APPENDIX B – STEERING COMMITTEE COMMENTARY

This project, like all NQF activities, has involved the active participation of representatives from across the spectrum of healthcare stakeholders. This appendix summarizes the deliberations supporting the recommended measures and additional recommendations of the Steering Committee.[1]

Background

The Steering Committee was specifically asked to recommend a core set of performance measures for chronic and post-acute care nursing facilities that are useful for public reporting to purchasers and consumers

During the course of the project, the Steering Committee met in-person on three occasions and held several conference calls. A Special Advisory Panel on risk adjustment was convened to provide the Committee with independent review of the different approaches to risk adjustment of nursing home performance measures. In addition, the Steering Committee's deliberations were informed by comments from NQF members and non-members during meetings of the Steering Committee.

Preparatory to its discussions, the Steering Committee reviewed two reports from the CMS contactor, Abt Associates:

> *Preliminary Report: Pilot Field Data Collection Efforts to Validate Nursing Home Quality Indicators (Performance Measures)* September 26, 2001. This report describes newly developed quality measures called "Mega QIs" based on the Minimum Data Set information.
>
> *Identification and Evaluation of Existing Quality Indicators That Are Appropriate for Use in Long-term Care Settings,* October 1, 2001. This report analyzes existing MDS-based performance measures.

Risk Adjustment

The newly developed Mega QI measures contain a facility-level risk adjustment method called the Facility Admission Profile (FAP). The Committee expressed discomfort with the technical complexity of the method and some members had difficulty understanding the

[1] The Committee held three in-person meetings on November 12, 2001; January 25, 2002; and February 27, 2002.

technical information in the reports. Questions regarding possible over or under adjustment using the FAP method were difficult for the Committee to evaluate. A Special Advisory Panel of three outside, independent consultants was convened to assist the Committee in resolving these and others concerns regarding risk adjustment methodology, and the Advisory Panel's recommendations were used to inform the Steering Committee's deliberations with respect to selecting the measures for the core sets.

In brief, Advisory Panel members were asked to:

- Review the risk adjustment methodology in the Mega QI project and other risk adjustment methodologies that are available and tested for the purpose of answering:
  - How well does each risk adjustment method aid in identifying high quality and poor quality facilities?
  - What are the pros and cons of each method when applied to an indicator being used for public reporting to consumers?
- Compare the Mega QI methodology to other available risk adjustment methods or measures that could be used.

Based on the Advisory Panel's recommendations, the Steering Committee reached the following conclusions regarding risk adjustment:

- Each measure should be evaluated independently with regard to the need for adjustment and, if required, the appropriate method for such adjustment.
- The Facility Admission Profile is a new, innovative, nontraditional method that needs further research to evaluate its validity and reliability. Two of the three consultants specifically recommended against using the FAP for public reporting of quality measures at this time.
- The risk adjustment method should be easy to understand and explain to the public.
- The adjustment should take into account only those characteristics that are not in part the result of facility care.
- The considerations for risk adjustment for the long-stay, chronic care population and the short-stay or post-acute care population are very different. In particular, the timing of the 5-day and 14-day assessments of the MDS does not included 40% of short-stay patients and may lead to selection bias.
- Head-to-head comparison of various risk adjustment methods has not been performed and is urgently needed.

At the last Committee meeting in February 2002, CMS advised the Committee that it planned to use the Mega QIs with the FAP for the pilot project beginning in April 2002. Committee members expressed serious concern with this decision on technical grounds and

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because additional research and validation was recommended by the Special Advisory Panel before using FAP for measures that would be publicly reported.

The Committee also discussed the measures that are currently on the Nursing Home Compare web site and noted that they are not risk-adjusted and generally expressed the view that any appropriate risk adjustment would be an improvement. Other Committee members expressed concern about the potential for confusing providers and the public vis a vis the reporting aspect. In a brief period of time multiple changes will be made as to what and how information about nursing home quality is reported – specifically, information on the existing Nursing Home Compare reporting (few indicators, no risk adjustment) will switch to information from the pilot in six states (new measures, new risk adjustment) to information from the final core set (some new / different measures and different risk adjustment).

Considerations in Selecting Measures

Prior to its systematic consideration of individual measures, the Steering Committee identified six domains for which quality measures would be sought and evaluated:

- structural – including nurse staffing, financial, ownership;
- clinical – including physical function and cognitive function;
- satisfaction – patient satisfaction, family satisfaction, employee satisfaction;
- quality of life;
- external assessments, i.e., accreditation, certification, deficiencies, and complaints; and
- participation in care processes, including planning, delivery, and evaluation.

Following identification of the domains, the Steering Committee identified the criteria it would adopt to select measures for the core set:

- high priority for nursing home residents and consumers;
- under control of the facility; and
- easily understood by consumers
- validity, including face validity, reliability, auditing, risk adjustment;
- burden, both the total number of measures and the burden of data collection;
- perverse incentives (such as admitting and care practices)should not be introduced; and
- the measure must be in the public domain.

Of the seven criteria, the Committee concurred that two of these criteria would be considered threshold criteria that any measure must meet in order for it to be evaluated against

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the remaining criteria. First, the measure must be in the public domain. Second, evidence must exist of a fairly formal, independent assessment of validity.

In addition to identifying domains of quality that the core sets should encompass and the criteria it would use to select measures for the sets, the Committee concluded that three overarching principles should guide its deliberations. The Committee felt that:

- The number of measures selected should be manageable for users.
- Each core set should be comprised of measures representing a cross-section of domains.
- The core set should be a group of measures in which each relates to the other to form a picture of the entire spectrum of nursing home quality.

Lastly, the Committee noted the need to be practical in selecting measures. Accordingly, it concluded that it would evaluate measures on the basis of readiness for implementation. Specifically, the Committee assessed whether the outlook for implementation was immediate (in use / ready for "prime time), short-term (currently being worked on and / or being validated and ready for use in 6-12 months), or long-term (requiring a significant amount of research and validation, and will not be ready for several years).

Selection of Measures

Based on the Steering Committee's deliberations, NQF staff broadly solicited measures that met the threshold criteria. The Committee explicitly agreed that it would not limit its consideration to measures derived from the Minimum Data Set (MDS) instrument. The Committee discussed the MDS tool and various problems its use in quality measurement presents, such as timing of assessments, definitions of some items such as pain, and its utility with the sub-acute population.

NQF staff identified 78 candidate measures for further consideration, and for each measure compiled information on the developer of the measure, data source, risk adjustment method, evidence of validation, and readiness for implementation. Measures were further grouped into domains, and within domains by general topic or clinical area the measure addressed.

As a result of the discussion with the Special Advisory Panel, the Steering Committee decided to select measures based on other criteria and then, consider the risk adjustment method. Because most of the measures fell into the clinical domain, the bulk of the Committee's deliberations focused on these measures.

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The Committee identified high priority clinical target areas: pressure sores, activities of daily living, restraints, pain, infections, weight loss, anti-psychotic drug use, immunization, prevalence of bedfast patients, depression, and incontinence. Additionally, the Committee agreed to eliminate from further consideration measures from the following clinical clusters: medication errors, injury or falls (although use of restraints was included), and locomotion (although bedfast prevalence was included). Measures from within clusters of similar clinical areas then were considered together. Finally, if measures were similar except for risk adjustment methodology the Committee selected a measure based on the measure's specifications and adjustments.

Recommended long-term care measures

- incidence of decline in late loss Activities of Daily Living (ADL)
- weight loss prevalence
- inadequate management of pain
- prevalence of pressure ulcers
- prevalence of physical restraints
- depression without antidepressant therapy
- prevalence of bladder or bowel incontinence
- prevalence of indwelling catheters
- prevalence of bedfast residents

For the measure "prevalence of bowel and bladder incontinence" the Committee voiced concerns about introducing an incentive to use catheters to reduce the prevalence of "incontinence" and agreed that the addition of the "prevalence of indwelling catheters measure" acts to balance that incentive –i.e., the two measures work together as a pair.

Post-acute measures

- inadequate pain management
- improvement in walking
- failure to improve and manage delirium; and
- re-hospitalization during stay at skilled nursing facility.[2]

[2] CMS has advised the Committee that on-going work has identified that the post-acute care re-hospitalization measure has some technical difficulties with data collection and data quality, although the belief is that these

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The Committee agreed on the importance of including a set of measures for the short-stay, post-acute population even though the candidate post-acute measures are new and preliminary validation evidence used the FAP methodology. At its February 2002 meeting, the Steering Committee accepted the post-acute measures with the FAP rather than recommend no measures for the short-stay population. In late March 2002, however, CMS announced that it would not be using the FAP method on the post-acute measures for its April 2002 pilot project on consumer reporting of nursing home quality information.

Given this situation, the Steering Committee reconsidered its recommendations for the post-acute measures and favored retaining the measures it had identified except that the FAP risk adjustment would not be applied. Current research in this area may provide better guidance as to the best method to adjust the post-acute measures in the future.

Structural measures

In considering structural measures, the Committee identified information that it considered essential to report to consumers but that cannot be characterized as a "performance measure." As noted in the report, the Committee concluded that information in two areas should be reported to the public: facility ownership and staffing information.

Additionally, the Steering Committee had hoped to be able to select measures from multiple domains. Most domains, however, contained no measures or did not contain measures that were ready for immediate implementation. The Committee's strong desire to include measures of satisfaction and quality of life was limited by lack of standardized data collection systems available in the near term. The Committee recommends fast-track research, development, and validation of public domain measures and data systems in these areas to make implementation feasible as soon as possible.

Finally, the Committee designated some important measures that were not selected for the core set as "next-generation" measures. These measures generated questions about data sources or specifications and so were not selected for the final set; ultimately the Committee limited their selection of core measures to MDS-based measures.

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problems can be remedied quickly. The Committee recommends the re-hospitalization measure with expectations that the data issues will be promptly resolved.

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In particular, the Committee felt that the clinical area of use of anti-psychotic and hypnotic medications is a high-priority but that current measures are problematic due to changing indications for medications, changing lists of medications considered to be "anti-psychotic" and "hypnotic," and a need to improve measure specifications.

Similarly, problems with CMS's Online Survey, Certification and Reporting (OSCAR) database ultimately led to the Committee's recommendation to exclude specific measures for immunization and staffing. Thus, the Committee recommends that more reliable and valid data systems, particularly for staffing information, be developed as soon as possible.

Public Reporting

Although the Steering Committee did not engage in a systematic and analytic review of how information from the core sets should be summarized and presented to the public, the Committee did generally discuss its views on reporting formats, including:

- Measures and indicators should be worded in positive or neutral terms whenever possible.
- Easily understood words should be used, such as "confusion" instead of "delirium".
- Alternative ways of presenting information about differences among facilities should be explored instead of merely providing a list of percentages.
- Presentation of the data should reflect meaningful differences – e.g., the use of quartiles with confidence intervals. Some members were especially concerned about the "tyranny of small differences" and how to help the public interpret the results appropriately.
- Trends over time should be considered for some measures (e.g., restraints, weight loss, etc.), since conditions in nursing homes can change rapidly.
- A priority should be placed on timeliness, and data that are nine months old should not be viewed as particularly useful to consumers.
- CMS should coordinate with the states regarding both presentation format and utilization of the measures in standard state surveys.
- A strong public education component must accompany public reporting to guide consumers in using the information effectively.

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