NQF Measure Applications Partnership Dual Eligible Beneficiaries Workgroup

DRAFT REPORT

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Introduction

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. In pursuit of the National Quality Strategy goals of improving the quality, affordability, and community impact of health care, MAP is convened and provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. Information and background on MAP is provided in Appendix A. MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations. Furthermore, the MAP Dual Eligible Beneficiaries Workgroup, a topic focused workgroup of the larger MAP enterprise, provides guidance on performance measures to assess and improve healthcare in the dually eligible for Medicare and Medicaid population. The MAP Dual Eligible Beneficiaries Workgroup is a 24-member, multistakeholder group which serves as one of four advisory workgroups to the MAP Coordinating Committee (Appendix B). The workgroups are responsible for advising the Coordinating Committee on the use of measures to encourage performance improvement based on the MAP Measure Selection Criteria (MSC) and other inputs (Appendix C). The MAP Coordinating Committee issues all final recommendations, taking into account Workgroup recommendations.

The MAP Dual Eligible Beneficiaries Workgroup is currently in its fifth year of work on performance measures for dual beneficiaries and this is the latest in a series of reports offering guidance from the Workgroup on performance measures to assess and improve healthcare in the dually eligible population. In previous reports, the Workgroup emphasized aligning measures across programs and facilitating development in priority gap areas. In an effort to reduce disparities in care, the Workgroup has also supported efforts to identify such disparities including through stratification by dual eligible beneficiary status in existing programs and exploring alternative methods. Building on earlier work identifying common issues across high-need subpopulations, the Workgroup continues to focus on addressing quality of care issues for individuals with multiple chronic conditions (MCCs).

In 1965, Medicare and Medicaid were enacted as separate programs with different benefits, enrollment criteria, and administrations. In 1972, Medicare extended beyond just those over 65 years of age to those with long-term disabilities and end stage renal disease. For Medicaid, eligibility is mainly based on having a household income significantly below the federal poverty line, and in the case of children, on age. The Medicare-Medicaid dual eligible population is a unique and diverse group generally characterized as "high-risk" because dual eligible individuals have a combination of complex clinical and behavioral conditions that are compounded by poverty. This is a particularly vulnerable population with 77% of individuals having diagnoses across two or more condition groups of physical or mental illness, 60% having diagnoses across three or more, 41% having diagnoses across four or more, and 25% having diagnoses across five or more condition groups.[1]

Dual beneficiaries are a growing population of nearly 11 million individuals with complex needs that require high levels of care.[2] Spending for dual beneficiaries is disproportionately high. Annually, dual beneficiaries comprise 20% of Medicare beneficiaries but account for 34% of the spending at

approximately $500 billion and comprise 14% of Medicaid beneficiaries but account for 34% of spending at approximately $340 billion.[3]

Continued as well as nascent efforts are underway to improve quality of care within the dual Medicare and Medicaid population. Efforts to bring more coordination between Medicaid and Medicare flourished with the evolution of the Program for All-Inclusive Care for the Elderly (PACE) and then the establishment of the Medicare-Medicaid Coordination Office (MMCO) created under the Patient Protection and Affordable Care Act. Moreover, the Financial Alignment Initiative began in 2011 to encourage the development and alignment of standardized measures to better monitor care coordination for the dual eligible population.[4] Thirteen state financial alignment demonstrations are currently participating in this initiative.

The Center for Medicare and Medicaid Services looks to the Workgroup for guidance and measurement expertise and Workgroup input is an important part of how CMS shapes policy and the strategic direction for future programmatic efforts. With input from the Workgroup, CMS has placed increased emphasis on addressing Workgroup-identified priority measurement gap areas for dual eligible beneficiaries including quality of life, outcome measures, person-reported outcomes, person and family centered care, and care coordination. Some recent pertinent activities include:

> A Draft Medicare-Medicaid Plan Quality Rating Strategy Report - a high-level roadmap for quality-ratings strategy for the Medicare-Medicaid plans that was posted for public comment.[5]

> Two evaluation reports on the Financial Alignment Initiative: (1) an evaluation of the measure implementation in participating states[6], many of which were recommended by the Workgroup; and (2) an issue brief with early Washington Managed Fee for Service Model demonstration results.[7] Additional publicly accessible annual reports for the state demonstrations under the Financial Alignment Initiative are forthcoming this year.[8]

> The Quality Measure Development and Maintenance for CMS Programs Serving Medicare and Medicaid Enrollees and Medicaid-only Enrollees: a measure development contract that involves collaboration across offices to address gaps for Medicare and Medicaid enrollees and adult Medicaid enrollees.[9] Workgroup input significantly informed this effort, which requires development of six measures tailored to the dual beneficiary population as well as complete testing of 13 Managed Long Term Services and Supports measures.[10] The measures will focus on the priority gap areas for dual beneficiaries of shared care plans and functional status assessment.[11]

The first section of this report describes updates to the MAP Family of Measures for Dual Eligible Beneficiaries, including related topics such as overcoming barriers to measure development, use of existing prioritized measures for improvement, and remaining measure gaps and development of new measures to address gap areas. The Workgroup's focus this year was on measurement topics for individuals with multiple chronic conditions as well as community integration and connection to community resources. The report also highlights the value of cross-pollination with other NQF endeavors such as those related to the topics of home and community-based services, risk adjustment for socioeconomic status (SES), disparities in health and healthcare and person- and family-centered care. Finally, this report notes promising models of and strategies for integrated care for individuals with

complex needs beyond the medical realm into social and community settings. In following NQF's dedication to transparency, we invite your comments on this draft report and look forward to your input.

Maintaining the Family of Measures

The MAP Family of Measures for Dual Eligible Beneficiaries is a group of best available measures that are selected and recommended for use to address the needs of this population and to identify high-leverage opportunities for improvement across the continuum of care. Since 2012, MAP has identified families of measures across a variety of topics such as patient safety and affordable care. The Family of Measures for Dual Eligible Beneficiaries was established by MAP in 2013 with the goal of driving improvement in specific areas that impact healthcare quality for dual beneficiaries.[12] In 2014, the MAP Dual Eligible Beneficiaries Workgroup established a starter set of measures meant to provide guidance to those selecting and implementing measures in the field as to the highest-priority measures for dual beneficiaries.[13]

Approach

All MAP workgroups including the MAP Dual Eligible Beneficiaries Workgroup rely on the Measure Selection Criteria (MSC) (Appendix C) to serve as a common foundation for evaluating measures and developing recommendations across all topics. The family of measures is selected based on these 7 criteria, with particular attention to criteria addressing person- and family-centered services, and healthcare disparities and cultural competence. In the absence of a specific quality measure reporting program, the MAP Dual Eligible Beneficiaries Workgroup makes recommendations about the use of measures to address the population needs.

The Workgroup periodically reviews changes to the family of measures to ensure it contains the best available measures at any given point in time. Periodic reviews are important as the dual beneficiary population continues to grow and measurement science changes to produce new measures with the potential to address the population's needs. To maintain the family, Workgroup members provide input, evaluate measures with changes to endorsement, newly available measures, and work to achieve consensus on any changes to measures included in the family.

The starter set of measures is a subset of measures in the family that are most ready for implementation as currently specified. Generally, these measures demonstrate the Workgroup's preference for cross-cutting measures and condition-specific measures that address critical clinical issues across the population. The starter set is periodically reviewed in tandem with the family of measures. The Workgroup updated the starter set this year by considering additions or removals based on the priorities for the population and the availability measures.

Achieving Consensus

The Workgroup's in-person meeting deliberation was supported by Workgroup input via a web meeting and prioritization exercises, as well as staff preliminary analysis. Workgroup members shared their feedback with staff at a public web meeting and via an independent prioritization exercise in advance of the in-person meeting on how well the measures in the family meet the population needs. This input was compiled and used to begin discussion of changes to the family at the in-person meeting. Workgroup discussion was also supported by staff preliminary analysis that took into consideration the

MSC, including alignment and population characteristics, along with the Workgroup's prior input on high-leverage opportunities for improvement and priority gap areas.

Changes to the family of measures were made through Workgroup consensus. Workgroup members discussed removing measures from the family if they had endorsement changes since their last in-person meeting in the spring of 2015; the discussion also included measures that were noted as low priority for the population, and any available alternatives. Members also considered measures that received NQF endorsement since the workgroup's last in-person deliberations, and if these newly-endorsed measures address the priorities for measurement or gap areas. Workgroup members voted on any changes to the family, obtaining consensus by establishing more that 60% of votes supporting a change.

Monitoring the NQF Trial Period on Risk-Adjustment for Socioeconomic Factors

The MAP Dual Eligible Beneficiaries Workgroup has a particular interest in addressing healthcare disparities because dual beneficiaries are by definition economically disadvantaged as evidence by their eligibility for Medicaid supports and services. The Workgroup has been monitoring NQF's Trial Period for SES Risk Adjustment, during which measure submissions for NQF endorsement review may include risk adjustment for SES factors, in addition to the case-mix or clinical risk adjustment that has always been allowed. Measure submissions with risk adjustment for SES factors must include a conceptual rationale as to why risk adjustment is necessary, test results based on risk adjustment methodology, and specifications with stratification instead of risk adjustment for these factors. Individual standing committees at NQF can also identify measures under review for inclusion into the trial period. NQF will review the final results of the trial period in April 2017, after which NQF will determine if there will be a permanent change of policy that allows the submission of measures that are risk adjusted for SES factors. More information about the trial period can be found on the project page along with frequently asked questions.[14] [15]

The MAP Dual Eligible Beneficiaries Workgroup received an update on the progress of the trial period during the April 2016 in-person meeting. Early findings from the trial period have highlighted the limited availability of patient-level data for SES factors.[16] The Workgroup discussed the importance of robust data on socioeconomic and other factors, as well as the potential of including variables of poverty or community characteristics when individual level variables are not available. Workgroup members encouraged the development of a standardized framework and methodology for risk adjustment in the field. One member commented on the role discriminatory practices play in healthcare disparities and stated that such practices should be considered in risk adjustment (e.g., women that use wheelchairs lacking accessible mammography services). The Workgroup reiterated ongoing support for the use of stratification to understand healthcare quality and outcomes in different populations.

Measures in the Family with Changes to Endorsement Status

The MAP Dual Eligible Beneficiaries Workgroup considered six measures in the family that have had changes in endorsement status since last meeting. Changes to endorsement can occur when a measure is harmonized with another measure, a measure is placed on reserve status due to limited opportunities for improvement, or endorsement is removed. Endorsement can be removed for a variety of reasons,

including concerns about the measure reliability, validity, or other [Measure Evaluation Criteria](#), retirement by the measures steward, or a variety of other reasons. Also, when measures are no longer being maintained by their stewards, their specifications are not kept current and reliability, validity, and performance data is not submitted to support endorsement. The Workgroup voted to remove all six of the measures that are no longer NQF endorsed from the family and expressed the importance of having reliable, valid, NQF endorsed measures to use across all populations.

Cultural Competency

The Workgroup voted to remove measure NQF# 0007 NCQA Supplemental Items for CAHPS 4.0 Adult Questionnaire because the measure is not being maintained by the steward. Updated specifications or performance information are not being provided while a new measure is under development. The Workgroup will consider the addition of the newly specified measure after it is fully developed and evaluated against the NQF endorsement criteria. The Workgroup continues to stress the importance of identifying measures that address the current measure gap related to cultural competency of healthcare providers and systems.

Pressure Ulcers

The Workgroup voted to remove measure NQF# 0201 Pressure Ulcer Prevalence (hospital acquired) because the measure was retired by the steward and is no longer being maintained. Pressure ulcers are highly impactful for the dual beneficiary population as these individuals are more than twice as likely to be hospitalized for a pressure ulcer compared to other Medicare beneficiaries.[17] The Workgroup considered five alternative measures and voted to include NQF# 0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) and NQF# 0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay) in the family of measures. These measures are recommended because of the high proportion of dual beneficiaries using nursing facility care. They also create minimal reporting burden because they are derived from the Minimum Data Set, which nursing facilities are already required to collect and is aligned across federal programs. The Workgroup encouraged the use of consistent measures across settings of care and noted a gap in measurement of this important condition still exists with respect to hospitals and home health settings.

Medication Reconciliation

Measure NQF# 0554 Medication Reconciliation Post-Discharge is no longer being maintained as an individual measure and is now combined with the updated measure NQF# 0097 Medication Reconciliation Post-Discharge (formerly Medication Reconciliation). Therefore, the Workgroup voted to remove NQF# 0554 from the family while retaining NQF# 0097.

Patient Reported Outcome Tools and Performance Measures

Patient reported outcomes (PRO), the tools used to collect them, and the performance measures (PRO-PMs) derived from such tools have received attention as a vitally important but methodologically challenging area in healthcare quality.[18, 19] MAP and the Workgroup have previously expressed support for the development of methodologically sound PRO-PMs.[20]

The Workgroup discussed the retention of three PRO-PMs in the family of measures - NQF# 0692 CAHPS Nursing Home Survey: Long-Stay Resident Instrument, NQF# 1902 Clinician/Groups Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy, and NQF# 1909 Medical Home System Survey. The NQF# 0692 and NQF# 1902 measures are no longer maintained by the steward and measure NQF# 1909 was withdrawn from re-endorsement consideration by the developer. The Workgroup voted to remove these three measures from the family while recognizing important gap areas persist with respect to experience of care for nursing home residents, outpatient care health literacy, and patient-centered medical homes. The Workgroup encouraged innovation in the development of performance measures for experience of care across all settings and populations that would meet the rigorous NQF evaluation criteria.

Consideration of Newly Endorsed Measures for Addition to the Family

The MAP Dual Eligible Beneficiaries Workgroup considered the measures newly endorsed by NQF since its last meeting, particularly those most recently endorsed by in the ongoing [NQF Person- and Family-Centered Care (PFCC) Project](). A majority of the measures were not recommended for inclusion into the family because they do not specifically address a priority gap area or high-leverage opportunity for improvement. In addition, several newly-endorsed measures are condition-, procedure-, or population-specific (e.g., end-stage renal disease, carotid stenting, pediatric-only measures).

Person- and Family-Centered Care Project

The 14 measures of functional status and outcomes recently endorsed during Phase 2 of the Person- and Family-Centered Care (PFCC) Project were considered for inclusion in the family. The workgroup acknowledged the importance of measures that address functional status, particularly given the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which, "…requires post-acute care providers to report standardized patient assessment data as well as data on quality, resource use, and other measures."[21] Functional status is a common and important component of the patient assessment data collected during post-acute care. However, the Workgroup voted to add one measure from Phase 2 to the family, but agreed the majority of measures from Phase 2 are not appropriate for inclusion in the family at this time because the measures were not specified for multiple care settings or levels of analysis. The Workgroup will continue to monitor the progress of Phase 3 of the PFCC Project and the endorsement of additional measures to address the priority gap areas for the dual eligible population, specifically measures of experience of care and outcomes that matter to the beneficiary.

Measures added to the Family

One newly-endorsed measure from Phase 2 of the PFCC project - NQF# 2624 Functional Outcome Assessment - was selected for addition to the family with the rationale being the measure addresses a priority gap area – measures related to optimal functioning. This measure addresses the Workgroup preference that there be a plan of care and follow up for any measure of assessment, plus identification of necessary resources to execute the plan of care. The measure is not viewed as burdensome because it is collected via administrative claims and is currently in use by providers participating in the Physician Quality Reporting System (PQRS). The measure is considered particularly relevant for the significant portion of the dual eligible population receiving care in outpatient settings. While the remaining measures newly-endorsed in Phase 2 of the PFCC project make important progress in addressing the gap

in functional outcome measures, the Workgroup plans to monitor the measure's performance over the next few years before recommending additional measures for inclusion into the family and use in the population.

Measure NQF# 1662 Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptive Blocker (ARB) Therapy was also voted for inclusion in the family of measures. The Workgroup agreed the measure addresses a performance gap in following appropriate clinical practice guidelines for individuals with significant disease burden. In particular, this measure addresses the critical impact these therapies have on the high number of individuals who experience multiple chronic conditions in the population and the close link these therapies have to quality of life and functional outcomes. Workgroup members discussed the importance of this measure across populations and encouraged expansion beyond individuals with chronic kidney disease.

Updates to the Starter Set of Measures

Similar to the process to maintain the family of measures, the Workgroup updated the starter set of measures for dual beneficiaries based on the changes to endorsement status and measurement priorities for the dual eligible population. The Workgroup voted to add seven measures to the starter set and remove two measures. Measure NQF# 1909 Medical Home System Survey was automatically removed from the starter set after being removed from the family of measures because it is no longer endorsed. The Workgroup voted to remove measure NQF# 0022 Use of High Risk Medications in the Elderly (DAE) from the starter set because the measure is age-specific. However, it is retained in the family of measures as an important issue for a significant portion of the population. Table 1 lists all the current measures in the starter set; an asterisk (*) indicates additions to the starter set.

Table 1 Starter Set of Measures for Dual Eligible Beneficiaries

NQF#	Measure Title	Measure Type	Measure Steward
0004	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*	Process	National Committee for Quality Assurance (NCQA)
0008	*Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)*	Composite	Agency for Healthcare Research and Quality
0018*	*Controlling High Blood Pressure*	Outcome	NCQA
0028	*Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention*	Process	AMA-convened Physician Consortium for Performance Improvement
0097*	*Medication Reconciliation Post-Discharge*	Process	NCQA
0101	*Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls*	Process	NCQA
0228	*3-Item Care Transition Measure (CTM-3)*	PRO	University of Colorado Denver Anschutz Medical Campus
0326*	*Advance Care Plan*	Process	NCQA
0418	*Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*	Process	Centers for Medicare & Medicaid Services (CMS)

NQF#	Measure Title	Measure Type	Measure Steward
0419	*Documentation of Current Medications in the Medical Record*	Process	CMS
0421	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*	Process	CMS
0576	*Follow-Up After Hospitalization for Mental Illness (FUH)*	Process	NCQA
0647*	*Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)*	Process	AMA-convened Physician Consortium for Performance Improvement
0648*	*Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)*	Process	AMA-convened Physician Consortium for Performance Improvement
1768	*Plan All-Cause Readmissions (PCR)*	Process	NCQA
2111*	*Antipsychotic Use in Persons with Dementia*	Process	Pharmacy Quality Alliance
2510*	*Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)*	Outcome	CMS

Medication Management

The starter set contains two measures of medication management; however, the Workgroup voted to only include NQF# 0097 Medication Reconciliation Post-Discharge in the starter set because it addresses the important issue of medication reconciliation after a transition in care when individuals are particularly vulnerable.

Care Transitions

In addition to NQF# 0228: 3-Item Transition Measure currently in the starter set, the Workgroup voted to include NQF# 0647 Transition Record with Specified Elements Received by Discharged Patients and NQF# 0648 Timely Transition of Transition Record to the starter set. Members expressed how these measures cumulatively address important aspects of care transitions, such as patients' experience of care, whether patients receive essential information, and whether providers transfer information.

Readmission

The Workgroup voted to add measure NQF# 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure to the starter set as a complement to the current measure of readmissions in the starter set, NQF# 1789 Plan All-Cause Readmissions. These measures together demonstrate the importance of shared responsibility across the system of care. Members noted the high portion of dual beneficiaries who have nursing facility stays as well as the importance of their transition out of the nursing facility. For dual beneficiaries, adequate support during the transition from the nursing facility to their residence is a vital element of high quality care.

Blood Pressure Control

Measure NQF# 0018 Controlling High Blood Pressure was added to the starter set of measures for dual beneficiaries because of the importance of achieving this essential standard of care across all populations. Members stressed the importance of updating the measure specifications and being compliant with the new clinical practice guidelines.

Advance Care Plan

Measure NQF# 0326 Advance Care Plan was added to the starter set because the Workgroup was supportive of individuals having their preferences and needs for care at end of life known, while also acknowledging that some individuals may prefer not to have an advance care plan. Members recognized that views on advance care plans can vary by cultural background and cultural competence is essential to discussing and obtaining clear information about beneficiary preferences near the end of life. Members encouraged the measure steward to consider expanding the measure to all populations by removing the age limitations and expressed the importance of the transmission of advance care plans across settings and between providers.

Antipsychotic Use in Vulnerable Populations

The Workgroup voted to include measure NQF# 2111 Antipsychotic Use in Person with Dementia in the starter set because of the importance of addressing over use and potential harm of unnecessary medications in at-risk populations. Members expressed the importance of preventing unnecessary medication use in all persons who present with behavioral health issues.

Pursuing High-Priority Gaps

The Workgroup continued to emphasize the importance of the high-priority measure gaps for dual eligible beneficiaries. While progress continues to be made in measure development in some of these topics, members encourage innovation across measurement science to address more of these areas. The Workgroup urges stakeholders and experts across disciplines to collaborate, share, and build on available information. In particular, members highlighted the rich source of innovative measures in use by states or in other countries. Measures in use at local, state, or regional levels that address these priorities should be carefully evaluated and supported for further development and testing.

High-Priority Measurement Gap Areas for Dual Eligible Beneficiaries:

Goal-directed, person-centered care planning and implementation
Shared decision-making
Systems to coordinate acute care, long-term services and supports and non-medical community resources
Beneficiary sense of control/ autonomy/ self-determination
Psychosocial needs
Community integration/inclusion and participation
Optimal Functioning

In addition to these areas, members emphasized gaps in measures for home and community based services (i.e., at-home pressure ulcer monitoring) as well as affordable and cost-effective care.

NQF Home and Community-Based Care Project

More than one quarter of dual beneficiaries use Medicaid waiver or state plan home and community-based services (HCBS).[22] NQF convened the HCBS Quality Committee to provide multistakeholder guidance on the highest priorities for measuring HCBS that support high-quality community living. The NQF HCBS project recently completed an environmental scan that resulted in over 700 measures, measures concepts, and instruments assessing HCBS quality. This scan also identified a dearth of measures in priority gap areas for dual beneficiary populations, such as community inclusion. More information on the HCBS Quality Committee is available on the project page.

The Workgroup members supported the focus of the HCBS definition and priority domains on the individual, families, and caregivers. Additionally, members highlighted the importance of dignity and respect for the individual receiving HCBS and leveraging opportunities to engage individuals and those in their lives in new and unique ways, such as designing novel HCBS systems. Members suggested considering opportunities to leverage data commonly used in technology platforms, avenues for individuals to submit feedback on their experiences with HCBS, and information about the use of other benefits and services to further understand the beneficiary needs and quality of care. Members stressed the importance of building on the multistakeholder work, such as the HCBS definition and domains, to effectively make progress in addressing measure gaps across healthcare and supportive services.

Addressing Connections Across Healthcare and Community Supports and Services

Dual eligible beneficiaries are a highly diverse population within which most social, ethnic and geographical groups are represented. However, performance measures relevant to this population are not contained within a single federal program, e.g., Medicaid only, CMS Physician Quality Reporting System (PQRS) only. Consequently, it is challenging to track and monitor the quality of care received by dual eligible beneficiaries since relevant performance measures are included in several different federal programs. The goal of the MAP Dual Eligible Beneficiaries Workgroup is to provide strategic input to overcome the challenge of tracking performance measures for dual eligible beneficiaries and to maximize quality of life for this population, including individuals who have multiple chronic conditions. Workgroup members noted that the prevalence of multiple conditions within the dually eligible population is not unique nor is it isolated.

Individuals who are dual beneficiaries have a combination of complex clinical and behavioral conditions, which are usually exacerbated and compounded by their social disadvantages. The prevalence of multiple chronic conditions (MCCs) is not uncommon in this population with 77% of beneficiaries with documentation across two or more subgroups of physical and mental conditions.[23] [24] Within MCCs, the five most common co-occurring conditions are heart conditions, mental health conditions, anemia, musculoskeletal disorders and diabetes; and mental health is the second most common co-occurring disease.[25] Given their complex needs and conditions, care for the dual beneficiaries is frequently a fragmented process with multiple providers, treatments, prescriptions and limited or no support system for guiding them through the intricacies of navigating both healthcare and support services.

The MAP Dual Eligible Beneficiaries Workgroup has previously considered a variety of issues related to the quality of care and outcomes for high-need subgroups such as multiple chronic conditions within the dual eligible beneficiary population. Issues related to shared decision-making, psychosocial needs, and community integration/inclusion and participation were discussed and the workgroup found that most of the high-priority issues were similar rather than disparate across the subgroups including individuals with multiple chronic conditions. However, available measures to address these issues were often limited, did not address condition specific needs, and gap areas were pervasive.

During the MAP Dual Eligible Beneficiaries Workgroup's web meeting, members had the opportunity to discuss and review three frameworks related to MCCs, specifically the Institute of Medicine Living Well with Chronic Illness report,[26] HHS Strategic Framework,[27] and NQF MCC Measurement Framework.[28] In reviewing the existing frameworks, the workgroup discussed the importance of social support systems, connection to community and non-medical resources in promoting overall health and well-being. These discussions coalesced around the need for active engagement of individuals in supportive relationships and socialization of their choosing to support the individual's goals. Services aimed at these issues have the potential to help prevent unhealthy behaviors resulting from isolation, loneliness, and helplessness, and to improve health outcomes such as optimal functioning and improved quality of life for the beneficiary and their families.[29]

Key themes noted by MAP Dual Eligible Beneficiaries Workgroup members were lack of connections and coordination between healthcare providers and providers of supportive services in the community. The group agreed that individuals, family members, providers, and policy makers share the goal of enabling individuals to live as independently as possible in the community. To meet this goal, a dual beneficiary may need or benefit from services and supports from non-medical and community providers, particularly during transitions – for example, around the time of discharge from a healthcare facility. However, the lack of coordination during transitions and effective communication are often-cited causes for low quality of care and poor outcomes.[30] This highlights the lack of alignment in the foundational structures for different types of providers. MAP Dual Eligible Beneficiaries Workgroup members observed that the processes, information systems, policies, and incentive structures applicable to healthcare versus non-medical and community providers are disjointed. Additionally, the workgroup had observed the inability to measure quality of care during transitions between different types of providers and settings, and indicated a desire to further explore recommendations to address these challenges.

Increasingly, the opportunities for connecting healthcare, supports and services has taken center stage in discussions regarding the needs of the dual eligible beneficiaries population, especially when discussing the role of social services in keeping individuals healthy and functional within this population. Any efforts to enhance connections within and across healthcare, social services and community is dependent on being able to collect and analyze necessary data as well as be able to implement lessons learned through novel models of care. These models of care are new and different in that they address social and clinical needs of the population once they are taken out of the clinical and medically necessary context and setting. The approach is to address health by focusing on the whole person and their needs while addressing basic determinants of health such as shelter, meaningful interactions and nutrition.

MAP Dual Eligible Beneficiaries Workgroup's goal in focusing on such concerted efforts of various stakeholders such as clinical providers, institutions of care, and social services is to address health from a whole person point-of-view, where individuals are empowered to attain their best health state while residing within their native settings and communities. Accordingly, the workgroup recognized and accepted a broad definition of health and psychosocial interventions as "interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being."[31] The goal is to recognize and promote the value of the community and individual independence and dignity within the context of population health. Attainment of this goal requires measures that capture the importance of connections across clinical and social settings, data that is portable and accessible by all types of care providers and a healthcare system that aligns clinical, social and human services seamlessly within the framework of population health.

Overcoming barriers to measure development

Developing measures that appropriately address the complexities and chronic conditions within the dual eligible beneficiary population are resource intensive efforts due to the costs related to data gathering and measure testing. MAP Dual Eligible Beneficiaries Workgroup members suggested that measure developers look outside of the realm of traditional measurement and seek out innovative measures that

cross the clinical-social divide as well as look to how other countries address quality measurement in complex populations. However, Workgroup members noted and emphasized that any measurement development endeavor requires data specifically related to the target populations.

The MAP Dual Eligible Beneficiaries Workgroup acknowledged that data on the dual eligible beneficiary population and sub-populations is lacking and data specific to complex patients with multiple chronic conditions is even sparser. In addition, clinically relevant information and measures for this population are limited given the lack of randomized clinical trials with clinically vulnerable populations. Their vulnerability is not only clinical in nature, but crosses over to social and socio-demographic arenas as well. Given the socio-demographic landscape for the dual eligible beneficiaries and a lack of identifiable data on them, appropriate measures for the population requires a concerted effort at connecting clinical and social data, and isolated measurement development focusing on clinical issues only is minimally impactful at best.

The MAP Dual Eligible Beneficiaries Workgroup members discussed the difficulties with data collection, gathering appropriately granular data, and having the infrastructure to support and store the data, e.g., staff with training in data collection, management and analysis. Finally, the data collected need to represent the population appropriately as well as be actionable and allow for improvements in care or services.

Additionally, measures are often developed based on benefits related to specific programs, such as Medicare or Medicaid. These program-specific measures may result in more narrow improvement efforts, limited care coordination and increased reporting burden. This lack of coordination in measurement development is particularly relevant for dual eligible beneficiaries, who are subject to two different programs, Medicare and Medicaid.

Unfunded mandates

During their discussions regarding the importance of measurement, MAP Dual Eligible Beneficiaries Workgroup members discussed and introduced the concept of an unfunded mandate. They defined this mandate as an expectation of services to be provided based on the application of measures without any reimbursement associated with the service. Examples of unfunded mandates include patient follow-up and care coordination efforts that are expected of providers as standards of care processes, but are not funded as additional services. The workgroup members expressed concern that such unfunded mandates will burden providers with obligations, particularly those with limited resources. The MAP Dual Eligible Beneficiaries Workgroup members discussed two examples of unfunded mandates that demonstrate opportunity as well as potential burden for providers.

The first example highlighted pharmacy services for chronically ill individuals with six or more co-occurring conditions and with multiple medications. These high need and high cost patients are covered by a per month per member benefit that allows pharmacies to provide in-home pharmacy services. Patients receive comprehensive medication reviews in their home setting where they not only have their new prescriptions, but may also have older non-current prescriptions. Review of all the available medications promotes adherence as well as mitigation of any instances of potentially harmful

interactions that may arise from taking an older and or harmful medication. In-home pharmacy services are the unfunded mandate where the per month per member benefit is stretched to provide a valuable service. However, the workgroup noted that it is not always possible to stretch resources and provide additional and/or enhanced services.

In the second example, the MAP Dual Eligible Beneficiaries Workgroup members noted that telehealth is considered a readily available tool for following patients remotely. However, workgroup members noted that many providers and states lack resources and infrastructure for adopting and using telehealth. Consequently, telehealth becomes an unfunded mandate where currently available resources are not sufficient to allow healthcare providers to follow patients remotely. Other examples of unfunded mandates are expectations placed on providers in primary care requiring them to follow home after discharge from the hospital or other setting and in-home services through office outreach.

The MAP Dual Eligible Beneficiaries Workgroup members noted that the application of measures creates expectations of what the provider should be doing in terms of services, even if there is no funding. Eventually, this expectation becomes an unfunded mandate by default. Workgroup members suggested that requiring unfunded mandates should be based on feasibility of adapting, stretching and maximizing resources to address needs, and that the unfunded mandate should not be included in performance measurement. The workgroup recommends that measurement of quality and care should be decoupled from requirements for which no incentive and or support is provided.

Measuring What Matters

When considering and capitalizing on opportunities for integration, coordination and data collection, measurement and measure development should not ignore an integral part of the healthcare arena, most importantly the consumer. Acknowledging and representing the consumer's voice requires a different way of addressing quality measurement, one that balances personal preference and needs with a population health perspective; thereby, requiring a universal set of measures that are applicable across the board. An analogy provided and discussed by the Workgroup members addressed these universal quality metrics as images on a car dashboard. This quality dashboard will be universally used and recognizable with each image representing a familiar parameter of quality. The dashboard model, however, moves the focus from the individual level experience to the population level, but measures and payment happens at the individual "in the weeds" level.

Given this conundrum and constant tension between population and individual level measures, the Workgroup suggested that the national focus be on population level measures and allow for states and individual programs to develop more specific individual level measures. Most measures, whether they be at the population and or individual level, have historically been clinically and medically defined. This lens of measure development has to be changed and expanded to be able to include the empowered patient perspective and to be measuring what matters most to the consumer.

Regardless of the analogy and or model being used to discuss data issues, patient empowerment and appropriate measures, the main component of the discussion needs to be the concept of integration through healthcare and social system connections. This systems-level view is being used to describe

various connections, hand-offs and touch-points among and between different providers in clinical and social settings, institutions, patients as consumers, community resources, and support services. The way to enhance and improve the Family of Measures for Dual Eligible Beneficiaries is to consider ways to improve these connections between healthcare supports and services providers, whether they are clinical and or social.

Data Issues

Successful connection among various care givers, support services and community resources requires effortless transition of data with the patient, where any and all providers in clinical, social and community settings have access to all necessary patient data. Access to data is affected by many factors such as data infrastructure, platforms and access points, along with workforce training and availability to capture the data, all of which are well known barriers. However, most discussions about barriers exclude other important roadblocks such as interoperability of existing data systems and privacy laws such as Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 (commonly referred to as "Part 2") governing the confidentiality of drug and alcohol abuse treatment and prevention records, which are meant to protect patients.[32] Promoting integration and connections across healthcare, supports and services will require assistance and encouragement from policies and regulations, where patient privacy safeguards do not inadvertently harm patients by placing barriers to data sharing necessary for appropriate care management. Workgroup members noted that social workers in the community often have to coordinate an individual's care and behavioral health services without the benefit of any previous treatment summaries and or clinical consultation records. In such cases, both patients and their advocates are placed at a disadvantage and the process hinders efforts to keep patients out of institutions and emergency departments as they transition to community settings and services.

The lack of data connections across various systems and sectors of care providers undermines efforts underway to make care more person-centered and coordinated. However, Workgroup members noted that success stories can be found at the local and state level, [33]and that one way forward would be to identify the successes of local work on core issues related to the dual eligible population and then elevate the processes and lessons learned to the national population health level.[34] Ultimately the concept of integration across healthcare, supports, and services should be incentivized with resources and supports at the state or federal level. Currently, most examples of successful integration efforts come from programs funded by federal and or non-profit grant making organizations and think tanks.

Improving connections between healthcare, supports, and services

MAP Dual Eligible Beneficiaries Workgroup members noted that demonstration projects on care models and how to improve connections between healthcare, supports and services have been ongoing for quite some time.[35] Most of these efforts involve some permutation of partnerships among medical, behavioral and long-term support services for the dual eligible population, such as PRIDE (Promoting Integrated Care for Dual Eligibles).[36]

Models of integrated care for people with complex needs

The PRIDE project validated the need for high-quality connections across medical, social and behavioral services with a dynamic person/family-centered care plan built on patient/caregiver involvement, where comprehensive and frequent assessments and reassessments capture and address changes in an individual's circumstances and preferences. Given the complexity of dual eligible beneficiaries and the complex needs of this population, this model addresses integration of care while empowering the individual beneficiary. Empowerment of consumers requires care coordinators who can access multidisciplinary care teams in an environment where data systems are fully integrated and readily available at point-of-care. The project also advocated for continuous quality improvement monitoring through performance metrics that are aligned across providers and deliver Triple Aim[37] centric results that improve patient and dually eligible population level care and experience while reducing cost. [38]

Sustaining an integrated paradigm of care requires scaling up from individual microcosm focused efforts as well as sustaining them over time through incentives and alignment of services. This requires buy-in from all providers as well as the patients and consumers. Given the connections across all spectrums of care, a new expanded definition of community was provided by the Workgroup members; where community is defined as the amalgamation of clinical and non-clinical providers, institutions, social services, supports and consumers.[39] Using this inclusive and expanded model, health is defined from a systems and/or population level perspective; where connections and integration is happening at a community level instead of one patient at a time.

The concept of an "integrator" along with integration across systems and communities is the common theme that unites the models. Given the roles and responsibilities of an integrator in a patient-centered environment, the commonly cited examples include patient navigators and social workers. However, the integrator can also be interagency agreements at the state level and or accountable care communities at the community level which becomes accountable care organizations at the provider level.[40] Thereby, integration can and should happen at all levels of care from a national and/or population level down to state, community and individual provider levels. The evolution of this concept along with recognition for the need of whole-person care has led to the development of resources and tools to facilitate integration regardless of the type and or model of care.

Strategies in the NQF Population Health Action Guide

While discussing potential models of care, the Workgroup noted that various projects internal to NQF address strategies for successful integration of clinical and social care with support services. The NQF Population Health Action Guide, a tool for maximizing community involvement while moving from individual to population health, is such a resource. The goal of such action guides is to help providers across settings address social, economic, and environmental factors that impact health, given that the current quality improvement and measurement arena is mostly focused on clinical care. Evidence suggests that with a quarter of healthcare costs related to modifiable health risks, programs and policies that improve wellness and healthy behaviors could yield a net savings of $19 billion over 10 years.[41] Therefore the purpose of the guide is to identify the key elements of population health which can then be incorporated into a tool that address elements such as community health needs assessment,

resource and asset mapping, selection and implementation of health improvement activities, scalability, and finally sustainability of efforts within the community setting and outside of the clinical care arena.

The NQF action guide capitalizes on the opportunities of changing the lens of care from the clinical to the community setting and the acknowledgement of the importance of social determinants of health that are easily addressed at the community level. MAP Dual Eligible Beneficiaries Workgroup members noted the value of this frame shift by mentioning that the connection between housing status and health outcomes is well established where shelter availability is a marker of health.

The following set of community focused questions that can effect health status change and facilitate integration with and across communities is provided as a starting point for addressing community needs within the healthcare arena[42]:

- How can individuals and multi-stakeholder groups come together to address community health improvement?
- Which individuals and organizations should be at the table?
- What processes and methods should communities use to assess their health?
- What data are available to assess, analyze, and address community health needs, and measure improvement?
- What incentives exist that can drive alignment and coordination to improve community health?
- How can communities advance more affordable care by achieving greater alignment, efficiency, and cost savings?

Moving from just looking at clinical care to including communities reflects a shift from health to public health efforts at improving health through integration of health and social services. The best examples and endorsement of these efforts are the successful field examples of integration of services at the local and or state level, where connections are being made and fostered across clinical, social, community and personal domains.

Field Examples

MAP Dual Eligible Beneficiaries Workgroup deliberations and discussions of the concept of connections and integration along with the role of community were followed by two presentations that reinforced the role of community and psychosocial factors in optimizing health and overall wellness. Previously, the workgroup members had noted that to appropriately address chronic health conditions within the context of patient centered care, measurement frameworks need to connect health outcomes to wellness outside of the clinical context and include quality of life and community integration. Providers and measure developers need to recognize that high-level functioning does not necessarily equate to a high quality of life; similarly, clinical outcomes of physical health are not necessarily indicative of living well and access to physical health services does not prevent loneliness.

The first presenter was Robyn Golden, MA, LCSW, from Rush University where she is responsible for developing and overseeing health promotion and disease prevention, mental health, care coordination, and transitional care services for older adults, family caregivers, and people with chronic conditions. Her

presentation provided information on two programs, Ambulatory Integration of the Medical and Social (AIMS) and the Bridge Model, from Rush University Medical Center that are examples of what can be done at the health system level to foster connections across clinical and social services and supports at the local level.

The second presenter was Alice Lind, BSN, MPH, from the Washington State Health Authority. Her presentation focused on Washington Health Authority's Financial Alignment Demonstration Project and some initial results. This presentation addressed how states can provide care coordination through integrated data systems and empower individuals to make decisions about their care needs as well as be active participants in their care plan.

Both presenters reiterated the importance of holistically addressing a patient's needs where social determinants such as food and shelter are just as much indicators of overall health as the prescribed treatment. Themes such as the need for planned and organized integration and alignment of clinical and community services and resources led to discussions around care management teams and the role of nonclinical individuals such as social workers and patient navigators as change agents and patient empowerment forces. These types of roles provide care coordination by working across the medical, community and support service realms. They create a social-service based care model that bridges elements necessary for delivering patient-centric patient-specific care.

Ambulatory Integration of the Medical and Social (AIMS) Model

The AIMs model addresses fragmentation of care and promotes care coordination by focusing on the patient's needs. Coordination is focused on social factors that are not addressed in the clinical arena and are known to affect and influence physical health outcomes. The AIMS model assesses psychosocial needs and provides risk-focused care coordination, where social workers act as facilitators and assist with any sociodemographic and or biopsychosocial issues that may affect the attainment of health and wellbeing while empowering and supporting patients in a patient-centric model. [43]

The Bridge Model - Social Work-Based Transitional Care

The Bridge Model addresses integration and coordination, but focuses on transitional care and the hospital-community connection where social workers ensure that the care continuum is seamless between hospitals and community based providers, supports and services. This interdisciplinary model is led by social workers and provides patient-centric transitional care. The strengths of this model come from repeated assessments and interviews focused on individual patients and their needs; information gathered is then used to tailor transitional care based on individual care, psychosocial and behavioral needs.[44]

Both the AIMS and Bridge Model addresses care coordination using social workers as the facilitators of coordination with the ultimate goal of addressing whole-person needs including social determinants such as nutrition and shelter along with psychosocial and behavioral needs.

Washington Health Authority Financial Alignment

Along with care coordination, the hallmark of the Washington based demonstration project is the integration of data across all systems of care. This seamlessly integrated data is available for all providers, both clinical and non-clinical, to facilitate care coordination, transition and management based on patient needs and preferences using a Home Health model. The availability of integrated data facilitates the recognition and timely intervention for any and all care needs including behavioral and mental health issues that otherwise may go untreated. The ultimate goal is to develop individualized chronic care management plans where patients manage their own care and chronic disease(s) based on personal preferences. Integration of data also allows for real-time access to patient data such as emergency department visits, care coordinator interactions with patients, tracking of prescriptions as well as gaps in care. The value of the data lies in being able to measure care and correlate it to patient outcomes. However, the most compelling evidence is data collected from actual patients on their experiences within the Home Health program.[45]

RTI International worked with the Washington Demonstration Project team and conducted focus groups with clients who received care coordination and enrolled in the Home Health program. During these focus groups, the value of coordination being facilitated through data integration is validated by one patient who shared a before and after care coordination experience as:

> Before joining the Home Health program "I was shut up in my house for years. My windows were drawn. I didn't have company. My house was horrible. I was completely off my psych medications, and I was on a lot of them for many years. "[46]

> After joining the Home Health program "I go outside. I interact with my neighbors. I go to church. My cholesterol is down to normal."[47]

All the models and programs presented share core values of care coordination across clinical, social and behavioral settings using care coordinators, social workers and or community health navigators. Therefore, adequate workforce training is essential for capacity building as well as meeting the needs of the dually eligible population, especially, given the changing and broadening nature of the definition of health and well-being. Even if staffing is adequate, the measurement enterprise still needs to recalibrate to be able to capture and address patient experiences. Measurement should align measures with elements that directly or through proxies capture a patient's health and well-being from a whole person perspective. This lens of looking at a whole person includes clinical aspects of their health along with social, behavioral and community related elements. Success of addressing whole patient care ultimately lies in the seamless integration of healthcare, supports and services across local microcosms of care. This ushers in an era of patient focused care where individuals including the dual eligible beneficiaries are empowered to make decisions about their care needs as well as be active participants in their care plan.

Opportunities and Lessons Learned:

A person-centered approach to health and wellness for the dual eligible population has been addressed in previous Workgroup reports from 2014 and 2015. However, the role of novel community partnerships

and connections with the medical field adds a facilitative layer of wrap-around services that promote health and wellbeing while addressing the unique needs of each individual beneficiary. These novel partnerships use social-workers and community paramedics as a new type of healthcare worker who facilitate connections within and across the medical and community settings. However, these partnerships require an adequately trained workforce that can be easily accessed by all beneficiaries.

The role of non-traditional providers in optimizing health and accessing resources in the community may currently be underutilized in many communities. Conversely, communities and social services may feel stretched by the increased demand for their services and resources, especially given the needs of population. . The examples shared with and from the Workgroup indicate that dual eligible beneficiaries would benefit from contributions of both medical and community services and supports.

Future Considerations

The dual eligible beneficiaries are a diverse population with complex needs and much of the complexity is related to social determinants of health. The deliberations and discussions of the Workgroup focused on the growing recognition that integration of care, supports and services across the healthcare and community spectrum is essential to adequately address the needs of these individuals. MAP Dual Eligible Beneficiaries Workgroup members noted that a new non-clinical model of care is possible where the lens of health is broadening to address the myriad of clinical and non-clinical, psychosocial, and behavioral issues affecting the dual eligible beneficiaries' population.

The Workgroup's 2016 discussions encompassed and emphasized the growing role of community in keeping the dual eligible beneficiaries population healthy given that health needs to encompass more than clinical care. Health is being redefined as a composite of clinical factors, sociodemographic factors such as nutrition and shelter as well as psychosocial factors such as loneliness and isolation. This integrative model of health promotion emphasizes the work being done to empower patients in a patient-centric model. Therefore, the goal and challenge is to harness the importance of the integration of healthcare and community supports and services through appropriate measure development and eventual measurement efforts.

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Appendix A: MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[a]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.

2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.

3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to

improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

Setting priorities and goals. The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.

Developing and testing measures. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).

Endorsing measures. NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

Impact and evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with specific topics provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

Figure A1. MAP Structure
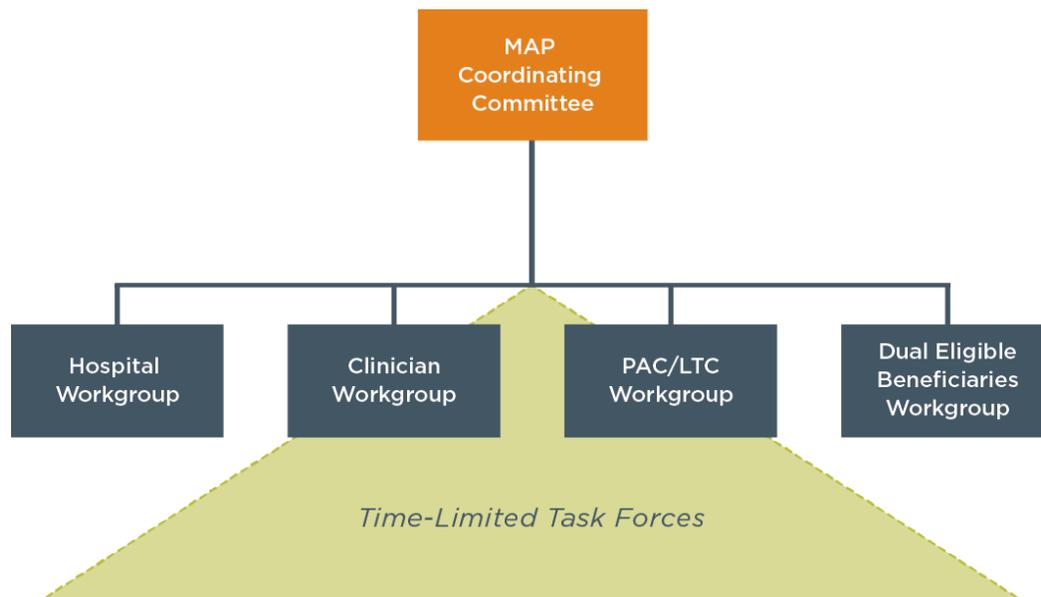
All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2015 Pre-Rulemaking Deliberations). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the **MAP Strategic Plan** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.

Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review, including the Medicaid Adult and Child Core Sets and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.

Appendix B: Rosters for the MAP Dual Eligible Beneficiaries Workgroup and MAP Coordinating Committee

Measure Applications Partnership Dual Eligible Beneficiaries Workgroup Members

WORKGROUP CO-CHAIRS (VOTING)
Jennie Chin Hansen, RN, MS, FAAN
Nancy Hanrahan, PhD, PN, FAAN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
AMDA – The Society for Post-Acute and Long-Term Care Medicine	Gwendolen Buhr, MD, MHS, Med, CMD
American Geriatrics Society	Gregg Warshaw, MD
Association for Community Affiliated Health Plans	Christine Aguiar
Centene Corporation	Michael Monson
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Easter Seals	Cheryl Irmiter, PhD
Homewatch CareGivers	Jette Hogenmiller, PhD, MN, APN, CDE, TNCC
Humana, Inc.	George Andrews, MD, MBA, CPE
iCare	Thomas H. Lutzow, PhD, MBA
National Association of Medicaid Directors	Alice Lind, BSN, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
New Jersey Hospital Association	Aline Holmes, DNP, MSN, RN

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)
Mady Chalk, MSW, PhD
James Dunford, MD
K. Charlie Lakin, PhD
Ruth Perry, MD
Kimberly Rask, MD PhD
Gail Stuart, PhD, RN

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)	REPRESENTATIVE
Administration for Community Living (ACL)	Eliza Bangit, JD, MA
Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office	Vanesa J. Day
Office of the Assistant Secretary for Planning and Evaluation	D.E.B. Potter, MS

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Elizabeth McGlynn, PhD, MPP
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Lynda Flowers, JD, MSN, RN
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
America's Health Insurance Plans	Aparna Higgins, MA
American Board of Medical Specialties	R. Barrett Noone, MD, FAcS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American HealthCare Association	David Gifford, MD, MPH
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III, MPH
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
The Leapfrog Group	Melissa Danforth
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Mary Barton, MD, MPP
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Elizabeth Mitchell
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Richard Kronick, PhD/Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MH, FACP
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

NQF Project Staff

STAFF MEMBER	TITLE
Debjani Mukherjee	Senior Director
Megan Duevel Anderson	Project Manager
Janine Amirault	Project Analyst

Appendix C: MAP Measure Selection Criteria

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

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

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

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

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

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

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

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

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

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

Subcriterion 2.3 Affordable care

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

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

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

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

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

Subcriterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Subcriterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

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

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

Subcriterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

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

Subcriterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

Appendix D: MAP Dual Eligible Beneficiaries Family of Measures (2016 Update)

The family of measures for Dual Eligible Beneficiaries is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The family of measures functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. The current family of measures was selected based on the MAP Measure Selection Criteria (Appendix MSC) and refined over time. Additional details about each measure are available on the NQF Quality Positioning System (QPS). The family of measures is also available in the spreadsheet accompanying this report on the project page.

An asterisk (*) indicates a measure in the Starter Set for Dual Eligible Beneficiaries. For information on the starter set see table 1 of the report.

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0004* **Endorsed** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) *National Committee for Quality Assurance (NCQA)*	Process	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System
0005 **Endorsed** CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child *Agency for Healthcare Research and Quality (AHRQ)*	Patient Reported Outcome Measure	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.	Patient Reported Data/ Survey	Clinician: Group/ Practice, Clinician: Individual

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0006 **Endorsed** Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial) *AHRQ*	Patient Reported Outcome Measure	The CAHPS Health Plan Survey is a standardized survey instrument which asks enrollees to report on their experiences accessing care and health plan information, and the quality of care received by physicians. HP-CAHPS Version 4.0 was endorsed by NQF in July 2007 (NQF #0006). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https:// cahps.ahrq.gov/ surveys-guidance/ hp/ index.html.	Patient Reported Data/ Survey	Health Plan
0008* **Endorsed** Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) *AHRQ*	Composite	52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Survey: Patient Reported Data/ Survey	Health Plan
0018* **Endorsed** Controlling High Blood Pressure *NCQA*	Outcome	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System
0022 **Endorsed** Use of High-Risk Medications in the Elderly (DAE) *NCQA*	Process	There are two rates for this measure: - The percentage of patients 65 years of age and older who received at least one high-risk medication. - The percentage of patients 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0027 **Endorsed** Medical Assistance With Smoking and Tobacco Use Cessation (MSC) *NCQA*	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System
0028* **Endorsed** Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team
0032 **Endorsed** Cervical Cancer Screening (CCS) *NCQA*	Process	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0034 Endorsed Colorectal Cancer Screening (COL) **NCQA**	Process	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Administrative claims, Electronic Clinical Data: Imaging/ Diagnostic Study, Electronic Clinical Data: Laboratory, Paper Medical Records	Health Plan, Integrated Delivery System
0043 **Endorsed Pneumococcal Vaccination Status for Older Adults (PNU)** **NCQA**	Process	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System
0097*** Endorsed Medication Reconciliation Post-Discharge** **NCQA**	Process	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Health Plan, Integrated Delivery System
0101 * **Endorsed** Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls *NCQA*	Process	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months B) Falls Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care for Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Administrative claims, Electronic Clinical Data, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0104 **Endorsed** Adult Major Depressive Disorder (MDD): Suicide Risk Assessment *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team
0105 **Endorsed** Antidepressant Medication Management (AMM) *NCQA*	Process	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System
0166 **Endorsed** HCAHPS *Centers for Medicare & Medicaid Services (CMS)*	Outcome	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Patient Reported Data/ Survey	Facility

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0176 **Endorsed** Improvement in management of oral medications *CMS*	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Electronic Clinical Data	Facility
0202 **Endorsed** Falls with injury *American Nurses Association*	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Electronic Clinical Data, Other, Paper Medical Records	Clinician: Team, Facility
0228* **Endorsed** 3-Item Care Transition Measure (CTM-3) *University of Colorado Denver Anschutz Medical Campus*	Patient Reported Outcome Measure	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Patient Reported Data/ Survey	Facility
0326* **Endorsed** Advance Care Plan *NCQA*	Process	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Administrative claims, Electronic Clinical Data	Clinician: Group/ Practice, Clinician: Individual

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0418* **Endorsed** Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan *CMS*	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual, Clinician: Team, Population: Community, Population: County or City, Population: National, Population: Regional, Population: State
0419* **Endorsed** Documentation of Current Medications in the Medical Record *CMS*	Process	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/Practice, Clinician: Individual
0420 **Endorsed** Pain Assessment and Follow-Up *CMS*	Process	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Individual
0421* **Endorsed** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up *CMS*	Process	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual, Population: County or City, Population: National, Population: Regional, Population: State

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0553 Endorsed Care for Older Adults (COA) – Medication Review *NCQA*	Process	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System
0557 Endorsed HBIPS-6 Post discharge continuing care plan created *The Joint Commission*	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National
0558 Endorsed HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge *The Joint Commission*	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0576* Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) *NCQA*	Process	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System
0640 Endorsed HBIPS-2 Hours of physical restraint use *The Joint Commission*	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National
0641 Endorsed HBIPS-3 Hours of seclusion use *The Joint Commission*	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0646 **Endorsed** Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System
0647* **Endorsed** Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0648* Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System
0649 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care) *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
[0674](#) **Endorsed** Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) *CMS*	Outcome	This measure reports the percentage of residents who have experienced one or more falls with major injury during their episode of nursing home care ending in the target quarter (3-month period). Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury. Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.	Electronic Clinical Data	Facility
[0678](#) **Endorsed** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) *CMS*	Outcome	This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments for Skilled Nursing Facility (SNF) / Nursing Home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage on admission. Of note, data collection and calculation for this measure are conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.	Electronic Clinical Data, Electronic Clinical Data: Laboratory	Facility, Population: National

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0679 **Endorsed** Percent of High Risk Residents with Pressure Ulcers (Long Stay) *CMS*	Outcome	This measure reports the percentage of long-stay residents identified as at high risk for pressure ulcers in a nursing facility who have one or more Stage 2-4 or unstageable pressure ulcer(s) reported on a target Minimum Data Set (MDS) assessment (OBRA, PPS, and/or discharge) during their episode during the selected target quarter. High risk populations are defined as those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition. Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care. A separate measure (NQF#0678, Percent of Residents With Pressure Ulcers That are New or Worsened (Short-Stay)) is to be used for residents whose length of stay is less than or equal to 100 days.	Electronic Clinical Data	Facility
0682 **Endorsed** Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) *CMS*	Process	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay. National Quality Forum (2008a, June). Revised voting draft for national voluntary consensus standards for influenza and pneumococcal immunizations. Received from the Health Services Advisory Group on August 19, 2011.	Electronic Clinical Data	Facility, Population: National

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
[0709] **Endorsed** Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. *Bridges To Excellence*	Outcome	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication. (Please reference attached document labeled NQF_Chronic_Care_PACs_Risk_Adjustment_2.9.10.xls).	Administrative claims, Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice, Health Plan, Population: County or City, Population: National, Population: Regional, Population: State
[0710] **Endorsed** Depression Remission at Twelve Months *MN Community Measurement*	Patient Reported Outcome Measure	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/ - 30 days) are also included in the denominator.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility
[0712] **Endorsed** Depression Utilization of the PHQ-9 Tool *MN Community Measurement*	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
[0729](#) **Endorsed** Optimal Diabetes Care *MN Community Measurement*	Composite	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c less than 8.0, Blood Pressure less than 140 systolic and less than 90 diastolic, Statin use unless contraindications or exceptions, Tobacco-free (non-user) and for patients with diagnosis of ischemic vascular disease daily aspirin or antiplatelet use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice
[1626](#) **Endorsed** Patients Admitted to ICU who Have Care Preferences Documented *RAND Corporation*	Process	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Health Plan, Integrated Delivery System
[1659](#) **Endorsed** Influenza Immunization *CMS*	Process	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Administrative claims, Paper Medical Records	Facility, Population: National, Population: Regional, Population: State

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
1662 **Endorsed** Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy *Renal Physicians Association*	Process	Percentage of patients aged 18 years and older with a diagnosis of CKD (not receiving RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual, Clinician: Team
1768* **Endorsed** Plan All-Cause Readmissions (PCR) *NCQA*	Process	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
1789 **Endorsed** Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) *CMS*	Outcome	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary risk-standardized readmission rate (RSRR), derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/ gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Admissions for planned procedures that are not accompanied by an acute diagnosis do not count as readmissions in the measure outcome. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.	Administrative claims	Facility
1927 **Endorsed** Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications *NCQA*	Process	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
[1932](#) **Endorsed** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) *NCQA*	Process	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State
[2079](#) **Endorsed** HIV medical visit frequency *Health Resources and Services Administration - HIV/ AIDS Bureau*	Process	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits A medical visit is any visit in an outpatient/ ambulatory care setting with a nurse practitioner, physician, and/ or a physician assistant who provides comprehensive HIV care.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility
[2091](#) **Endorsed** Persistent Indicators of Dementia without a Diagnosis—Long Stay *American Medical Directors Association*	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Electronic Clinical Data	Facility
[2092](#) **Endorsed** Persistent Indicators of Dementia without a Diagnosis—Short Stay *American Medical Directors Association*	Process	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Electronic Clinical Data	Facility

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2111* **Endorsed** Antipsychotic Use in Persons with Dementia *Pharmacy Quality Alliance*	Process	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Administrative claims	Health Plan
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling *AMA-convened Physician Consortium for Performance Improvement*	Process	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team
2158 Endorsed Payment-Standardized Medicare Spending Per Beneficiary (MSPB) *CMS*	Cost/ Resource Use	The MSPB Measure assesses the cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode, which comprises the period immediately prior to, during, and following a patient's hospital stay. Beneficiary populations eligible for the MSPB calculation include Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance.	Administrative Claims	Hospital/ facility/ agency
2380 Endorsed Rehospitalization During the First 30 Days of Home Health *CMS*	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2456 **Endorsed** Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient *Brigham and Women´s Hospital*	Outcome	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period. At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/ Survey	Facility
2502 **Endorsed** All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) *CMS*	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an IRF discharge. The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility
2505 **Endorsed** Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health *CMS*	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2510* **Endorsed** Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) *CMS*	Outcome	This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions.	Administrative claims, Other	Facility
2512 **Endorsed** All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) *CMS*	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from a Long-Term Care Hospital (LTCH) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an LTCH discharge. The measure is based on data for 24 months of LTCH discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility
2597 **Endorsed E-measure Approved for Trial Use** Substance Use Screening and Intervention Composite *American Society of Addiction Medicine*	Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Group/ Practice, Clinician: Individual

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
[2599] **Endorsed** Alcohol Screening and Follow-up for People with Serious Mental Illness *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
[2600] **Endorsed** Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported. Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2601 **Endorsed** Body Mass Index Screening and Follow-Up for People with Serious Mental Illness *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/ m2). Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
2602 **Endorsed** Controlling High Blood Pressure for People with Serious Mental Illness *NCQA*	Outcome	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
2603 **Endorsed** Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2604 **Endorsed** Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2605 **Endorsed** Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence *NCQA*	Process	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: - The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.	Administrative claims	Health Plan, Population: State

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2606 **Endorsed** Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/ 90 mm Hg) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is <140/ 90 mm Hg. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/ 90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2607 **Endorsed** Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2608 **Endorsed** Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan

Measure Title, Type, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2609 **Endorsed** Diabetes Care for People with Serious Mental Illness: Eye Exam *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2624 **Endorsed** Functional Outcome Assessment *CMS*	Process	NOTE: Specification information in this section is from the 2014 Physician Quality Reporting System Manual. Note that Testing Information is based on the specification in the 2012 Physician Quality Reporting System Manual. Both 2012 and 2014 Specifications are included in the attached "NQF Endorsement Measurement Submission Summary Materials" Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Administrative claims, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual

An asterisk (*) indicates a measure in the Starter Set for Dual Eligible Beneficiaries. For information on the starter set see table 1 of the report.

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