## Measure Applications PartnershipCoordinating Committee Discussion Guide

*Notes for Measure Deliberations*

*Conference call date:* February 27, 2015

## Full Agenda

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| 12:00 pm   | Welcome, Introductions, and Review of Meeting Objectives  |
|  | * George Isham, MAP Coordinating Committee Co-Chair
* Beth McGlynn, MAP Coordinating Committee Co-Chair
 |
| 12:10 pm   | MAP Off-Cycle Review Approach |
|  | Rob Saunders, NQF  |
| 12:15 pm   | IMPACT ACT Reporting Requirements |
|  | Tara McMullen, CMS  |
| 12:30 pm   | Themes from PAC/LTC Workgroup Deliberations |
|  | Carol Raphael  |
| 12:45 pm   | Finalize Recommendations on Off-Cycle Measures |
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|  | Programs under consideration: IMPACT Act Programs  |
|  | 1. **Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened** (MUC ID: E0678)
	* *Description:* This measure captures the percentage of short-stay residents, patients, and persons with new or worsening Stage II-IV pressure ulcers.
	* *Public comments received:* 7
	* *Workgroup Rationale:* The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. The measure is NQF-endorsed for the SNF, IRF and LTCH settings (NQF #0678). The measure is currently in use in the IRF and LTCH quality reporting programs and the Nursing Home Quality Initiative. In the 2015 MAP pre-rulemaking cycle, MAP conditionally supported X3704 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened for Home Health Quality Reporting. MAP recommended that the CMS continue to work to refine the adaption of this measure for the home health setting to ensure proper risk adjustment and exclusions.
	* *Workgroup Recommendation:* Support
	* *Notes:*
2. **Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury** (MUC ID: E0674)
	* *Description:* This measure reports the percent of patients, residents, and persons who have experienced one or more falls with major injury reported in the target period or look-back period. "Falls that result in a major injury" are defined as: falls that result in a major injury such as bone fractures, joint dislocations, closed head injuries, subdural hematoma, and altered consciousness, among other major injuries.
	* *Public comments received:* 8
	* *Workgroup Rationale:* The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. This measure is curretnly in use in the Nursing Home Quality Initiative and finalized for use in the LTCH QRP for the FY 2018 payment determination and subsequent years. and MAP conditionally supported this measure pending proper risk adjustments and attribution for the home health setting.
	* *Workgroup Recommendation:* Conditional Support
	* *Notes:*
3. **All-Cause Readmission measure** (MUC ID: X4210)
	* *Description:* IRF: This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients 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 will be based on data for 24 months of IRF discharges to lower levels of care or to the community. SNF: 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. LTCH: This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients 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 will be based on data for 24 months of LTCH discharges to lower levels of care or to the community. HH: 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.
	* *Public comments received:* 10
	* *Workgroup Rationale:* The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. NQF has recently endorsed these readmission measures for all four settings (IRF #2502; SNF #2510; LTCH #2512; HH #2380.) Skilled Nursing Facilities: In the 2015 pre-rulemaking cycle, MAP supported #2510 for the SNF Value-Based Purchasing Program. Measure #2510 was also recently finalized for use in MSSP in the 2015 PFS rule. The IRFQR, LTCHQR and HHQR programs currently include an all-cause unplanned readmission measure. The measures are all harmonized in the approach to capturing readmissions.
	* *Workgroup Recommendation:* Support
	* *Notes:*
4. **Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function** (MUC ID: S2631)
	* *Description:* This quality measure reports the percentage of residents, patients, and persons with an admission and discharge functional assessment and a care plan that addresses function.
	* *Public comments received:* 11
	* *Workgroup Rationale:* The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. MAP conditionally supported this measure pending NQF-endorsement and resolution of concerns about the use of two different functional status scales for quality reporting and payment purposes. MAP reiterated its support for adding measures addressing function, noting the group's especial interest in this PAC/LTC core concept.
	* *Workgroup Recommendation:* Conditional Support
	* *Notes:*
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| 1:35 pm   | Opportunity for Public Comment |
|  |  |
| 1:45 pm   | Next Steps |
|  | Wunmi Isijola, Senior Project Manager, NQF  |
| 2:00 pm   | Adjourn |
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