## Measure Applications Partnership PAC/LTC Workgroup Discussion Guide

*Notes for Measure Deliberations*

*Version Number*: 5.1  
*Meeting Date:* December 14-15, 2016

## Full Agenda

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| **Day 1** |  |
|  |  |
| 8:30 am | Breakfast |
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| 9:00 am | Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives |
|  | Gerri Lamb, Workgroup Co-Chair Debra Saliba, Workgroup Co-Chair Sarah Sampsel, Senior Director, NQF Jean-Luc Tilly, Project Manager, NQF Mauricio Menendez, Project Analyst, NQF Ann Hammersmith, General Counsel, NQF |
| 9:15 am | CMS Opening Remarks |
|  | Alan Levitt, CMS |
| 9:30 am | NQF Strategic Plan |
|  | Helen Burstin, Chief Scientific Officer, NQF |
| 9:45 am | MAP Pre-Rulemaking Approach and Voting Instructions |
|  | Jean-Luc Tilly, Project Manager, NQF |
| 10:15 am | Break |
|  |  |
| 10:30 am | Hospice Quality Reporting Program (HQRP) • Overview of the HQRP (10 minutes) • Opportunity for Public Comment: Measures under Consideration and Program Measure Set (15 minutes) • Pre-Rulemaking Input: HQRP Measures Under Consideration Consent Calendar (30 minutes) • Current Measure Review and Discussion: HQRP |
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|  | Programs under consideration: Hospice Quality Reporting Program |
|  | 1. **CAHPS Hospice Survey: Getting Emotional and Spiritual Support** (MUC ID: MUC16-037)    * *Description:* Multi-item measure P1: “While your family member was in hospice care, how much emotional support did you get from the hospice team?” P2: “In the weeks after your family member died, how much emotional support did you get from the hospice team?” P3: “Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?” (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the experiences of hospice patients and their primary caregivers.The measures proposed here include the following six multi-item measures.•Hospice Team Communication•Getting Timely Care•Treating Family Member with Respect•Getting Emotional and Religious Support•Getting Help for Symptoms•Getting Hospice TrainingIn addition, there are two other measures, also called “global ratings.”•Rating of the hospice care•Willingness to recommend the hospiceBelow we list each multi-item measure and its constituent items, along with the two ratings questions. Then we briefly provide some general background information about CAHPS surveys.List of CAHPS Hospice Survey MeasuresMulti-Item MeasuresHospice Team Communication (Composed of 6 items)+While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?+While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?+How often did the hospice team listen carefully to you when you talked with them about problems with your family member’s hospice care?+While your family member was in hospice care, how often did the hospice team keep you informed about your family member’s condition?+While your family member was in hospice care, how often did the hospice team listen carefully to you?+While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member’s condition or care?Getting Timely Care (Composed of 2 items)+While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?+How often did you get the help you needed from the hospice team during evenings, weekends, or holidays? 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The survey is completed by the primary caregiver of the patient who died while receiving hospice care (hereafter, “decedent”). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent’s hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent’s death.The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hospice/index.html. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a “dry run” for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available at: http://www.hospicecahpssurvey.org/.A list of the CAHPS Hospice Survey measures, including the components of the multi-item measures can be found in Appendix A.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Although the CAHPS Hospice Survey is currently incorporated in the Hospice Quality Reporting Program, this measure allows greater precision in performance evaluation by breaking out an individual survey item into a performance measure. Eight new performance measures are proposed to add to the aggregate Hospice CAHPS measure. In addition, inclusion of the CAHPS Hospice metrics supports the National Quality Strategy and goals of the Affordable Care Act for greater focus on person and family centered care.      + *Impact on quality of care for patients:*Measuring performance on how patients and family caregivers perceive their emotional and spiritual needs to have been met allows hospices to evaluate their progress on this dimension of care unique to the setting. While the existing measure set includes assessments of symptom management and respect for treatment preferences, many other aspects of hospice care exist that are not captured by individual measures. The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 2. **CAHPS Hospice Survey: Getting Help for Symptoms** (MUC ID: MUC16-039)    * *Description:* Multi-item measure P1: “Did your family member get as much help with pain as he or she needed?” P2: “How often did your family member get the help he or she needed for trouble breathing?” P3: “How often did your family member get the help he or she needed for trouble with constipation?” P4: “How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness?” (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. 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The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 3. **CAHPS Hospice Survey: Getting Hospice Care Training** (MUC ID: MUC16-035)    * *Description:* Multi-item measure P1: Did the hospice team give you the training you needed about what side effects to watch for from pain medication? P2: Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member? P3: Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing? P4: Did the hospice team give you the training you needed about what to do if your family member became restless or agitated? P5: Side effects of pain medicine include things like sleepiness. 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The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 4. **CAHPS Hospice Survey: Getting Timely Care** (MUC ID: MUC16-036)    * *Description:* Multi-item measure P1: “While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?” P2: “How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?” (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. 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While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?Getting Help for Symptoms (Composed of 4 items)+Did your family member get as much help with pain as he or she needed?+How often did your family member get the help he or she needed for trouble breathing? +How often did your family member get the help he or she needed for trouble with constipation?+How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness?Getting Hospice Care Training (Composed of 5 items)+Did the hospice team give you enough training about what side effects to watch for from pain medicine? +Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?+Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?+Did the hospice team give you the training you needed about what to do if your family member became restless or agitated? +Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with your or your family member?Rating Measures:In addition to the multi-item measures, there are two “global” ratings measures. These single-item measures indicate on the one hand the need for quality improvement and on the other hand provide families and patients looking for care with evaluations of the care provided by the hospice. The items are rating of hospice care and willingness to recommend the hospice.+Rating of Hospice Care: Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?+Willingness to Recommend Hospice: Would you recommend this hospice to your friends and family?The CAHPS Hospice Survey is a standardized survey instrument designed to collect reports and ratings of experiences with hospice care. The survey is completed by the primary caregiver of the patient who died while receiving hospice care (hereafter, “decedent”). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent’s hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent’s death.The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hospice/index.html. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a “dry run” for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available at: http://www.hospicecahpssurvey.org/.A list of the CAHPS Hospice Survey measures, including the components of the multi-item measures can be found in Appendix A)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Although the CAHPS Hospice Survey is currently incorporated in the Hospice Quality Reporting Program, this measure allows greater precision in performance evaluation by breaking out an individual survey item into a performance measure. Eight new performance measures are proposed to add to the aggregate Hospice CAHPS measure. In addition, inclusion of the CAHPS Hospice metrics supports the National Quality Strategy and goals of the Affordable Care Act for greater focus on person and family centered care.      + *Impact on quality of care for patients:*Measuring performance on how hospice staff communicate with patients and family caregivers allows hospices to evaluate their approach to patient care. While the existing measure set includes assessments of symptom management and respect for treatment preferences, many other aspects of hospice care exist that are not captured by individual measures. The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 6. **CAHPS Hospice Survey: Rating of Hospice** (MUC ID: MUC16-031)    * *Description:* Individual survey item asking respondents: "Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?" 0-10 rating scale with 0=Worst hospice care possible and 10=Best hospice care possible (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the experiences of hospice patients and their primary caregivers.The measures proposed here include the following six multi-item measures.•Hospice Team Communication•Getting Timely Care•Treating Family Member with Respect•Getting Emotional and Religious Support•Getting Help for Symptoms•Getting Hospice TrainingIn addition, there are two other measures, also called “global ratings.”•Rating of the hospice care•Willingness to recommend the hospiceBelow we list each multi-item measure and its constituent items, along with the two ratings questions. 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The survey is completed by the primary caregiver of the patient who died while receiving hospice care (hereafter, “decedent”). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent’s hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent’s death.The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hospice/index.html. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a “dry run” for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available at: http://www.hospicecahpssurvey.org/.A list of the CAHPS Hospice Survey measures, including the components of the multi-item measures can be found in Appendix A.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Although the CAHPS Hospice Survey is currently incorporated in the Hospice Quality Reporting Program, this measure allows greater precision in performance evaluation by breaking out an individual survey item into a performance measure. Eight new performance measures are proposed to add to the aggregate Hospice CAHPS measure. In addition, inclusion of the CAHPS Hospice metrics supports the National Quality Strategy and goals of the Affordable Care Act for greater focus on person and family centered care.      + *Impact on quality of care for patients:*Measuring performance on how patients and family caregivers rate their experience with care allows hospices to gain a holistic sense of their performance. While the existing measure set includes assessments of symptom management and respect for treatment preferences, many other aspects of hospice care exist that are not captured by individual measures. The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 7. **CAHPS Hospice Survey: Treating Family Member with Respect** (MUC ID: MUC16-040)    * *Description:* Multi-item measure P1: “While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?” P2: “While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member? (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the experiences of hospice patients and their primary caregivers.The measures proposed here include the following six multi-item measures.•Hospice Team Communication•Getting Timely Care•Treating Family Member with Respect•Getting Emotional and Religious Support•Getting Help for Symptoms•Getting Hospice TrainingIn addition, there are two other measures, also called “global ratings.”•Rating of the hospice care•Willingness to recommend the hospiceBelow we list each multi-item measure and its constituent items, along with the two ratings questions. 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In addition, inclusion of the CAHPS Hospice metrics supports the National Quality Strategy and goals of the Affordable Care Act for greater focus on person and family centered care.      + *Impact on quality of care for patients:*Measuring performance on whether family caregivers felt they were treated with respect allows hospices to evaluate whether they are effectively engaging family caregivers as partners in care. While the existing measure set includes assessments of symptom management and respect for treatment preferences, many other aspects of hospice care exist that are not captured by individual measures. The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* 8. **CAHPS Hospice Survey: Willingness to Recommend** (MUC ID: MUC16-033)    * *Description:* Individual survey item asking respondents: “Would you recommend this hospice to your friends and family?” (The endorsed specifications of the measure are: The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the experiences of hospice patients and their primary caregivers.The measures proposed here include the following six multi-item measures.•Hospice Team Communication•Getting Timely Care•Treating Family Member with Respect•Getting Emotional and Religious Support•Getting Help for Symptoms•Getting Hospice TrainingIn addition, there are two other measures, also called “global ratings.”•Rating of the hospice care•Willingness to recommend the hospiceBelow we list each multi-item measure and its constituent items, along with the two ratings questions. 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The survey is completed by the primary caregiver of the patient who died while receiving hospice care (hereafter, “decedent”). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent’s hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent’s death.The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hospice/index.html. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a “dry run” for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available at: http://www.hospicecahpssurvey.org/.A list of the CAHPS Hospice Survey measures, including the components of the multi-item measures can be found in Appendix A.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Although the CAHPS Hospice Survey is currently incorporated in the Hospice Quality Reporting Program, this measure allows greater precision in performance evaluation by breaking out an individual survey item into a performance measure. Eight new performance measures are proposed to add to the aggregate Hospice CAHPS measure. In addition, inclusion of the CAHPS Hospice metrics supports the National Quality Strategy and goals of the Affordable Care Act for greater focus on person and family centered care.      + *Impact on quality of care for patients:*Measuring performance on whether patients and family caregivers would recommend the hospice allows facilities to gain a holistic sense of their performance. While the existing measure set includes assessments of symptom management and respect for treatment preferences, many other aspects of hospice care exist that are not captured by individual measures. The CAHPS Hospice measures support the National Quality Aim for Better Care, and the Priority of ensuring that each person and family is engaged as partners in their care.    * *Preliminary analysis result:* Support    * *Notes:* |
| 11:20 am | Long-Term Care Hospital Quality Reporting Program (LTCH QRP) • Overview of the LTCH QRP (10 minutes) • Opportunity for Public Comment: Measures under Consideration and Program Measure Set (15 minutes) |
|  |  |
| 11:50 am | Lunch |
|  |  |
| 12:35 pm | Pre-Rulemaking Input: LTCH QRP Measures Under Consideration Consent Calendar (30 minutes) • Feedback on Current LTCH QRP Measure Set |
|  |  |
|  | Programs under consideration: Long-Term Care Hospital Quality Reporting Program |
|  | 1. **Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-144)    * *Description:* This quality measure reports the percent of LTCH patient stays with Stage 2-4 or unstageable pressure ulcers that are new or worsened since admission (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Pressure ulcers are recognized as a serious medical condition. Considerable evidence exists regarding the seriousness of pressure ulcers, and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations (Casey, 2013; Gorzoni and Pires, 2011; Thomas et al., 2013; Wuite-Chu, et al., 2011). Pressure ulcers interfere with activities of daily living and functional gains made during rehabilitation, predispose patients to osteomyelitis and septicemia, and are strongly associated with longer hospital stays, longer IRF stays, and mortality (Bates-Jensen, 2001; Park-Lee and Caffrey, 2009; Wang, et al., 2014). The measure offers the opportunity for monitoring of pressure ulcer incidence and prevelance and thus can identify where quality improvement efforts might be implemented or strengthened.      + *Impact on quality of care for patients:*The National Pressure Ulcer Advisory Panel (NPUAP) considers the vast majority of pressure ulcers to be preventable or minimized with appropriate identification and mitigation of risk factors. NPUAP recommends prevention through risk assessment, skin care, nutrition, repositioning and mobilization, and education. If pressure ulcers are identified and mitigated, there should be a resulting decrease in morbidity and mortality.    * *Preliminary analysis result:* Support for Rulemaking    * *Notes:* 2. **Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings** (MUC ID: MUC16-321)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the previous provider/home at admission or the start/resumption of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the subsequent provider/home.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* 3. **Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings** (MUC ID: MUC16-327)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the PAC provider to the subsequent provider/home at discharge or end of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the next.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*The transfer of information between settings at PAC discharge is part of a paired set of measures that assesses transitions of care at admission and discharge as patients move between care settings. The measure addresses care coordination, a key leverage area identified for the PAC/LTC settings.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* |
| 1:35 pm | Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) • Overview of the IRF QRP (10 minutes) • Opportunity for Public Comment: Measures under Consideration and Program Measure Set (15 minutes) • Pre-Rulemaking Input: IRF QRP Measures Under Consideration Consent Calendar (30 minutes) • Feedback on Current IRF QRP Measure Set |
|  |  |
|  | Programs under consideration: Inpatient Rehabilitation Facility Quality Reporting Program |
|  | 1. **Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-143)    * *Description:* This quality measure reports the percent of IRF patient stays with Stage 2-4 or unstageable pressure ulcers that are new or worsened since admission (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Pressure ulcers are recognized as a serious medical condition. Considerable evidence exists regarding the seriousness of pressure ulcers, and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations (Casey, 2013; Gorzoni and Pires, 2011; Thomas et al., 2013; Wuite-Chu, et al., 2011). Pressure ulcers interfere with activities of daily living and functional gains made during rehabilitation, predispose patients to osteomyelitis and septicemia, and are strongly associated with longer hospital stays, longer IRF stays, and mortality (Bates-Jensen, 2001; Park-Lee and Caffrey, 2009; Wang, et al., 2014). The measure offers the opportunity for monitoring of pressure ulcer incidence and prevelance and thus can identify where quality improvement efforts might be implemented or strengthened.      + *Impact on quality of care for patients:*The National Pressure Ulcer Advisory Panel (NPUAP) considers the vast majority of pressure ulcers to be preventable or minimized with appropriate identification and mitigation of risk factors. NPUAP recommends prevention through risk assessment, skin care, nutrition, repositioning and mobilization, and education. If pressure ulcers are identified and mitigated, there should be a resulting decrease in morbidity and mortality.    * *Preliminary analysis result:* Support for Rulemaking    * *Notes:* 2. **Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings** (MUC ID: MUC16-319)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the previous provider/home at admission or the start/resumption of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the subsequent provider/home.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* 3. **Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings** (MUC ID: MUC16-325)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the PAC provider to the subsequent provider/home at discharge or end of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the next.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* |
| 2:35 pm | Break |
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| 2:45 | Home Health Quality Reporting Program (HH QRP) • Overview of the HH QRP (10 minutes) • Opportunity for Public Comment: Measures under Consideration and Program Measure Set (15 minutes) • Pre-Rulemaking Input: HH QRP Measures Under Consideration Consent Calendar (30 minutes) • Feedback on Current HH QRP Measure Set |
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|  | Programs under consideration: Home Health Quality Reporting Program |
|  | 1. **The Percent of Home Health Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function** (MUC ID: MUC16-061)    * *Description:* This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident. (The endorsed specifications of the measure are: This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*In addition to satisfying a requirement of the IMPACT Act, this MUC promotes the importance of using standardized functional assessment items across PAC populations. Whether a patient is discharged to home or to another care setting for continuing healthcare, the patient’s functional status is an important aspect of a person’s health status to document at the time of the transition.      + *Impact on quality of care for patients:*This quality measure offers the opportunity to inform providers about opportunities to improve care related to functional status and level of support needed and strengthen incentives for quality improvement. In addition, it should assist with improving care transitions and care coordination across settings of care.    * *Preliminary analysis result:* Conditional Support for Rulemaking    * *Notes:* 2. **The Percent of Home Health Residents Experiencing One or More Falls with Major Injury** (MUC ID: MUC16-063)    * *Description:* This quality measure reports the percentage of patients/residents who experience one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) during the Home Health episode. (The endorsed measure specifications are: This measure reports the percentage of residents who have experienced one or more falls with major injury during their episode of nursing home care ending in the target quarter (3-month period). Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury. Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Treating fall injuries is very costly. In 2015, costs for falls to Medicare alone totaled over $31 billion. Because the U.S. population is aging, both the number of falls and the costs to treat fall injuries are likely to rise. In addition to satisfying a requirement of the IMPACT Act, incorporating this measure into the Home Health Quality Reporting Program will measure a critical driver of patient safety and cost burden. Moreover, the measure aligns with other reporting programs that evaluate post-acute and long-term care settings. Falls are prevalent among community-dwelling older adults and a major source of morbidity and mortality. (source: http://www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html, accessed 11/21/2016)      + *Impact on quality of care for patients:*The current population of older adults (i.e., greater than 65) in the United States is increasing rapidly due to medical advancements and longer life expectancies. Along with this increase in population, the incidence of fall-related injuries and hospitalizations is also rising. In adults over the age of 65, approximately 30% of individuals experience a fall annually (Avin et al., 2015). Using data from the Web-based Injury Statistics Query and Reporting System, a study conducted by Orces and Alamgir (2014) found that fall-related hospitalization rates among the same population were increasing as well by 4% per year. If this increase remains constant, the number of fall-related injuries may increase from 2.4 million in 2012 to 5.7 million by the year 2030 (Orces & Alamgir, 2014). A likely contributor to this rapid escalation is that the annual rate of falls increases by 50 percent among individuals who are over 80 years old—the fastest growing age segment of adults (Grundstrom, 2012; Orces, 2013). Falls during home health episodes that result in major injuries have not been widely studied in the Medicare population. Home health care services, however, are a growing medical trend due to the convenience and associated cost savings of receiving health care at home. The adoption of effective fall prevention interventions by home health agencies may therefore provide patients with more focused care and avoid preventable falls, resulting in lower overall costs to the Medicare program (Bamgbade & Dearmon, 2016).1.Avin, G. K., Hanke, A. T., Kirk-Sanche, N., McDonough, M. C., Shubert, E. T., Hardage, J., & Hartley, G. (2015). Management of falls in community-dwelling older adults: clinical guidance statement from the Academy of Geriatric Physical Therapy of the American Physical Therapy Association. Physical Therapy, 95(6), 815–8342.Bamgbade, S., & Dearmon, V. (2016). Fall prevention for older adults receiving home healthcare. Home Healthcare Now, 34(2), 68-75. 3.Grundstrom, A. C., Guse, C. E., & Layde, P. M. (2012). Risk factors for falls and fall-related injuries in adults 85 years of age and older. Archives of Gerontology and Geriatrics, 54: 421-428.4.Orces, C. H. (2013). Emergency department visits for fall-related fractures among older adults in the USA: a retrospective cross-sectional analysis of the National Electronic Injury Surveillance System All Injury Program, 2001-2008. BMJ Open, 3:e001722. doi:10.1136/bmjopen-2012-0017225.Orces, C. H. & Alamgir, H. (2014). Trends in fall-related injuries among older adults treated in emergency departments in the USA. Injury Prevention, 20: 421-423.    * *Preliminary analysis result:* Conditional Support for Rulemaking    * *Notes:* 3. **The Percent of Residents or Home Health Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-145)    * *Description:* This quality measure reports the percent of Home Health patient episodes with Stage 2-4 or unstageable pressure ulcers that are new or worsened since Start of Care (SOC) or Resumption of Care (ROC). (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Pressure ulcers are recognized as a serious medical condition. Considerable evidence exists regarding the seriousness of pressure ulcers, and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations (Casey, 2013; Gorzoni and Pires, 2011; Thomas et al., 2013; Wuite-Chu, et al., 2011). Pressure ulcers interfere with activities of daily living and functional gains made during rehabilitation, predispose patients to osteomyelitis and septicemia, and are strongly associated with longer hospital stays, longer IRF stays, and mortality (Bates-Jensen, 2001; Park-Lee and Caffrey, 2009; Wang, et al., 2014). The measure offers the opportunity for monitoring of pressure ulcer incidence and prevelance and thus can identify where quality improvement efforts might be implemented or strengthened.      + *Impact on quality of care for patients:*The National Pressure Ulcer Advisory Panel (NPUAP) considers the vast majority of pressure ulcers to be preventable or minimized with appropriate identification and mitigation of risk factors. NPUAP recommends prevention through risk assessment, skin care, nutrition, repositioning and mobilization, and education. If pressure ulcers are identified and mitigated, there should be a resulting decrease in morbidity and mortality.    * *Preliminary analysis result:* Support for Rulemaking    * *Notes:* 4. **Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings** (MUC ID: MUC16-347)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the previous provider/setting at admission or the start/resumption of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the subsequent provider/setting.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* 5. **Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings** (MUC ID: MUC16-357)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the PAC provider to the subsequent provider/provider at discharge or end of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the next.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* |
| 4:00 pm | Skilled Nursing Quality Reporting Program (SNF QRP) • Overview of the SNF QRP (10 minutes) • Opportunity for Public Comment: Measures under Consideration and Program Measure Set (15 minutes) • Pre-Rulemaking Input: SNF QRP Measures Under Consideration Consent Calendar (30 minutes) • Feedback on Current SNF QRP Measure Set |
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|  | Programs under consideration: Skilled Nursing Facility Quality Reporting Program |
|  | 1. **Application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)** (MUC ID: MUC16-142)    * *Description:* This quality measure reports the percent of SNF resident Part A stays with Stage 2-4 or unstageable pressure ulcers that are new or worsened since admission (The endorsed measure specifications are: This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcer(s) that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments ofSkilled Nursing Facility (SNF) / nursing home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients and the the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcer(s) that were not present or were at a lesser stage on admission.Of note, data collection and measure calculation for this measure is conducted and reported separately for each of the three provider settings and will not be combined across settings. For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.)    * *Preliminary analysis summary*      + *Contribution to program measure set:*Pressure ulcers are recognized as a serious medical condition. Considerable evidence exists regarding the seriousness of pressure ulcers, and the relationship between pressure ulcers and pain, decreased quality of life, and increased mortality in aging populations (Casey, 2013; Gorzoni and Pires, 2011; Thomas et al., 2013; Wuite-Chu, et al., 2011). Pressure ulcers interfere with activities of daily living and functional gains made during rehabilitation, predispose patients to osteomyelitis and septicemia, and are strongly associated with longer hospital stays, longer IRF stays, and mortality (Bates-Jensen, 2001; Park-Lee and Caffrey, 2009; Wang, et al., 2014). The measure offers the opportunity for monitoring of pressure ulcer incidence and prevelance and thus can identify where quality improvement efforts might be implemented or strengthened.      + *Impact on quality of care for patients:*The National Pressure Ulcer Advisory Panel (NPUAP) considers the vast majority of pressure ulcers to be preventable or minimized with appropriate identification and mitigation of risk factors. NPUAP recommends prevention through risk assessment, skin care, nutrition, repositioning and mobilization, and education. If pressure ulcers are identified and mitigated, there should be a resulting decrease in morbidity and mortality.    * *Preliminary analysis result:* Support for Rulemaking    * *Notes:* 2. **Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings** (MUC ID: MUC16-314)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the previous provider/home at admission or the start/resumption of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the subsequent provider/home.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* 3. **Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings** (MUC ID: MUC16-323)    * *Description:* The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the PAC provider to the subsequent provider/home at discharge or end of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the next.    * *Preliminary analysis summary*      + *Contribution to program measure set:*When care transitions are enhanced through care coordination activities such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, 2010) and prevent readmissions and medical errors (Institute of Medicine Committee on Identifying and Preventing Medication Errors, 2010; Starmer et al, 2014; Verhaegh et al, 2015). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between transferring and receiving providers. (AHRQ, 2016, Murray & Laditka, 2010; LaMantia et al, 2010; Verhaegh et al, 2015). In a systematic review of interventions to improve transitional care between nursing homes and hospitals, a standardized patient transfer form was found to facilitate communication of advance directives and medication reconciliation (LaMantia et al, 2010).      + *Impact on quality of care for patients:*Transfer forms, continuity of care forms, and other types of forms are among the tools used by hospitals and PAC providers to communicate and transfer information at transitions. Medicare sets standards for discharge planning for hospitals and PAC settings. Some states set minimum data standards including required information to be sent at care transitions/transfers. Despite these standards, there is limited information about the types of information transferred by and to PAC providers at transitions and the methods (e.g., paper-based, verbal, and electronic) used to transfer this information. Increasingly information exchange with and by PAC is recognized as necessary to improve quality and coordination care and reduce unnecessary costs. This quality measure will help CMS to better understand and monitor how patient or resident health information is transferred between PAC, acute care, home, and community settings during transitions.    * *Preliminary analysis result:* Refine and Resubmit Prior to Rulemaking    * *Notes:* |
| 4:45 pm | Summary of Day |
|  | Gerri Lamb, Workgroup Co-Chair Debra Saliba, Workgroup Co-Chair |
| 5:00 pm | Opportunity for Public Comment |
|  |  |
| 5:15 pm | Adjourn |
|  |  |
| **Day 2** |  |
|  |  |
| 8:30 am | Breakfast |
|  |  |
| 9:00 am | Recap of Day 1 and Goals for Day 2 |
|  | Gerri Lamb, Workgroup Co-Chair Debra Saliba, Workgroup Co-Chair |
| 9:15 am | The PROMIS Tool Overview and Discussion |
|  | Ashely Wilder Smith, NIH |
| 10:15 am | Break |
|  |  |
| 10:30 am | Skilled Nursing Facility Value Based Purchasing Program (SNF VBP) • Overview of the SNF VBP (10 minutes) • Opportunity for Public Comment: Program Measure Set (15 minutes) • Feedback on Current SNF VBP Measure Set |
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| 11:15 am | Opportunity for Public Comment |
|  |  |
| 11:30 am | Summary of In-Person Meeting and Next Steps |
|  | Gerri Lamb, Workgroup Co-Chair Debra Saliba, Workgroup Co-Chair Jean-Luc Tilly, Project Manager, NQF |
| 11:45 am | Adjourn & Lunch |
|  |  |