

## Starter Set of Measures

MAP concluded that a small number of measures within the core measure set should be called out as the most promising for use in the short term. MAP considered measures that would work well as they are currently specified, with minimal

modification. This process balanced MAP's desire to be thorough and inclusive with its desire to provide HHS with a specific, actionable, and parsimonious list of measures. Table 3 presents MAP's recommendations for a Starter Set of Measures.

**TABLE 3. STARTER SET OF MEASURES**

Measure Name, NQF Measure Number, and Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
<b>Screening for Clinical Depression and Follow-Up Plan</b> 0418 Endorsed	Administrative Claims and Other Electronic Clinical Data	Screening and Assessment, Mental Health/ Substance Use	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core Set. Proposed for Meaningful Use Stage 2
<b>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement</b> 0004 Endorsed	Administrative Claims, EHR, and Paper Records	Care Coordination, Mental Health/ Substance Use	Ambulatory Care	Clinician, Health Plan, Integrated Delivery System, Population	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Set, and Health Homes Core
<b>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey</b> Multiple Endorsed: 0005, 0006, 0007, 0009, 0258, 0517	Patient Survey	N/A	Various, including: <ul style="list-style-type: none"> <li>• Health Plan</li> <li>• Clinician and Group</li> <li>• Experience of Care and Health Outcomes (ECHO) for Behavioral Health</li> <li>• Home Health Care</li> <li>• Hospital</li> <li>• In-Center Hemodialysis</li> <li>• Nursing Home</li> <li>• Supplemental Item Sets, topics including: <ul style="list-style-type: none"> <li>- People with Mobility Impairments</li> <li>- Cultural Competence</li> <li>- Health IT</li> <li>- Health Literacy</li> <li>- Patient-Centered Medical Home</li> </ul> </li> </ul>	Clinician, Facility, Health Plan, Integrated Delivery System, Population	Multiple programs, depending on version
<b>3-Item Care Transition Measure (CTM-3)</b> 0228 Endorsed	Patient Reported	Care Coordination	Hospital	Facility	Proposed for Hospital Inpatient Reporting as part of HCAHPS

Measure Name, NQF Measure Number, and Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
<b>Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)</b> 1789 Endorsed	Administrative Claims	Care Coordination	Hospital/Acute Care Facility	Facility	Proposed for Inpatient Quality Reporting
<b>Plan All-Cause Readmission</b> 1768 Endorsed	Administrative Claims	Care Coordination	Hospital/Acute Care Facility, Behavioral Health/ Psychiatric: Inpatient	Health Plan	
<b>Falls: Screening for Fall Risk</b> 0101 Endorsed	Administrative Claims	Screening and Assessment	Ambulatory Care, Home Health, Hospice, PAC/LTC Facilities	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, and Value Modifier. Proposed for Meaningful Use Stage 2

In recommending the measures, MAP considered their suitability for addressing the needs of the heterogeneous dual eligible population. Priority measures also needed to capture complex care experiences that extend across varied care settings and types of healthcare providers. Considered broadly, the prioritized list captures concepts of critical importance to the dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up, treatment for behavioral health conditions, and ongoing management of health conditions and risks.

Most chronic conditions have significantly higher prevalence rates in the dual eligible population than in the general Medicare population.<sup>12</sup> Some conditions such as diabetes, cardiovascular disease, and depression are especially common. Each affects more than 20 percent of dual eligible beneficiaries. Other conditions such as multiple sclerosis, cerebral palsy, and end stage renal disease are less common but disproportionately affect dual eligible beneficiaries. Moreover, a majority of dual eligible beneficiaries live with multiple chronic conditions (MCCs).<sup>13</sup> Clinical practice guidelines that

inform the development of performance measures typically focus on the management of a single disease, and strict adherence to disease-specific guidelines can potentially result in harm to patients with MCCs.<sup>14, 15, 16</sup> A separate NQF project has developed a measurement framework for MCCs.<sup>17</sup>

This heterogeneity complicates efforts to select a small number of measures that would accurately reflect dual eligible beneficiaries' care experiences. MAP followed its guiding principle that a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent that they address critical issues for high-need subpopulations. The Starter Set does not attempt to include all valid measures of effective clinical care for these and other chronic diseases.

The first measure in the Starter Set is Screening for Clinical Depression and Follow-up Plan (Measure O418). This measure addresses the two high-leverage opportunity areas of screening and assessment as well as mental health and substance use. It can be applied to many care settings in which dual eligible beneficiaries receive services.

## Expansion Set of Measures Needing Modification

MAP also sought to provide specific guidance regarding opportunities to improve existing measures. MAP members offered many suggestions for broadening and improving measures' specifications for use with dual eligible beneficiaries. The members first performed

an initial ranking to yield the Starter Set, then performed a second ranking to identify the measures that would be preferred *if the suggested modifications could be made*. This measure set would build on the Starter Set, expanding the range of quality issues addressed. Table 4 presents the results from the prioritization as an Expansion Set of Measures.

**TABLE 4. EXPANSION SET OF MEASURES NEEDING MODIFICATION**

Measure Name, NQF Measure Number, Status, and Steward	Measure Description	Suggested Modifications and Other Considerations
<p><b>Assessment of Health-Related Quality of Life (Physical &amp; Mental Functioning)</b>  <b>O260 Endorsed</b>                      Steward:                      RAND Corporation</p>	<p>Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year.</p> <ul style="list-style-type: none"> <li>• Data Source: Patient Reported</li> <li>• Care Setting: Dialysis Facility</li> <li>• Current Programs: MAP supported for ESRD Quality Incentive Program</li> </ul>	<ul style="list-style-type: none"> <li>• MAP emphasized this measure for its consideration of quality of life, a rarity among available measures.</li> <li>• Current survey is dialysis specific and therefore inappropriate to use more broadly. Comments suggested that it remain unmodified. Rather, it should be used as a template for the development of a related measure of general health-related quality of life.</li> <li>• Construction of this concept as a process measure is not ideal.</li> </ul>
<p><b>Medical Home System Survey</b>  <b>O494 Endorsed</b>                      Steward:                      National Committee for Quality Assurance</p>	<p>Percentage of practices functioning as a patient-centered medical home by providing ongoing coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a) Improved access and communication, b) Care management using evidence-based guidelines, c) Patient tracking and registry functions, d) Support for patient self-management, e) Test and referral tracking, and f) Practice performance and improvement functions</p> <ul style="list-style-type: none"> <li>• Data Source: Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data</li> <li>• Care Setting: Ambulatory Care</li> <li>• Current Programs: None</li> </ul>	<ul style="list-style-type: none"> <li>• Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site).</li> <li>• A health home's approach to care management must consider both Medicaid and Medicare benefits.</li> <li>• Measure may have broader application in shared accountability models such as ACOs and health homes.</li> <li>• It may be more important to measure whether the beneficiary has access to a usual source of primary care rather than the primary care provider's ability to meet these standards.</li> </ul>
<p><b>HBIPS-6: Post-Discharge Continuing Care Plan Created</b>  <b>O557 Endorsed</b>                      Steward:                      The Joint Commission</p>	<p>Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).</p> <ul style="list-style-type: none"> <li>• Data Sources: Administrative Claims, Paper Records, Other Electronic Clinical Data</li> <li>• Care Setting: Hospital, Behavioral Health/ Psychiatric: Inpatient</li> <li>• Current Programs: Proposed for Inpatient Psychiatric Facility Quality Reporting</li> </ul>	<ul style="list-style-type: none"> <li>• This type of transition planning and communication is universally important.</li> <li>• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox.</li> <li>• This measure is paired and should be used in conjunction with HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.</li> </ul>

Measure Name, NQF Measure Number, Status, and Steward	Measure Description	Suggested Modifications and Other Considerations
<p><b>HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge</b>                      0558 Endorsed                      Steward:                      The Joint Commission</p>	<p>Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).</p> <ul style="list-style-type: none"> <li>• Data Sources: Administrative Claims, Other Electronic Clinical Data, and Paper Records</li> <li>• Care Setting: Hospital, Behavioral Health/ Psychiatric: Inpatient</li> <li>• Current Programs: Proposed for Inpatient Psychiatric Facility Quality Reporting</li> </ul>	<ul style="list-style-type: none"> <li>• This type of transition planning and communication is universally important.</li> <li>• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox.</li> <li>• Information should be transmitted to both nursing facility and primary care provider, if applicable.</li> <li>• This measure is paired and should be used in conjunction with HBIPS-6: Post- Discharge Continuing Care Plan Created.</li> </ul>
<p><b>Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment</b>                      0209 Endorsed                      Steward:                      National Hospice and Palliative Care Organization</p>	<p>Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.</p> <ul style="list-style-type: none"> <li>• Data Sources: Patient Reported</li> <li>• Care Setting: Hospice</li> <li>• Current Programs: Finalized for Use in Hospice Quality Reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum it could be applied more broadly to other types of palliative care.</li> <li>• Comments suggested that advance care directives are equally important to ensure high-quality, patient-centered care.</li> </ul>
<p><b>Change in Daily Activity Function as Measured by the AM-PAC</b>                      0430 Endorsed                      Steward:                      CREcare</p>	<p>The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified, which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.</p> <ul style="list-style-type: none"> <li>• Data Sources: Other Electronic Clinical Data</li> <li>• Care Setting: Hospital, PAC/LTC Facilities, Home Health, Ambulatory Care</li> <li>• Current Programs: None</li> </ul>	<ul style="list-style-type: none"> <li>• MAP emphasized this measure for its consideration of functional status, a rarity among available measures.</li> <li>• Broaden beyond post-acute care.</li> <li>• Measure has curative orientation. Include maintenance of functional status if this is all that can be realistically expected. If the goal of care is to slow the rate of decline, then this measure may not be appropriate.</li> <li>• Address floor effects observed when tool is applied to very frail/complex patients.</li> <li>• Incorporate community services in supporting post-acute recovery.</li> <li>• The measure may present a relatively larger data collection burden; brief surveys are preferred.</li> </ul>