Measure Applications Partnership
All MAP Web Meeting #2

December 8, 2011

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

- *Review HHS List of Measures under consideration for 2012 rulemaking*
- *Preview approach to MAP pre-rulemaking task*
- *Consider MAP Dual Eligible Beneficiaries Workgroup cross-cutting input*

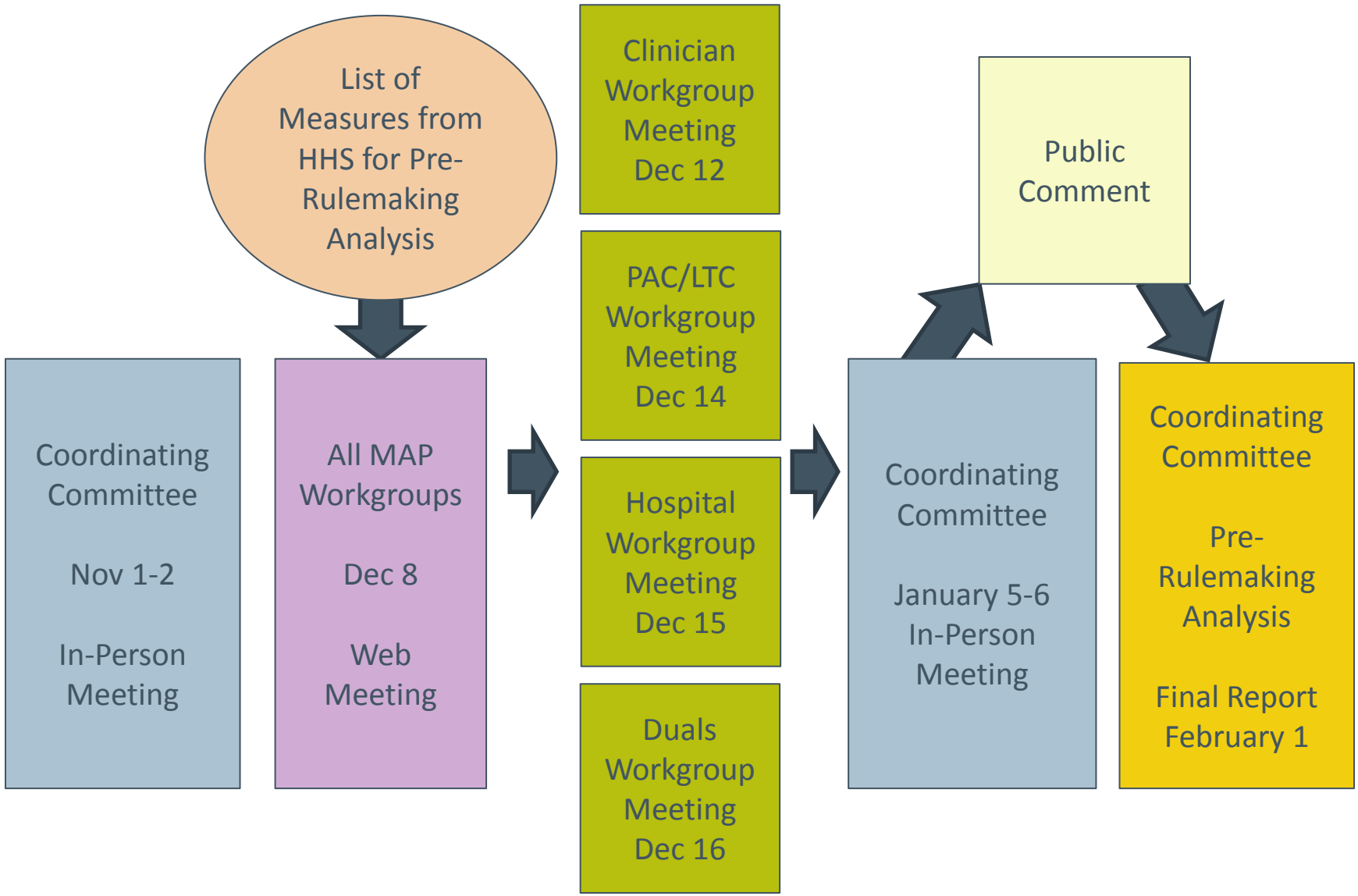
MAP Pre-Rulemaking Approach

MAP Coordinating Committee Charge

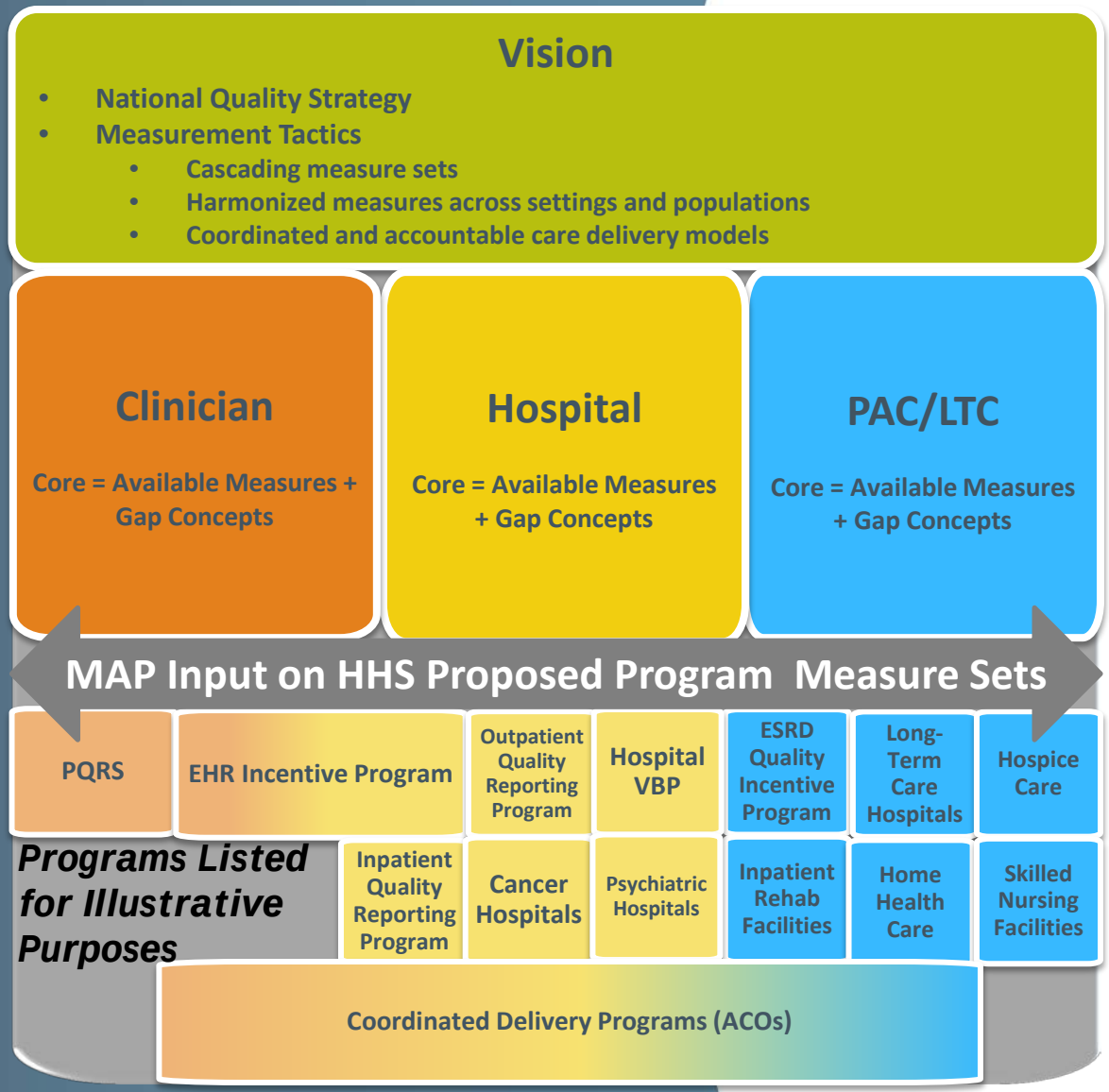
The charge of the Measure Applications Partnership Coordinating Committee is to:

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

Pre-Rulemaking Process and Timeline



MAP Pre-Rulemaking Approach



MAP Pre-Rulemaking Approach

Vision

- National Quality Strategy
- Measurement Tactics
  - Cascading measure sets
  - Harmonized measures across settings and populations
  - Coordinated and accountable care delivery models

- Vision
  - National Quality Strategy
  - "Cascading measures," or families of measures applied at each level of the system to provide a comprehensive picture of quality

MAP Pre-Rulemaking Approach

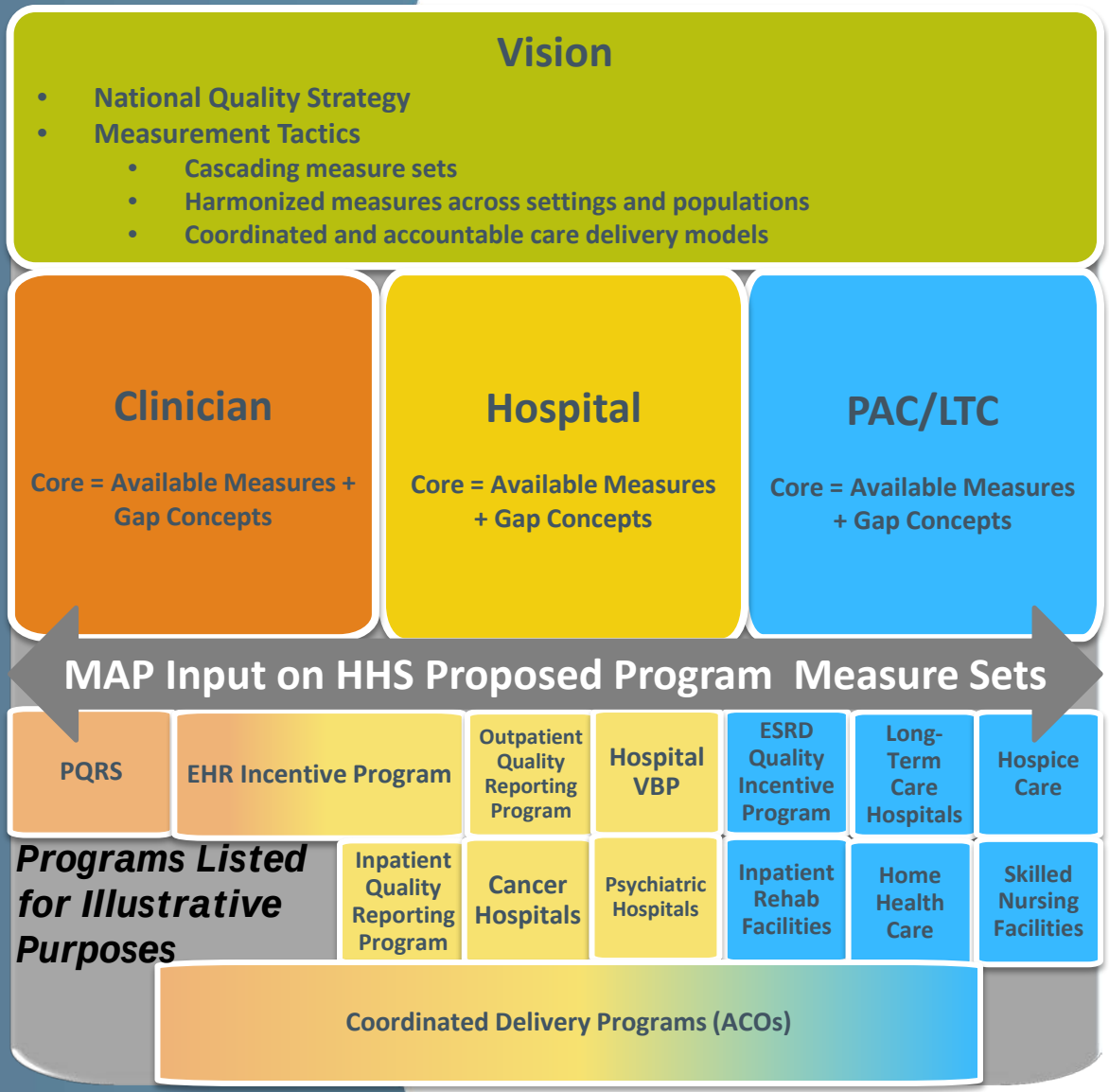
Vision

- National Quality Strategy
- Measurement Tactics
  - Cascading measure sets
  - Harmonized measures across settings and populations
  - Coordinated and accountable care delivery models

- Current landscape
  - "Siloed" nature of various Federal public reporting and performance-based payment programs
  - Lack alignment in strategic focus and technical specifications for measurement

MAP Pre-Rulemaking Approach

- Core measure sets
  - Connecting programs to the vision
  - Consisting of existing measures and prioritized measure gaps



HHS List of Measures under Consideration

Setting the Stage for CMS 2011 Measure List for MAP

Patrick Conway, MD, MSc
Chief Medical Officer, CMS
Director, CMS/OCSQ

December 8, 2011

Overview

1 Our Goals for this Process

1. To obtain expert multi-stakeholder input on measures prior to proposal for implementation into programs. Types of questions to consider:
   - Which measures to include in programs?
   - Which measures are highest priority?
   - How measure selection can best support alignment of measures across programs when possible?

2. We value this process and your time and expertise.

1 High Level Objectives

- **Support the National Quality Strategy**

- **Three Aims**
  1. Better Care
  2. Better Health
  3. Lower Costs through improvement

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

1 Draft of how high level objectives translate into programs and their measures

Draft hospital example

1. Hospital care is as safe as possible (NQS P1)
2. Care is patient and family-centered with effective communication (NQS P2 and P3)
3. Coordination of care is improved and readmissions decreased (NQS P3)
4. Evidence-based care linked to better outcomes is delivered reliably (NQS P4)
5. Care delivery is as efficient and affordable as possible (NQS P6)

Types of Questions for MAP

- What dimensions of quality are applicable to the given program?
- Which measures would you recommend? Note: can consider all measures currently in programs as provided by CMS.
- Are there remaining gaps in quality dimensions? If so, are there measures MAP would recommend to close these gaps?
- How best to align measures across programs?
- What is the relative priority for measures? (e.g., core measures required by all in program vs. optional measures)

2 Affordable Care Act Statutory Requirements

Sec. 3014 of the Affordable Care Act establishes a new federal "pre-rulemaking process" for the adoption of quality measures that includes:

- Making publicly available by December 1st annually a list of measures currently under consideration by HHS for qualifying programs;
- Providing the opportunity for multi-stakeholder groups to review and provide input by February 1st annually to HHS on the measures under consideration, and for HHS to consider this input;
- Publishing the rationale for the selection of any quality and efficiency measures that are not endorsed by the National Quality Forum (NQF); and
- Assessing the impact of endorsed quality and efficiency measures at least every three years (the first report due to the public by March 1, 2012).

2 Measure Selection Process: Rulemaking vs. Pre-rulemaking

Federal Rulemaking Process

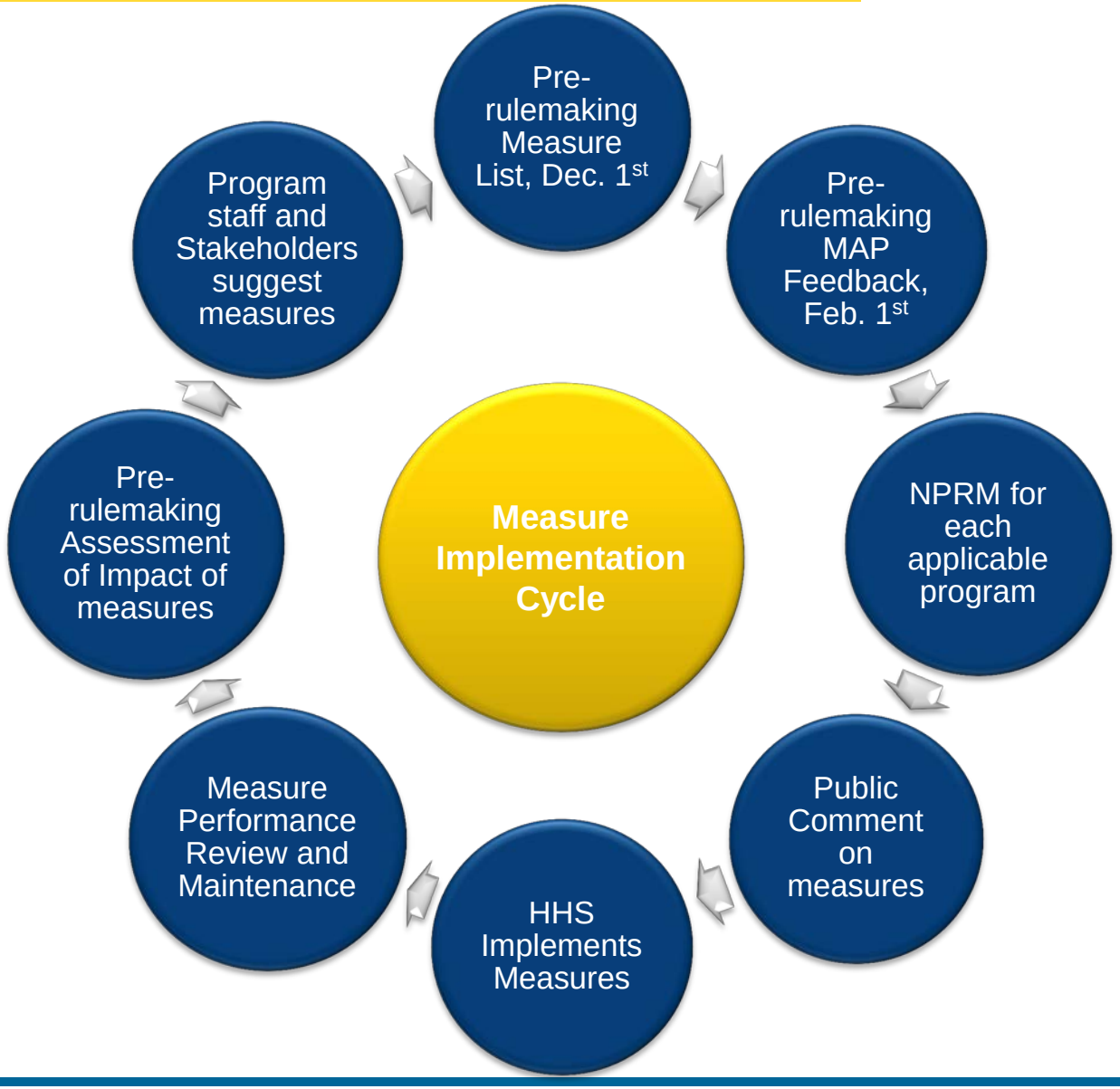
- Includes notice to the public of measures proposed for adoption,
- Opportunity for public comment on proposed measures,
- Opportunity for CMS to take into account this public input, and
- The publication of a final regulation to officially adopt measures.

VS.

Pre-rulemaking Process

- Occurs prior to rulemaking annually,
- Early public preview of measures to be considered, and
- Multi-stakeholder groups provide focused feedback to guide measure selection by HHS.

2 Measure Selection Process



CMS Quality Programs

Measures Subject to Pre-rulemaking

- Measures implemented through the federal rulemaking process and measure sets listed specifically in Section 1890(b)(7)(B)(i)(I) of the Social Security Act (or);
- Measures implemented through the federal rulemaking process and used for reporting quality and efficiency performance data to the public (or);
- Measures implemented through the federal rulemaking process and for use in health care programs other than for use under the Social Security Act.

3 CMS Quality Programs

Hospital Quality Reporting	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program • PPS-Exempt Cancer Hospitals • Inpatient Psychiatric Facilities • Inpatient Quality Reporting • Outpatient Quality Reporting • Ambulatory Surgical Centers	• Medicare and Medicaid EHR Incentive Program • PQRS • eRx quality reporting	• Inpatient Rehabilitation Facility • Nursing Home Compare Measures • LTCH Quality Reporting • ESRD QIP • Hospice Quality Reporting • Home Health Quality Reporting	• Medicare Shared Savings Program • Hospital Value-based Purchasing • Physician Feedback/Value-based Modifier*	• Medicaid Adult Quality Reporting* • CHIPRA Quality Reporting* • Health Insurance Exchange Quality Reporting* • Medicare Part C* • Medicare Part D*

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

4 2011 MAP Measures List Highlights

CMS PROGRAM	NO. OF MEASURES UNDER CONSIDERATION	MEASURES UNDER CONSIDERATION WITH CATEGORY 1	MEASURES UNDER CONSIDERATION WITH CATEGORY 2	MEASURES UNDER CONSIDERATION WITH CATEGORY 3
Ambulatory Surgical Center Quality Reporting	0	0	0	0
CMS Nursing Home Quality Initiative and Nursing Home Compare Measures	0	0	0	0
End Stage Renal Disease Quality Improvement	5	5	0	0
e-Rx Incentive Program	0	0	0	0
Home Health Quality Reporting	0	0	0	0
Hospice Quality Reporting	6	0	6	0
Hospital Inpatient Quality Reporting	21	4	16	1
Hospital Outpatient Quality Reporting	0	0	0	0
Hospital Value-Based Purchasing	13	1	0	12
Inpatient Psychiatric Facility Quality Reporting	6	6	0	0
Inpatient Rehabilitation Facility Quality Reporting	8	3	0	5
Long-Term Care Hospital Quality Reporting	8	3	0	5
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	92	18	30	44
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	39	9	4	26
Medicare Shared Savings Program	0	0	0	0
Physician Quality Reporting System	153	0	153	0
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	5	5	0	0
Children's Health Insurance Program Reauthorization Act Quality Reporting	0	0	0	0
Health Insurance Exchange Quality Reporting	0	0	0	0
Medicaid Adult Quality Reporting	0	0	0	0
Medicare Part C Plan Rating - Quality and Performance Measures	0	0	0	0
Medicare Part D Plan Rating - Quality and Performance Measures	0	0	0	0
Physician Feedback/Value-Based Modifier Program				
a. Physician Quality and Resource Use Report[1]	see footnote	see footnote	see footnote	see footnote
b. Value-Based Payment Modifier	10	6	2	2
Total	**366**	**60**	**211**	**95**

[1]Physician Quality and Resource Use Report includes quality measures reported from the Physician Quality Reporting System, and the Value-Based Payment Modifier which includes 4 Prevention Quality Indicators (PQI) and 1 cost measure. Therefore, measures in this component are only listed in the Physician Quality Reporting System and Value-Based Payment Modifier and are not duplicated in the ACA 3014 Measures list.

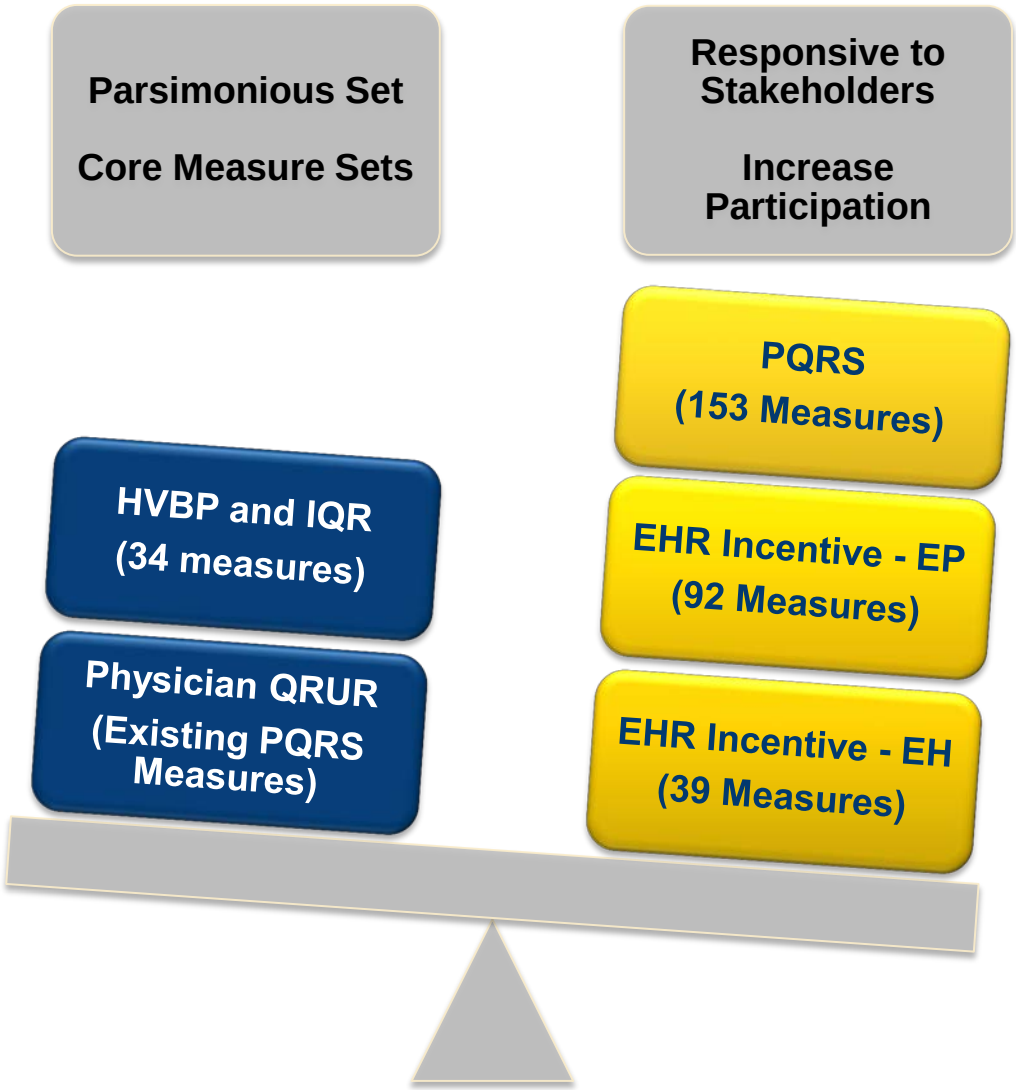
4 2011 MAP Measures List Highlights

1. The measures list includes those measures currently under consideration. Inclusion of a measure does not require CMS to select the measure for the identified program. Similarly, although this list contains all measures currently under consideration, CMS may adopt other measures that are not included in this list if necessary.
2. There are 23 CMS programs involved.
3. CMS categorized 60 new quality and efficiency "measures under consideration" as likely to be included in 2012 in the referenced 23 CMS programs.
4. Over 95% of the measures are supported by external stakeholders who suggested the measures, or are measures endorsed by multi-stakeholder groups such as NQF.
5. The vast majority of the new measures under consideration will not be required for reporting; instead the measures will be optional for providers who choose to report.
6. CMS will continue its goal of aligning measures across programs, including establishing "core" measure sets using existing program measures for new programs (e.g., establishing a core hospital measure set for the Hospital Value-based Purchasing Program using measures that were previously implemented in the Hospital Inpatient Quality Reporting Program). Similarly, CMS will also work to align across core sets (e.g., for meaningful use and other programs) when possible.

4 2011 MAP Measures List Highlights

7. CMS has an obligation, by statute for some programs, to provide measures applicable to all providers if possible. As such, CMS sought to be comprehensive in its inclusion of new measures in the ACA 3014 Measures List and to be responsive to stakeholder feedback (e.g., 153 measures recommended by stakeholders for the Physician Quality Reporting System (PQRS) were included in the list), but anticipates only a subset of measures will actually be adopted for its programs.
8. Similarly, particular CMS programs must balance competing goals of establishing parsimonious sets of measures, while including sufficient measures to facilitate provider participation (e.g., PQRS and the Medicare and Medicaid EHR Incentive Program, which together include the bulk of proposed measures (284 measures)).

5 Balancing Measurement Goals



5 Balancing Measurement Goals

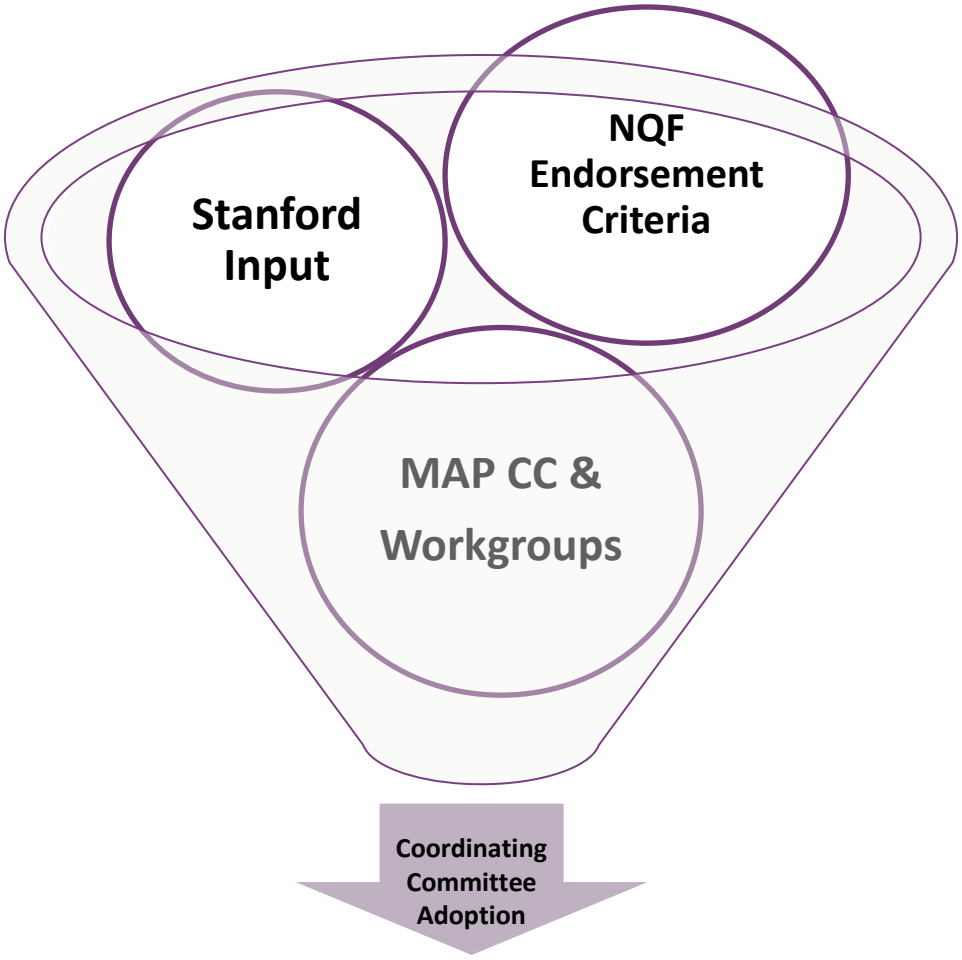
CMS Quality Reporting & Public Reporting will…	In order to…
Achieve high participation rates by providers	• Enable improvement and assess the performance of all providers and to empower patients with this information
Align new Affordable Care Act reporting requirements with current HHS high priority conditions and topics	• Address and measure high priority conditions and priority topics in order to provide a comprehensive assessment of the quality of health care delivered
Increase the quality reporting of healthcare-associated infections by providers	• Reduce the number of healthcare-associated infections and improve the quality of care
Implement EHR reporting for quality reporting programs	• Improve quality of care through the meaningful use of EHRs
Assure patient focus by reporting outcome measures on Compare sites	• Improve the usefulness of the Compare websites by making them more person-centered and patient focused
Increase the transparency, availability and usefulness of quality data	• Empower providers and the public with information to make informed decisions and drive quality improvement.

HHS List of Measures under Consideration

http://www.qualityforum.org/MAP

MAP Workgroup Pre-rulemaking Task

Review of finalized MAP Measure Selection Criteria



Measure Selection Criteria

Meeting/Activities	Output
May Coordinating Committee	Measure Selection Principles
June Coordinating Committee	Measure Selection Criteria "Strawperson"
July • Clinician Workgroup • Dual Eligible Beneficiaries Workgroup	Feedback on Measure Selection Criteria "Strawperson"
August • Coordinating Committee • Public Comment via MAP Clinician Report	Draft Measure Selection Criteria
September/October • Hospital Workgroup Survey Exercise and Meeting • PAC/LTC Workgroup • Public Comment	Draft Measure Selection Criteria Refinement Developed Interpretive Guide
November 1-2 Coordinating Committee	Finalized Measure Selection Criteria

MAP Measure Selection Criteria

1. **Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review**

2. **Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities**

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

4. **Program measure set promotes alignment with specific program attributes, as well as alignment across programs**

MAP Measure Selection Criteria

5. **Program measure set includes an appropriate mix of measure types**

6. **Program measure set enables measurement across the person-centered episode of care**

7. **Program measure set includes considerations for healthcare disparities**

8. **Program measure set promotes parsimony**

Preview of meeting stepwise approach and supporting materials

Pre-Rulemaking Task

- Process:
  - Utilizing a structured discussion guide, workgroups will conduct program-by-program analyses
    - » Measures from 18 federal programs will be assessed by workgroups, regardless of whether there are new measures under consideration
    - » The MAP Measure Selection Criteria will be the basis for decision making
  - Coordinating Committee will review and finalize workgroup conclusions at the January 5-6, Coordinating Committee Meeting
  - January public comment period
  - Report due to HHS on February 1

Pre-Rulemaking Task

- Materials will be sent to workgroup members prior to meeting date
  - Workgroup members will receive the following documents per program:
    - » Structured discussion guide
    - » Reference materials:
      - *Program summary sheet*
      - *Program measure chart*
      - *Individual measure information*
      - *Considerations from the Dual Eligible Beneficiaries Workgroup*

Pre-Rulemaking Task Discussion Guide (DRAFT Example)

Provides stepwise approach for the workgroup meeting

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

PAC/LTC Workgroup
Pre-Rulemaking Discussion Guide

Meeting Objectives:

- *Review measures proposed by Centers for Medicare & Medicaid Services (CMS) for inclusion in the following federal programs: Nursing Home Quality Initiative, Home Health Quality Reporting, Inpatient Rehabilitation Facility Quality Reporting, Long-Term Care Hospital Quality Reporting End Stage Renal Disease Quality Improvement, and Hospice Quality Reporting;*
- *Consider MAP Dual Eligible Beneficiaries Workgroup cross cutting input.*
- *Identify gaps in measurement for each program measure set;*
- *Finalize input to the MAP Coordinating Committee on measures for use in federal programs.*

Time	Issue/Question	Considerations
10:15- 11:00 am	**Rulemaking Input for Inpatient Rehabilitation Facility Quality Reporting Program** • Staff review program summary, gaps, relationship to core measure concepts	
10:20	1. Additional considerations for evaluation of the program set?	• Nine of the PAC/LTC Workgroup core concepts are not addressed. Are there additional gaps to highlight?
10:30	2. One measure considered for addition is endorsed and aligns with core set. Do you recommend adding this measure to the set?	NQF # 0675 Pain Management- • The measure addresses the core measure concepts
10:33	3. Four measures considered for addition are endorsed but do not align with core set. Do these measures address priority quality issues specific to IRFs?	NQF #0376 Incidence of VTE potentially preventable and NQF #0431 Staff Immunization • NQF #0682 Pneumococcal Vaccination and NQF# 0680 Influenza Immunization • Promotes parsimony- used in nursing home quality reporting, proposed for use in LTCH's

Pre-Rulemaking Task Program Summary Sheet (DRAFT Example)

Program Summary: Inpatient Rehabilitation Facilities (IRFs)

Provides description of program, statutory requirements, and analysis of program measure set

Program Description

As indicated in Section 3004 of the Affordable Care Act, CI
requirements for inpatient rehabilitation facilities (IRFs). S
failure to report quality data will result in a 2% reduction i
the data must be made available to public, with IRFs provi
prior to its release. [i] Two measures are required for FY 201
future years. Program Priorities and Goals:

Statutory Requirements for Measures[ii]:

- Measures should align with the NQS three-part aim including better care for the individual, better population health, and lower cost through better quality
- Measures should be relevant to the priorities in IRFs setting, such as improving patient safety (e.g., avoiding healthcare associated infections and adverse events), reducing adverse events, and encouraging better coordination of care and person- and family-centered care
- Measures should serve the primary role of IRFs, addressing the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge

Program Measure Set Analysis

Measure Summary:

	Current	Proposed Addition	Proposed Deletion	Total
Total Measures	2	8	0	10
NQF-Endorsed®	2	5	0	7
NQS Priority				
Safer Care	2	1	0	3
Effective Care Coordination	0	5	0	5
Prevention and Treatment of Leading Causes of Mortality and Morbidity	0	0	0	0
Person and Family Centered Care	0	0	0	0
Supporting Better Health in Communities	0	3	0	3
Making Care More Affordable	0	0	0	0
Addresses High Impact Conditions	0	0	0	0
Measure Type				
Process Measures	0	3	0	3

Pre-Rulemaking Task Program Measure Chart (DRAFT Example)

Provides specific program measure set information (e.g., mapping to NQS, measure type)

Inpatient Rehabilitation Facility Quality Reporting Program

Measure Name	NQF Measure # and Status	NQS Priority						Condition/Topic Area	Aligned w/ Program Attributes	Measure Type	Spans E	Address	etc)	to
		Safer Care	Care Coordination	Prevention/treatment leading causes of mortality/	Person and Family Centered Care	Better health in communities	Affordable Care							
Functional Outcome Measure (change from)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts. Potential issue of parsimony with other funcational outcome measures?	Measure under consideration 1
Functional Outcome Measure (change in mobility)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts.	Measure under consideration 1
Functional Outcome Measure (change in self-care)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts.	Measure under consideration 1
Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients	0138 Endorsed	X						Safety	Yes	Outcome	No	No	Aligns with PAC/LTC core concepts.	Current
Incidence of venous thromboembolism (VTE), potentially preventable	0376 Endorsed	X	X					Safety	Yes	Outcome	No	No		Measure under consideration 1
Staff immunization	0431 Endorsed					X		Safety	Yes	Process	No	No		Measure under consideration 1

Pre-Rulemaking Task Individual Measure Information (DRAFT Example)

Provides specific individual measure information (e.g., description, numerator, denominator)

NQF Measure # and Status
0167 Endorsed
Measure Name
Improvement in Ambulation/locomotion
Description
Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of
Numerator
Number of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of
Denominator
All home health episodes except those where either of the following conditions applies: (1) The value recorded for the OASIS item M0702 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be
NQF Re-tooled eMeasure
No
Steward
CMS
National Quality Strategy Priorities
Communication and Care Coordination

Pre-Rulemaking Task Considerations from Dual Eligible Beneficiaries Workgroup (DRAFT Example)

Pre-Rulemaking Considerations from MAP Dual Eligible Beneficiaries Workgroup

In providing input to HHS regarding the selection of measures for Federal payment and public reporting programs, MAP must consider how the programs may impact the quality of care delivered to Medicare-
eligible for both Medicare and Medicaid comprise a heterogeneous
by either program. Despite their particularly intense and complex n
individuals are often highly fragmented. HHS is pursuing several stra
beneficiaries, including tasking MAP with considering the implicatio

Provides specific considerations from the Dual Eligible Beneficiaries Workgroup

General Principles for Measure Selection

In reviewing potential measures for individual programs, consider th
measurement can provide the most leverage in improving the overa
coordination, screening and assessment, mental health and substanc
which are collectively being considered a draft core set is provided

Also consider that the following issues are strongly related to qualit

- **Health-related goals:** Wherever possible, measurement should promote a broad view of health and wellness, encouraging development of person-centered plans of care to manage medical, behavioral, and social needs. Developed in concert with a beneficiary's team of providers, a plan of care should establish health-related goals and preferences for care. Because of the chronic needs of the beneficiary population, plans are more likely to be long-term than episode-based.
- **Chronicity of care:** More than 60 percent of dual eligible beneficiaries have three or more multiple chronic conditions, with the most common being cardiovascular disease, diabetes, Alzheimer's and related disorders, arthritis, and depression.
- **Cognitive status**: More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment. Etiologies of these impairments vary and may be the result of intellectual/developmental disability, serious mental illness, dementia, substance abuse, stroke, or other cause.
- **Care transitions and communication:** Many factors, including those listed above, make dual eligible beneficiaries more vulnerable to problems that arise during all types of care transitions. Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Input for the Hospital/Clinician/PAC/LTC Workgroup

The MAP Dual Eligible Beneficiaries Workgroup considered the core set of measures developed by the Hospital/Clinician/PAC/LTC Workgroup and the MAP Coordinating Committee. In response, they suggest:

Measure Gaps in the Hospital/Clinician/PAC/LTC Core Set

Measures Suggested for Removal

Other Considerations for Hospital/Clinician/PAC/LTC Programs

MAP Dual Eligible Beneficiaries Workgroup: Draft Core Set of Measures

The workgroup identified the draft core set presented below from an extensive list of current measures. Potential measures were considered in five areas previously identified by the workgroup as most closely linked to quality of care:

- Quality of Life;
- Care Coordination;
- Screening and Assessment;
- Mental Health and Substance Use; and
- Structural Measures.

Discussion

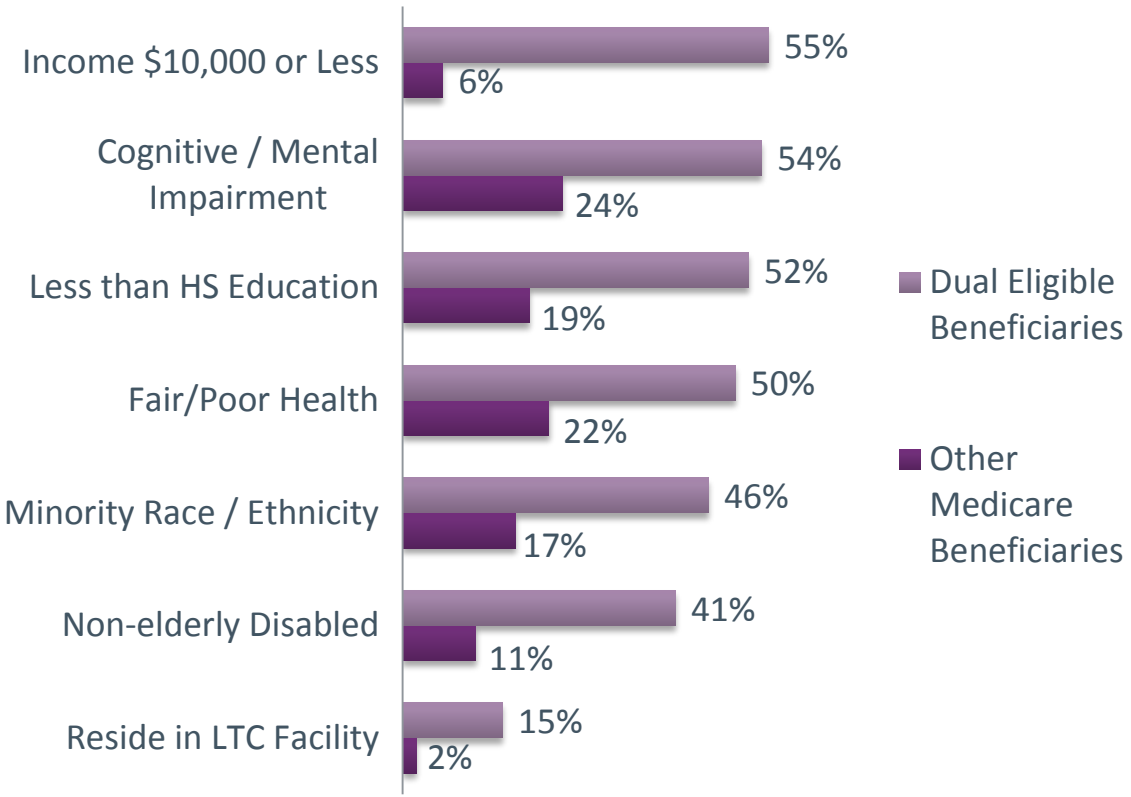
MAP Dual Eligible Beneficiaries Workgroup Cross-Cutting Input

Why Consider Dual Eligible Beneficiaries?

- HHS has identified the dual eligible beneficiary population as a priority consideration for all MAP tasks. In providing input to HHS on measurement programs, MAP must consider the implications for the country's 9 million dual eligibles
- Many of the poorest and sickest individuals in the health system are dual eligible beneficiaries
- Not all high-need patients have this insurance status, but they are likely to benefit from the same improvements in care delivery
- Factors including low income, poor English proficiency, cognitive impairment, and comorbidity make this population especially vulnerable to deficits in quality
- The group is disproportionately expensive and provides an important opportunity to address the affordability aspect of National Quality Strategy

Who Are Dual Eligible Beneficiaries? A **Heterogeneous** Group

- Only factor that all dual eligible beneficiaries share is low income
- Approximately a third of duals are younger adults with disabilities and the remaining two thirds are older than 65. Almost no children.
- More than 40% of duals have a mental or cognitive condition
- One in three duals have limitations in 3 or more ADLs
- Conditions like HIV/AIDS, Alzheimer's, cerebral palsy, ESRD, and schizophrenia disproportionately impact dual eligible beneficiaries



Workgroup-Specific Considerations: Hospital

- For hospitals, quality is tightly linked to person-centeredness, patient safety, medication management, care coordination/transitions, and readmissions from both community and long-term care settings
- Considering the heterogeneity of the population, think broadly about measures of care coordination, patient experience, outcomes, and integration of care needs and care teams across specialty areas
- Consider quality from the perspective of vulnerable patients accessing care through the emergency department or other “frequent users”
- Ensure that clinical process measures do not negatively impact quality of life decisions made in collaboration with a patient and his/her family
- Measure gaps in hospital core:
  - Geriatric measures, informed decision making, appropriateness of initial hospital admission, discharge planning and coordination of follow-up care
- Exceptions:
  - Most condition-specific measures are marginally important compared to the cross-cutting issues identified above

Workgroup-Specific Considerations: Clinician

- For clinicians, quality is tightly linked to screening, ongoing assessment, and management of chronic conditions (including mental illness); care coordination through primary care or other medical home; and medication management
- Consider measures that are applicable across clinical conditions, or to individuals with multiple chronic conditions
  - Functional status, quality of life, communication, patient experience, etc.
- To evaluate care for specific high-impact conditions such as diabetes and heart disease, emphasize outcome and composite measures
- Measure gaps in clinician core:
  - Patient understanding of treatment plan, pain management, capacity to serve as a medical home, coordination with non-medical providers of long-term supports, providing assistance in accessing specialty care
- Exceptions:
  - Appropriateness of preventive services and screenings must be evaluated for each patient

Workgroup-Specific Considerations: Post-Acute Care/Long-Term Care

- Most of the issues in PAC/LTC are relevant to duals and vice versa
- In these settings, quality is linked to person- and family-centeredness, delivering supports and services in the least intense setting possible, fidelity to a plan of care that incorporates individualized goals and promotes self-determination, medication management, and care coordination/transitions
- Consider measures related to the appropriateness of the setting and reducing the intensity of services where possible:
  - Patients of appropriate acuity admitted to IRFs and SNFs
  - Systems in place to facilitate transitions from institutional care settings to home- and community-based services (HCBS)
- Measure gaps in PAC/LTC core:
  - Identification and treatment of mental illness (especially depression), communication across an integrated care team, appropriate prescribing and dosing, patient/caregiver experience, caregiver support, cost/resource use, and structural measures related to HIT

High-Leverage Areas and Construction of the Draft Core Set

High-Leverage Areas for Quality Improvement Through Measurement

- Quality of Life
- Care Coordination
- Screening and Assessment
- Mental Health and Substance Use
- Structural Measures

The Workgroup identified the draft core set from an extensive list of current measures that applied to the five areas listed above. Many measure gaps and limitations of current measures also surfaced during the process. The draft core set is presented as a starting point for discussion, as it highlights measure concepts that were identified as important.

DRAFT Core Measures: 1 of 2 (subject to modification)

# and Status	Measure Title
0005 Endorsed	CAHPS Adult Primary Care Survey: Shared Decision Making
0006 Endorsed	**CAHPS Health Plan Survey v 4.0 - Adult questionnaire: Health Status/Functional Status***
0490 Endorsed	The Ability to use Health Information Technology to Perform Care Management at the Point of Care
0494 Endorsed	Medical Home System Survey
0523 Endorsed	Pain Assessment Conducted
0101 Endorsed	**Falls: Screening for Fall Risk***
0729 Endorsed	Optimal Diabetes Care
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0418 Endorsed	**Screening for Clinical Depression and Follow-up Plan***
0028 Endorsed	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

***Bolded measures received >90% agreement on inclusion**

DRAFT Core Measures: 2 of 2 (subject to modification)

# and Status	Measure Title
0558 Endorsed	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
0576 Endorsed	**Follow-up after hospitalization for mental illness***
0228 Endorsed	3-Item Care Transition Measure (CTM-3)
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
0329 Endorsed	**All-Cause Readmission Index (risk adjusted)***
0167 Endorsed	Improvement in Ambulation/locomotion
0208 Endorsed	Family Evaluation of Hospice Care
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid coverage
Not Endorsed	Screening and Brief Intervention for Alcohol Misuse
Not Endorsed	Potentially Harmful Drug-Disease Interactions in the Elderly

***Bolded measures received >90% agreement on inclusion**

Using the Cross-Cutting Guidance

- How MAP workgroups can use this population-specific guidance:
  - In reviewing CMS' proposed measures for a given program, consider whether there is representation of the issues presented in the five high-leverage opportunity areas and the list of draft core measures
  - If not, is it appropriate to add any measures to fill that gap?
  - Does a list include measures which are inappropriate or counterproductive to use with vulnerable populations?
- The Dual Eligible Beneficiaries Workgroup will be checking the progress of the other workgroups on its December 16 web meeting and making additional recommendations to the Coordinating Committee

Discussion

Public Comment

Next Steps

Upcoming Meetings

Clinician Workgroup In-Person Meeting
December 12, 2011

PAC/LTC Workgroup In-Person Meeting
December 14, 2011

Hospital Workgroup In-Person Meeting
December 15, 2011

Dual Eligible Beneficiaries Workgroup Web Meeting
December 16, 2011 1:00-3:00 pm ET

Coordinating Committee In-Person Meeting #5
January 5-6, 2012