## Measure Applications PartnershipPAC/LTC Workgroup Discussion Guide

*Notes for Measure Deliberations*

*Version Number*: 3.2
*Meeting Date:* December 14-15, 2015

## Full Agenda

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| **Day 1: December 14**   |  |
|  |  |
| 8:30 am    | Breakfast |
|  |  |
| 9:00 am   | Welcome, Disclosures of Interest, and Review Meeting Objectives |
|  | Carol Raphael, Workgroup Co-Chair; Debra Saliba, Workgroup Co-Chair; Chris Cassel, CEO, NQF; Sarah Sampsel, NQF Consultant; Margaret Terry, NQF; Ann Hammersmith, General Counsel, NQF  |
| 9:15 am   | Overview of Post-Acute Care Quality Reporting Programs: Statutory Guidelines |
|  | Alan Levitt, CMS; Tara McMullen, CMS  |
| 9:45 am   | MAP Pre-Rulemaking Approach and Voting Instructions |
|  | Erin O'Rouke, Senior Project Manager, NQF  |
| 10:00 am   | Opportunity for Public Comment on Measures Under Consideration for IMPACT Act: Medication Reconciliation  |
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| 10:15 am   | Consent Calendar: IMPACT Act - Medication Reconciliation |
|  | Jennifer Thomas; Cari Levy (Lead Discussants) |
|  | 1. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1127)
	* *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure of medication reconciliation addresses an important aspect of care for patients as they transition from one setting to another. During transitions of care, there can be many changes to the drug regimen. Identifying medication issues and resolving these with a physician or physician-designee are important steps to prevent issues such as; adverse drug reaction, ineffective drug therapy, drug interactions, duplicate therapy, dosage errors etc., any of which could lead to hospitalization or re-hospitalization. Medication reconciliation is currently one of the Joint Commission National Patient Safety Goals –which is to maintain and communicate accurate patient medication information.
		+ *Impact on quality of care for patients:*The improvement in the patient’s medical condition, decrease in medication errors or events as well as a decrease in use of the Emergency Department (ED) and hospitalization are all outcomes that would improve the quality of care for patients.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1128)
	* *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure of medication reconciliation addresses an important aspect of care for patients as they transition from one setting to another. During transitions of care, there can be many changes to the drug regimen. Identifying medication issues and resolving these with a physician or physician-designee are important steps to prevent issues such as; adverse drug reaction, ineffective drug therapy, drug interactions, duplicate therapy, dosage errors etc., any of which could lead to hospitalization or re-hospitalization. Medication reconciliation is currently one of the Joint Commission National Patient Safety Goals –which is to maintain and communicate accurate patient medication information.
		+ *Impact on quality of care for patients:*The improvement in the patient’s medical condition, decrease in medication errors or events as well as a decrease in use of the Emergency Department (ED) and hospitalization are all outcomes that would improve the quality of care for patients.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
3. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1129)
	* *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure of medication reconciliation addresses an important aspect of care for patients as they transition from one setting to another. During transitions of care, there can be many changes to the drug regimen. Identifying medication issues and resolving these with a physician or physician-designee are important steps to prevent issues such as; adverse drug reaction, ineffective drug therapy, drug interactions, duplicate therapy, dosage errors etc., any of which could lead to hospitalization or re-hospitalization. Medication reconciliation is currently one of the Joint Commission National Patient Safety Goals –which is to maintain and communicate accurate patient medication information.Currently; there are not medication management measures in the LTCH QRP. This measure fills a significant gap area and is expected to reduce hospitalizations, adverse events related to medications, and improve health outcomes.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to promote medication reconciliation and medication review for clinically significant issues. This measure is intended to improve health outcomes and quality of care for patients in the LTCH setting.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
4. **Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1130)
	* *Description:* Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure of medication reconciliation addresses an important aspect of care for patients as they transition from one setting to another. During transitions of care, there can be many changes to the drug regimen. Identifying medication issues and resolving these with a physician or physician-designee are important steps to prevent issues such as; adverse drug reaction, ineffective drug therapy, drug interactions, duplicate therapy, dosage errors etc., any of which could lead to hospitalization or re-hospitalization. Medication reconciliation is currently one of the Joint Commission National Patient Safety Goals –which is to maintain and communicate accurate patient medication information.
		+ *Impact on quality of care for patients:*The improvement in the patient’s medical condition, decrease in medication errors or events as well as a decrease in use of the Emergency Department (ED) and hospitalization are all outcomes that would improve the quality of care for patients.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 10:45 am   | Break  |
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| 11:00 am   | Opportunity for Public Comment on Measures Under Consideration for IMPACT Act: Discharge to Community  |
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| 11:15 am   | Consent Calendar: IMPACT Act - Discharge to Community |
|  | Joseph Agostini; Gerri Lamb (Lead Discussants) |
|  | 1. **Discharge to Community-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-523)
	* *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*A study of 66,510 Medicare beneficiaries during pre- and post-HH episodes, revealed that 64 percent of beneficiaries discharged from HH did not use any other Medicare-reimbursed acute or post-acute services in the 30 days following HH discharge. Significant numbers of patients were admitted to inpatient facilities (29 percent) and lesser numbers to skilled nursing facilities (7.6 percent), inpatient rehabilitation (1.5 percent) and home health (7.2 percent) or hospice (3.3 percent) within 30 days of HH discharge (Wolff et al., 2008). <http://www.ncbi.nlm.nih.gov/pubmed/18953231>The value of this measure is to gather information on use of health care services during an extended period (3O days) following an episode of care. It evaluates whether agencies have prepared patients/caregivers to care for themselves through obtaining the knowledge, resources and confidence after their care in home health episode. It evaluates whether agencies have provided the patient/caregiver with the “right” tools and whether agencies have adequately evaluated the patient/caregiver capacity to maintain their level of health and functioning.Over 70 percent of patients with COPD enrolled in the VA home care telehealth program had a significant reduction in the numbers of ED visits, hospital admissions and total exacerbations (Alrajab, Smith el al., 2012). This study suggests the value of telehealth in reducing hospitalizaton and ED visits following a home health episode of care.<http://www.ncbi.nlm.nih.gov/pubmed/23082792>
		+ *Impact on quality of care for patients:*Keeping patients out of the institutional care following home health care as well as tracking the status of patients will potentially improve the transition of care for patients helping them stay in the community. Patients would benefit from home health agencies providing the resources and knowledge for patients to keep them in the community without a hospitalization or use of other institutional settings.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Discharge to Community-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-408)
	* *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure meets the priorities, needs and requirements of the IRF QRP, addresses a high-impact area of function and resource use, and meets the requirements of the IMPACT Act. This measure would be unique to the IRF QRP in terms of addressing this quality issue (discharge to community); the program does not currently include any resource use measures in this area.
		+ *Impact on quality of care for patients:*Restoring functional status is a primary focus on IRF care and returning home is very important to patients. This is a resource use measure that assesses discharge to community and is being proposed to meet the requirements of the IMPACT Act. IRF discharge rates vary across providers, ranging from 60% to 75%. MedPAC found in FY 2013 the average rate for discharge to the community for IRFs within 100 days was around 75%. Implementing this measure could help consumers make choices about post-acute care that are aligned with their goals of returning to the community.
	* *Preliminary analysis result:* Encourage continued development
	* *Notes:*
3. **Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-414)
	* *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This is a high value measure that addresses the multifaceted care coordination needs of discharge patients to the community. Although the developers noted anticipated performance gaps in the measure due to variation in discharge and readmission rates based on facility and patient characteristics, this measure has the potential to assess the degree to which patients who are not prepared to live in a community are being inappropriately discharged.
		+ *Impact on quality of care for patients:*The potential impact of this measure could lead to improved discharge to community rates, decreased costs, and increases quality of care within the facility to ensure patients are appropriately discharged. This measure can also support the care coordination needs of the patients upon discharge and improve overall patient health outcomes.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
4. **Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-462)
	* *Description:* This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure meets the priorities, needs and requirements of the SNF QRP, addresses a high-impact area of function and resource use, and meets the requirements of the IMPACT Act. This measure would be unique to the SNF QRP in terms of addressing this quality issue (discharge to community); the program does not currently include any resource use measures in this area.
		+ *Impact on quality of care for patients:*The ultimate goals of post-acute care are avoiding institutionalization and returning patients to their previous level of independence and functioning, with discharge to community being the primary goal for the majority of post-acute patients. For many, home is a symbol of independence, privacy, and competence. Discharge to community is considered a valuable outcome to measure because it is a multifaceted measure that captures the patient’s functional status, cognitive capacity, physical ability, and availability of social support at home.
	* *Preliminary analysis result:* Encourage continued development
	* *Notes:*
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| 11:45 am   | Opportunity for Public Comment on Measures Under Consideration for IMPACT Act: Potentially Preventable Readmission Rates  |
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| 12:00 am   | Consent Calendar: IMPACT Act - Pontentially Preventable Readmission Rates |
|  | James Lett; Sandy Markwood (Lead Discussants) |
|  | 1. **Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-234)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates.
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure is valuable as it is an indicator of the ability of home health agencies to keep patients out of the hospital following the proximal acute hospitalization. It evaluates whether patients are adequately prepared to care for themselves, maintain their level of care and have the knowledge and resources to stay in the community. Some of the resources and knowledge for the patient include the ability to: obtain and take medications correctly, obtain supplies and care for non-healed wound, and obtain home supplies such as oxygen. Patients will also need to know the “red flags” for their condition and when and where to seek help when needed.
		+ *Impact on quality of care for patients:*Keeping patients out of the hospital is one of the key goals during and following a home health episode of care. Patients would benefit from home health agencies providing the resources and knowledge for patients to keep them in the community without a re-hospitalization.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-496)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure would address a gap in assessing care coordination and hospital readmissions. Additionally, this measure would meet an IMPACT Act requirement.
		+ *Impact on quality of care for patients:*MedPAC estimates that 76% of hospital readmissions may be potentially preventable. Risk-standardized readmission rates across IRFs have been found to range from 11 to 16 percent. Implementing this measure could help reduce variation and close this performance gap.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
3. **Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-498)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This is a high value measure that is not duplicative, captures a broader population of condition specific readmissions.
		+ *Impact on quality of care for patients:*The potential impact of this measure could lead to decreased readmissions rates, decreased costs, and increases quality of care within the facility to ensure patients are properly diagnosed and discharged if needed. This measure can also support the care coordination needs of the patients upon discharge. Overall, this measure has potential to improve patient outcomes upon discharge to their communities from LTCH.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
4. **Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-495)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This is a high value measure that is not duplicative, captures a broader population of condition specific readmissions.
		+ *Impact on quality of care for patients:*The potential impact of this measure could lead to decreased readmissions rates, decreased costs, and increases quality of care within the facility to ensure patients are properly diagnosed and discharged if needed. This measure can also support the care coordination needs of the patients upon discharge. Overall, this measure has potential to improve patient outcomes upon discharge to their communities from SNF.
	* *Preliminary analysis result:* Encourage continued development
	* *Notes:*
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| 12:30 pm   | Lunch |
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| 1:00 pm   | Opportunity for Public Comment on Measures Under Consideration for Inpatient Rehabilitation Facility Quality Reporting Program  |
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| 1:15 pm   | Pre-Rulemaking Input on Measures Under Consideration for Inpatient Rehabilitation Facility Quality Reporting Program  |
|  | James Lett; Sandy Markwood (Lead Discussants) |
|  | 1. **Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities** (MUC ID: MUC15-497)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates occurring during an IRF stay
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This risk-adjusted measure would be the first to evaluate potentiallly preventable re-hospitalization in while a patient is in an inpatient rehabilitation facility.
		+ *Impact on quality of care for patients:*MedPAC estimates that 76 percent of 30-day readmissions for Medicare beneficiaries overall were due to five potentially preventable conditions (heart failure, electrolyte imbalance, respiratory infection, sepsis, and urinary tract infection (MedPAC 2007). By focusing on improved clinical management of patients with potentially preventable conditions, IRFs have an opportunity to reduce readmission rates for patients under their care.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 1:30 pm   | Opportunity for Public Comment on Measures Under Consideration for Skilled Nursing Facility Quality Reporting Program  |
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| 1:45 pm   | Consent Calendar: Skilled Nursing Facility Quality Reporting Program |
|  | Kim Elliott; Pamela Roberts (Lead Discussants) |
|  | 1. **Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)** (MUC ID: MUC15-527)
	* *Description:* This quality measure estimates the risk-adjusted mean change in mobility score between admission and discharge among Skilled Nursing Facility residents. (*The endorsed specifications of the measure are: This measure estimates the mean risk-adjusted mean change in mobility score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.*)
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Research has shown differences in SNF residents’ functional outcomes by geographic region and race/ethnicity after adjusting for key patient demographic characteristics and admission clinical status, which supports the need to monitor SNF residents’ functional outcomes.
		+ *Impact on quality of care for patients:*The mobility and self-care quality measures will standardize the collection of functional status data, which can improve communication when patients are transferred between providers. Most SNF patients receive care in an acute care hospital prior to the SNF stay, and many SNF patients receive care from another provider after the SNF stay. Use of standardized clinical data to describe a patient´s status across providers can facilitate communication across providers. In describing the importance of functional status, the National Committee on Vital and Health Statistics Subcommittee on Health (2001) noted, “Information on functional status is becoming increasing essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life space of the effects of people’s health conditions on their ability to do basic activities and participate in life situations, in other words, their functional status.” This quality measure will inform SNF providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)** (MUC ID: MUC15-236)
	* *Description:* This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among SNF residents. (*The endorsed specifications of the measure are: This measure estimates the risk-adjusted mean change in self-care score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.*)
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Research has shown differences in SNF residents’ functional outcomes by geographic region and race/ethnicity after adjusting for key patient demographic characteristics and admission clinical status, which supports the need to monitor SNF residents’ functional outcomes.
		+ *Impact on quality of care for patients:*The mobility and self-care quality measures will standardize the collection of functional status data, which can improve communication when patients are transferred between providers. Most SNF patients receive care in an acute care hospital prior to the SNF stay, and many SNF patients receive care from another provider after the SNF stay. Use of standardized clinical data to describe a patient´s status across providers can facilitate communication across providers. In describing the importance of functional status, the National Committee on Vital and Health Statistics Subcommittee on Health (2001) noted, “Information on functional status is becoming increasing essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life space of the effects of people’s health conditions on their ability to do basic activities and participate in life situations, in other words, their functional status.” This quality measure will inform SNF providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
3. **Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)** (MUC ID: MUC15-529)
	* *Description:* This quality measure estimates the percentage of Skilled Nursing Facility residents who meet or exceed an expected discharge mobility score. (*The endorsed specifications of the measure are: This measure estimates the percentage IRF patients who meet or exceed an expected discharge mobility score.*)
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Research has shown differences in SNF residents’ functional outcomes by geographic region and race/ethnicity after adjusting for key patient demographic characteristics and admission clinical status, which supports the need to monitor SNF residents’ functional outcomes.
		+ *Impact on quality of care for patients:*The mobility and self-care quality measures will standardize the collection of functional status data, which can improve communication when patients are transferred between providers. Most SNF patients receive care in an acute care hospital prior to the SNF stay, and many SNF patients receive care from another provider after the SNF stay. Use of standardized clinical data to describe a patient´s status across providers can facilitate communication across providers. In describing the importance of functional status, the National Committee on Vital and Health Statistics Subcommittee on Health (2001) noted, “Information on functional status is becoming increasing essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life space of the effects of people’s health conditions on their ability to do basic activities and participate in life situations, in other words, their functional status.” This quality measure will inform SNF providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
4. **Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)** (MUC ID: MUC15-528)
	* *Description:* This quality measure estimates the percentage of Skilled Nursing Facility residents who meet or exceed an expected discharge self-care score. (*The endorsed specifications of the measure are: This measure estimates the percentage of IRF patients who meet or exceed an expected discharge self-care score.*)
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Research has shown differences in SNF residents’ functional outcomes by geographic region and race/ethnicity after adjusting for key patient demographic characteristics and admission clinical status, which supports the need to monitor SNF residents’ functional outcomes.
		+ *Impact on quality of care for patients:*The mobility and self-care quality measures will standardize the collection of functional status data, which can improve communication when patients are transferred between providers. Most SNF patients receive care in an acute care hospital prior to the SNF stay, and many SNF patients receive care from another provider after the SNF stay. Use of standardized clinical data to describe a patient´s status across providers can facilitate communication across providers. In describing the importance of functional status, the National Committee on Vital and Health Statistics Subcommittee on Health (2001) noted, “Information on functional status is becoming increasing essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life space of the effects of people’s health conditions on their ability to do basic activities and participate in life situations, in other words, their functional status.” This quality measure will inform SNF providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
5. **Percent of Skilled Nursing Facility Residents Who Newly Received an Antipsychotic Medication** (MUC ID: MUC15-1133)
	* *Description:* This measure reports the percentage of skilled nursing facility residents who are receiving an antipsychotic medication during a quarter but who were not receiving an antipsychotic medication at admission.
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Currently, there are no medication management measures in the SNF QRP. This measure fills a significant gap area within a vulnerable population and is expected to reduce hospitalizations, adverse events related to medications, and improve health outcomes.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to promote medication management within the older adult population taking antipsychotic medications. This measure is intended to improve health outcomes and quality of care for patients in the SNF setting.This measure is similar to a currently endorsed NQF measure: Antipsychotic Use in Persons with Dementia (#2111),a health plan Part D measure and consideration may be given to alignment/harmonization since these measures have congruent rationale.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
6. **Percent of Skilled Nursing Facility Residents Who Self-Report Moderate to Severe Pain** (MUC ID: MUC15-1131)
	* *Description:* This measure reports the percentage of skilled nursing facility residents who have reported daily pain with at least one episode of moderate to severe pain, or severe or horrible pain of any frequency in the 5 days prior to the assessment. (*The endorsed specifications of the measure are: This measure reports the percentage of short-stay residents, of all ages, in a nursing facility, who have reported almost constant or frequent pain, and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the target assessment. This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments. Short-stay residents are identified as residents who have had 100 or fewer days of nursing facility care.* )A separate measure (NQF#0677, Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)) is to be used for residents who had at least 100 days of nursing facility care.
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Pain assessment has been identified as a key and systematic component of ensuring patient engagement and goal attainment for post-acute settings; this measure will promote a standardized and continuous assessment of patient perceptions of pain and impact on quality of life.
		+ *Impact on quality of care for patients:*This measure will promote patient engagement and specifically ensuring care/treatment is delivered to address patient preferences and goal attainment.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
7. **Percent of Skilled Nursing Facility Residents Who Were Assessed and Appropriately Given the Influenza Vaccine** (MUC ID: MUC15-1132)
	* *Description:* The measure reports the percentage of skilled nursing facility residents who are assessed and appropriately given the seasonal influenza vaccine. (*The endorsed specifications of the measure are: The measure reports the percentage of residents or patients who are assessed and appropriately given the seasonal influenza vaccine.*)This measure includes residents or patients 180 days of age or older on target date of assessment in the denominator. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Version 1.2 assessments for Inpatient Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version 2.01 assessments of LTCH patients.Data are collected in each of these three settings using standardized items across the three assessment instruments. For the nursing homes/skilled nursing facilities, the measure is limited to short-stay residents, identified as residents who have had 100 or fewer days of nursing facility care. For the LTCHs, this measure will include all patients, irrespective of a patient’s length of stay. For IRFs, this measure will include all Medicare Part A and Part C patients, irrespective of a patient’s length of stay. This measure mirrors the NQF standard specifications that were developed to achieve a uniform approach to data collection across healthcare settings and populations by addressing who is included in and excluded from the target denominator population, who is included in and excluded from the numerator population, time window for measurement and time window for vaccinations. National Quality Forum. (2008, December).
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure addresses NQS priorities and contributes to overall PAC and SNF program goals of promoting preventive care to improve outcomes.
		+ *Impact on quality of care for patients:*Influenza is a significant contributor to morbidity and mortality in the target population, and evidence indicates substantial room for improvement in the delivery of vaccinations to prevent the condition.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 2:30 pm   | Opportunity for Public Comment on Measures Under Consideration for Skilled Nursing Facility Value-Based Purchasing Program |
|  |  |
| 2:45 pm   | Consent Calendar: Skilled Nursing Facility Value-Based Purchasing Program |
|  | Robyn Grant (Lead Discussants) |
|  | 1. **Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) (required by PAMA)** (MUC ID: MUC15-1048)
	* *Description:* All-condition risk-adjusted potentially preventable hospital readmission rates (required under PAMA)
	* *Programs under consideration:* Skilled Nursing Facility Value-Based Purchasing Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Outcome measures are considered of high-value for program implementation. In addition, this MUC meets a PAMA legislation mandate for the implementation of an outcome measure focusing on potentially preventable readmissions.
		+ *Impact on quality of care for patients:*Several analyses of hospital readmissions of SNF patients suggest there is opportunity for reducing hospital readmissions among SNF patients (Li et al., 2012; Mor et al., 2010), and multiple studies suggest SNF structural and process characteristics that impact readmission rates (Coleman et al., 2004; MedPAC 2011).
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 3:00 pm    | Break |
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| 3:15 pm   | Opportunity for Public Comment Measures on Under Consideration for Long-Term Care Hospital Reporting Program |
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| 3:30 pm   | Consent Calendar: Long-Term Care Hospital Quality Reporting Program |
|  | Sean Muldoon; Bruce Leff (Lead Discussants) |
|  | 1. **Compliance with Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial)) by Day 2 of the LTCH Stay** (MUC ID: MUC15-400)
	* *Description:* This measure assesses facility-level compliance with Spontaneous Breathing Trial (SBT), including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) breathing trial, by Day 2 of the LTCH stay for patients on invasive mechanical ventilation (IMV) support upon admission, and for whom at admission weaning attempts were expected or anticipated. Compliance is calculated and reported separately for the following two components: 1. the percentage of patients who were assessed for readiness for SBT (including TCT or CPAP breathing trial) by Day 2 of the LTCH stay, 2. the percentage of patients found ready for SBT (including TCT or CPAP breathing trial) for whom an SBT (including TCT or CPAP breathing trial) was performed by Day 2 of LTCH stay.
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure has high value potential for the progam measure set and can allow for better complaince with ventilator process elements during LTCH stay, improve patient safety, health outcomes, and decrease costs at the facility level.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to improve patient safety outcomes and decrease costs. This measure was reviewed by the MAP PAC/LTC Workgroup in the 2014-2015 Pre-rulemaking Cycle (#X3705). The workgroup encouraged this measure for continued development because it addresses an important patient safety priority for LTCHs. It is estimated that 25% of ventilated patients in LTCHs acquire ventilator-associated pneumonia. There is evidence for interventions developed to decrease incidence of ventilator-associated pneumonia and improve ventilator care. VAP and VAE are associated with substantial morbidity, mortality, and excess healthcare costs. Furthermore, during the public comment period, MAP received two comments in support of MAP's recommendation noting its importance to patient safety and suggesting that the measure be further developed with adjustment for sociodemographic status.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Percent of Patients Who Received an Antipsychotic (AP) Medication** (MUC ID: MUC15-530)
	* *Description:* This measure reports the percentage of patients in a Long Term Care Hospital who receive antipsychotic medications during the target period.
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Currently, there are not medication management measures in the LTCH QRP. This measure fills a significant gap area within a vulnerable population and is expected to reduce hospitalizations, adverse events related to medications, and improve health outcomes.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to promote medication management within the older adult population taking antipsychotic medications. This measure is intended to improve health outcomes and quality of care for patients in the LTCH setting.This measure is similar to a currently endorsed NQF measure: Antipsychotic Use in Persons with Dementia (#2111),a health plan Part D measure and consideration may be given to alignment/harmonization since these measures have congruent rationale.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
3. **Ventilator Weaning (Liberation) Rate** (MUC ID: MUC15-398)
	* *Description:* For patients admitted to an LTCH on invasive mechanical ventilation support and for whom weaning attempts were expected or anticipated at admission, this measure reports: (1) percentage of patients fully weaned at discharge (alive) (Ventilator Weaning/Liberation Rate), and (2) percentage of patients not fully weaned at discharge (alive).
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure has high value potential for the program because successful weaning is associated with decreased morbidity, mortality, and resource use.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to improve patient safety outcomes and decrease costs. This measure was reviewed by the MAP PAC/LTC Workgroup in the 2014-2015 Pre-rulemaking cycle. This measure addresses an important safety priority for LTCHs. MedPAC estimates that 16% of LTCH patients use ventilator services. Weaning is the process of decreasing the amount of support a patient receives from the ventilator. Furthermore, during the public comment period, MAP received two comments in support of MAP's recommendation noting its importance to patient safety and suggesting that the measure be further developed with adjustment for sociodemographic status.Additional impact data may be available from the CMS measure developer contractor for this measure, RTI, as noted in the MUC form.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 4:00 pm   | Opportunity for Public Comment on Measures Under Consideration for Home Health Quality Reporting Program  |
|  |  |
| 4:15 pm   | Consent Calendar: Home Health Quality Reporting Program  |
|  | E. Liza Greenberg; Lisa Winstel (Lead Discussants) |
|  | 1. **Falls risk composite process measure** (MUC ID: MUC15-207)
	* *Description:* Percentage of patients who were assessed for falls risk and whose care plan reflects the assessment and was implemented as appropriate.
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Falls among older people are high risk events associated with mortality, injury, and substantial amounts of health care resource use. A Cochrane review of 111 RCTs reports a 30% fall rate among community dwelling older people with evidence that multifactorial assessment and interventions reduce the rate of falls but not the risk of falls. Some studies demonstrated that both the risk of falls and rate of falls were reduced with certain interventions. <http://www.ncbi.nlm.nih.gov/pubmed/19370674>Another study shows that assessment and the adoption of strategies to prevent falls were effective. The Tinetti et al., (2008) study showed that the adoption of effective risk assessments and strategies for the prevention of falls (e.g., medication reduction and balance and gait training) produced an 11% reduction in serious fall in person over 70 yrs of age. The outcomes were rates of serious fall-related injuries (hip and other fractures, head injuries, and joint dislocations) and fall-related use of medical services per 1000 person-years among persons who were 70 years of age or older. One of the settings for this study was home health agencies. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3472807/pdf/nihms410481.pdf>
		+ *Impact on quality of care for patients:*This measure will encourage home health agencies to promote patient safety by conducting fall risk assessment and implementation of a plan of care to prevent falls for patients aged 65 or older. It will promote patient safety and potentially lower the number of falls and related complications.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Improvement in Dyspnea in Patients with a Primary Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and/or Asthma** (MUC ID: MUC15-235)
	* *Description:* Percentage of home health episodes of care during which a patient with a primary diagnosis of CHF, asthma and/or COPD became less short of breath or dyspneic.
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*Dyspnea is the subjective experience – of discomfort with breathing and is described as breathlessness. Dyspnea is a cardinal symptom of Chronic Obstructive Pulmonary Disease (COPD), as well as Heart Failure (HF) and Asthma. Although the underlying etiology for these diseases is different, research has shown that evidence-based practices can improve the patient’s ability to breath. Dyspnea for three disease groups is related to the previous measure 0179 -Improvement in Dyspnea interfering with activity. Dyspnea interfering with activity is an important health status indicator that impacts quality of life and substantially affects a patient’s ability to engage in a wide variety of activities. The etiology of dyspnea interfering with activity varies (disease-related and/or related to deconditioning from an extended time of limited activity like bedrest), but a high proportion of home health care patients are affected based on the data reported by home health care agencies where 70% of patients are reported as having some dyspnea interfering with activity.Dyspnea interfering with activity has been identified as a risk factor for hospitalization among Medicare home care patients in one large study (n = 922) of home health care <http://www.ncbi.nlm.nih.gov/pubmed/17099104>Research supports the benefits of beta-2 long and short acting agonists, anticholinergics broncodilators as well as other interventions that can improve the COPD patient’s shortness of breath. <http://www.goldcopd.org> For HF patients there are a number of strategies to improve the symptoms of HF including dyspnea. These include the ability to self- manage care, dietary restriction, daily weighing, exercise and medication adherence <http://www.ncbi.nlm.nih.gov/pubmed/17099104>
		+ *Impact on quality of care for patients:*Reporting of this measure is important for home health care patients. This symptom affects patients and can be debilitating. It can lead to frequent hospitalizations and poor quality of life. There has been improvement in this measure over time, suggesting that agencies are improving care for this outcome. There are number of best practice improvement packages developed by Home Health Quality Improvement (HHQI) in the scope of work focused on dyspnea and interventions to improve dyspnea.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 4:45 pm   | Public Comment |
|  |  |
| 4:55 pm   | Summary of Day |
|  | Carol Raphael, Workgroup Co-Chair; Debra Saliba, Workgroup Co-Chair  |
| 5:00 pm   | Adjourn  |
|  |  |
| **Day 2: December 15**   |  |
|  |  |
| 8:30 am    | Breakfast |
|  |  |
| 9:00 am    | Recap of Day 1 and Goals for Day 2 |
|  | Carol Raphael, Workgroup Co-Chair; Debra Saliba, Workgroup Co-Chair  |
| 9:15 am   | Opportunity for Public Comment on Measures Under Consideration for IMPACT ACT: Medicare Spending Per Beneficiary |
|  |  |
| 9:30 am   | Consent Calendar: IMPACT Act - Medicare Spending Per Beneficiary |
|  | Sarah Sampsel, NQF Consultant |
|  | 1. **Medicare Spending Per Beneficiary-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-1134)
	* *Description:* The MSPB-PAC Measure for HHAs evaluates providers’ efficiency relative to the efficiency of the national median HHA provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by the initiation of a 60 day HHA service period. The treatment period begins at the trigger and ends on the last day of the service period. The associated services period begins at the trigger and ends 30 days after the end of the treatment period. These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the HHA provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to HHA responsibilities (e.g., planned care and routine screening).
	* *Programs under consideration:* Home Health Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*The Medicare Spending Per Beneficiary is a measure that compares the cost for each episode per beneficiary of home health care with all other home health agencies. This measure could incentivize agencies to lower the cost of care per patient. Agencies could look for ways to standardize care and processes to ensure consistency of practices. It will be important to evaluate whether agencies “cherry pick” patients who have fewer needs for care.
		+ *Impact on quality of care for patients:*The potential impact is that patients may receive additional support, education and services to enable them to transition to the community and stay in the community without hospitalizations, emergency department use as well as admissions to SNFs and home health care.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
2. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-287)
	* *Description:* The MSPB-PAC Measure for IRFs evaluates providers’ efficiency relative to the efficiency of the national median IRF provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to an IRF stay. The treatment period begins at the trigger and ends at discharge. The associated services period begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the IRF provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to IRF responsibilities (e.g., planned care and routine screening).
	* *Programs under consideration:* Inpatient Rehabilitation Facility Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*The Medicare Spending per beneficiary measure assesses the cost to Medicare for services performed by PAC providers and other healthcare providers during an episode.This measure could incentivize providers to lower the cost of care per patient. Providers could look for ways to standardize care and processes to ensure consistency of practices. This measure would address an IMPACT Act requirement.
		+ *Impact on quality of care for patients:*The Medicare Payment Advisory Commission (MedPAC ) has found significant regional variation in post acute care spending. This measure would allow comparisons between providers and incent providers to lower costs.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
3. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-289)
	* *Description:* The MSPB-PAC Measure for LTCHs evaluates providers’ efficiency relative to the efficiency of the national median LTCH provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to an LTCH stay. The treatment period begins at the trigger and ends at discharge. The Measure is constructed differently for cases in which the LTCH stay is paid according to the standard MS-LTC-DRG versus cases in which the LTCH stay is paid a site neutral rate comparable to the IPPS payment rates. The associated services period for standard payment rate cases begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). The associated services period for site neutral payment rate cases begins at the close of the treatment period and ends 30 days after, to parallel the MSPB-Hospital measure. For the standard and site neutral cases, these periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. For the standard cases, the MSPB-PAC episode includes all services during the episode window that are attributable to the LTCH provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to LTCH responsibilities (e.g., planned care and routine screening). For the site neutral cases, the MSPB-PAC episode includes all services during the episode window that are attributable to the LTCH provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to LTCH responsibilities (e.g., planned care and routine screening). As discussed above, there is a difference in the construction of the associated services period for these cases, in that it only begins at discharge and ends 30 days after.
	* *Programs under consideration:* Long-Term Care Hospital Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*The potential value of this measure is to assess the level of health care costs in the MSPB-PAC population and increase alignment across high priority gap areas. This measure has the potential to identify the determining factors of high cost of health care and can lead to new efficiency measures that can result in reduced costs.
		+ *Impact on quality of care for patients:*The potential impact of this measure is to promote efficiency and reduce the cost of spending in the MSPB-PAC population.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
4. **Medicare Spending per Beneficiary-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program (Required under the IMPACT Act)** (MUC ID: MUC15-291)
	* *Description:* The MSPB-PAC Measure for SNFs evaluates providers’ efficiency relative to the efficiency of the national median SNF provider. Specifically, the MSPB-PAC Measure assesses the cost to Medicare for services during an episode of care, which consists of a treatment period and an associated services period. The episode is triggered by an admission to a SNF stay. The treatment period begins at the trigger and ends at discharge. The associated services period begins at the trigger and ends 30 days after the end of the treatment period (i.e., discharge). These periods constitute the episode window during which beneficiaries’ Medicare services are counted toward the episode. The MSPB-PAC episode includes all services during the episode window that are attributable to the SNF provider and those rendered by other providers, except those services during the associated services period that are clinically unrelated to SNF responsibilities (e.g., planned care and routine screening).
	* *Programs under consideration:* Skilled Nursing Facility Quality Reporting System
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*The potential value of this measure is to assess the level of health care costs in the MSPB-PAC population and increase alignment across high priority gap areas. This measure has the potential to identify the determining factors of high cost of health care and can lead to new efficiency measures that can result in reduced costs.
		+ *Impact on quality of care for patients:*The potential impact is that patients may receive additional support, education and services to enable them to transition to the community and stay in the community without hospitalizations, ED use as well as admissions to SNFs and home health care.
	* *Preliminary analysis result:* Encourage for continued development
	* *Notes:*
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| 10:30 am    | Break |
|  |  |
| 10:45 am   | Opportunity for Public Comment on Measures Under Consideration for Hospice Quality Reporting Program |
|  |  |
| 11:00 am    | Consent Calendar: Hospice Quality Reporting Program  |
|  | Margaret Terry, Senior Director, NQF |
|  | 1. **Hospice Visits When Death Is Imminent** (MUC ID: MUC15-227)
	* *Description:* This measure will assess hospice staff visits to patients and caregivers in the last week of life.
	* *Programs under consideration:* Hospice Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*This measure meets the priorities, needs and requirements of the HQRP. Process measures focused on assessment are generally many steps removed from relevant outcomes. However, there aren’t currently any measures in the program that are related to the assessment of hospice staff visits to patients and caregivers in the last week of life. This measure could be considered to fill a gap in that it adds to the relatively limited set if measures specific to this area.
		+ *Impact on quality of care for patients:*<http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx> NQF’s Framework for Preferred Practices for Palliative Care recommends that signs and symptoms of impending death are recognized, communicated and educated, and care appropriate for the phase of illness is provided. Assessing hopice staff visits in the last week of life can be linked to hospices more proactively checking on their patients, which creates better opportunities of recognizing signs of impending death, communicating and eduation about symptoms and providing appropriate care.
	* *Preliminary analysis result:* Encourage continued development
	* *Notes:*
2. **Hospice and Palliative Care Composite Process Measure** (MUC ID: MUC15-231)
	* *Description:* This measure will assess percentage of hospice patients who received care processes consistent with guidelines at admission. This is a composite measure based on select measures from 7 NQF-endorsed measures: NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617.
	* *Programs under consideration:* Hospice Quality Reporting Program
	* *Preliminary analysis summary*
		+ *Contribution to program measure set:*The inclusion of this measure in the Hospice Reporting Program will promote alignment with the existing measures and reduce redundancies in reporting. It provides an opportunity for the integration of multiple identified gap priority areas to be addressed and standardized.
		+ *Impact on quality of care for patients:*The measure will promote standardization of the collection and reporting of data prioritized by the hospice community to be of importance for the clinical treatment of hospice patients and recognition of hospice patient/family/caregiver goals.
	* *Preliminary analysis result:* Encourage Continued Development
	* *Notes:*
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| 11:30 am    | MAP PAC/LTC Core Concepts Discussion |
|  | Erin O’Rourke, Senior Project Manager, NQF  |
| 12:00 pm   | MAP PAC/LTC Measurement Gaps: IMPACT Act and Federal Programs  |
|  | Sarah Sampsel, NQF Consultant  |
| 12:30 pm   | Public Comment |
|  |  |
| 12:45 pm   | Summary of In Person Meeting and Next Steps |
|  | Carol Raphael, Workgroup Co-Chair; Debra Saliba, Workgroup Co-Chair  |
| 1:00 pm   | Adjourn and Lunch |
|  |  |