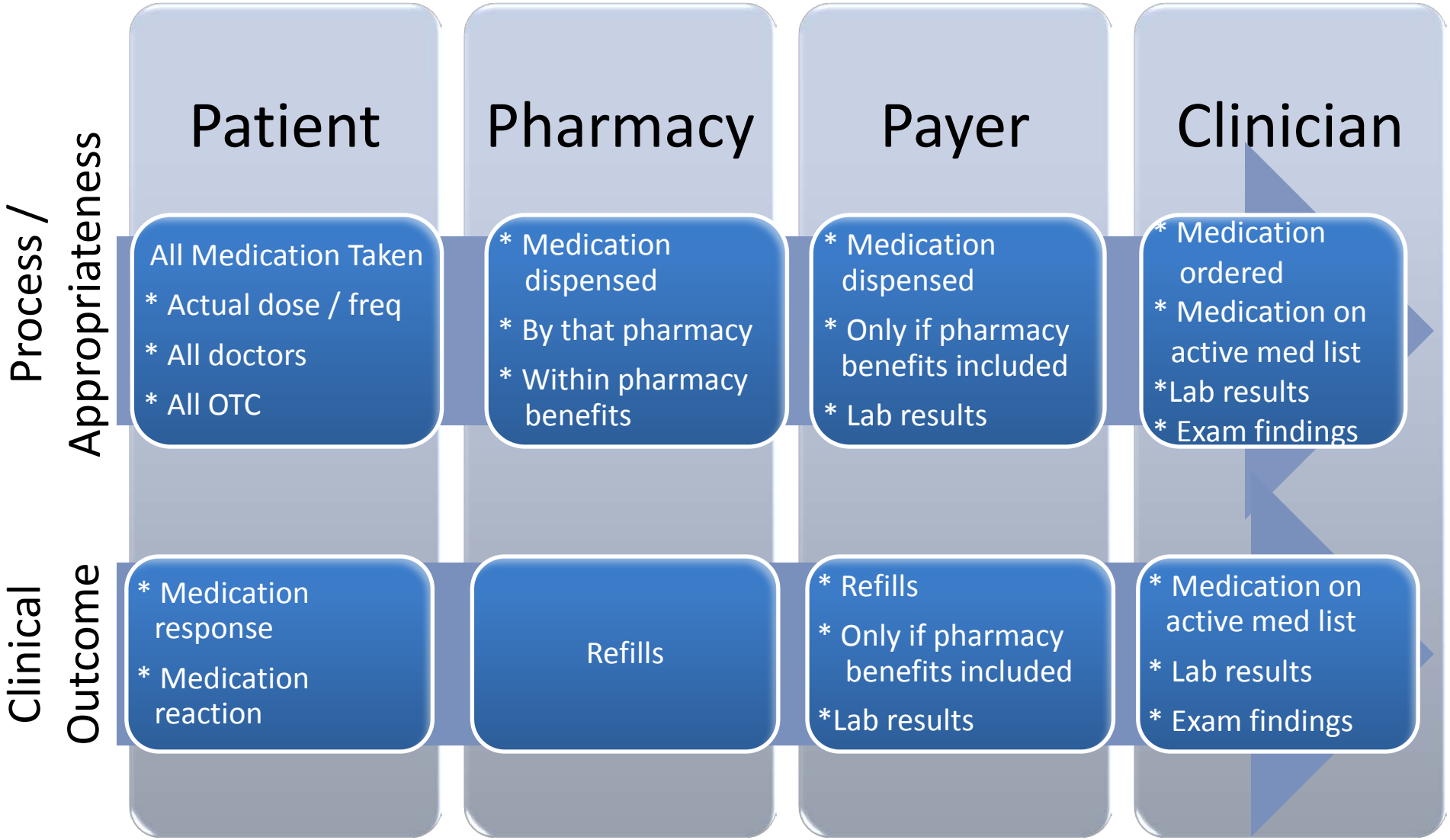
Data sources:
- Claims
- Clinical

Clinician

Measures:
- Care coordination across providers
- shared decision making
- Clinical outcomes

Data sources:
- Claims
- Clinical
- Registries

Example: Medication Adherence (Future)



Key Questions: eMeasures, Data Sources and Platforms, and Stakeholders

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Issue	Potential Policy Solutions	HIT Role

How can a coordinated strategy move the system toward electronic measures and interoperable data platforms?	• Certification and Meaningful Use criteria using the same standards for primary data capture and interoperability as for secondary uses
	  • Templates
	  • Vocabulary
		• Parsimoniously harmonize overlapping standards
		• Fill gaps where standards are lacking

How should the data platform (e.g., EHR) be constructed to support various levels of analysis Clinician vs. site vs. health plan vs. health system vs. community	• Consensus for attribution at individual, group, and higher levels • Criteria to differentiate patient outcomes vs. provider effectiveness (not always a direct relationship)	• Standards for rolling up individual providers to groups, and higher levels
How can approaches to data collection best be coordinated to the minimize burden on providers, stakeholders?	• Certification and Meaningful Use criteria that require data driven approach to information	• Standard model in information (QDM)

Key Issues: Public and Private Programs, Measure Reporting Requirements, Data Sources, and Standards

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Issue	Potential Policy Solutions	HIT Role
Separate reporting processes for the same measures under different public and private programs	• Harmonization of public and private programs • Alignment and use of same criteria and formats for requesting and reporting information for measurement	• Parsimoniously harmonize overlapping standards for measure specification and reporting
Submission of data vs. measure calculations with certified EHR technology	• Harmonization of public and private programs • Certification of EHR modular capabilities • Policy decision	• Standards to enable workflow for data submission or summary reporting (QRDA)
Lack of standardized set of data elements for EHRs	• Certification and Meaningful Use requirements for standard vocabularies and templates	• Standard value sets for incorporation within EHRs (QDM)
Clarification of best use of claims, registries, and EHRs	• Consensus for appropriate workflows as guidance to enable local implementation decisions • Standardization of information submission to registries identical to interoperability models	• Consistent, standard model for expressing information (QDM)

Discussion and Questions

Opportunity for Public Comment

Special Considerations for Medicare/Medicaid Dual Eligible Beneficiaries

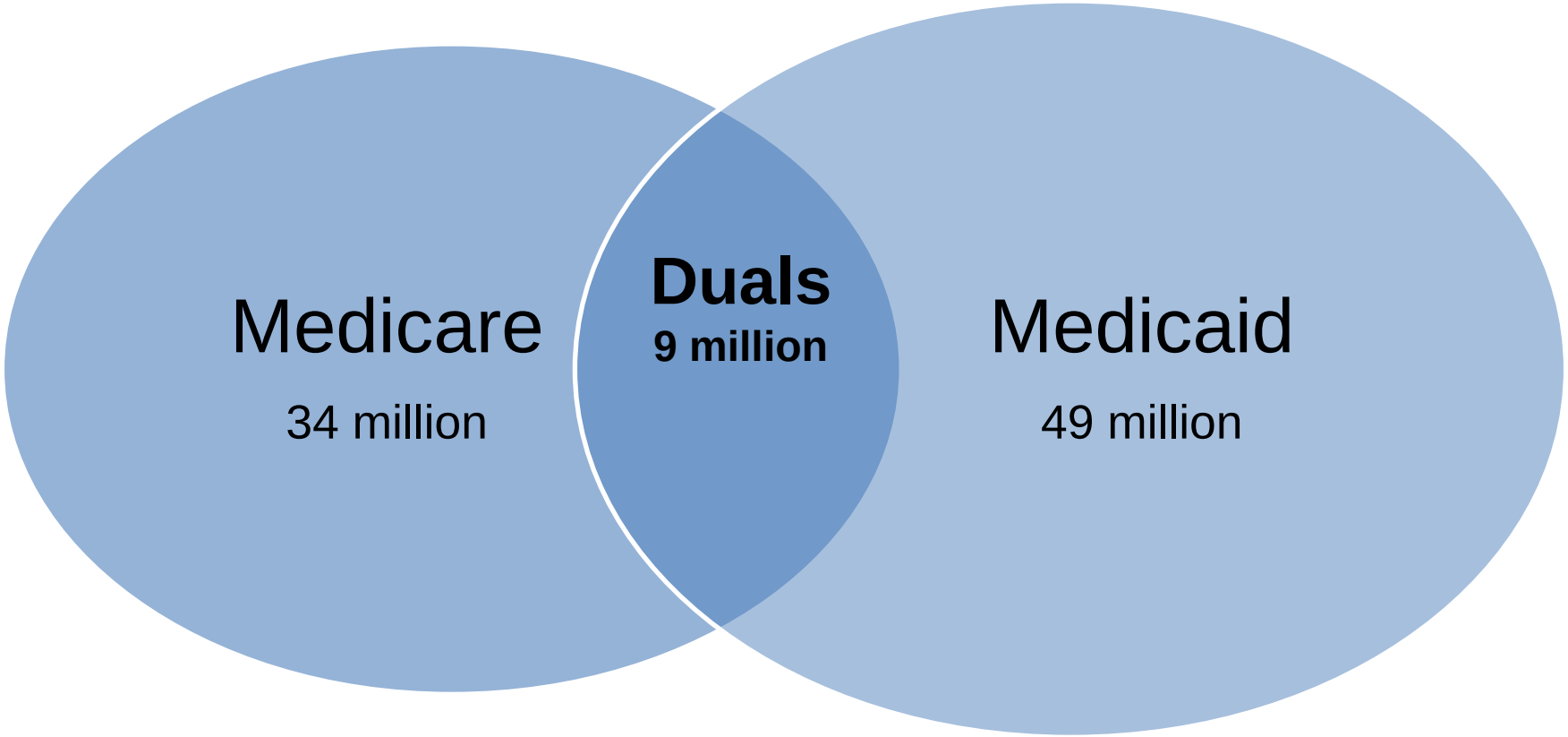
Overview of the Medicare/Medicaid Dual Eligible Population

Background

- Dual eligible beneficiaries receive healthcare coverage through both Medicare and Medicaid
- ~9.2 million people are dually enrolled (2008 data)
- While most duals are vulnerable in one or more ways, the population is not homogenous: range of physical and cognitive impairments, number of chronic conditions, settings in which care is delivered
- Population is low income by definition/design; more than half of duals have incomes less than $10,000/year
- Considerable healthcare needs and in the population lead to patient complexity, high utilization, and spending

Beneficiary Overlap, 2007

Duals comprise 21% of the Medicare population and 15% of the Medicaid population.

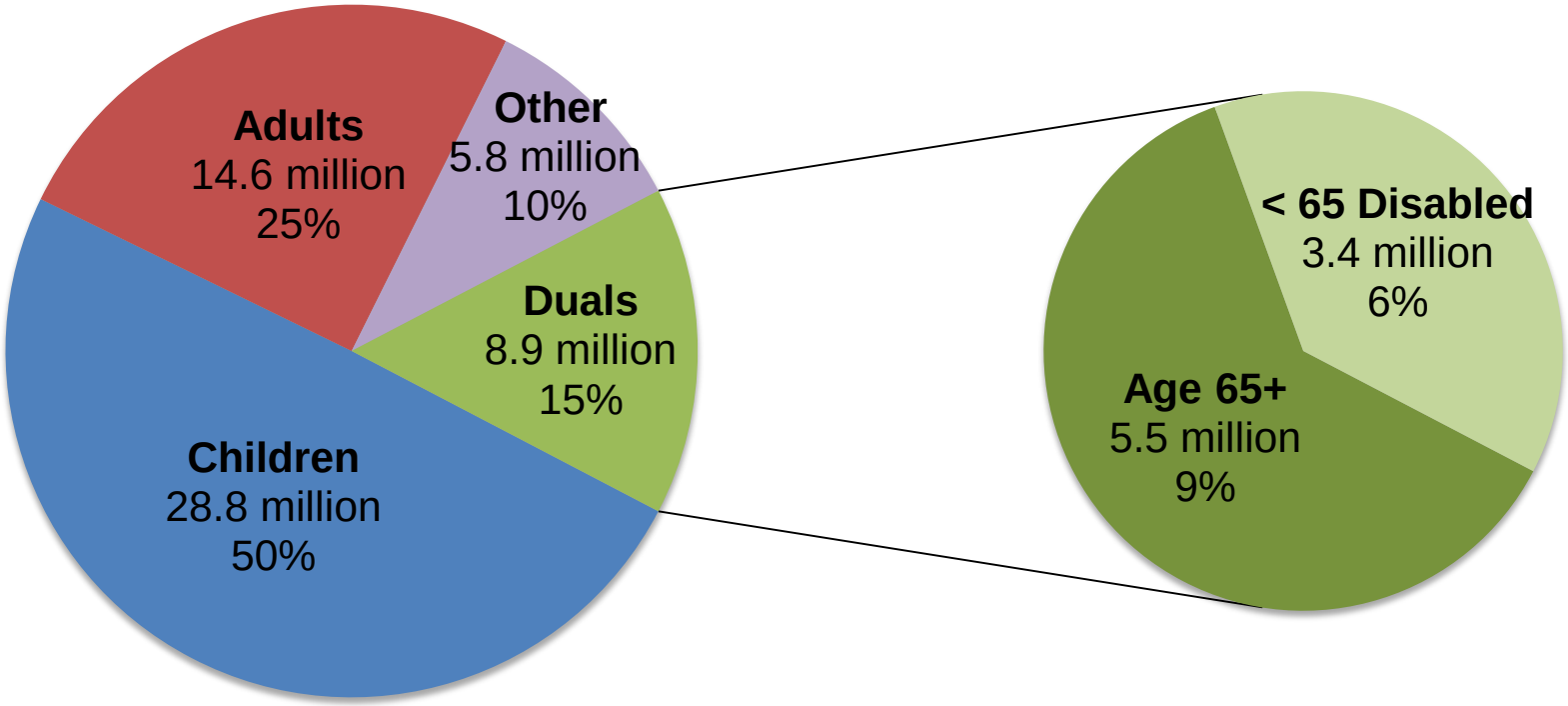


Total Medicare beneficiaries = 43 million

Total Medicaid beneficiaries = 58 million

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2007 and Urban Institute estimates based on data from the 2007 MSIS and CMS-Form 64.

Medicaid Enrollment, FFY 2007

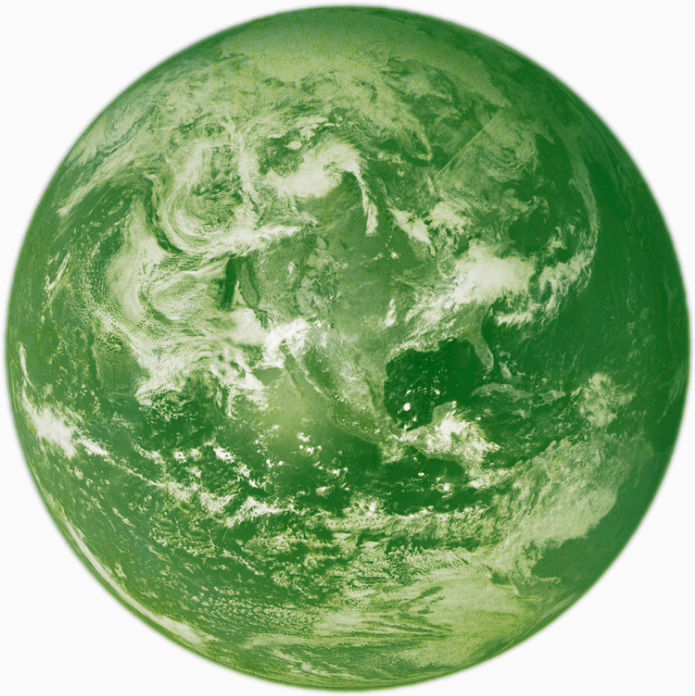


Total Medicaid Enrollment = 58.1 million

Duals' share of Medicaid enrollment varies significantly across states (10%-25%)
Duals account for 39% of all Medicaid expenditures, despite comprising only 15% of the beneficiary population.

SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Ethnicity and Geography



Ethnicity

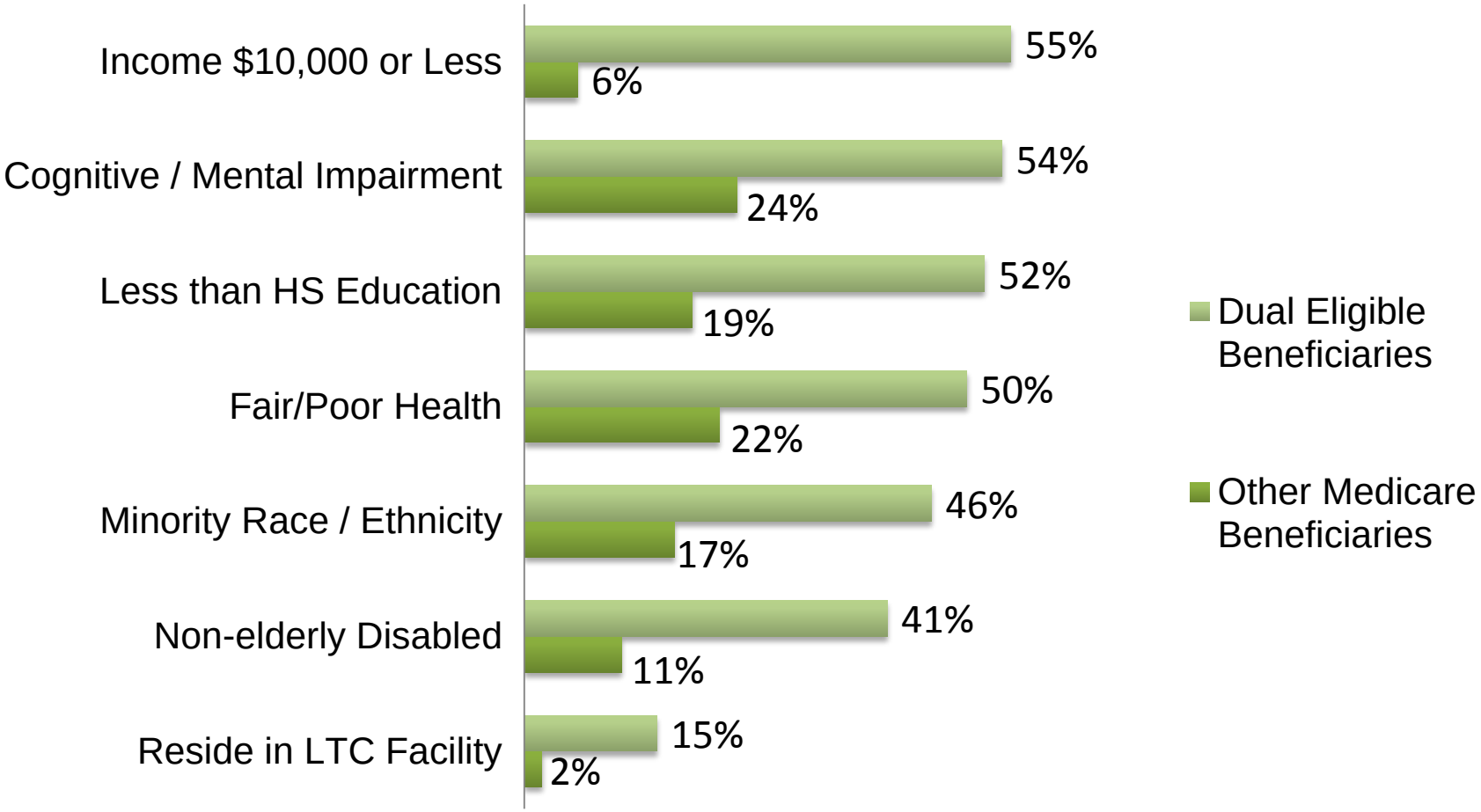
- Dual eligible population is more diverse than the overall Medicare population
- 40% minority population vs. 20% minority in overall Medicare
  - 59% White non-Hispanic
  - 21% Black non-Hispanic
  - 12% Hispanic
  - 9% Other

Geography

- 79% of duals live in urban areas
- 21% of duals live in rural areas

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of MSIS-MCBS 2003 linked file.

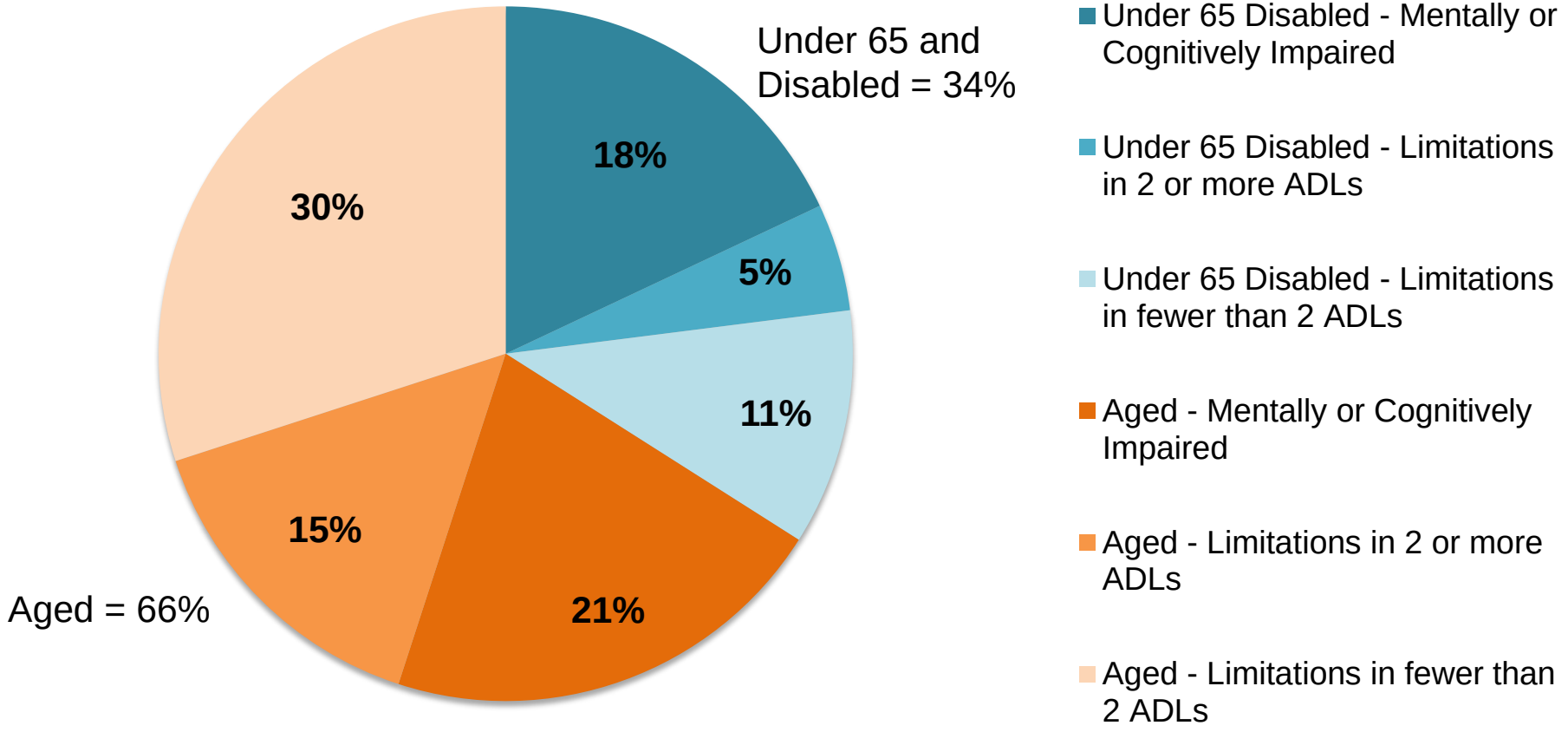
Characteristics of Dual Eligible Beneficiaries, 2008



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey 2008 Access to Care File.

Type and Level of Impairment Among Duals

About a third of dual eligible beneficiaries have limitations in three or more ADLs, but 45% of duals did not report any impairments.



NOTES: ADL = activity of daily living. Analysis excludes beneficiaries with ESRD
SOURCE: MedPAC analysis of Cost and Use file 1999-2001 MCBS

Prevalence of Mental/Cognitive Conditions

	Dual Eligibles				All Other Medicare Beneficiaries
	18-64	65-79	80+	All	
Alzheimer's/ dementia	5.8	12.9	39.0	16.1*	7.3
Depression	27.6	17.4	25.3	22.9*	8.4
Intellectual/ developmental disability	6.7	--	--	3.1*	--
Schizophrenia	11.8	3.5	--	6.2*	0.4
Affective and other serious disorders	27.1	17.1	21.4	21.7*	8.3
Total with any mental/cognitive condition	49.2	34.1	52.5	43.8*	18.4

* = p< 0.05 using adjusted Wald F test.
-- = Fewer than 30 cases unweighted.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file.

Prevalence of Chronic Physical Conditions

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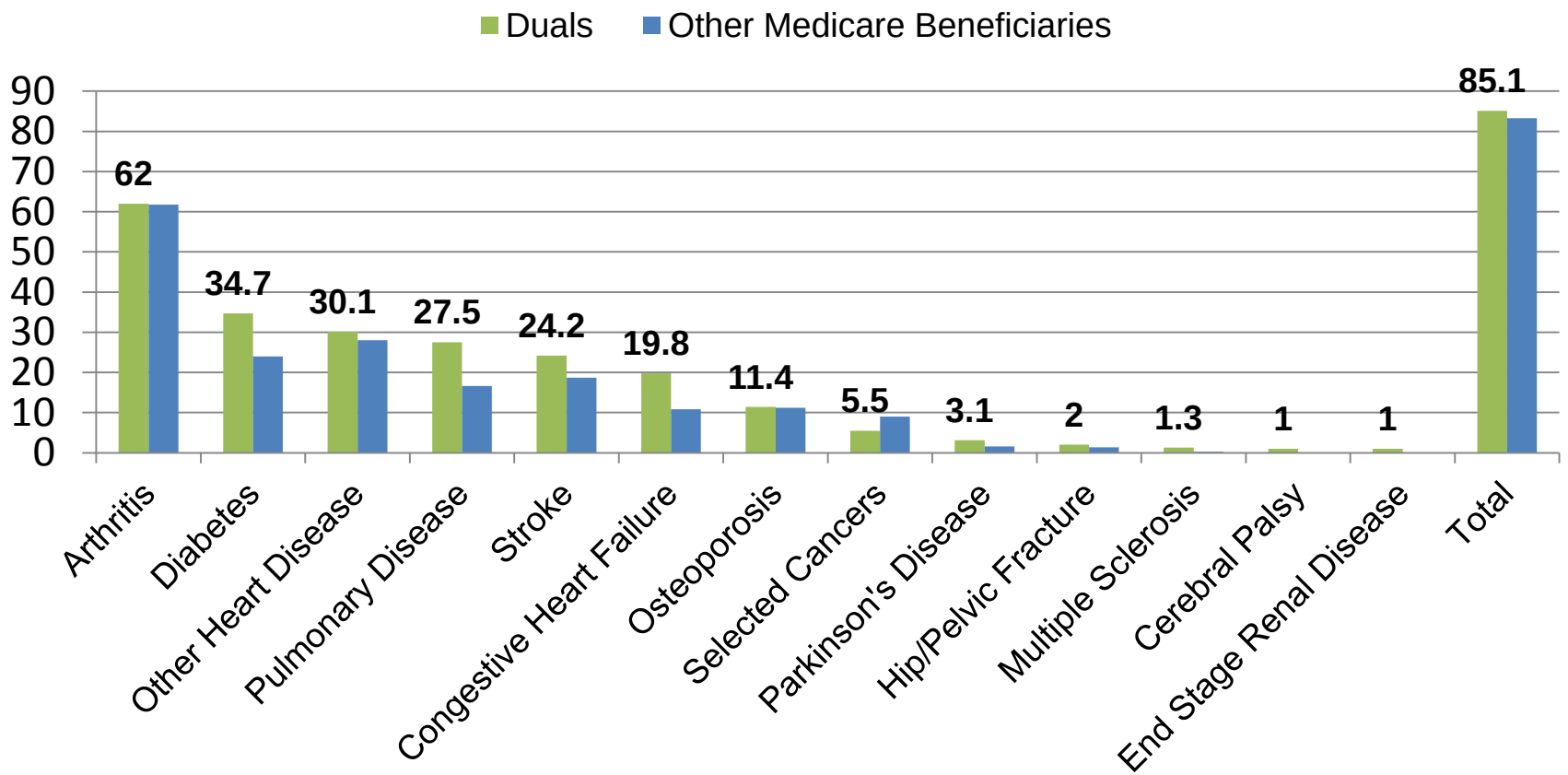
Differences in prevalence between duals and other Medicare beneficiaries are statistically significant for all conditions except arthritis and osteoporosis.



p< 0.05 using adjusted Wald F test.
Selected cancers are breast, colorectal, prostate, lung, and endometrial.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file.

High-Impact Conditions Affecting Duals

High Prevalence Conditions Among Duals

- Alzheimer's disease and other dementia
- Congestive heart failure
- Depression
- Diabetes
- Other heart disease
- Hypertension
- Pulmonary disease
- Stroke
- Others?

Conditions Disproportionately Affecting Duals

- Cerebral palsy
- End-stage renal disease
- Multiple sclerosis
- Parkinson's disease
- Schizophrenia
- Others?

Starting place for discussion based on data presented on previous slides

MAP Dual Eligible Beneficiaries Workgroup Guiding Principles and High-Leverage Opportunities

Guiding Principles

Workgroup's Initial Vision for High Quality Care:
Individuals should have reliable access to a person-centered, culturally competent support system that helps them reach their personal goals through access to a range of healthcare services and community resources

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

High-Leverage Improvement Opportunities

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

Discussion and Questions

Opportunity for Public Comment

Ad Hoc Safety Workgroup: Input from PAC/LTC Workgroup

Partnership for Patients

HHS has a new patient safety initiative called the **Partnership for Patients** focusing on improvement in readmissions and healthcare acquired conditions (HACs).

Establishes 2 goals to achieve by the end of 2013:

- Preventable HACs would decrease by 40% compared to 2010
- Preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010

HACs and Readmissions

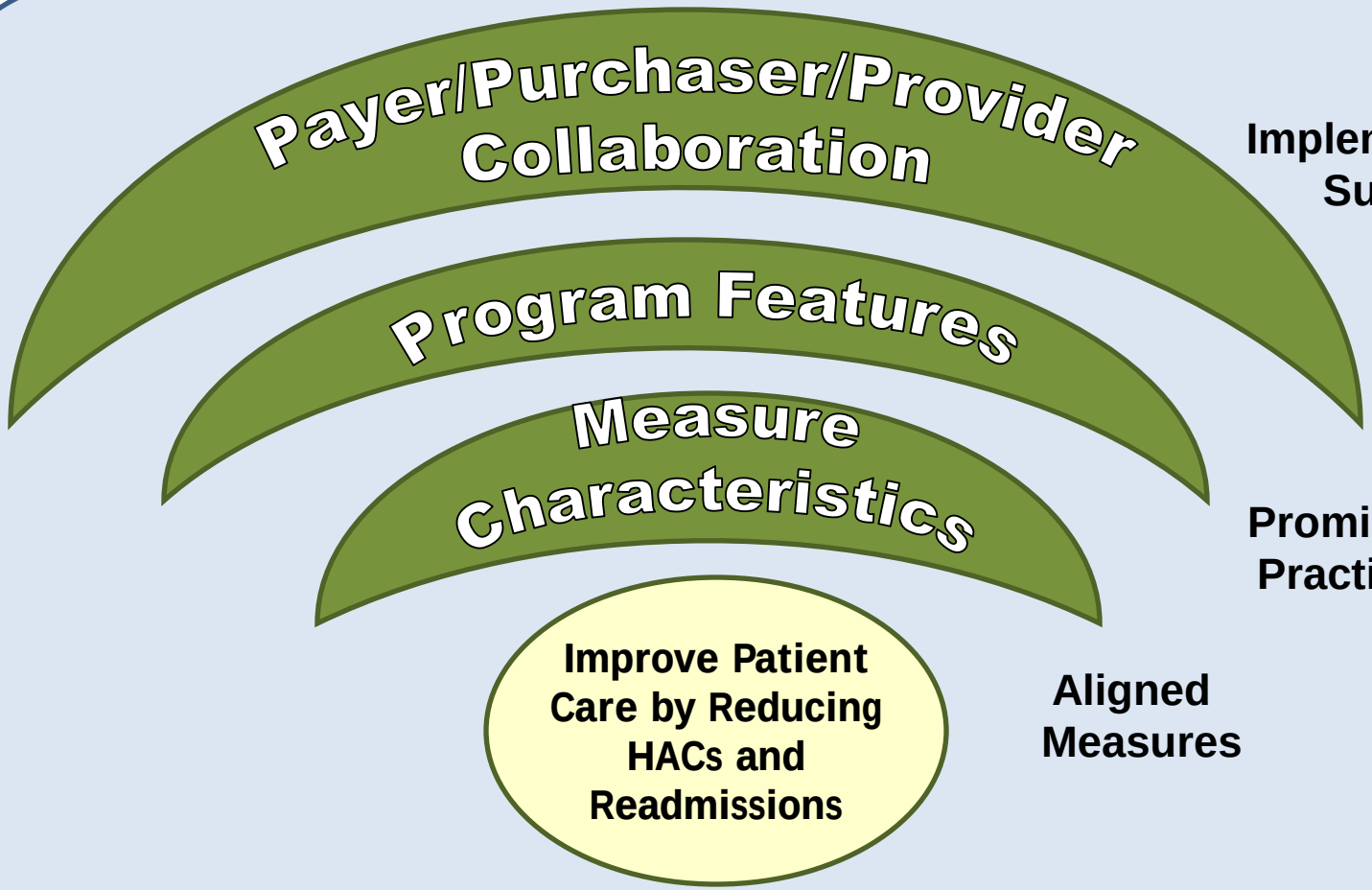
The Partnership for Patients has identified nine areas of focus for HACs:

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism (VTE)
- Ventilator-Associated Pneumonia (VAP)

The Partnership work is not limited to these areas, and will pursue the reduction of all-cause harm as well.

Dimensions of Public-Private Payer Alignment

Dimensions of Payer Alignment



Key Elements of a Coordination Strategy

HACs and Readmissions: Unique Considerations

There were many commonalities identified for an overall payer coordination strategy to reduce HACs and readmissions, though a few unique elements were noted:

HAC discussions focused on

- Data sources
- Processes

Readmissions discussions focused on

- Medical homes
- Patient-centeredness
- Communication systems
- Community

HACs and Readmissions: Collaboration

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- Ensure that collaboration extends beyond payers and providers to include purchasers, communities, and patients/families/caregivers
  - Support improvement on the frontlines
  - Establish organizational cultures that encourage reporting safety issues
  - Reinforce teamwork and shared accountability
  - Engage patients in reduction of events (e.g., education using plain language, pharmacist education to prevent adverse drug events)

- Create joint accountability between hospitals, other providers, and community entities
  - Open communication lines between healthcare facilities and community supports
  - Consider impact of patient's home environment and social determinants on health

HACs and Readmissions: Collaboration

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- Share data and information across providers and settings
  - Provide real-time data to improve the care process (e.g., track admissions to different facilities, detect HAC post-discharge, notify whether prescriptions are filled, avoid drug-drug interactions, and drug allergies)
  - Identify high risk patients through predictive modeling and share information with providers
  - Utilize the resources and toolkits of payers to advance improvement on the frontlines
  - Create a learning community to share promising practices
  - Provide data to purchasers and consumers to inform decision making

HACs and Readmissions: Program Features

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- Create incentive structures that support better care
  - Alignment of efforts across continuum to send consistent signals
  - Comprehensive care transition business model costs more than the cost of the readmissions penalty
- Bridge transition from hospital to community
  - Discharge planning and follow up both essential
  - Patient education to facilitate self-management
  - Medication reconciliation
  - Communication/collaboration between provider and community entities
  - Home visits
- Transparency is essential to drive improvement

HACs and Readmissions: Measure Characteristics

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- Measure alignment across public programs and public/private payers is essential
  - Consider statutory requirements for public programs (CMS, AHRQ, CDC, states)
  - Public/private payer measure alignment complicated by different populations
- Anticipate and monitor for consequences
  - Beyond unintended consequences, such as cost shifting/cherry picking
  - Length of stay and observation status as balancing measures
  - Optimum rate of readmissions may not be zero
- Attention to disparities
  - Risk adjustment vs. stratification
  - Improvement, as well as achievement; delta measures
- Measures should promote shared accountability (e.g., hospitals, other providers, community entities)

HACs and Readmissions: Measure Characteristics

- Measures must be meaningful to all stakeholders and actionable
- Move beyond measures of occurrence to promoting preventive activities (e.g., ventilator bundle, central line insertion checklist)
- Consider pros and cons of different approaches to readmission measurement
  - 30 vs. 90 days
  - All payer vs. segmented
  - All cause readmissions vs. exclusions
  - All condition admissions vs. specific conditions
- Account for burden of data collection on providers
  - Volume, reliability, validity
- Measures would ideally be suitable for multiple purposes
  - Driving improvement vs. public reporting vs. payment

Guidance Requested by the Safety Workgroup

- How can payer approaches to measuring HACs and readmissions be aligned across post-acute environments (rehab, SNF, nursing home, home care)?
- How can payer approaches to measuring HACs and readmissions be aligned across the various levels of care (ambulatory, acute, post-acute)?
- What are the barriers to alignment?
- Are there other opportunities for alignment beyond those identified by the Ad Hoc Safety Workgroup?

Discussion and Questions

Opportunity for Public Comment

Summation and the Path Forward

Next Steps

- Develop a core measure set
  - Use measure selection criteria to identify an initial core set
  - Determine how the core set aligns with the coordination strategy considerations we discussed today
  - Identify measure gaps

- Identify and address any additional alignment issues

Upcoming Work & Timeline

August, 2011

- Convene a web meeting to discuss the decision-making criteria and framework developed by the Coordinating Committee

Coordinating Committee Meeting – August 17-18

Sep 8-9, 2011

- Conduct second in-person meeting to discuss the coordination strategy for PAC-LTC performance measurement

Coordinating Committee Meeting – November 1-2

Dec 14, 2011

- Convene third in-person meeting to react to proposed measures

Coordinating Committee Meeting – January 2012

Feb 1, 2012

- Final report due to HHS from the MAP Coordinating Committee regarding the PAC-LTC coordination strategy

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Measure Applications Partnership
Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of the Partnership.

- Willingness to work collaboratively with other Partnership members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests, though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented, not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups.

- Commitment to attending meetings. Individuals selected for membership will not be allowed to send substitutes to meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice. If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.

- Demonstration of respect for the Partnership's decision making process by not making public statements about issues under consideration until the Partnership has completed its deliberations.

- Acceptance of the Partnership's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Adopted by the NQF Board of Directors on September 23, 2010

Measure Applications Partnership
Convened by the National Quality Forum

MAP Member Principles for Media and Public Engagement

As a participant in the MAP, you play a central and important role in making measure applications recommendations to the federal government. We anticipate sustained media and public interest in MAP. To ensure we are consistent in our approach to communications, and mindful of the sensitive nature of our collaborative work, please find below MAP Principles for Media and Public Engagement.

Press Releases and Supportive External Materials

NQF staff will develop all MAP-related press releases and supportive external materials, including releases about our public meetings and reports to HHS. MAP Coordinating Committee Co-Chairs will review and approve all press releases as part of their leadership responsibilities. NQF staff will share final press materials with members in advance of their public release. NQF media relations staff will serve as the central point of contact for members' communications staff and the press.

Press Engagement

MAP members will not engage with press on deliberations that are before the MAP. Members or their communications staff should refer press questions about deliberations, MAP processes, or MAP progress to the NQF press office. Once final reports that include recommendations are publicly issued, NQF is prepared to provide press and messaging support to you if you receive press calls. We encourage MAP members to answer press questions about the recommendations once they have been submitted; if you are not comfortable doing so, please refer any press calls to NQF. MAP members who are interested in developing their own press material about their role in MAP are encouraged to share drafts with NQF media relations staff in advance of distribution.

Public Engagement/Talks

MAP members are welcome to include information on MAP in their public engagements, but are asked to refrain from commenting on issues currently being deliberated by the MAP. Once final reports that include recommendations are publicly issued, members are encouraged to integrate information about the reports and recommendations into their scheduled talks. NQF staff will provide communications assistance in the form of Q&A, slides, key messages, and fact sheets to assist you with external engagement on the MAP.

Measure Applications Partnership (MAP) Backgrounder (as of April 6, 2011)

The Measure Applications Partnership (MAP) will play a valuable role in improving the quality and value of healthcare.

As a participant in MAP, we thought you might benefit from this backgrounder for your use as you begin to receive and respond to inquiries about this important Partnership or weave information about MAP into your work. Please let us know if we can provide any additional background.

MAP Basics

1. What is MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum. MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

2. Why is MAP important?

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. MAP is a unique voice in healthcare, blending the views of diverse groups who all have a vested interest in improving the quality of healthcare.

Through MAP activities, a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection.

3. How will MAP determine on which priorities and goals to focus?

The MAP Coordinating Committee will compile a decision-making framework, which will include priorities from a number of different sources, including the newly released National Quality Strategy, the upcoming National Patient Safety Initiative and National Prevention and Health Promotion Strategy, the high-priority Medicare and child health conditions, and the patient-focused episodes of care model. Additionally, the committee will develop measure selection criteria to help guide their decision making.

4. Will MAP recommend only NQF-endorsed measures for government public reporting and payment reform programs? Will part of this effort point out measurement gaps and include those gaps in recommendations?

MAP will recommend the best measures available for specific uses, giving first consideration to NQF-endorsed measures. If MAP is seeking a type of measure currently not represented in the portfolio of NQF-endorsed measures, it will look outside for other available measures. When non-endorsed measures are used, the measure developer will be asked to submit the measure to an NQF endorsement project for consideration. Gaps identified in the endorsed measures available will be captured to inform subsequent measure development.

MAP Structure

5. How will MAP be structured?

MAP will be composed of a two-tiered structure. MAP's overall strategy will be set by the Coordinating Committee, and this committee will provide final input to HHS. Working directly under the Coordinating Committee will be four advisory workgroups—three that are settings-based and one that focuses on the dual eligible beneficiary population. The workgroups are flexible and can be changed as the work in the program evolves. More than 60 organizations representing major stakeholder groups, 40 individual experts, and nine federal agencies are represented in the Coordinating Committee and workgroups.

6. How will the Coordinating Committee and workgroups be appointed?

MAP's Coordinating Committee and workgroups were selected based on NQF Board-adopted selection criteria, which included nominations and an open public commenting period. Balance among stakeholder groups was paramount. Due to the complexity of MAP's tasks, it was also imperative that individual subject matter experts were included in the groups. Other considerations included adding individuals with expertise in health disparities and vulnerable populations, state representation, and individuals with experience in health IT. Federal government *ex officio* members are non-voting because federal officials cannot advise themselves.

A Nominating Committee, composed of seven NQF Board members, oversaw the appointment of the members of the Coordinating Committee through a public nominations process that was required by statute. The nomination period remained open for one month each for the Coordinating Committee (Sept. 29-Oct. 28, 2010) and the workgroups (Jan. 10-Feb. 7, 2011). The Nominating Committee proposed a roster for each group, which was vetted publicly, as required by statute. After careful consideration of public comments, the rosters were given final approval by the full NQF Board for the Coordinating Committee on Jan. 24, 2011, and for the workgroups on March 31, 2011. MAP members will serve staggered three-year terms, with the initial members drawing one-, two-, or three-year terms at random, allowing additional opportunities to serve to be available annually.

7. To whom will the committees report?

The Coordinating Committee will be overseen by the NQF Board, which was responsible for establishing MAP and selecting its members. The Board will review any procedural questions that arise about MAP's structure or function and will periodically evaluate MAP's structure, function, and effectiveness. The NQF Board will not review the MAP Coordinating Committee's input to HHS.

The Coordinating Committee will provide its input directly to HHS, while the workgroups will be charged by and report directly to the Coordinating Committee.

MAP: How NQF and HHS Work Together

8. Why did HHS choose NQF for this project?

The Affordable Care Act specifies the involvement of a neutral convener to manage engagement and coordination and to take a leadership role in the quality measurement field. With a wealth of measure endorsement experience, a deep network of members and partners, sufficient analytic support to assist in decision making, its relationship with HHS as a consensus-based entity, as well as its experience in convening the National Priorities Partnership, NQF is uniquely structured to meet these criteria. NQF's independence is also critical in filling this important advisory capacity.

9. Why can't HHS do this on its own?

Choosing measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task.

NQF's organizational structure and independent nature makes it uniquely positioned to be a neutral convener and to act as an additional resource to provide coordinated expertise into the HHS decision-making process.

10. Are HHS and CMS required to accept and implement NQF's recommendations?

HHS is required to take into consideration any input from MAP in its selection of quality measures for various uses, but final decisions about implementation are solely at HHS's discretion.

The Administrative Procedures Act requires that HHS's decisions be made through routine rulemaking processes. MAP is not a subregulatory process. Should HHS via its decision making decide to select a measure that is not NQF endorsed, it must publish a rationale for its decision.

11. How does all of this relate to the National Quality Strategy?

The National Quality Strategy (NQS) was released on March 21, 2011, by the Secretary of HHS. The NQS is very important to MAP, as it represents the primary basis not only for the MAP decision-making framework developed by the Coordinating Committee, but also for the overall MAP strategy designed to guide the workgroups. The MAP decision-making framework will remain somewhat fluid to allow it to evolve along with the NQS.

12. How quickly will MAP provide input, and how quickly thereafter do you predict the government will implements any or all of its recommendations?

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in calendar year 2012.

MAP Impact on the General Public

13. How will the public benefit from this project?

MAP is designed to support broader national efforts to create better, more affordable care. Its work will strengthen public reporting, which has been demonstrated to improve quality, and will give people more and better information when making healthcare choices and help providers improve their performance. MAP recommendations also will help shape payment programs, creating powerful financial incentives to providers to improve care. Consumer and purchaser stakeholders will have a place and a voice in every discussion. Lastly, measure selection decisions made in public programs often have a spillover effect in private insurance markets, so choices made by HHS may have a much broader impact over time.

14. Will the public have input into the MAP process? How will MAP achieve transparency?

MAP's overriding goal in intent and in statute is to maintain transparency for the public and encourage public engagement throughout MAP's work.

The public has been involved in the MAP process from early on, starting with two rounds of public comment on the NQF Board's establishment of MAP to another two rounds of public nominations and public vetting of the rosters for both the MAP Coordinating Committee and its workgroups. All MAP meetings will be open to the public, and meeting summaries and conclusions will be posted on the NQF website. MAP will seek public comment on all input to HHS.

15. What might be the ultimate implication of MAP's work?

The Measure Applications Partnership has real potential to enact positive change in our nation's healthcare system and build on a decade of remarkable work to develop measures that can help bring greater value into healthcare. We now have hundreds of measures, but MAP can help users pick the right ones for their applications.

Some outcomes we hope to see from the project include a defragmentation of care delivery, heightened accountability of clinicians and providers, better and more information for consumer decision making, higher value for spending by aligning payment with performance, a reduced data collection burden through the alignment of measurement activities, and an improvement in the consistent provision of evidence-based care across measured domains.

FOR IMMEDIATE RELEASE
April XX, 2011

CONTACT: [Insert Name]
[Insert Phone Number]
[Insert Email Address]

[ABC Company] CEO Selected as Member of Newly Formed Measure Application Partnership [Coordinating Committee/Workgroup Name]

Washington, DC – [Name, Title, Company], has been selected to participate as a member of the newly established Measure Applications Partnership (MAP) [Coordinating Committee/ Workgroup Name]. MAP is a public-private partnership convened by the National Quality Forum (NQF) for the explicit purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs, as required in The Affordable Care Act.

The National Quality Forum, a private-sector, consensus-based, standard-setting organization whose efforts center on the evaluation and endorsement of standardized performance measurement, formalized its agreement with HHS to convene the multi-stakeholder groups established for MAP in late March.

[Insert quote from committee/workgroup member]

Through MAP activities, the private sector and a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection. MAP activities, including comment periods and meetings, will be made open to the public via the NQF website.

MAP measure selections will be made within the framework of the newly released National Quality Strategy, with the intention of selecting measures that address our national healthcare priorities and goals, such as making care safer and ensuring that each person and family are engaged as partners in their care.

The MAP Coordinating Committee and its four workgroups span more than 60 organizations and include 40 subject matter experts and nine federal agencies. Government agencies are ex-officio members and will not vote on items before the coordinating committee.

"The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task," said Janet Corrigan, PhD, MBA, president and CEO of the National Quality Forum. "MAP's diverse composition—representing the full spectrum of

healthcare stakeholders—and NQF's strong background as a neutral convener will be instrumental in ensuring that well-rounded, evidence-based input makes its way to the HHS Secretary for her consideration on which measures to use for public reporting and performance-based payment programs."

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in the calendar year 2012. More information about MAP is available here. (INSERT HYPERLINK).

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MAP Post-Acute Care/Long Term Care Workgroup Charge

Purpose

The charge of the Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup is to advise the Coordinating Committee on a coordination strategy for quality reporting for post-acute care and long-term care setting, and measures for hospice quality reporting. The PAC/LTC Workgroup will also advise the Coordinating Committee on measures to be implemented through the Federal rulemaking process that are applicable to post-acute settings.

Through the two-tiered structure, the PAC/LTC Workgroup will not give input directly to HHS; rather, the Workgroup will advise the Coordinating Committee on quality issues and the selection and coordination of measures to encourage improvement in post-acute care and long-term care settings and hospice programs. The PAC/LTC Workgroup will be guided by the decision making framework and measure selection criteria adopted by the Coordinating Committee, including alignment with the HHS National Quality Strategy. The Workgroup will give explicit consideration to the performance measures needed for dual eligible beneficiaries.

The activities and deliverables of the MAP PAC/LTC workgroup do not fall under NQF's formal consensus development process (CDP).

Tasks

The PAC-LTC Workgroup will advise the Coordinating Committee through the following tasks:

1. Development of a coordination strategy for quality reporting across post-acute care and long-term care settings, including long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, nursing facilities, home health care, and hospice, that is aligned across settings through the following tasks:
    a. Identification of a core set of available measures, including clinical quality measures and patient-centered cross-cutting measures, and
    b. Identification of critical measure development and endorsement gaps across the post-acute and long-term care settings.
2. Identification of measures for quality reporting for hospice programs and facilities.
3. Input on measures to be implemented through the Federal rulemaking process, based on an overview of the quality problems in hospice programs and facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health care; the manner in which those problems could be improved; and the related measures for encouraging improvement.

Timeframe

Development of the initial post-acute care and long-term care coordination strategy will begin in June 2011 and will be completed by February 1, 2012. Input on the measures to be implemented through the Federal rulemaking will be completed by February 1, 2012. Input on

measures to be used for measuring performance for hospice programs will begin in January 2012 and will be completed by June 1, 2012.

Membership

Attachment A contains the MAP Coordinating Committee roster.

The terms for MAP members are for three years. The initial members will serve staggered terms, determined by random draw at the first in-person meeting. MAP workgroups are convened by the Coordinating Committee, thus a workgroup may be dissolved as the work of the MAP evolves.

Procedures

Attachment B contains the MAP member responsibilities and operating procedures.

Overview of Post-Acute/Long-Term Care Settings

Setting	Description of the Setting
Post- Acute Care (PAC)	*Post-acute care is health care following an acute hospitalization.(General Description)* Post-Acute care can be provided in various settings including: • Skilled nursing facilities, • inpatient rehabilitation facilities, • Long-term care hospitals • Home health care, and • Outpatient rehabilitation. [i]
Long-term Care (LTC)	Long-term care is a variety of services including medical and non-medical care to people who have a chronic illness or disability. Long-term care can be provided in the following settings: • Community-based services • Home health care • In-law apartments • Housing for aging and disabled individuals • Board and care homes • Assisted living • Continuing care retirement • Nursing homes[ii]
Nursing Home	Nursing home facilities provide a wide range of personal care and health services to people who can't be cared for at home or in the community. This care generally is to assist people with support services such as the activities of daily living (ADL). [iii]
Skilled Nursing Facilities (SNFs)	SNFs provide physical, occupational, and other rehabilitative therapies to their residents in addition to providing care and assistance with ADL. [iv]
Inpatient Rehabilitation Facilities (IRFs)	IRFs are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense

Overview of Post-Acute/Long-Term Care Settings

Setting	Description of the Setting
	rehabilitation services per day.[v] To become an IRF, a facility must: • Have a preadmission screening process • Ensure patient receives various services (e.g., physical, occupational, rehab therapy; social services; prosthetic services) • Use interdisciplinary approach with nurse, social worker and/or therapist • Meet compliance threshold: no fewer than 60 percent of all patients admitted to the IRF must have at least 1 of 13 conditions, • Initiate therapy within 36 hours after admission.[vi]
Long-Term Care Hospitals (LTCHs)	Long-term care hospitals provide intensive care to patients who have multiple comorbidities and require inpatient hospital care over an extended period. [vii]
Home Health Care	Home health care is a wide range of health care services given in the home with the goal to treat an injury or illness. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician. Services may also include medical social services or assistance from a home health aide.[viii]
Hospice Program	Hospice care involves providing care to terminally ill individuals, which includes: • nursing care, • physical or occupational therapy, or speech-language pathology services, • medical social services, • (i) services of a home health aide (ii) homemaker services, • medical supplies, • physicians' services, • short-term inpatient care, • counseling, and • any other item or service which is specified in the care

Overview of Post-Acute/Long-Term Care Settings

Setting	Description of the Setting
	plan[ix]
End Stage Renal Disease (ESRD) Facilities	A renal dialysis facility is a unit that is approved to furnish dialysis service(s) directly to ESRD patients.[x]

[i] https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityPACFullReport.pdf.
[ii] http://www.medicare.gov/longtermcare/static/home.asp.
[iii] http://www.medicare.gov/longtermcare/static/NursingHome.asp.
[iv] http://www.medicare.gov/longtermcare/static/NursingHome.asp.
[v] https://www.cms.gov/CertificationandComplianc/16_InpatientRehab.asp.
[vi] http://healthcare-economist.com/2011/05/23/medpacs-analysis-of-inpatient-rehabilitation-facilities/.
[vii] https://www.cms.gov/Hospice/.
[viii] http://www.medicare.gov/HomeHealthCompare/About/GettingCare/WhatisHomeHealthCare.aspx.
[ix] Ibid.
[x] http://www.cms.gov/certificationandcomplianc/05_dialysisproviders.asp.

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Post-Acute Care Payment Reform Initiative Applies to: Skilled Nursing Facilities, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Home Health Care, and Outpatient Rehabilitation	As a component of the Deficit Reduction Act of 2005 (S1932.Title V.Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). [a]	The goal of this initiative is to standardize patient assessment information among PAC settings and to employ these data to guide payment policy in the Medicare program. The initiative is carried out in two parts: 1) develop a standardized patient assessment tool called the Continuity Assessment Record and Evaluation (CARE) tool for measurement and 2) conduct a PAC payment reform demonstration to examine differences in costs and outcomes for PAC patients of similar case mix who use different types of PAC providers. [b]	Data is collected using the CARE tool, which is an Internet-based Uniform Patient Assessment Instrument that will measure the health and functional status of Medicare acute discharges and measure changes in severity and other outcomes for Medicare PAC patients. The CARE tool includes two types of items: 1. Core items which are asked of every patient in that setting, regardless of condition, and 2. Supplemental items which are only asked of patients	Four major domains are included in the CARE tool: medical, functional, cognitive impairments, and social/environmental factors. These domains either measure case mix severity differences within medical conditions or predict outcomes such as discharge to home or community, rehospitalization, and changes in functional or medical status. [e]	The data from the assessment will be used to guide payment policy in the Medicare program. [f]	

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			having a specific condition. The supplemental items measure severity or degree of need for those who have a condition. [c] Data is submitted through web-based data submission systems.[d]			
Quality Measurement Reporting Program Applies to: LTCHs, IRFs, and Hospice Programs	Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs, IRFs, and Hospice Programs. [g]	The Act requires The Centers for Medicare and Medicaid Services (CMS) to establish quality reporting programs for LTCHs, IRFs and hospice programs, which in turn, require providers to submit data on selected quality measures to receive annual payment update for fiscal year 2014 and subsequent fiscal years.[h]	Measures can be generated from standards-based CARE data set. [i]	CMS envisions the implementation of high priority, site-specific and cross-setting quality measures for LTCHs, IRFs, and hospices that are valid, meaningful, feasible to collect, and that address symptom management, patient preferences, and avoidable adverse events. [j]	For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2% reduction in the annual payment update.[k]	According to the act, no later than October 1, 2012, the Secretary of HHS is required to publish the quality measures that must be reported by LTCHs, IRFs, and Hospice Programs. All data summited will be made available to the public; however, the Secretary is required to establish procedures to ensure

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
						that the reporting hospital or hospice has an opportunity to review the data that is to be made public before it is released.[l]
Minimum Data Set (MDS) Applies to: Nursing Home, Skilled Nursing Facility	Legislation enacted in 1987 required the implementation of the National Resident Assessment Instrument (RAI) for all nursing homes participating in the federal health care programs Medicare and Medicaid. The RAI is comprised of two parts, the MDS and Resident Assessment Protocols (RAPs).[m]	MDS is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. MDS assessment forms are completed for all residents in certified nursing homes regardless of source of payment at the time of admission and then periodically. [n] The MDS is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes and non-critical access hospital swing beds (SBs). [o]	Nursing homes transmit MDS information electronically to the MDS database in their respective state. Subsequently, the information from the state databases is captured into the national MDS database at CMS.[p]	The MDS contains items that measure physical, psychological and psychosocial functioning, which provide a multidimensional view of the patient's functional capacities and identify health problems.[q]		MDS assessment data are used to generate the reports on CMS website. The reports include the following: Quality Measure/Indicator Report, Quality Indicator Reports, Active Resident Reports, Assessment Counts by Reason for Assessment, Resource Utilization Groups (RUGS), RUGS by Reason for Assessment, Q1a counts by County.[r]

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
CAHPS® Nursing Home Surveys Applies to: Nursing Home, Skilled Nursing Facility		The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to support the assessment of consumers' experiences with health care. The CAHPS Nursing Home Surveys are comprised of three separate instruments: an in-person structured interview for long-term residents, a mail questionnaire for recently discharged short-stay residents, and a mail questionnaire for residents' family members.[s]	The CAHPS Nursing Home Surveys for residents include long-stay resident and discharged resident instruments. The long-stay resident instrument is for residents living in nursing home facilities more than 100 days. The instrument is designed to be administered in person and has been endorsed by the National Quality Forum (NQF) as a measure of nursing home quality in March 2011. The instrument for residents recently discharged from nursing homes after short stays not exceeding 100 days is	The instruments include the following topics: environment, care, communication and respect, autonomy, and activities. [u]		The Nursing Home Surveys can be used in monitoring programs designed to improve both care quality and patient satisfaction. Like all CAHPS surveys, the instruments are in the public domain.[v]

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			designed to be administered by mail. NQF endorsed this instrument in March 2011 on a provisional basis, pending final analyses of reporting composites. The two resident questionnaires, long-stay and discharged resident instruments, are similar in concept, except the discharged resident instrument also covers therapy services. Both instruments include questions about the quality of care residents have received at their nursing home and their quality of life in the facility.[t]			
Nursing Home Compare	• The Social Security Act (the ACT) mandates the	CMS has developed Nursing Home Compare	The data for the Nursing Home	The Nursing Home Compare performance domains include		Nursing Home Compare web site

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Applies to: Nursing Home, Skilled Nursing Facility	establishment of minimum health and safety and CLIA standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs. These standards are found in the 42 Code of Federal Regulations. According to the Act, providers and suppliers that are subject to these standards include hospitals, critical access hospitals, hospices, nursing homes, home health agencies, laboratories, clinics, and ambulatory surgery centers. [w] • The Five-Star Quality Rating System is based on the Omnibus Reconciliation Act of 1987 (OBRA '87), a nursing home reform law, and other quality improvement campaigns such as the Advancing Excellence in America's Nursing Homes, a coalition of consumers, health care providers, and nursing	web site to assist consumers, their families, and caregivers in informing their decisions regarding choosing a nursing home. The Nursing Home Compare includes the Five-Star Quality Rating System which assigns each nursing home a rating of 1 to 5 stars, with 5 representing the above average quality and 1 indicating the below average quality. [y]	Compare is collected through different mechanisms such as annual inspection surveys and complaint investigations findings, the CMS Online Survey and Certification Reporting (OSCAR) system, and MDS quality measures (QMs).[z]	the following: Health Inspections — facility ratings for this domain are based on the number, scope, and severity of deficiencies discovered during the three most recent annual surveys in conjunction with major findings from the most recent 36 months of complaint investigations. Other factors considered under this domain are the number of revisits required to ensure that deficiencies have been resolved. Staffing — facility ratings on this domain are based on two measures: RN hours per resident day and total staffing hours including RN, LPN, and nurse aide hours per resident day. QMs — facility ratings for this domain are based on performance on 10 of the 19		provides consumers, their families, and caregivers with information on the quality of care individual nursing homes offer.

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
	home professionals. [x]			QMs. These measures have been developed from MDS-based indicators and are currently posted on the Nursing Home Compare web site. The QMs include seven long-stay and three short-stay measures. [aa] Star ratings are assigned for each of the three domains and are also combined to calculate an overall rating. [bb]		
Quality Indicator Survey (QIS)[cc] Applies to: Nursing Home, Skilled Nursing Facility	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. To certify a SNF or NF, a state surveyor completes at least a Life Safety Code (LSC) survey, and a standard survey. [dd]	The QIS is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the federal requirements. [ee]	Data collection is conducted through site visits, which entail three components: medical record review, resident interviews, and resident observations. [ff]	The areas for assessment include the following: Identify residents who had or were at risk for specified conditions, and review diagnoses and medication that may impact a resident's condition by reviewing their medical records Conduct resident interview, which includes questions about pressure ulcers, urinary incontinence, nutrition,		

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
				choices, and activities. Preform resident observations which include: continuous observations for toileting and positioning, 60-minute behavioral observations, dining observations, and ADL-choice observations. [gg]		
Medicare Quality Improvement Organization (QIO) care transitions theme Applies to: Nursing Home, Skilled Nursing Facility		The care transition theme involves 14 QIOs and focuses on improving coordination across the continuum of care. QIOs promote seamless transitions from the hospital to home, skilled nursing care, or home health care. QIOs will work to reduce unnecessary readmissions to hospitals. QIOs are implementing three types of interventions: [hh] • System level process of care interventions,		CMS will measure the rate of 30 day hospital readmissions in the Care Transitions communities and will also identify the QIOs success in reducing rehospitalizations.[ii]		

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		• Disease specific interventions, and • Community specific interventions.				
Outcome and Assessment Information Set (OASIS) Applies to: Home Health Care	42 CFR Part 484[jj] required Home Health Agencies (HHAs) to submit OASIS data.	The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is proposed to be an integral part of the revised Conditions of Participation for Medicare-certified HHAs. The OASIS is a group of data elements that: •Represent core items of a comprehensive assessment for an adult home care patient •Form the basis for measuring patient outcomes for purposes of	HHAs must encode and transmit data using software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set. HAVEN is software provided free from CMS for HHAs to use to submit their OASIS data.[ll]	The OASIS includes six major domains: • sociodemographic, • environmental, • support system, • health status, and • functional status Additionally, selected health service utilization items are included.[mm]	Any HHA seeking Medicare certification is required to meet the Medicare Conditions of Participation (CoP) prior to certification. This includes compliance with the OASIS collection and transmission requirements. [nn]	Since fall 2003, CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website Home Health Compare.[oo]

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		outcome-based quality improvement (OBQI).[kk]				
Home Health Compare Applies to: Home Health Care	42 CFR Part 484[pp] required HHAs to submit OASIS data. Since 2003 CMS has posted a subset of this data on the Home Health Compare website.	Home Health Compare provides information about the quality of care provided by "Medicare-certified"[i] home health agencies throughout the nation.[qq]		Domains of the quality measurement include: managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.[rr]		Home Health Compare includes a subset of OASIS-based quality measures. These publicly reported measures include outcome measures that indicate how well health agencies assist their patients in regaining or maintaining their ability to function and process measures that evaluate the rate of home health agency use of specific evidence-based processes of care.[ss]

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

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) Applies to: IRFs	Section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33), as amended by section 125 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (Public Law 106-113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554), authorizes the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units - referred to as inpatient rehabilitation facilities (IRFs). The IRF PPS will use information from a patient assessment instrument (IRF- PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are	The Medicare IRF-PAI contains data items that were developed primarily for IRF PPS. However, the data collected will also be used for quality of care purposes. The IRF-PAI will be collected on all Medicare Part A fee-for-service patients who receive services under Part A from an IRF at admission and upon discharge. [uu] The Functional Independence Measure (FIM) is a functional assessment measure used in the rehabilitation community which has been embedded in IRF-PAI. The FIM instrument was designed for adult rehabilitation patients and is used with a computerized analysis and reporting system. For	To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains. Before the IRF-PAI data can be transmitted to the CMS national assessment collection database, an IRF must be assigned a login and password for accessing the Medicare data communication network (MDCN) and a login and password for accessing the national assessment collection	IRF-PAI data items address the physical, cognitive, functional, and psychosocial status of patients. [xx]	Each IRF must report the date that it transmitted the IRF-PAI instrument to the database on the claim that it submits to the fiscal intermediary. If an IRF transmits the instrument more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.[yy]	

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
	calculated for each group, including the application of case and facility level adjustments.[tt]	nearly 2 decades the FIM instrument and its reporting and analysis systems were used in the various rehabilitation settings.[vv]	database.[ww]			
Dialysis Facility Compare (DFC) Applies to: End Stage Renal Disease (ESRD) Facilities	The Balance Budget Act (BBA) of 1997 required the Secretary of Health and Human Services to measure and report the quality of renal dialysis services provided under the Medicare program.[zz]	In 2001, the DFC tool was launched on www.medicare.gov to assist patients and their family members and professionals to review and compare facility characteristics and quality information on all Medicare approved dialysis facilities in the United States. The information consists of nine facility characteristics and three quality measures on dialysis facilities.[aaa]	For the following measures, percent of patients who had enough wastes removed from their blood during dialysis and percent of patients who have their anemia under control, information is originated in the CMS Statistical Analytical Files (Medicare Claims). The rates are calculated each year by the University of Michigan's Kidney Epidemiology and Cost Center based on information that the	The quality measures used in the DFC include the following: • Percent of patients who had enough wastes removed from their blood during dialysis • Percent of patients who have their anemia (low blood count) under control • Patient survival rate [ccc]		The Medicare.gov website includes the quality information and the services provided in each dialysis facilities. [ddd]

Overview of Post-Acute/Long-Term Care Quality Performance Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			facilities send monthly. For the patient survival rate, the information is originated in the CMS Program Medicare Management and Information System (PMMIS/REBUS) and Standard Information Management System (SIMS) databases. [bbb]			
End-stage Renal Disease Quality Incentive Program (ESRD QIP)	The ESRD QIP pay-for-performance (value-based purchasing) quality incentive program was established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c).[eee]	The ESRD QIP is the first pay-for-performance program in a Medicare prospective payment system aimed to improve the quality of care for beneficiaries by changing the way dialysis facilities in the ESRD program are reimbursed. [fff]	The measures used in the program are claims-based measures. [ggg]	The ESRD QIP focuses on three core measures:[hhh] • Two measures covering anemia management • One measure capturing hemodialysis adequacy.	Providers/facilities that do not meet or exceed a certain total performance score would have payment reduced from between 0.5 percent to 2.0 percent. [iii]	CMS will report facility performance results in two locations: • Dialysis Facility Compare website, and • A certificate showing ESRD Quality Incentive Program scores posted at each participating

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
						facility. [jjj]
Quality Assessment and Performance Improvement (QAPI) Applies to: End Stage Renal Disease (ESRD) Facilities	Centers for Medicare and Medicaid Services (CMS) Conditions of Coverage for End Stage Renal Disease Facilities § 494.110 Condition: Quality assessment and performance improvement. [kkk]	Each dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program to CMS.[lll]		The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. [mmm]		

[a] http://www.cms.gov/DemoProjectsEvalRpts/downloads/PACPR_Section5008.pdf
[b] PACPR_RTI_CMS_PAC_PRD_Overview.pdf

[c] http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool.
[d] Ibid.
[e] Ibid.
[f] Ibid.
[g] http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/.
[h] Development of a CMS Quality Reporting Program for Long Term Care Hospital, Inpatient Rehabilitation Hospitals and Hospice Programs. Centers for Medicare & Medicaid Services Special Open Door Forum Presentation. 2010.
[i] Ibid.
[j] https://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/.
[k] Ibid.
[l] Ibid.
[m] http://www.elsevier.es/es/node/2455610.
[n] http://www.cms.gov/MDSPubQIandResRep/.
[o] https://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.
[p] Ibid.
[q] http://www.cms.gov/IdentifiableDataFiles/10_LongTermCareMinimumDataSetMDS.asp.
[r] Ibid.
[s] https://www.cahps.ahrq.gov/content/products/PROD_FacilitiesSurveys.asp?p=102&s=22.
[t] https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Resident.asp?p=1022&s=223.
[u] https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Resident.asp?p=1022&s=223#Long-Stay.
[v] https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Intro.asp?p=1022&s=223#UseNursingHome.
[w] https://www.cms.gov/CertificationandComplianc/01_Overview.asp#TopOfPage.
[x] Nursing Home Important Information. Five Star Quality Rating. Available at: http://www.medicare.gov/NHCompare/static/tabhelp.asp?language=English&activeTab=6&subTab=0version=default.
[y] https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp.
[z] CMS. Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide. July 2010. Available at: https://www.cms.gov/CertificationandComplianc/Downloads/usersguide.pdf. Last accessed June 2011.
[aa] Ibid.
[bb] http://www.medicare.gov/NHCompare/static/tabhelp.asp?language=English&activeTab=6&subTab=0version=default.
[cc] http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-21.pdf.
[dd] http://www.cms.gov/CertificationandComplianc/12_NHs.asp.
[ee] http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-21.pdf.
[ff] http://www.cms.gov/surveycertificationgeninfo/downloads/SCLetter09_46.pdf.
[gg] http://www.cms.gov/CertificationandComplianc/Downloads/QISExecSummary.pdf.
[hh] http://www.cfmc.org/caretransitions/.
[ii] http://www.cfmc.org/caretransitions/about.htm.
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[oo] http://www.cms.gov/HomeHealthQualityInits/.
[pp] http://www.cms.gov/OASIS/Downloads/OASISNewRegulation.pdf.
[qq] http://www.medicare.gov/HomeHealthCompare/About/overview.aspx.
[rr] http://www.medicare.gov/HomeHealthCompare/About/FindanAgency/QualityofCare.aspx.
[ss] http://www.cms.gov/HomeHealthQualityInits/01_Overview.asp.
[tt] https://www.cms.gov/InpatientRehabFacPPS/01_Overview.asp#TopOfPage.
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[yy] http://oig.hhs.gov/oas/reports/region1/10900507.asp.
[zz] http://www.cms.gov/DialysisFacilityCompare/.
[aaa] Ibid.
[bbb] http://www.medicare.gov/Dialysis/Static/Glossary.asp?dest=NAV|Home|Resources|Glossary#HCTG33.
[ccc] http://www.medicare.gov/Dialysis/Static/AboutDFC.asp?dest=NAV|Home|About|Overview#TabTop.
[ddd] Ibid.
[eee] http://www.cms.gov/ESRDQualityImproveInit/.
[fff] https://www.cms.gov/ESRDQualityImproveInit/downloads/QIPODF09212010.pdf.
[ggg] Ibid.
[hhh] Ibid.
[iii] Ibid.
[jjj] Ibid.
[kkk] Patient Safety Improvement Plan Basics available at: http://www.kidneypatientsafety.org/toolkit.aspx.
[lll] Ibid.
[mmm] Ibid.

MAP Measure Set Selection Criteria
"Strawperson" for Coordinating Committee Reaction
(Revised End of Day 1 – June 21, 2011)

Measure Sets "Fit for a Specific Purpose"

The MAP Coordinating Committee has been charged with identifying selection criteria to be applied to measure sets for public reporting and payment programs. Collectively, these criteria should address if a measure set under consideration is fit for its intended purpose. The measure set should be inclusive enough to achieve the program goals and be applicable to all entities that have an opportunity to contribute to achieving those objectives.

Inputs to the Strawperson Measure Set Selection Criteria

Several inputs informed the strawperson measure set selection criteria list proposed below. These included:

MAP Coordinating Committee and workgroup deliberations

The MAP Coordinating Committee members weighed in on guiding principles for measure set selection criteria at their first meeting. Subsequent feedback from the Clinician, Dual Eligible Beneficiaries, and Safety Workgroups was instrumental in shaping the strawperson criteria.

NQF measure endorsement criteria

As was agreed at the first MAP Coordinating Committee meeting, the underlying assumption is that the NQF measure endorsement criteria will serve as the baseline. Individual endorsed measures are suitable for a variety of accountability applications, as well as for quality improvement. An NQF-endorsed measure has been determined to address a high impact aspect of healthcare with an opportunity for improvement and sufficient evidence (importance to measure and report); is a reliable and valid indicator of quality (scientific acceptability of measure properties); is understandable and useful for decisions related to accountability and improvement (usable); and is feasible to implement. Therefore, when considering measure set selection criteria, the focus is on sets of measures to achieve specific program goals, rather than on reexamining the integrity of individual measures.

Stanford team

A team assembled by Arnie Milstein, MD, completed a thorough analysis of historical criteria sets, conducted "use cases" across various applications, and reached out to key informants to help elucidate criteria relevant to selecting measures for specific public reporting and payment programs.

Strawperson Measure Set Selection Criteria (Revised End of Day 1 – June 21, 2011)

Based on the inputs above, the following measure set selection criteria have emerged for the Committee's consideration and deliberation:

Measure sets for specific public reporting and payment programs should:

- Align with the priorities in the National Quality Strategy ---safe care; patient and family engagement; effective prevention and treatment; effective communication and care coordination; working with communities to enable healthy living; and affordable care --and consider high impact conditions with the greatest burden and potential gain to patients and the overall population.

- Address health and health care across the lifespan while promoting:
  - seamless care across transitions;
  - systemness;
  - individual and shared accountability among patients, providers, purchasers, health plans, and settings.

- Include measures of total cost of care, efficiency, and appropriateness.

- Be understandable, meaningful, and useful to the intended audiences:
  - Focus on outcome measures and measures with a clear link to improved outcomes
  - Balance issues of feasibility and evidence with users' needs.
  - Have ability to aggregate measures so that they provide meaningful interpretation of results for the given application.

- Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multidimensional view of quality.

- Have safeguards in place to detect or mitigate unintended consequences, such as adverse selection, through the use of "balancing measures" or other mechanisms to detect exclusion of high risk patients.

- Address specific program features including target population, setting, level of analysis, transparency and availability of data from various sources.

Individual measures within measure sets for specific public reporting and payment programs should be:

- NQF-endorsed, or if not endorsed, meet conditions for consideration of endorsement (e.g., measures should have been tested).
- Build on measure endorsement thresholds including:
  - Magnitude of the improvability gap;
  - Ability to discriminate to allow for meaningful comparisons; and
  - Proximity to outcomes, including patient-reported outcomes.
- Measures tested for the setting and level of analysis in which it will be implemented.
- Ensure measures have broad applicability across populations and settings.
- Ensure an adequate sample size for stable and meaningful comparison across the intended accountable entities (e.g., ACOs, hospitals, nursing homes, clinicians).

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

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American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
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 and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurse Associations of America	Emilie Deady, RN, MSN, MGA

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Care Coordination	Gerri Lamb, PhD
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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, PT
Suzanne Snyder is the Director of Rehabilitation Utilization and Compliance at Carolinas Rehabilitation. 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, a Bachelors in Physical Therapy and a Certification in Utilization 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. She has appealed Medicare denials from multiple Fiscal Intermediaries and through the Medicare Appeals Council level and Medicaid Program Integrity Denials in the state of North Carolina. Suzanne was instrumental in the creation and continuation of the EQUADRSM (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 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.

Family Caregiver Alliance
Kathleen Kelly, MPA

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.

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 now a consultant for long-term care and care transitions issues.

Providence Health and Services
Robert Hellrigel
Robert has been serving as the Chief Executive for Providence Senior and Community Services (PSCS), an operating division of Providence Health & Services, since November 2002. The service lines of PSCS include low-income supportive senior housing, skilled nursing, assisted living, home health, hospice, palliative care, LTC pharmacy services, home infusion and the State's only PACE (Program for All-inclusive Care for the Elderly). The ministries of PSCS support more than 13,000 people each day across a broad geography of Washington State, Portland, OR and Oakland, CA. Robert has 22 years of health care administration experience, including sixteen years as a member of senior management of Catholic sponsored healthcare systems. Prior to joining Providence Health & Services, Robert served in the mission of the Sisters of Providence of Holyoke, MA (a member of Catholic Health East) and the Sisters of Charity of Convent Station at the St. Raphael Healthcare System in New Haven, CT. Robert holds a B.A. in Economics and Health Systems Management from the University of Connecticut and has completed graduate studies in long-term care administration from the University of Connecticut and executive leadership at Seattle University.

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 Nurse Associations of America
Emilie Deady, RN, MSN, MGA
Emilie M. Deady, RN, MSN, MGA is a consultant in home health and hospice. Ms. Deady has served as the CEO/President of the Visiting Nurse Home Care Services located in Northern Virginia that included certified home health and hospice and a private duty corporation for over 21 years. In addition, she served as the Deputy Director of the Office of Medical Services for the Peace Corps and was primarily responsible for the day to day functions of the headquarters office and the Peace Corps offices overseas in 70 plus countries. These past responsibilities included oversight of quality initiatives in both agencies. Ms. Deady has degrees in nursing from the University of Maryland, a master's degree in community health nursing from The Catholic University of America, and a master's degree in general administration with a health care focus from the University College of the University of Maryland.

Individual Subject Matter Expert Members (voting)

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. 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 papers and published extensively on processes and outcomes of care across service settings. Her funded research focuses on hospital care coordination and adverse outcomes associated with transfers between hospitals and nursing home settings. In a recent project funded by the Robert Wood Johnson Foundation, she and her team developed a new instrument to measure nurse care coordination and an educational program about improving nurse care coordination based on their research findings. She recently completed a grant as Co-PI with Dr. Joseph Ouslander to evaluate the impact of The INTERACT program, a set of clinical tools and resources to assist nursing home staff reduce hospital transfers of residents. Their team is currently working on a distance educational program to disseminate INTERACT to over 100 nursing homes. For the last several years, Dr. Lamb has been very involved in a number of national quality and safety initiatives. She co-chaired the National Quality Forum's Steering Committee on Care Coordination. She currently chairs the American Academy of Nursing's Expert Panel on Quality and 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 (PCPI) Measurement Advisory Committee and recently was selected to serve on NQF's Measurement Applications Partnership in post-acute and long-term care. She has been a faculty facilitator for the Quality and Safety Education for Nurses (QSEN) Initiative for several years.

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 multimorbidity, guideline development, performance measurement, 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 directs 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 Governors of the American College of Physicians, President-elect of the American Academy of Home Care Physicians, and is an Associate Fellow of InterRAI.

State Medicaid
MaryAnne Lindeblad, MPH
MaryAnne Lindeblad is currently the Assistant Secretary, Aging and Disability Services Administration, Department of Social and Health Services. She served as Director, Division of Healthcare Services, Medicaid Purchasing Administration; Assistant Administrator Public Employees Program, Washington State Health Care Authority; and Director of Operations, Unified Physicians of Washington. In 2009, she was selected to the inaugural class of the Medicaid Leadership Institute, sponsored by the Robert Wood Johnson Foundation. Ms. Lindeblad currently serves as chair of the Medicaid Managed Care Technical Advisory Group and is a member of the Executive Committee for the National Academy for State Health Policy, and chairs their Long Term and Chronic Care subcommittee. She serves as board President of the Olympia Free Medical Clinic and board Vice Chair of the Family Support Center. She holds a B.S. in Nursing from Eastern Washington University's Intercollegiate Nursing Program and a Master's in Public Health from the University of Washington.

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

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
Judy Sangl, ScD

Centers for Medicare & Medicaid Services (CMS)
Shari Ling, MD

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 for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente’s 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative

effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health's COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new micro simulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. 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 BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

National Quality Forum Staff

Janet M. Corrigan, PhD, MBA

Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human

Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

Thomas B. Valuck, MD, JD, MHSA

Thomas B. Valuck, MD, JD, is senior vice president, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. 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 public reporting, payment incentives, accreditation and certification, workforce development, 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 Program Director, Strategic Partnerships, at the National Quality Forum (NQF). Miss Pittman leads the Clinician Workgroup and the Post-Acute Cae/Long-Term Care Workgroup of the Measure Applications Partnership (MAP). Additionally, Ms. Pittman leads 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. 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 currently employed at the National Quality Forum, a non-profit, multi-stakeholder organization, as part of its Strategic Partnerships department. Specifically, she serves as a Project Analyst supporting the Measure Applications Partnership. Before coming to NQF Ms. O'Rourke worked in Outcomes Research at United BioSource Corporation. While at UBC, she worked to develop patient-reported outcome measures (PROs) and evaluate the measurement qualities of PROs. 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 worked with The Foundation for Informed Medical Decision Making, a non-profit organization working to promote shared decision-making and patient engagement. Ms. O'Rourke 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.

Taroon Amin, MPH, MA

Taroon Amin, MPH, MA, is Senior Director in Strategic Partnerships and Performance Measures, at the National Quality Form (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Amin provides leadership support to multiple workgroups within the Measures Applications Partnership (MAP) and resource measures under NQF-review in the Consensus Development Process (CDP). Mr. Amin comes to NQF from the Schneider Institutes for Health Policy at Brandeis University, where he was an Agency for Health Care Research and Quality (AHRQ T-32) fellow. During his time there, Taroon worked with Health Care Incentives Improvement Institute (HCI3), American Board of Medical Specialties Research and Education Foundation (ABMS-REF), and American Medical Association-convened Physicians Consortium for Performance Improvement (AMI-PCPI) to develop the Patient-Centered Episode Grouper System (PACES), a public sector episode grouper system for the Medicare Program. Also at Schneider, Taroon worked with the American Association of Medical Colleges and Teaching Hospitals (AAMC) on the development of Health Innovation Zones (HIZs) in response to Section XVIII of the Patient Protection and Affordable Care Act and also worked with the Government of India on the evaluation of public sector insurance schemes. Before joining Schneider, Taroon led Six Sigma/ Lean quality improvement projects at New York-Presbyterian Hospital, the University Hospitals of Cornell and Columbia and the Morgan Stanley Children's Hospital. Taroon holds a degree in international health systems management from Case Western Reserve University with his international training from Tsinghua University (Beijing), École des Sciences Politiques (Paris) and the Indian Institute of

Management (Ahmedabad). Taroon also holds a master's degree in public health from Columbia University and a master's degree in social policy from Brandeis University, where he is currently a PhD candidate. Philanthropically, Mr. Amin serves as founding member of International Health Care Leadership (IHL), an independent non-profit organization developed to train Chinese healthcare professionals how to incorporate healthcare public policy into healthcare reform and hospital management.

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of In-Person Meeting #1

An in-person meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Tuesday, May 3 and Wednesday, May 4, 2011. For those interested in reviewing an online archive of the web meeting please click on the link below:

http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Coordinating_Committee.aspx

The next meeting of the Coordinating Committee will be an in-person meeting on June 21-22, 2011, in Washington, DC.

Committee Members in Attendance at the May 3-4, 2011 Meeting:

George Isham (Co-Chair)
Elizabeth McGlynn (Co-Chair)
Richard Antonelli
David Baker, ACP
Christine A. Bechtel, National Partnership for Women and Families
Bobbie Berkowitz
Joseph Betancourt
Judith A. Cahill, AMCP
Mark R. Chassin, The Joint Commission
Maureen Dailey, ANA (substitute for Marla Weston)
Suzanne F. Delbanco, Catalyst for Payment Reform
Joyce Dubow, AARP
Steven Findlay, Consumers Union
Nancy Foster, AHA (substitute for Rhonda Anderson)
Victor Freeman, HRSA
Foster Gesten, NAMD
Aparna Higgins, AHIP
Eric Holmboe, ABMS (substitute for Christine Cassel)
Chip N. Kahn, FAH
William E. Kramer, PBGH
Sam Lin, AMGA
Karen Milgate, CMS
Elizabeth Mitchell (phone), MHMC
Ira Moscovice
Michael A. Mussallem, AdvaMed
John O'Brien, OPM
Peggy O'Kane, NCQA
Frank G. Opelka, ACS
Cheryl Phillips, LeadingAge
Harold Pincus
Carol Raphael
Chesley Richards, CDC
Gerald Shea, AFL-CIO
Carl A. Sirio, AMA
Thomas Tsang, ONC
Nancy J. Wilson, AHRQ

This was the first in-person meeting of the Measure Applications Partnership Coordinating Committee. The primary objectives of the meeting were to:

- Establish the decision making framework for the MAP,
- Consider measure selection criteria,
- Finalize workgroup charges,
- Review the Ad Hoc Safety Workgroup roster, and
- Direct workgroups to consider measurement strategies for HACs and readmissions.

Committee Co-Chairs, George Isham and Beth McGlynn, as well as Janet Corrigan, President and CEO, NQF, began the meeting with a welcome and introductions. This was followed by disclosures of interest by the Committee and a review of the MAP member responsibilities and media policies.

Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the Coordinating Committee charge and brief review of the strategies and models that contribute to the MAP decision making framework. These inputs include the HHS National Quality Strategy, the HHS Partnership for Patients safety initiative, the NQF-endorsed Patient-focused Episode of Care Model, and the high impact conditions as identified by the NQF-convened Measure Prioritization Advisory Committee. Regarding the high impact conditions, the Committee discussed the importance of viewing these lists as inputs to the MAP, not limitations, and the need to consider how measurement may impact persons with multiple chronic conditions. NQF staff raised how the HHS Multiple Chronic Conditions Framework and the Multiple Chronic Conditions Performance Measurement Framework (currently in development as an NQF project under contract with HHS) will help support this consideration.

The Committee members drew for their terms of membership. The chart below presents the terms for all Coordinating Committee members.

Helen Burstin, Senior Vice President, Performance Measures, NQF, provided background information on NQF's current endorsement criteria. Tom Valuck discussed the relationships among the roles of the National Priorities Partnership, a multi-stakeholder group that provides input to the HHS National Quality Strategy; the role of measure endorsement, which endorses measures for public reporting and quality improvement; and the role of the MAP in selecting measures for particular purposes, such as public reporting and payment reform.

Tom Valuck, Helen Burstin, and Beth McGlynn discussed how the measure selection criteria, which are currently in development and will be used by the MAP with regard to selection of measures, should not duplicate the endorsement criteria and are meant to build on the foundation of endorsement. Arnie Milstein, Director, Stanford Clinical Excellence Research Center, presented the work of the MAP measure selection criteria project. The Committee's discussion led to the following considerations that the measure selection criteria should address:

- Promoting 'systemness' and shared accountability,
- Addressing the various levels of accountability in a cascading fashion to contribute to a coherent measure set,
- Enabling action by providers,
- Helping consumers make rational judgments,
- Assessing quantifiable impact and contributing to improved outcomes, and
- Considering and assessing the burden of measurement.

Additionally, consideration was given to tailoring the criteria for various purposes (e.g., payment reform, public reporting, and program evaluation), addressing public/private alignment, and contributing to parsimony.

George Isham and Nalini Pande, Senior Director, Strategic Partnerships, NQF, discussed the charges and tasks for each of the Workgroups. In discussing the workgroup charges, the Committee offered the following considerations for all of the workgroups:

- While addressing the specific HHS tasks contractually outlined, each workgroup should consider alignment with the private sector;
- Given that this work is on a short timeline, each workgroup should take the timeline into consideration, setting expectations accordingly and identifying what work will need to be done in subsequent phases; and
- There should be a focus on models of care rather than individual measures.

Further, the Coordinating Committee proposed the following:

- The Hospital Workgroup should consider cancer care beyond PPS-exempt cancer hospitals.
- The Dual Eligible Beneficiaries Workgroup should consider opportunities for cross-linking with the post-acute care/long-term care tasks.
- The Post-Acute Care/Long-Term Care Workgroup should specifically look at quality from a family perspective of hospice care delivery.

The first day of the meeting concluded with a review of the evening assignment where Committee Members were asked to further consider a list of inputs to the measure selection criteria; specifically, members were asked to identify historical sets of criteria that should be considered and to recommend additional strategies to resolve the criteria gaps and conflicts in existing criteria. Committee Members were asked to email the Co-Chairs and NQF staff with any additional information they would like to share after the meeting.

The second day of the meeting began with Beth McGlynn providing a recap of day 1, followed by the full Committee providing comments regarding the evening assignment. Additional considerations raised regarding the measure selection criteria included the following:

- Resource use, efficiency, and cost need to be explicitly addressed within the criteria;
- Appropriateness needs to be considered as efficiency cannot be addressed without considering appropriateness;
- Patient preference should be incorporated;
- While there is agreement that there needs to be ‘systemness’, it is a data challenge to do so, therefore, usability and feasibility need to be addressed to promote ‘systemness’;
- Measures need to serve multiple audiences and cross points of delivery;
- The criteria stress test needs to look for unintended consequences.

George Isham and Nalini Pande reviewed the healthcare-acquired conditions (HACs) and readmissions tasks, including the formation of the Ad Hoc Safety Workgroup. The Ad Hoc Safety Workgroup must be composed of MAP workgroup members that have already been vetted through the nomination and roster review process. The Committee’s Co-Chairs proposed that the Ad Hoc Safety Workgroup be composed of the Hospital Workgroup and all the payers and purchasers represented on the other MAP workgroups and the Coordinating Committee. The Committee accepted this recommendation, while noting that the Ad Hoc Safety Workgroup should invite additional experts to present during Safety

Workgroup meetings. Regarding the charge of the Ad Hoc Safety Workgroup, the Coordinating Committee discussed that alignment of the strategy for addressing HACs and readmissions is more important to this task than specific metrics. Additionally, the current set of metrics does not address regional variation.

The meeting concluded with a summary of day 2 and discussion of next steps. The next meeting of the Coordinating Committee will be in-person on June 21-22, in Washington, DC.

Coordinating Committee Member Terms, Beginning May 2011

1-Year Term	2-Year Term	3-Year Term
National Partnership for Women and Families, represented by Christine A. Bechtel, MA	Bobbie Berkowitz, PhD, RN, CNAA, FAAN	AHA, represented by Rhonda Anderson, RN, DNSc, FAAN
The Joint Commission, represented by Mark R. Chassin, MD, FACP, MPP, MPH	Joseph Betancourt, MD, MPH	Richard Antonelli, MD, MS
Catalyst for Payment Reform, represented by Suzanne F. Delbanco, PhD	AMCP, represented by Judith A. Cahill	ACP, represented by David Baker, MD, MPH, FACP
HRSA, represented by Victor Freeman, MD, MPP	ABMS, represented by Christine Cassel, MD	NAMD, represented by Foster Gesten, MD
AHIP, represented by Aparna Higgins, MA	AARP, represented byJoyce Dubow, MUP	George Isham, MD, MS
PBGH, represented by William E. Kramer, MBA	Consumers Union, represented by Steven Findlay, MPH	Elizabeth McGlynn, PhD, MPP
MHMC, represented by Elizabeth Mitchell	FAH, represented by Chip N. Kahn	CMS, represented by Karen Milgate, MPP
LeadingAge, represented by Cheryl Phillips, MD, AGSF	AMGA, represented by Sam Lin, MD, PhD, MBA, MPA, MS	Ira Moscovice, PhD
Harold Pincus, MD	ACS, represented by Frank G. Opelka, MD, FACS	AdvaMed, represented by Michael A. Mussallem
Carol Raphael, MPA	AMA, represented by Carl A. Sirio, MD	OPM, represented by John O'Brien
AFL-CIO, represented by Gerald Shea	ONC, represented by Thomas Tsang, MD, MPH	NCQA, represented by Peggy O'Kane, MPH
AHRQ, represented by Nancy J. Wilson, MD, MPH	ANA, represented by Marla J. Weston, PhD, RN	CDC, represented by Chesley Richards, MD, MPH