## Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup Discussion Guide

*Notes for Measure Deliberations*

*Web meeting date:* February 9, 2015

### Agenda

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| 3:30 pm | **Welcome, Introductions, and Review of Meeting Objectives** |
|  | * Carol Raphael, Workgroup Chair * Mitra Ghazinour, NQF |
| 3:40 pm | **MAP Off-Cycle Review Approach** |
|  | * Erin O'Rourke, NQF |
| 3:45 pm | **IMPACT ACT Reporting Requirements** |
|  | * Carol Raphael * Mitra Ghazinour * Erin O'Rourke |
| 3:55 pm | **CMS Approach to Standardizing Measures Under the IMPACT Act** |
|  | * Stace Mandl, CMS * Tara McMullen, CMS * Carol Raphael |
| 4:05 pm | **Input on Measures under Consideration** |
|  | Provide recommendations on measures under consideration |
|  | 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.  *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.  *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.  *Notes:* 4. **Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function** (MUC ID: S2637) *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.  *Notes:* |
|  | *Notes on Session:* |
| 5:15 pm | **Opportunity for Public Comment** |
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| 5:25 pm | **Next Steps** |
|  | * Carol Raphael |
| 5:30 pm | **Adjourn** |
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