Geriatrics and Palliative Care, Spring 2019 Review Cycle: CDP Report

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Executive Summary

Factors including the aging U.S. population, the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations, and increases in ethnic and cultural diversity, have intensified the importance of improving the quality of palliative and end-of-life care, and geriatric care, with an emphasis on the need for individualized, person-centered care. To date, the National Quality Forum (NQF) has endorsed more than 30 measures that address geriatric care, palliative care, and end-of-life care. These measures address physical, spiritual, and legal aspects of care, as well as the care of patients nearing the end of life.

During its spring 2019 evaluation cycle, NQF's Geriatrics and Palliative Care Standing Committee evaluated two new geriatrics measures against NQF's standard evaluation criteria and recommended both measures for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Committee's decision to recommend the measures for endorsement. The two endorsed measures are:

- 3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients
- 3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

The body of this report summarizes the measures evaluated in this cycle. Appendix A provides detailed summaries of the Committee's discussion and ratings of the criteria for each measure.

Introduction

Improving the quality of both palliative and end-of-life care, and geriatric care more generally, is becoming increasingly important due to factors that have intensified the need for individualized, person-centered care. Some of these factors include the aging U.S. population; the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations; and increases in ethnic and cultural diversity.[1] In 2018, the 65 and older population numbered 50.9 million individuals (15.6 percent of the U.S. population), and this figure is expected to increase to 94.7 million by 2060.[2] As many as 35 percent of older Americans have some type of disability (e.g., vision, hearing, ambulation, cognition), while 46 percent of those 75 and over report limitations in physical functioning.[3] Additionally, data indicate that 46 percent of the noninstitutionalized U.S. population age 65 or older have two or three chronic conditions, and 15 percent have four or more.[4]

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering throughout the continuum of a person's illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.[5] Palliative care is holistic, thus requiring an interdisciplinary, team-based approach to care. With its focus on improving quality of life, palliative care is distinct from care intended to cure an illness or condition, although it can be delivered concurrently with curative therapies, and can begin at any point in the disease progression. It can be provided in any setting, including outpatient care settings and at home.

Although palliative care is still provided primarily by specially trained teams of professionals in hospitals and through hospice, there is increased focus on provision of palliative care in the community,[6] often by clinicians who are not palliative care specialists. The provision of palliative care has been shown to increase patient and family satisfaction with care,[7] reduce emergency department visits, hospital admissions, and hospital readmissions,[8] and decrease costs to the healthcare system.[9,10] However, access to hospital-based specialty palliative care continues to vary by hospital size and location, and even when programs are available, not all patients who could benefit actually receive those services.[11]

Palliative care is appropriate for those who are expected to recover, as well as for those who have chronic, progressive, and/or terminal illness. For those with a terminal illness, high-quality end-of-life care is comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of illness.[12] Much end-of-life care is palliative, when life-prolonging interventions are no longer appropriate, effective, or desired.[13] Thus, for patients nearing the end of life, there often will be a greater emphasis on palliative care over curative treatment. In many instances, this care is provided in the form of hospice.

Hospice is a service delivery system that relies on an interdisciplinary approach that emphasizes symptom management for patients near the end of life. While hospice care is covered through Medicaid and most private insurance plans, approximately 85 percent of hospice enrollees receive coverage through the Medicare hospice benefit.[14] Almost 1.5 million Medicare beneficiaries and their families received hospice care in 2017.[15] For these individuals, the average length of stay was 76.1 days; however, the median length of stay was only 24 days, meaning that many enrolled in hospice too late to

fully realize the benefits of the program.[16] Beginning in 2014, Medicare-certified hospices were required to report performance on quality measures as part of the Hospice Quality Reporting Program; those not reporting face a reduction in payments from Medicare. Performance rates for these measures are publicly reported on the Centers for Medicare and Medicaid Services (CMS) Hospice Compare website.[17]

Since 2006, when it first developed a measurement framework for palliative and end-of-life care and endorsed 38 evidence-based preferred practices for high-quality palliative care programs,[18] NQF has endorsed more than 30 measures in this topic area, many of which currently are used in federal quality improvement and public reporting programs.

In 2017, NQF expanded the scope of the Standing Committee charged with the oversight of the palliative and end-of-life care measures portfolio by adding measures specifically relevant to older adults (i.e., the geriatric population). Several previously seated and new members of this renamed "Geriatrics and Palliative Care Standing Committee" are geriatric healthcare professionals. Thus, the Committee has the requisite expertise to assume oversight of measures that focus on key issues specific to older adults, such as multimorbidity and frailty. At present, measures specifically relevant to the geriatric population remain aspirational. Thus, for the time-being, the geriatrics measures evaluated by this Committee include setting-specific measures that primarily affect older individuals and are either not condition-specific or cannot be evaluated by other topic-based committees due to capacity issues. Examples of such measures include those that assess care provided by home health agencies or other home-based care providers.

NQF Portfolio of Performance Measures for Geriatrics and Palliative Care

The Geriatrics and Palliative Care Standing Committee (Appendix C) oversees NQF's portfolio of Geriatrics and Palliative Care measures (Appendix B). This portfolio contains 36 measures: 18 process measures, 17 outcome measures, and one composite measure (see table below).

Table 1. NQF Geriatrics and Palliative Care Portfolio of Measures

	Process	Outcome	Composite
Palliative/End-of-Life Care			
Physical Aspects of Care	9	–	–
Psychological and Psychiatric Aspects of Care	–	–	–
Social Aspects of Care	–	–	–
Spiritual, Religious, and Existential Aspects of Care	1	–	–
Cultural Aspects of Care	–	–	–
Care of the Patient Nearing the End of Life	3	12	1
Ethical and Legal Aspects of Care	3	–	–
Geriatrics	2	5	–
Total	18	17	1

Some of the measures in the Geriatrics and Palliative Care portfolio will be evaluated by other NQF standing committees. These include a cultural communication measure (Patient Experience and Function Committee) and pain measures for cancer patients (Cancer Committee).

Geriatrics and Palliative Care Measure Evaluation

On June 18, 2019, the Geriatrics and Palliative Care Standing Committee evaluated two new measures against NQF's standard evaluation criteria.

Table 2. Geriatrics and Palliative Care Measure Evaluation Summary, Spring 2019

	Maintenance	New	Total
Measures under consideration	0	2	2
Measures endorsed	0	2	2

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation commenting period opened on May 8, 2019 and closed on June 1, 2019. NQF did not receive any comments on the measures during this period.

Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on September 6, 2019. Following the Committee's evaluation of the measures under review, NQF received five comments from two NQF member organizations and two members of the public. All comments for each measure under review have been summarized in Appendix A. Comments included support for the measures, concern about the 90-day denominator exception for new patients, and suggestions to broaden the target population and data source specified in the measures.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. However, no NQF members provided an expression of support for the measures evaluated in this cycle.

Overarching Issues

The Committee did not identify any overarching issues related to the two measures under endorsement consideration.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

3497 Evaluation of Function Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients (Johns Hopkins/American Academy of Home Care Medicine): Endorsed

Description: Percentage of actively enrolled home-based primary care and palliative care patients who receive an ADL and IADL assessment; **Measure Type**: Process; **Level of Analysis**: Clinician-Individual; **Setting of Care**: Home Care, Other; **Data Source**: Registry Data

Data from the CMS Independence at Home Demonstration indicate that poor functional status is highly prevalent in the home-bound population and is a major contributor to the high costs of care that are associated with multimorbidity in those with chronic illness. This new process measure focuses on whether providers evaluate the functional status (i.e., basic and instrumental activities of daily living) of their home-based primary care and palliative care patients.

The Committee agreed that functional status assessments are included in comprehensive geriatric assessments (CGAs), and therefore, the literature linking CGAs to reductions in long-term care admissions provides evidence to support this measure. The Committee also suggested that results from the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) program (Szanton, et al., 2016) provide additional support for this measure. Committee members agreed that the wide variation in performance on the measure, which ranged from 16 percent to 93 percent across 221 participants in the National Home-Based Primary Care & Palliative Care Registry, demonstrates opportunity for improvement. The Committee did not voice concerns with the reliability, validity, or feasibility of this measure. This measure currently is being used in both accountability programs and internal quality improvement programs, and CMS intends to publicly report results for this measure in the future.

NQF received four comments on this measure. Two were general statements supportive of the measure. While the other two comments also were supportive in nature, they included suggestions for modifying the measure exclusions and expanding the measure to other patient populations and data sources. Specifically, one commenter expressed concern that allowing a numerator exception for newly-enrolled patients when their most recent encounter occurred within the last 90 days of the measurement period does not factor in the possibility of seasonal or geographic variation and creates a perverse incentive to neglect assessment for new patients in the last 90 days of the measurement period. Another commenter recommended modifying this measure to include a broader target population (e.g., those not home-bound, those who may not yet need palliative care, etc.). Regarding the concern about the 90-day grace period, the Committee noted that seasonal or geographic variation should not affect ability of providers to conduct functional status assessments in their home-bound patients. However, the Committee encouraged the developer to consider shortening the grace period to minimize the potential perverse incentive of neglecting these assessments for their new patients. Regarding the suggestions to expand the target population and data sources for the measure, the Committee agreed on the need for similar measures targeted toward geriatric patients, those receiving community-based palliative care, and those with serious illness more broadly. The Committee encouraged the developer to track other uses of the measure and, potentially, expand the specifications and testing of the measure beyond the registry data source.

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients (Johns Hopkins/American Academy of Home Care Medicine): Endorsed

Description: Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability; **Measure Type**: Process; **Level of Analysis**: Clinician-Individual; **Setting of Care**: Home Care, Other; **Data Source**: Registry Data

Millions of adults in the United States are home-bound as a consequence of medical conditions, functional limitations, and/or frailty, limiting their access to office-based primary care. Consequently, both healthcare providers and policymakers now support the provision of both primary and palliative care in patients' homes. This new process measure focuses on whether providers assess the cognitive function of their home-based primary care and palliative care patients.

The Committee agreed that cognitive assessments are included in comprehensive geriatric assessments (CGAs), and therefore, the literature linking CGAs to reductions in long-term care admissions provides evidence to support this measure. Given the fairly low performance rate for this measure (mean=40 percent), the Committee agreed that there is the opportunity to improve this care process for the measured population. The Committee did not voice concerns with the reliability, validity, or feasibility of the measure. This measure is currently being used in both accountability programs and internal quality improvement programs, and CMS intends to publicly report results for this measure in the future.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Endorsed

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Submission | Specifications

Description: Percentage of actively enrolled home-based primary care and palliative care patients who receive an ADL and IADL assessment.

*Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; Instrumental ADLs (IADL) must include but are not limited to: telephone use and managing own medications

Numerator Statement: Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients who were assessed for basic ADL and IADL impairment at enrollment.

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients who were assessed for ADL and IADL impairment at enrollment and annually

Denominator Statement: Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

Exclusions: Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Individual

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Registry Data

Measure Steward: American Academy of Home Care Medicine

STANDING COMMITTEE MEETING 06/18/2019

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0**; **M-14**; **L-0**; **I-0**; 1b. Performance Gap: **H-1**; **M-13**; **L-0**; **I-0**

Rationale:

- The developer cited recommendations from three clinical practice guidelines to support this measure (i.e., Clinical Practice Guidelines for Quality Palliative Care, 4th edition; Assessment of Physical Function and Age-related Changes in Health, both included in: Evidence-Based Geriatric Nursing Protocols for Best Practice). However, the committee agreed that the majority of the evidence supporting these recommendations does not meet NQF's requirements, as it reflects case studies or expert opinion and/or is tangential to the measure focus.
- The developer also cited meta-analyses and systematic reviews that assessed the value of comprehensive geriatric assessments (CGAs) for older adults in a variety of care settings, noting that CGAs always include functional status assessments. Two of these studies focused on community-dwelling older adults in the context of home-based care. The findings of these reviews of fair-to-moderate quality randomized trials suggest a link between home-based care of older adults and reduced admissions to institutional long-term care. The findings also suggest a link between preventive home visit programs with reductions in functional decline. The Committee agreed that CGAs include functional status assessments and that the population for which CGAs are administered (i.e., primarily homebound adults) makes this literature an appropriate source of evidence to support this measure.
- The Committee also suggested that results from the CAPABLE program (Szanton, et al., 2016) provide additional support for this measure. Committee members also suggested that studies cited by Reckrey et al. (2018) may provide additional support.
- To demonstrate opportunity for improvement, the developer presented data from 221 providers who contributed data to the National Home-Based Primary Care & Palliative Care (NHBPC&PC) Registry for 2017-2018. These data reveal a relatively low average performance rate for the measure (67 percent) and a wide variation in performance (ranging from 16 percent to 93 percent).

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-5**; **M-9**; **L-0**; **I-0**; 2b. Validity: **H-3**; **M-10**; **L-1**; **I-0**

Rationale:

- The developer assessed score-level reliability via a signal-to-noise analysis using the Adams beta-binomial method (mean=0.95; range by decile= 0.94 to 0.99). Data for the testing were obtained from the NHBPC&PC Registry during the period between November 2017 and October 2018 (n=221 providers; 64,394 patients).
- The developer conducted score-level validity testing via a face validity assessment by 12 experts. Of these, 11 (92%) either agreed or strongly agreed that this measure can accurately distinguish good from poor quality of care, while one person disagreed with the statement. The average rating was 4.5 (from a 5-point scale).

- The committee did not voice significant concerns regarding the reliability or validity of this measure. One member specifically noted agreement with an exclusion specified for this measure. The exclusion provides a 90-day "grace period", post-enrollment, for conducting the functional status assessment. However, another committee member noted that 90 days may be excessive, as assessment of functional status should be conducted closer to the time of admission.
- The committee noted the lack of missing data in the NHBPC&PC Registry. In response to NQF staff's desire for more information about how the registry is populated, the developer described the direct transfer of data from participating providers' electronic health records (EHRs) to the registry.

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3. Feasibility: H-3; M-11; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The data source for this measure is the National Home-Based Primary Care & Palliative Care Registry.
- The Committee acknowledged the $350 annual cost associated with participation in, and use of the registry. However, members voiced no concerns regarding this cost, even for smaller providers. The developer noted that the fee allows providers to satisfy meaningful use requirements under the Merit-based Incentive Payment System (MIPS) program and allows providers to report data to CMS for MIPS quality reporting.
- While the measure is copyrighted and there is a license agreement required for commercial use of the measure, the developer clarified that there is no charge for use of the measure.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-14; No Pass-0** *4b. Usability:* **H-4; M-10; L-0; I-0**

Rationale:

- When discussing the Use subcriterion, the Committee noted that this measure is being used in a collaborative program for internal quality improvement, as well as in the MIPS payment program and as part of the American Board of Internal Medicine (ABIM) certification program.
- The Committee also highlighted CMS's intention to publicly report results of the measure on Physician Compare in the future.
- Committee members noted that feedback on the measure is provided to registry participants via monthly reports. In addition, they noted that the developer specifically incorporated feedback when combining assessment of ADLs and IADLs into this single measure, rather than assessing via two separate measures.
- The Committee acknowledged the decreased level of participation in the registry between 2016 and 2018, and the variable performance over that timeframe by participating providers. However, members did not further discuss potential reasons for the drop in participation.

- The Committee asked the developer about potential use of the measure in the Serious Illness Payment Model. The developer believes there will be a role for the measure in this model, but at that time, the regulations had not yet been written/released.

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5. Related and Competing Measures

- **This measure is related to:**
    - **2524e**: Rheumatoid Arthritis: Patient-Reported Functional Status Assessment [*clinician-level measure used in outpatient setting; target population: adults with rheumatoid arthritis*]
    - **2624**: Functional Outcome Assessment [*clinician-level measure (individual and group) used in outpatient setting; target population: adults with outpatient visit*]
    - **2631**: Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function [*facility-level measure used in outpatient setting; target population: long-term care hospital patients*]
- During the post-comment call on October 3, 2019, NQF described the related measures and asked the Committee to consider whether the developer of measure #3497 should consider specifying use of reliable and valid instruments or standardized tools to assess functional status and whether expanding the measure to include a care plan component would be a reasonable future modification of the measure. The developer acknowledged that the measure does not specify use of standardized tools for assessing functional status. However, the developer noted that the specifications require assessment of basic ADLs that must include, but are not limited to, bathing, transferring, toileting. The specifciations also require assessment of instrumental ADLs that must include, but are not limited to, telephone use and managing own medications. The developer also noted the many options for assessing functional status in practice, yet no agreed-upon standard for scoring such assessments. Thus, the developer believes the measure is standardized to the extent possible at this time. The Committee agreed with the developer's rationale regarding standardization and did not recommend modification of the measure. The Committee also did not recommend addition of a care plan component.

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6. Standing Committee Recommendation for Endorsement: **Y-14**; **N-0**

7. Public and Member Comment

- NQF received five comments from two member organizations and two members of the public. These comments pertained to measures #3497 and #3500. Overall, commenters were supportive of the Committee's endorsement recommendations.
- One commenter expressed concern with the denominator exception for those patients whose most recent patient encounter occurs within the last 90 days of the 12-month measurement period. The commenter suggested that this exception does not factor in the possibility of seasonal or geographic variation. The commenter also believes this exception creates a perverse incentive to neglect assessment of activities of daily living (ADL) and cognition for new patients in the last 90 days of the measurement period.
    - Measure Steward/Developer Response: There are two measures under consideration—one examines the rate of functional assessment in the homebound population while the other focuses on cognitive assessment completed in the homebound population. Fall risk assessment is a worthy endeavor; however, functional assessment in this measure is

focused on traditional basic activities of daily living and instrumental activities of daily living, which are supported by an extensive evidence base that has been developed over the past several decades. There are a number of approaches for fall risk assessment, but this is distinct from assessment of basic and instrumental activities of daily living. While the ability to transfer and ambulate may be components of some fall risk assessment approaches, the focus of the functional assessment is not on fall risk, per se. While we do not disagree that seasonal or regional influences could affect fall rates, we do not expect that these influences would have an impact on rates of cognitive or functional status assessments in the homebound population, as defined in the measure.

Regarding the 90-day perverse incentive concern, the primary exceptions are for Newly-Enrolled (Submission Criteria 1) patients who enroll within the last 90 days of the measurement period. This allows for instances when the provider may require more than one visit/encounter to complete the assessment before the end of the measurement period. This was considered to be a reasonable exception by the experts who guided the development of the measure. Very few providers (~6) used this exception in the testing data. This exception is not applied in Established Patients (Submission Criteria 2).

- Committee Response: The Committee agrees that the concern regarding seasonal or geographic variation could affect fall rates but should not affect ability of providers to conduct functional status or cognitive assessments in their homebound patients. The Committee agrees with the sentiment of the 90-day exception in providing time for assessments to be completed for new patients and recognizes that few providers use this exception. However, the Committee encourages the developer to consider shortening the grace period to minimize the potential perverse incentive of neglecting these assessments for their new patients.

- Another commenter encouraged the Committee to focus on measures that address the benefit of functional status and cognitive assessment measures for broader palliative care populations, including patients who may not require home visits. Additionally, the commenter encouraged the Committee and measure steward to consider how these measures may be modified to address populations who are further upstream in their clinical progression (e.g., who may not yet require palliative care services), but who would nonetheless benefit from functional and cognitive status assessments.
    - Measure Steward/Developer Response: Patients need not be exclusively enrolled in palliative care to be included in the measure. The measure aims to improve quality for patients receiving either primary care or palliative care in the home. The focus on the home derives from the lack of current functional assessment measures focused on homebound populations. Many patients receiving home-based primary care have palliative care needs, some of which may be addressed by home-based primary care providers. In other instances, palliative medicine provider input is needed. These measures are applicable to any upstream palliative care services provided to patients in the home.
    - Committee Response: Thank you for your comment. The Committee agrees that similar measures that could be used for community-based palliative care are needed, as are similar measures targeted toward geriatric patients or those with serious illness more broadly.

- The same commenter also encouraged the measure steward to make these measures more broadly available for use beyond the National Home-Based Primary Care & Palliative Care Registry. The commenter noted that doing so could help integrate functional and cognitive status assessment into routine care for patients experiencing, or at risk of, serious illness, and ensure timely access to palliative care services.
    - Measure Steward/Developer Response: The measure developer agree that NQF endorsement is a critical first step for expanding the use of these measures beyond the National Home-Based Primary Care & Palliative Care Registry. These measures are currently also used in Quality Improvement activities approved by both the American Board of Internal Medicine and the National Home-Based Primary Care and Palliative Care Learning Collaborative. Now that the measure is endorsed by NQF, the measure developer will continue to advocate for the importance and use of this measure in other relevant programs as opportunities arise.
    - Committee Response: Thank you for your comment. The Committee agrees that use of these measures should be expanded beyond the National Home-Based Primary Care & Palliative Care Registry. It also encourages the developers to track other uses of the measure and, potentially, seek to expand the specifications and testing of the measure beyond the registry data source.

---

8. Consensus Standards Approval Committee (CSAC) Vote: Y-14; N-0 (October 21, 2019: Approved for endorsement)

- CSAC upheld the Committee's decision to recommend the measure for endorsement.

---

9. Appeals

NQF did not receive appeals for this measure.

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Submission | Specifications

Description: Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability.

Numerator Statement: Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients for whom cognitive assessment was performed

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients for whom cognitive assessment was performed annually

Denominator Statement: Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

Exclusions: Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

1. Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

2. Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) or Documentation of patient reason(s) for not assessing cognition

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Individual

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Registry Data

Measure Steward: American Academy of Home Care Medicine

STANDING COMMITTEE MEETING 06/18/2019

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0**; **M-14**; **L-0**; **I-0**; 1b. Performance Gap: **H-5**; **M-9**; **L-0**; **I-0**

Rationale:

- The developer cited recommendations from three clinical practice guidelines to support this measure (i.e., Clinical Practice Guidelines for Quality Palliative Care, 4th edition; Assessment of Cognitive Function in Evidence-Based Geriatric Nursing Protocols for Best Practice; and the Practice Guideline for the Treatment of Patients with Alzheimer´s Disease and Other Dementias). However, the committee agreed that the majority of the evidence supporting these recommendations does not meet NQF's requirements, as it reflects case studies or expert opinion and/or is tangential to the measure focus.
- The developer also cited meta-analyses and systematic reviews that assessed the value of comprehensive geriatric assessments (CGAs) for older adults in a variety of care settings, noting that CGAs always include cognitive status assessments. Two of these studies focused on community-dwelling older adults in the context of home-based care. The findings from Elkan, et al. (2001), which reviewed fair-to-moderate quality randomized trials, suggest a link between home-based care of older adults with reduced admissions to institutional long-term care. The Committee agreed that CGAs do include cognitive status assessments. Moreover, Committee members agreed that the population for which CGAs are administered (i.e., primarily homebound adults) make this literature an appropriate source of evidence to support this measure.
- To demonstrate opportunity for improvement, the developer presented data from 220 providers who contributed data to the National Home-Based Primary Care & Palliative Care (NHBPC&PC) Registry for 2017-2018. These data reveal a low performance on average (40 percent) and wide variation in performance (ranging from 6 percent to 80 percent).

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-7**; **M-7**; **L-0**; **I-0**; 2b. Validity: **H-1**; **M-12**; **L-1**; **I-0**

Rationale:

- The developer assessed score-level reliability via a signal-to-noise analysis using the Adams beta-binomial method (mean=0.97; range by decile= 0.96 to 0.99). Data for the testing were obtained from the NHBPC&PC Registry during the period between November 2017 and October 2018) (n=220 providers; 63,849 patients).
- The developer conducted score-level validity testing via a face validity assessment by 12 experts. Of these, nine (75%) either agreed or strongly agreed that this measure can accurately distinguish good from poor quality, while one person disagreed. The average rating was 4.25 (from a 5-point scale).
- The Committee did not voice any significant concerns regarding the reliability or validity of this measure. One member specifically noted agreement with an exclusion to this measure. This exclusion provides a 90-day "grace period" for conducting the cognitive status assessment and allow for medical or patient reasons for not conducting the assessment (e.g., the patient has advanced dementia).

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3. Feasibility: H-3; M-11; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The data source for this measure is the National Home-Based Primary Care & Palliative Care (NHBPC&PC) Registry. All data elements in the measure are collected in defined fields in this registry.
- While the measure is copyrighted and there is a license agreement required for commercial use of the measure, the developer noted that there is no charge for use of the measure.
- Although alluded to only in the discussion of #3497, as with that measure, there is a $350 annual cost associated with participation in, and use of, the NHBPC&PC registry. In that discussion, committee members did not voice concerns regarding this cost.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-14; No Pass-0** *4b. Usability:* **H-4; M-10; L-0; I-0**

Rationale:

- When discussing the Use subcriterion, the Committee noted that this measure is being used in a national collaborative program for internal quality improvement, as well as in the MIPS payment program and as part of the ABIM certification program.
- The Committee also highlighted CMS's intention to publicly report results of the measure on Physician Compare in the future.
- Committee members also noted that feedback on the measure is provided to 220 registry participants via monthly reports. They also approved of the mechanism for providing feedback about the measure (i.e., via e-mail and the MIPS Qualified Clinical Data Registry (QCDR) portal).
- The Committee acknowledged both the decreased level of participation in the registry between 2016 and 2018 and the variable performance over that timeframe by participating providers. The developer suggested that the performance results reflect participation in the registry by different providers over the 2016-2018 timeframe. The developer also noted a general trend of increased provision of home-based care in the past several years and expressed their belief that this trend will continue.

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5. Related and Competing Measures

- This measure is related to:
    - **2872e**: Dementia: Cognitive Assessment [*clinician-level eCQM (group/practice and individual) used in hospital and outpatient settings; target population: patients diagnosed with dementia*]
- During the post comment call on October 3, 2019, NQF described the related measure (#2872e) that focuses on cognitive assessment in patients with dementia. However, due to differences in the care setting and target population, these measures are harmonized to the extent possible. Therefore, the Committee had no additional discussion regarding harmonization.

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6. Standing Committee Recommendation for Endorsement: **Y-14**; **N-0**

7. Public and Member Comment

- NQF received five comments from two member organizations and two members of the public pertaining to measures 3497 and 3500. Overall, commenters were supportive of the Committee's endorsement recommendations.
- One commenter expressed concern with the denominator exception for those patients whose most recent patient encounter occurs within the last 90 days of the 12-month measurement period. The commenter suggested that this exception does not factor in the possibility of seasonal or geographic variation. The commenter also believes this exception creates a perverse incentive to neglect assessment of activities of daily living (ADL) and cognition for new patients in the last 90 days of the measurement period.
    - Measure Steward/Developer Response: There are two measures under consideration—one examines the rate of functional assessment in the homebound population while the other focuses on cognitive assessment completed in the homebound population. Fall risk assessment is a worthy endeavor; however, functional assessment in this measure is focused on traditional basic activities of daily living and instrumental activities of daily living, which are supported by an extensive evidence base that has been developed over the past several decades. There are a number of approaches for fall risk assessment, but this is distinct from assessment of basic and instrumental activities of daily living. While the ability to transfer and ambulate may be components of some fall risk assessment approaches, the focus of the functional assessment is not on fall risk, per se. While we do not disagree that seasonal or regional influences could affect fall rates, we do not expect that these influences would have an impact on rates of cognitive or functional status assessments in the homebound population, as defined in the measure.

      Regarding the 90-day perverse incentive concern, the primary exceptions are for Newly-Enrolled (Submission Criteria 1) patients who enroll within the last 90 days of the measurement period. This allows for instances when the provider may require more than one visit/encounter to complete the assessment before the end of the measurement period. This was considered to be a reasonable exception by the experts who guided the development of the measure. Very few providers (~6) used this exception in the testing data. This exception is not applied in Established Patients (Submission Criteria 2).
    - Committee Response: The Committee agrees that the concern regarding seasonal or geographic variation could affect fall rates but should not affect ability of providers to conduct functional status or cognitive assessments in their homebound patients. The Committee agrees with the sentiment of the 90-day exception in providing time for assessments to be completed for new patients and recognizes that few providers use this exception. However, the Committee encourages the developer to consider shortening the grace period to minimize the potential perverse incentive of neglecting these assessments for their new patients.
- Another commenter encouraged the Committee to focus on measures that address the benefit of functional status and cognitive assessment measures for broader palliative care populations, including patients who may not require home visits. Additionally, the commenter encouraged the Committee and measure stewards to consider how these measures may be modified to address populations who are further upstream in their clinical progression (e.g., who may not yet require palliative care services), but who would nonetheless benefit from functional and cognitive status assessments.

- Measure Steward/Developer Response: Patients need not be exclusively enrolled in palliative care to be included in the measure. The measure aims to improve quality for patients receiving either primary care or palliative care in the home. The focus on the home derives from the lack of current functional assessment measures focused on homebound populations. Many patients receiving home-based primary care have palliative care needs, some of which may be addressed by home-based primary care providers. In other instances, palliative medicine provider input is needed. These measures are applicable to any upstream palliative care services provided to patients in the home.
- Committee Response: Thank you for your comment. The Committee agrees that similar measures that could be used for community-based palliative care are needed, as are similar measures targeted toward geriatric patients or those with serious illness more broadly.

- The same commenter also encouraged the measure steward to make these measures more broadly available for use beyond the National Home-Based Primary Care & Palliative Care Registry. The commenter noted that doing so could help integrate functional and cognitive status assessment into routine care for patients experiencing or at risk of serious illness and ensure timely access to palliative care services.
    - Measure Steward/Developer Response: The measure developers agree that NQF endorsement is a critical first step for expanding the use of these measures beyond the National Home-Based Primary Care & Palliative Care Registry. These measures are currently also used in Quality Improvement activities approved by both the American Board of Internal Medicine and the National Home-Based Primary Care and Palliative Care Learning Collaborative. Now that the measure is endorsed by NQF, the measure developers will continue to advocate for the importance and use of this measure in other relevant programs as opportunities arise.
    - Committee Response: Thank you for your comment. The Committee agrees that use of these measures should be expanded beyond the National Home-Based Primary Care & Palliative Care Registry. It also encourages the developers to track other uses of the measure and, potentially, seek to expand the specifications and testing of the measure beyond the registry data source.

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-14; N-0 (October 21, 2019: Approved for endorsement)

- CSAC upheld the Committee's decision to recommend the measure for endorsement.

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9. Appeals

NQF did not receive appeals for this measure.

Appendix B: Geriatrics and Palliative Care Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of June 25, 2019
0167	Improvement in Ambulation and Locomotion	Home Health Value Based Purchasing (Implemented)
0174	Improvement in Bathing	Home Health Value Based Purchasing (Implemented)
0175	Improvement in Bed Transferring	Home Health Value Based Purchasing (Implemented)
0176	Improvement in Management of Oral Medications	Home Health Value Based Purchasing (Implemented) Home Health Quality Reporting (Implemented)
0177	Improvement in pain interfering with activity	Home Health Value Based Purchasing (Implemented) Home Health Quality Reporting (Implemented)
0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	N/A
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Hospital Care (Implemented) Prospective Payment System-Exempt Cancer Hospital Quality Reporting (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0384	Oncology: Medical and Radiation - Pain Intensity Quantified (paired with 0383)	Merit-Based Incentive Payment System (MIPS) Program (Implemented) Medicaid Promoting Interoperability Program (Proposed)
0420	Pain Assessment and Follow-Up	N/A
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Hospice Quality Reporting (Implemented)
1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Prospective Payment System-Exempt Cancer Hospital Quality Reporting (Considered)
1634	Hospice and Palliative Care — Pain Screening	Hospice Quality Reporting (Implemented)
1637	Hospice and Palliative Care — Pain Assessment	Hospice Quality Reporting (Implemented)

[a] Per CMS Measures Inventory Tool as of 07/22/2019

NQF #	Title	Federal Programs: Finalized or Implemented as of June 25, 2019
1638	Hospice and Palliative Care — Dyspnea Treatment	Hospice Quality Reporting (Implemented)
1639	Hospice and Palliative Care — Dyspnea Screening	Hospice Quality Reporting (Implemented)
1647	Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	Hospice Quality Reporting (Implemented)
0326	Advance Care Plan	Home Health Value Based Purchasing (Implemented) Merit-Base Incentive Payment System (MIPS) Program (Finalized) Ambulatory Surgical Center Quality Reporting (Considered) Hospital Outpatient Quality Reporting (Considered)
1626	Patients Admitted to ICU who Have Care Preferences Documented	N/A
1641	Hospice and Palliative Care – Treatment Preferences	Prospective Payment System-Except Cancer Hospital Quality Reporting (Considered) Hospice Quality Reporting (Implemented)
0210	Proportion receiving chemotherapy in the last 14 days of life	Merit-Base Incentive Payment System (MIPS) Program (Finalized) Hospital Compare (Finalized) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Finalized)
0213	Proportion admitted to the ICU in the last 30 days of life	Merit-Base Incentive Payment System (MIPS) Program (Finalized) Hospital Compare (Finalized) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Finalized)
0215	Proportion not admitted to hospice	Merit-Base Incentive Payment System (MIPS) Program (Finalized) Hospital Compare (Finalized) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Finalized)

NQF #	Title	Federal Programs: Finalized or Implemented as of June 25, 2019
0216	Proportion admitted to hospice for less than 3 days	Merit-Base Incentive Payment System (MIPS) Program (Finalized) Hospital Compare (Finalized) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Finalized)
1623	Bereaved Family Survey	N/A
1625	Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	N/A
2651	CAHPS Hospice Survey (Experience with Care): 8 PRO-PMs: (Hospice Team Communication; Getting Timely Care; Getting Emotional and Religious Support; Getting Hospice Training; Rating of the Hospice Care; Willingness to Recommend the Hospice; Treating Family Member with Respect; Getting Help for Symptoms)	Hospice Quality Reporting (Implemented)
3235	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	Hospice Quality Reporting (Implemented)

Appendix C: Geriatrics and Palliative Care Standing Committee and NQF Staff

STANDING COMMITTEE

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Senior Project Manager

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Appendix D: Measure Specifications

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

STEWARD

American Academy of Home Care Medicine

DESCRIPTION

Percentage of actively enrolled home-based primary care and palliative care patients who receive an ADL and IADL assessment.

*Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; Instrumental ADLs (IADL) must include but are not limited to: telephone use and managing own medications

TYPE

Process

DATA SOURCE

Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry.

LEVEL

Clinician : Individual

SETTING

Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services

NUMERATOR STATEMENT

Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients who were assessed for basic ADL and IADL impairment at enrollment.

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients who were assessed for ADL and IADL impairment at enrollment and annually

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; IADL must include but are not limited to: telephone use and managing own medications.

Submission Criteria 1 - Newly enrolled:

Report NHBPC15.NUMER.1.YES - Basic ADL and IADL assessment performed and documented within 90 days of New Patient Encounter

Submission Criteria 2 - Established patients:

Report NHBPC15.NUMER.3.YES - ADL and IADL assessment performed and documented within performance period

DENOMINATOR STATEMENT

Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

Submission Criteria 1 - Newly enrolled:

New/Established Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345

AND

At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

Submission Criteria 2 - Established patients:

At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

EXCLUSIONS

Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

EXCLUSION DETAILS

Time Period for Data Collection: During the measurement period.

Submission Criteria 1 - Newly enrolled:

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient

characteristics, or patient preferences. This measure has been developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients, exceptions may include most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Exception is determined by date(s) of encounter(s).

Submission Criteria 2 - Established patients:

Not applicable.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows:

Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]

To calculate performance rates for Submission Criteria 1 - Newly enrolled:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

To calculate performance rates for Submission Criteria 2 - Established patients:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

If the patient does not meet the numerator, this case represents a quality failure. 140560

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

STEWARD

American Academy of Home Care Medicine

DESCRIPTION

Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability.

TYPE

Process

DATA SOURCE

Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry.

LEVEL

Clinician : Individual

SETTING

Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services

NUMERATOR STATEMENT

Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients for whom cognitive assessment was performed

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients for whom cognitive assessment was performed annually

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Cognitive assessment must be performed with validated tools such as the Montreal Cognitive Assessment tool, the Mini-Mental State Examination, the Mini-Cog, etc.

Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance.

Submission Criteria 1 - Newly enrolled:

Report NHBPC14.NUMER.1.YES - Cognitive assessment performed and documented within 90 days of New Patient Encounter

Submission Criteria 2 - Established patients:

Report NHBPC14.NUMER.3.YES - Cognitive assessment performed and documented within performance period

DENOMINATOR STATEMENT

Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

Submission Criteria 1 - Newly enrolled:

New Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345

AND

At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

Submission Criteria 2 - Established patients:

At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

EXCLUSIONS

Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

1. Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

2. Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) or Documentation of patient reason(s) for not assessing cognition

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

EXCLUSION DETAILS

Time Period for Data Collection: During the measurement period.

Submission Criteria 1 - Newly enrolled:

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient

characteristics, or patient preferences. This measure has been developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients, exceptions may include most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Exception 1 is determined by date(s) of encounter(s).

Submission Criteria 2 - Established patients:

Not applicable.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco, and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows:

Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]

To calculate performance rates for Submission Criteria 1 - Newly enrolled:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure

based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

To calculate performance rates for Submission Criteria 2 - Established patients:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

If the patient does not meet the numerator, this case represents a quality failure. 140560

Appendix E1: Related and Competing Measures (tabular version)

Comparison of NQF 3497, NQF 2524e, NQF 2624, and NQF 2631

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
Steward	American Academy of Home Care Medicine	AMERICAN COLLEGE OF RHEUMATOLOGY	Centers for Medicare and Medicaid Services	Centers for Medicare & Medicaid Services
Description	Percentage of actively enrolled home-based primary care and palliative care patients who receive an ADL and IADL assessment. *Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; Instrumental ADLs (IADL) must include but are not limited to: telephone use and managing own medications	Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis for whom a functional status assessment was performed at least once during the measurement period.	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	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.
Type	Process	Process	Process	Process
Data Source	Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry.	Other Data source: electronic health records Instrument: RA MEASURE TESTING DATA COLLECTION FORM	Claims, Paper Medical Records, Registry Data The source is the medical record, which provides patient information for the encounter. Medicare Part B claims data is provided for test purposes.	Other The Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00 (LTCH CARE Data Set v3.00) No data collection instrument provided No data dictionary

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	No data collection instrument provided No data dictionary	Available in attached appendix at A.1 Attachment Functional_Status_Assessment_Updated_Value_Sets_2018-03-30.xls	No data collection instrument provided Attachment FOA_Code_Table_S.2b.xlsx	
Level	Clinician : Individual	Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Facility
Setting	Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services	Outpatient Services	Outpatient Services	Post-Acute Care
Numerator Statement	Submission Criteria 1 - Newly enrolled: Number of newly enrolled home-based primary care and palliative care patients who were assessed for basic ADL and IADL impairment at enrollment. Submission Criteria 2 - Established patients:	Number of patients with functional status assessment documented using an ACR-preferred instrument at least once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.	Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies	The numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal. For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	Number of established home-based primary care and palliative care patients who were assessed for ADL and IADL impairment at enrollment and annually			discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment. For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment. Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
				may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.
Numerator Details	Time Period for Data Collection: At least once during the measurement period GUIDANCE: Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; IADL must include but are not limited to: telephone use and managing own medications. Submission Criteria 1 - Newly enrolled: Report NHBPC15.NUMER.1.YES - Basic ADL and IADL assessment performed and documented within 90 days of New Patient Encounter Submission Criteria 2 - Established patients: Report NHBPC15.NUMER.3.YE	Functional status can be assessed by using one of a number of instruments, including several instruments originally developed and validated for screening purposes. Examples include, but are not limited to: -Health Assessment Questionnaire-II (HAQ-II) -Multi-Dimensional Health Assessment Questionnaire (MDHAQ) -PROMIS Physical Function 10-item (PROPF10) -PROMIS Physical Function 20-item (PROPF20) -PROMIS Physical Function Computerized Adaptive Tests (PROPFCAT)	Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used. Definitions: Standardized Tool – A tool that has been normed and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL). Note: A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale	For patients with a complete stay, each functional assessment item listed below must have a valid score or code at admission and discharge and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. Providers use the 6-point rating scale when coding discharge goals. For patients with an incomplete stay, each functional assessment item listed below must have a valid score or code at admission and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. No discharge data are required for patients with incomplete stays. The self-care functional assessment items are: GG0130A. Eating GG0130B. Oral hygiene GG0130C. Toileting hygiene GG0130D. Wash upper body Valid scores/codes for the self-care functional assessment items are: 06 - Independent 05 - Setup or clean-up assistance 04 - Supervision or touching assistance 03 - Partial/moderate assistance 02 - Substantial/maximal assistance

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	S - ADL and IADL assessment performed and documented within performance period		(VAS), does not meet the criteria of a functional outcome assessment standardized tool. Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms. Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days. Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches. Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations,	01 - Dependent 07 - Patient refused 09 - Not applicable 88 - Not attempted due to medical condition or safety concerns The mobility functional assessment items are: GG0170A. Roll left and right GG0170B. Sit to lying GG0170C. Lying to sitting on side of bed GG0170D. Sit to stand GG0170E. Chair/bed-to-chair transfer GG0170F. Toilet transfer For patients who are walking: GG0170I. Walk 10 feet GG0170J. Walk 50 feet with two turns GG0170K. Walk 150 feet For patients who use a wheelchair, complete the following items: GG0170R. Wheel 50 feet with two turns GG0170RR1. Indicate the type of wheelchair/scooter used GG0170S. Wheel 150 feet GG0170SS1. Indicate the type of wheelchair/scooter used Valid scores/codes for the mobility functional assessment items are: 06 - Independent

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan. Not Eligible (Denominator Exception) – A patient is not eligible if one or more of the following reason(s) is documented at the time of the encounter: Patient refuses to participate Patient unable to complete questionnaire Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status NUMERATOR NOTE: The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but submission is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented	05 - Setup or clean-up assistance 04 - Supervision or touching assistance 03 - Partial/moderate assistance 02 - Substantial/maximal assistance 01 - Dependent 07 - Patient refused 09 - Not applicable 88 - Not attempted due to medical condition or safety concerns Valid scores/codes for the self-care and mobility discharge goal items are: 06 - Independent 05 - Setup or clean-up assistance 04 - Supervision or touching assistance 03 - Partial/moderate assistance 02 - Substantial/maximal assistance 01 – Dependent Cognitive Function C1610A-E2. Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]): C1610A. and C1610B. Acute Onset and Fluctuating Course C1610C. Inattention C1610D. Disorganized Thinking C1610E1 and C160E2. Altered Level of Consciousness

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			functional outcome assessment, the numerator quality-data code G8942 should be used for submission purposes. Numerator Quality-Data Coding Options: Functional Outcome Assessment Documented as Positive AND Care Plan Documented Performance Met: G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented OR Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required Performance Met: G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required OR Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within	Valid codes for C1610-Signs and Symptoms of Delirium are: 1 - Yes 0 - No Communication: Understanding and Expression BB0700. Expression of Ideas and Wants Valid codes are: 4 - Expresses without difficulty 3 - Expresses with some difficulty 2 - Frequently exhibits difficulty with expressing needs and ideas 1 - Rarely/Never expresses self or speech is very difficult to understand BB0800. Understanding Verbal Content: Valid codes are: 4 - Understands 3 - Usually understands 2 - Sometimes understands 1 - Rarely/Never understands Bladder Continence H0350. Bladder Continence Valid codes are: 0 - Always continent 1 - Stress incontinence only 2 - Incontinent less than daily 3 - Incontinent daily

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			the Previous 30 Days Performance Met: G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented OR Functional Outcome Assessment not Documented, Patient not Eligible Denominator Exception: G8540: Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter OR Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible Denominator Exception: G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter OR	4 - Always incontinent 5 - No urine output 9 - Not applicable For patients with incomplete stays, admission data and at least one goal are required for the patient to be counted in the numerator. No discharge data are required. Patients with incomplete stays are identified based on the following data elements: 1) Patients with incomplete stays due to a medical emergency. These patients are excluded if: a) Item A0250. Reason for Assessment is coded 11 = Unplanned discharge OR b) The length of stay is less than 3 days based on item A0220. Admission Date and A0270: Discharge Date OR c) Item A2110. Discharge Location is coded 04 = Hospital emergency department OR 05 = Short-stay acute care hospital OR 06 = Long-term care hospital OR 08 = Psychiatric hospital or unit. 2) Patients who leave the LTCH against medical advice. These patients are identified based on the reason for the assessment: a) Item A0250. Reason for Assessment is coded as 11 = Unplanned discharge OR b) Item A2110. Discharge Location is coded 12 = Discharged Against Medical Advice. 3) No discharge functional status data are required if a patient dies while in the LTCH.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			Functional Outcome Assessment not Documented, Reason not Given Performance Not Met: G8541: Functional outcome assessment using a standardized tool not documented, reason not given OR Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given Performance Not Met: G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given	These patients are identified based on the reason for the assessment: a) Item A0250. Reason for Assessment is coded 12 = Expired.
Denominator Statement	Submission Criteria 1 - Newly enrolled: Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes	Patients age 18 and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.	All visits for patients aged 18 years and older	The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	with a provider from the practice within the reporting period. Submission Criteria 2 - Established patients: Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.			
Denominator Details	Time Period for Data Collection: 12 consecutive months Submission Criteria 1 - Newly enrolled: New/Established Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345	SEE ATTACHMENT IN S2B	The following information is provided in the specification in order to identify and calculate the numerator criteria: Denominator Criteria (Eligible Cases): Patients aged = 18 years on date of encounter AND Patient encounter during the performance period (CPT): 97161, 97162, 97163, 97164, 97165, 97166,	The denominator includes all LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period, including patients of all ages and patients with all payer sources. Patients are selected based on submitted LTCH CARE Data Set Admission and Discharge forms.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	AND At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497 Submission Criteria 2 - Established patients: At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497		97167, 97168, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	
Exclusions	Submission Criteria 1 - Newly enrolled: Denominator Exceptions: Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period Submission Criteria 2 - Established patients:	N/A	A patient is not eligible or can be considered a denominator exception and excluded from the measure if one or more of the following reason(s) is documented at the time of the encounter: Patient refuses to participate Patient unable to complete questionnaire Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment	There are no denominator exclusions for this measure.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	There are no exceptions or exclusions for this submission criteria.		would jeopardize the patient's health status	
Exclusion Details	Time Period for Data Collection: During the measurement period. Submission Criteria 1 - Newly enrolled: Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. This measure has been	N/A	The information required to identify and calculate the measure exceptions follows: Functional Outcome Assessment not Documented, Patient not Eligible G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter OR Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter	There are no denominator exclusions for this measure.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients, exceptions may include most recent new patient encounter (with subsequent established patient encounter)			

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	occurs within the last 90 days of the measurement period. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Exception is determined by date(s) of encounter(s).			

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	Submission Criteria 2 - Established patients: Not applicable.			
Risk Adjustment	No risk adjustment or risk stratification 140560 140560	No risk adjustment or risk stratification 136880| 146682| 146683 136880| 146682| 146683	No risk adjustment or risk stratification 141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517 141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517	No risk adjustment or risk stratification 138203| 141592 138203| 141592
Stratification	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity,	N/A	No stratification.	This measure does not use stratification.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	administrative sex, and payer.			
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows: Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]	CASES MEETING TARGET PROCESS / TARGET POPULATION 136880| 146682| 146683	To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exceptions (B). Numerator (A): Number of patients meeting numerator criteria Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion Denominator Exceptions (B): Number of patients with valid exceptions 1) Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes during the performance period. 2) Identify which of those patients meet the numerator criteria (A), which includes patients with a documented current functional outcome assessment using a	1) For each LTCH, the stay records of patients discharged during the 12 month target time period are identified and counted. This count is the denominator. 2) The records of patients with complete stays are identified and the number of these patient stays with complete admission functional assessment data AND at least one self-care or mobility discharge goal AND complete discharge functional assessment data is counted. 3) The records of patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data AND at least one self-care or mobility discharge goal is counted. 4) The counts from step 2 (complete LTCH stays) and step 3 (incomplete LTCH stays) are summed. The sum is the numerator count. 5) The numerator count is divided by the denominator count to calculate this quality measure. For the numerator, complete data are defined as: 1. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	To calculate performance rates for Submission Criteria 1 - Newly enrolled: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie,		standardized tool AND a documented care plan based on the identified functional outcome deficiencies. 3) For those patients who do not meet the numerator criteria, determine whether an appropriate exception applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/ [Performance Denominator (PD) - Denominator Exceptions (B)]. 141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517	the functional assessment items on the admission assessment; and 2. a valid numeric score for one or more of the self-care or mobility items that is a discharge goal; 3. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the discharge assessment. (Note: Discharge data are not required for patients with incomplete LTCH stays.) Denominator: The denominator for this quality measure is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period. 138203| 141592

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period]. If the patient meets any exception criteria, they should be			

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. To calculate performance rates for Submission Criteria 2 - Established patients: 1. Find the patients who meet the initial			

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients			

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	in the numerator is less than or equal to the number of patients in the denominator. If the patient does not meet the numerator, this case represents a quality failure. 140560			
Submission items	5.1 Identified measures: 2524 : Rheumatoid Arthritis: Patient-Reported Functional Status Assessment 2624 : Functional Outcome Assessment 2631 : Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: 0050 : Osteoarthritis: Function and Pain Assessment 0112 : Bipolar Disorder: Level-of-function evaluation 0422 : Functional status change for patients with Knee impairments 0423 : Functional status change for patients with Hip impairments 0424 : Functional status change for patients with Foot and Ankle impairments 0425 : Functional status change for patients with lumbar impairments 0426 : Functional status change for patients with Shoulder impairments 0427 : Functional status change for patients with elbow, wrist and hand impairments	5.1 Identified measures: 0167 : Improvement in Ambulation/locomotion 0174 : Improvement in bathing 0175 : Improvement in bed transferring 0183 : Low-risk residents who frequently lose control of their bowel or bladder 0184 : Residents who have a catheter in the bladder at any time during the 14-day assessment period. (risk adjusted) 0185 : Recently hospitalized residents with symptoms of delirium (risk-adjusted) 0422 : Functional status change for patients with Knee impairments 0423 : Functional status change for patients with Hip impairments 0425 : Functional status change for patients with lumbar impairments 0426 : Functional status change for patients with Shoulder impairments 0427 : Functional status change for patients with elbow, wrist and hand impairments

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
	difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Three measures were identified as related to this measure. However, the target population and/or setting for this measure (home based primary care and home based palliative care) differs from each of those identified and listed here. There were no competing measures identified.		0428 : Functional status change for patients with General orthopaedic impairments 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: There are 9 partially related measures (having partial measure focus or partial target populations). The differences between the related measure and the submitted measure #2624 are listed below: 0422 - Functional status change for patients with knee impairments: the population in this measure has the same age criteria as #2624 (18 years and older), however, this measure only include target population with specific body part impairment to be assessed whereas #2624 includes a broader target population, not limited to a body part impairment. In addition, there is no requirement for a standardized assessment tool or a care plan based on deficiencies in 0422. In addition 0422 is an Outcome measure whereas #2624 is a Process measure. 0423 - Functional status change for patients with hip impairments: same	0428 : Functional status change for patients with General orthopaedic impairments 0429 : Change in Basic Mobility as Measured by the AM-PAC: 0430 : Change in Daily Activity Function as Measured by the AM-PAC: 0685 : Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay) 0686 : Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The quality measures listed above focus on functional activities and impairments but do not apply to the same patient population (patients who are chronically critically ill) 5b.1 If competing, why superior or rationale for additive value: There are no competing measures that are NQF endorsed.

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			differences as 0422. 0424 - Functional status change for patients with foot/ankle impairments: same differences as 0422. 0425 - Functional status change for patients with lumbar spine impairments: same differences as 0422. 0426 - Functional status change for patients with shoulder impairments: same differences as 0422. 0427- Functional status change for patients with elbow, wrist, or hand impairments: same differences as 0422. 0428 - Functional status change for patients with general orthopedic impairments: 0428 is an Outcome measure whereas #2624 is a Process measure. The population in #0428 has the same age criteria as #2624 (18 years and older), however, #0428 only include target population with general orthopedic impairments whereas #2624 includes a broader target population, not limited to patients with general orthopedic impairments. In 0428 there is no requirement for a standardized assessment tool or a care plan based on deficiencies. 0050 – Osteoarthritis: Function and Pain	

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			Assessment: This measure assesses for function in the 21 years and older population, whereas #2624 has an age criteria of 18 years and older. Also the target population of #0050 is patients with a diagnosis of osteoarthritis (OA), whereas #2624 targets a broader population, which is not limited to patients with osteoarthritis. In addition, #0050 assesses for pain. There is no requirement for a standardized assessment tool or a care plan based on deficiencies in #0050. Both #2624 and #0050 are process measures. 0112-Bipolar Disorder: Level-of-function evaluation: Both 0112 and 2624 are process measures. 0112 has a target population of patients 18 years and older with an initial or new episode of bipolar disorder, whereas 2624 targets a broader population, not limited to patients with bipolar disorder. #0112 also documents a level-of functioning monitoring tool, whereas #2624 documents use of a standardized functional assessment tool. However #0112 looks for an evaluation that is done at initial assessment and again 12 weeks of initiating treatment,	

	3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	2624 Functional Outcome Assessment	2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
			however does not address a treatment/care plan, whereas #2624 does require a care plan based on the functional deficiencies. 5b.1 If competing, why superior or rationale for additive value: N/A	

Comparison of NQF 3500 and NQF 2872e

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
Steward	American Academy of Home Care Medicine	PCPI Foundation
Description	Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability.	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period
Type	Process	Process
Data Source	Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry. No data collection instrument provided No data dictionary	Electronic Health Records Not applicable. No data collection instrument provided Attachment CMS_149_Value_Sets_Addendum092018.xlsx
Level	Clinician : Individual	Clinician : Group/Practice, Clinician : Individual
Setting	Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services	Inpatient/Hospital, Other, Outpatient Services Occupational Therapy Services, Domiciliary, Rest Home or Custodial Care Services
Numerator Statement	Submission Criteria 1 - Newly enrolled: Number of newly enrolled home-based primary care and palliative care patients for whom cognitive assessment was performed Submission Criteria 2 - Established patients: Number of established home-based primary care and palliative care patients for whom cognitive assessment was performed annually	Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period
Numerator Details	Time Period for Data Collection: At least once during the measurement period GUIDANCE: Cognitive assessment must be performed with validated tools such as the Montreal Cognitive Assessment tool, the Mini-Mental State Examination, the Mini-Cog, etc. Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance. Submission Criteria 1 - Newly enrolled: Report NHBPC14.NUMER.1.YES - Cognitive assessment performed and documented within 90 days of New Patient Encounter Submission Criteria 2 - Established patients:	Time Period for Data Collection: At least once during the measurement period DEFINITION: Cognition can be assessed by the clinician during the patient's clinical history. Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to: -Blessed Orientation-Memory-Concentration Test (BOMC) -Montreal Cognitive Assessment (MoCA) -St. Louis University Mental Status Examination (SLUMS)

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
	Report NHBPC14.NUMER.3.YES - Cognitive assessment performed and documented within performance period	-Mini-Mental State Examination (MMSE) [Note: The MMSE has not been well validated for non-Alzheimer's dementias] -Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) -Ascertain Dementia 8 (AD8) Questionnaire -Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) [Note: Validated for use with nursing home patients only] -Formal neuropsychological evaluation -Mini-Cog NUMERATOR GUIDANCE: Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed": "Cognitive Assessment" included in the numerator logic below. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.
Denominator Statement	Submission Criteria 1 - Newly enrolled: Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period. Submission Criteria 2 - Established patients: Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.	All patients, regardless of age, with a diagnosis of dementia
Denominator Details	Time Period for Data Collection: 12 consecutive months Submission Criteria 1 - Newly enrolled: New Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345 AND	Time Period for Data Collection: 12 consecutive months DENOMINATOR GUIDANCE: The requirement of two or more visits is to establish that the eligible professional or eligible clinician has an existing relationship with the patient.

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
	At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497 Submission Criteria 2 - Established patients: At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497	The DSM-5 has replaced the term dementia with major neurocognitive disorder and mild neurocognitive disorder. For the purposes of this measure, the terms are equivalent. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.
Exclusions	Submission Criteria 1 - Newly enrolled: Denominator Exceptions: 1. Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period 2. Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) or Documentation of patient reason(s) for not assessing cognition Submission Criteria 2 - Established patients: There are no exceptions or exclusions for this submission criteria.	Documentation of patient reason(s) for not assessing cognition
Exclusion Details	Time Period for Data Collection: During the measurement period. Submission Criteria 1 - Newly enrolled: Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. This measure has been developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients, exceptions may	Time Period for Data Collection: 12 consecutive months Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Dementia: Cognitive Assessment, exceptions may include patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
	include most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Exception 1 is determined by date(s) of encounter(s). Submission Criteria 2 - Established patients: Not applicable.	patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.
Risk Adjustment	No risk adjustment or risk stratification 140560 140560	No risk adjustment or risk stratification 140560| 135810| 141015 140560| 135810| 141015
Stratification	Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco, and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows: Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
	To calculate performance rates for Submission Criteria 1 - Newly enrolled: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. To calculate performance rates for Submission Criteria 2 - Established patients:	defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 141015

	3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	2872e Dementia: Cognitive Assessment
	1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. If the patient does not meet the numerator, this case represents a quality failure. 140560	
Submission items	5.1 Identified measures: 2000 : Dementia: Cognitive Assessment 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: One measure was identified as conceptually related to the current measure. The related measure (NQF 2872e- Dementia: Cognitive Assessment) is intended to ensure an annual cognitive evaluation is completed on patients with an existing diagnosis of dementia. This is different from the current measure, which is intended to ensure an annual cognitive evaluation is completed for all patients enrolled in home-based primary care and palliative care, regardless of diagnosis.	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not applicable

Appendix E2: Related and Competing Measures (narrative version)

Comparison of NQF 3497, NQF 2524e, NQF 2624, and NQF 2631

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients
2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment
2624 Functional Outcome Assessment
2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Steward

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

American Academy of Home Care Medicine

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

AMERICAN COLLEGE OF RHEUMATOLOGY

2624 Functional Outcome Assessment

Centers for Medicare and Medicaid Services

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Centers for Medicare & Medicaid Services

Description

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Percentage of actively enrolled home-based primary care and palliative care patients who receive an ADL and IADL assessment.

*Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; Instrumental ADLs (IADL) must include but are not limited to: telephone use and managing own medications

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis for whom a functional status assessment was performed at least once during the measurement period.

2624 Functional Outcome Assessment

Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

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.

Type

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Process

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Process

2624 Functional Outcome Assessment

Process

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Process

Data Source

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry.

No data collection instrument provided No data dictionary

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Other Data source: electronic health records

Instrument: RA MEASURE TESTING DATA COLLECTION FORM

Available in attached appendix at A.1 Attachment Functional_Status_Assessment_Updated_Value_Sets_2018-03-30.xls

2624 Functional Outcome Assessment

Claims, Paper Medical Records, Registry Data The source is the medical record, which provides patient information for the encounter. Medicare Part B claims data is provided for test purposes.

No data collection instrument provided Attachment FOA_Code_Table_S.2b.xlsx

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Other The Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00 (LTCH CARE Data Set v3.00)

No data collection instrument provided No data dictionary

Level

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Clinician : Individual

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Clinician : Individual

2624 Functional Outcome Assessment

Clinician : Group/Practice, Clinician : Individual

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Facility

Setting

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Outpatient Services

2624 Functional Outcome Assessment

Outpatient Services

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Post-Acute Care

Numerator Statement

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients who were assessed for basic ADL and IADL impairment at enrollment.

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients who were assessed for ADL and IADL impairment at enrollment and annually

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Number of patients with functional status assessment documented using an ACR-preferred instrument at least once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.

2624 Functional Outcome Assessment

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

Numerator Details

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Basic ADLs must include but are not limited to: bathing, transferring, toileting, and feeding; IADL must include but are not limited to: telephone use and managing own medications.

Submission Criteria 1 - Newly enrolled:

Report NHBPC15.NUMER.1.YES - Basic ADL and IADL assessment performed and documented within 90 days of New Patient Encounter

Submission Criteria 2 - Established patients:

Report NHBPC15.NUMER.3.YES - ADL and IADL assessment performed and documented within performance period

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Functional status can be assessed by using one of a number of instruments, including several instruments originally developed and validated for screening purposes. Examples include, but are not limited to:

-Health Assessment Questionnaire-II (HAQ-II)

-Multi-Dimensional Health Assessment Questionnaire (MDHAQ)

-PROMIS Physical Function 10-item (PROPF10)

-PROMIS Physical Function 20-item (PROPF20)

-PROMIS Physical Function Computerized Adaptive Tests (PROPFCAT)

2624 Functional Outcome Assessment

Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used.

Definitions:

Standardized Tool – A tool that has been normed and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

Note: A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does not meet the criteria of a functional outcome assessment standardized tool.

Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.

Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.

Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations, goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.

Not Eligible (Denominator Exception) – A patient is not eligible if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but submission is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for submission purposes.

Numerator Quality-Data Coding Options:

Functional Outcome Assessment Documented as Positive AND Care Plan Documented

Performance Met: G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required Performance Met: G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required

OR

Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days Performance Met: G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment not Documented, Patient not Eligible

Denominator Exception: G8540: Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible

Denominator Exception: G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

OR

Functional Outcome Assessment not Documented, Reason not Given Performance Not Met: G8541: Functional outcome assessment using a standardized tool not documented, reason not given

OR

Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given Performance Not Met: G8543: Documentation of a positive functional

outcome assessment using a standardized tool; care plan not documented, reason not given

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

For patients with a complete stay, each functional assessment item listed below must have a valid score or code at admission and discharge and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. Providers use the 6-point rating scale when coding discharge goals.

For patients with an incomplete stay, each functional assessment item listed below must have a valid score or code at admission and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. No discharge data are required for patients with incomplete stays.

The self-care functional assessment items are:

GG0130A. Eating

GG0130B. Oral hygiene

GG0130C. Toileting hygiene

GG0130D. Wash upper body

Valid scores/codes for the self-care functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance

01 - Dependent

07 - Patient refused

09 - Not applicable

88 - Not attempted due to medical condition or safety concerns

The mobility functional assessment items are:

GG0170A. Roll left and right

GG0170B. Sit to lying

GG0170C. Lying to sitting on side of bed

GG0170D. Sit to stand

GG0170E. Chair/bed-to-chair transfer

GG0170F. Toilet transfer

For patients who are walking:

GG0170I. Walk 10 feet

GG0170J. Walk 50 feet with two turns

GG0170K. Walk 150 feet

For patients who use a wheelchair, complete the following items:

GG0170R. Wheel 50 feet with two turns

GG0170RR1. Indicate the type of wheelchair/scooter used
GG0170S. Wheel 150 feet
GG0170SS1. Indicate the type of wheelchair/scooter used
Valid scores/codes for the mobility functional assessment items are:
06 - Independent
05 - Setup or clean-up assistance
04 - Supervision or touching assistance
03 - Partial/moderate assistance
02 - Substantial/maximal assistance
01 - Dependent
07 - Patient refused
09 - Not applicable
88 - Not attempted due to medical condition or safety concerns
Valid scores/codes for the self-care and mobility discharge goal items are:
06 - Independent
05 - Setup or clean-up assistance
04 - Supervision or touching assistance
03 - Partial/moderate assistance
02 - Substantial/maximal assistance
01 – Dependent
Cognitive Function
C1610A-E2. Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):
C1610A. and C1610B. Acute Onset and Fluctuating Course
C1610C. Inattention
C1610D. Disorganized Thinking
C1610E1 and C160E2. Altered Level of Consciousness
Valid codes for C1610-Signs and Symptoms of Delirium are:
1 - Yes
0 - No
Communication: Understanding and Expression
BB0700. Expression of Ideas and Wants
Valid codes are:
4 - Expresses without difficulty
3 - Expresses with some difficulty
2 - Frequently exhibits difficulty with expressing needs and ideas
1 - Rarely/Never expresses self or speech is very difficult to understand
BB0800. Understanding Verbal Content:
Valid codes are:
4 - Understands

3 - Usually understands

2 - Sometimes understands

1 - Rarely/Never understands

Bladder Continence

H0350. Bladder Continence

Valid codes are:

0 - Always continent

1 - Stress incontinence only

2 - Incontinent less than daily

3 - Incontinent daily

4 - Always incontinent

5 - No urine output

9 - Not applicable

For patients with incomplete stays, admission data and at least one goal are required for the patient to be counted in the numerator. No discharge data are required. Patients with incomplete stays are identified based on the following data elements:

1) Patients with incomplete stays due to a medical emergency. These patients are excluded if:

a) Item A0250. Reason for Assessment is coded 11 = Unplanned discharge OR

b) The length of stay is less than 3 days based on item A0220. Admission Date and A0270: Discharge Date OR

c) Item A2110. Discharge Location is coded 04 = Hospital emergency department OR 05 = Short-stay acute care hospital OR 06 = Long-term care hospital OR 08 = Psychiatric hospital or unit.

2) Patients who leave the LTCH against medical advice. These patients are identified based on the reason for the assessment:

a) Item A0250. Reason for Assessment is coded as 11 = Unplanned discharge OR

b) Item A2110. Discharge Location is coded 12 = Discharged Against Medical Advice.

3) No discharge functional status data are required if a patient dies while in the LTCH.

These patients are identified based on the reason for the assessment:

a) Item A0250. Reason for Assessment is coded 12 = Expired.

Denominator Statement

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Patients age 18 and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

2624 Functional Outcome Assessment

All visits for patients aged 18 years and older

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

Denominator Details

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: 12 consecutive months

Submission Criteria 1 - Newly enrolled:

New/Established Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345

AND

At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

Submission Criteria 2 - Established patients:

At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

SEE ATTACHMENT IN S2B

2624 Functional Outcome Assessment

The following information is provided in the specification in order to identify and calculate the numerator criteria:

Denominator Criteria (Eligible Cases):

Patients aged = 18 years on date of encounter

AND

Patient encounter during the performance period (CPT): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

The denominator includes all LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period, including patients of all ages and patients with all payer sources.

Patients are selected based on submitted LTCH CARE Data Set Admission and Discharge forms.

Exclusions

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

N/A

2624 Functional Outcome Assessment

A patient is not eligible or can be considered a denominator exception and excluded from the measure if one or more of the following reason(s) is documented at the time of the encounter:

Patient refuses to participate

Patient unable to complete questionnaire

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Exclusion Details

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: During the measurement period.

Submission Criteria 1 - Newly enrolled:

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. This measure has been developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients, exceptions

may include most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Exception is determined by date(s) of encounter(s).

Submission Criteria 2 - Established patients:

Not applicable.

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

N/A

2624 Functional Outcome Assessment

The information required to identify and calculate the measure exceptions follows:

Functional Outcome Assessment not Documented, Patient not Eligible G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

There are no denominator exclusions for this measure.

Risk Adjustment

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

No risk adjustment or risk stratification

140560

140560

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

No risk adjustment or risk stratification

136880| 146682| 146683

136880| 146682| 146683

2624 Functional Outcome Assessment

No risk adjustment or risk stratification

141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517

141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

No risk adjustment or risk stratification

138203| 141592

138203| 141592

Stratification

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

N/A

2624 Functional Outcome Assessment

No stratification.

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

This measure does not use stratification.

Type Score

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

Rate/proportion better quality = higher score

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

Rate/proportion better quality = higher score

2624 Functional Outcome Assessment

Rate/proportion better quality = higher score

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Rate/proportion better quality = higher score

Algorithm

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and

Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows:

Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]

To calculate performance rates for Submission Criteria 1 - Newly enrolled:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

To calculate performance rates for Submission Criteria 2 - Established patients:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

If the patient does not meet the numerator, this case represents a quality failure. 140560

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

CASES MEETING TARGET PROCESS / TARGET POPULATION 136880| 146682| 146683

2624 Functional Outcome Assessment

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exceptions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exceptions (B): Number of patients with valid exceptions

1) Identify the patients who meet the eligibility criteria for the denominator (PD), which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes during the performance period.

2) Identify which of those patients meet the numerator criteria (A), which includes patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies.

3) For those patients who do not meet the numerator criteria, determine whether an appropriate exception applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/ [Performance Denominator (PD) - Denominator Exceptions (B)]. 141592| 124369| 145084| 141015| 139607| 146273| 138697| 125056| 146977| 146982| 146894| 147517

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

1) For each LTCH, the stay records of patients discharged during the 12 month target time period are identified and counted. This count is the denominator.

2) The records of patients with complete stays are identified and the number of these patient stays with complete admission functional assessment data AND at least one self-care or mobility discharge goal AND complete discharge functional assessment data is counted.

3) The records of patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data AND at least one self-care or mobility discharge goal is counted.

4) The counts from step 2 (complete LTCH stays) and step 3 (incomplete LTCH stays) are summed. The sum is the numerator count.

5) The numerator count is divided by the denominator count to calculate this quality measure.

For the numerator, complete data are defined as:

1. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the admission assessment; and

2. a valid numeric score for one or more of the self-care or mobility items that is a discharge goal;

3. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the discharge assessment. (Note: Discharge data are not required for patients with incomplete LTCH stays.)

Denominator: The denominator for this quality measure is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period. 138203| 141592

Submission items

3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

5.1 Identified measures: 2524 : Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

2624 : Functional Outcome Assessment

2631 : Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: Three measures were identified as related to this measure. However, the target population and/or setting for this measure (home based primary care and home based palliative care) differs from each of those identified and listed here. There were no competing measures identified.

2524e Rheumatoid Arthritis: Patient-Reported Functional Status Assessment

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

2624 Functional Outcome Assessment

5.1 Identified measures: 0050 : Osteoarthritis: Function and Pain Assessment

0112 : Bipolar Disorder: Level-of-function evaluation

0422 : Functional status change for patients with Knee impairments

0423 : Functional status change for patients with Hip impairments

0424 : Functional status change for patients with Foot and Ankle impairments

0425 : Functional status change for patients with lumbar impairments

0426 : Functional status change for patients with Shoulder impairments

0427 : Functional status change for patients with elbow, wrist and hand impairments

0428 : Functional status change for patients with General orthopaedic impairments

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: There are 9 partially related measures (having partial measure focus or partial target populations). The differences between the related measure and the submitted measure #2624 are listed below: 0422 - Functional status change for patients with knee impairments: the population in this measure has the same age criteria as #2624 (18 years and older), however, this measure only include target population with specific body part impairment to be assessed whereas #2624 includes a broader target population, not limited to a body part impairment. In addition, there is no requirement for a standardized assessment tool or a care plan based on deficiencies in 0422. In addition 0422 is an Outcome measure whereas #2624 is a Process measure. 0423 - Functional status change for patients with hip impairments: same differences as 0422. 0424 - Functional status change for patients with foot/ankle impairments: same differences as 0422. 0425 - Functional status change for

patients with lumbar spine impairments: same differences as 0422. 0426 - Functional status change for patients with shoulder impairments: same differences as 0422. 0427- Functional status change for patients with elbow, wrist, or hand impairments: same differences as 0422. 0428 - Functional status change for patients with general orthopedic impairments: 0428 is an Outcome measure whereas #2624 is a Process measure. The population in #0428 has the same age criteria as #2624 (18 years and older), however, #0428 only include target population with general orthopedic impairments whereas #2624 includes a broader target population, not limited to patients with general orthopedic impairments. In 0428 there is no requirement for a standardized assessment tool or a care plan based on deficiencies. 0050 – Osteoarthritis: Function and Pain Assessment: This measure assesses for function in the 21 years and older population, whereas #2624 has an age criteria of 18 years and older. Also the target population of #0050 is patients with a diagnosis of osteoarthritis (OA), whereas #2624 targets a broader population, which is not limited to patients with osteoarthritis. In addition, #0050 assesses for pain. There is no requirement for a standardized assessment tool or a care plan based on deficiencies in #0050. Both #2624 and #0050 are process measures. 0112-Bipolar Disorder: Level-of-function evaluation: Both 0112 and 2624 are process measures. 0112 has a target population of patients 18 years and older with an initial or new episode of bipolar disorder, whereas 2624 targets a broader population, not limited to patients with bipolar disorder. #0112 also documents a level-of functioning monitoring tool, whereas #2624 documents use of a standardized functional assessment tool. However #0112 looks for an evaluation that is done at initial assessment and again 12 weeks of initiating treatment, however does not address a treatment/care plan, whereas #2624 does require a care plan based on the functional deficiencies.

5b.1 If competing, why superior or rationale for additive value: N/A

2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

5.1 Identified measures: 0167 : Improvement in Ambulation/locomotion

0174 : Improvement in bathing

0175 : Improvement in bed transferring

0183 : Low-risk residents who frequently lose control of their bowel or bladder

0184 : Residents who have a catheter in the bladder at any time during the 14-day assessment period. (risk adjusted)

0185 : Recently hospitalized residents with symptoms of delirium (risk-adjusted)

0422 : Functional status change for patients with Knee impairments

0423 : Functional status change for patients with Hip impairments

0425 : Functional status change for patients with lumbar impairments

0426 : Functional status change for patients with Shoulder impairments

0427 : Functional status change for patients with elbow, wrist and hand impairments

0428 : Functional status change for patients with General orthopaedic impairments

0429 : Change in Basic Mobility as Measured by the AM-PAC:

0430 : Change in Daily Activity Function as Measured by the AM-PAC:

0685 : Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)

0686 : Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The quality measures listed above focus on functional activities and impairments but do not apply to the same patient population (patients who are chronically critically ill)

5b.1 If competing, why superior or rationale for additive value: There are no competing measures that are NQF endorsed.

Comparison of NQF 3500 and NQF 2872e

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients
2872e Dementia: Cognitive Assessment

Steward

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

American Academy of Home Care Medicine

2872e Dementia: Cognitive Assessment

PCPI Foundation

Description

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of their cognitive ability.

2872e Dementia: Cognitive Assessment

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

Type

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Process

2872e Dementia: Cognitive Assessment

Process

Data Source

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Registry Data The data source is the National Home-Based Primary Care & Palliative Care Registry.

No data collection instrument provided No data dictionary

2872e Dementia: Cognitive Assessment

Electronic Health Records Not applicable.

No data collection instrument provided Attachment CMS_149_Value_Sets_Addendum092018.xlsx

Level

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Clinician : Individual

2872e Dementia: Cognitive Assessment

Clinician : Group/Practice, Clinician : Individual

Setting

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Home Care, Other Home-based primary care and home-based palliative care; Settings include: Home, Boarding home, Domiciliary, Assisted Living Facilities, Rest Home or Custodial Care Services

2872e Dementia: Cognitive Assessment

Inpatient/Hospital, Other, Outpatient Services Occupational Therapy Services, Domiciliary, Rest Home or Custodial Care Services

Numerator Statement

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Number of newly enrolled home-based primary care and palliative care patients for whom cognitive assessment was performed

Submission Criteria 2 - Established patients:

Number of established home-based primary care and palliative care patients for whom cognitive assessment was performed annually

2872e Dementia: Cognitive Assessment

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

Numerator Details

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: At least once during the measurement period

GUIDANCE:

Cognitive assessment must be performed with validated tools such as the Montreal Cognitive Assessment tool, the Mini-Mental State Examination, the Mini-Cog, etc.

Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance.

Submission Criteria 1 - Newly enrolled:

Report NHBPC14.NUMER.1.YES - Cognitive assessment performed and documented within 90 days of New Patient Encounter

Submission Criteria 2 - Established patients:

Report NHBPC14.NUMER.3.YES - Cognitive assessment performed and documented within performance period

2872e Dementia: Cognitive Assessment

Time Period for Data Collection: At least once during the measurement period

DEFINITION:

Cognition can be assessed by the clinician during the patient's clinical history.

Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

-Blessed Orientation-Memory-Concentration Test (BOMC)

-Montreal Cognitive Assessment (MoCA)

-St. Louis University Mental Status Examination (SLUMS)

-Mini-Mental State Examination (MMSE) [Note: The MMSE has not been well validated for non-Alzheimer's dementias]

-Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

-Ascertain Dementia 8 (AD8) Questionnaire

-Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) [Note: Validated for use with nursing home patients only]

-Formal neuropsychological evaluation

-Mini-Cog

NUMERATOR GUIDANCE:

Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed": "Cognitive Assessment" included in the numerator logic below.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

Denominator Statement

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Total number of newly enrolled (and active) home-based primary care and palliative care patients. The enrollment period includes 90 days from the first recorded new patient E&M visit code with the practice. *A patient is considered active if they have at least 2 E&M visit codes with a provider from the practice within the reporting period.

Submission Criteria 2 - Established patients:

Total number of established enrolled and active home-based primary care and palliative care patients. A patient is considered established if they have at least 2 Established Patient Encounter E&M visit codes with a provider from the practice within the reporting period.

2872e Dementia: Cognitive Assessment

All patients, regardless of age, with a diagnosis of dementia

Denominator Details

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: 12 consecutive months

Submission Criteria 1 - Newly enrolled:

New Patient Encounter during the performance period (CPT): 99324, 99325, 99326, 99327, 99328, 99341, 99342, 99343, 99344, 99345

AND

At least one subsequent Established Patient Encounter during the performance period (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

Submission Criteria 2 - Established patients:

At least two instances of Established Patient Encounter (CPT): 99334, 99335, 99336, 99337, 99347, 99348, 99349, 99350, 99497

2872e Dementia: Cognitive Assessment

Time Period for Data Collection: 12 consecutive months

DENOMINATOR GUIDANCE:

The requirement of two or more visits is to establish that the eligible professional or eligible clinician has an existing relationship with the patient.

The DSM-5 has replaced the term dementia with major neurocognitive disorder and mild neurocognitive disorder. For the purposes of this measure, the terms are equivalent.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

Exclusions

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Submission Criteria 1 - Newly enrolled:

Denominator Exceptions:

1. Most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period

2. Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) or Documentation of patient reason(s) for not assessing cognition

Submission Criteria 2 - Established patients:

There are no exceptions or exclusions for this submission criteria.

2872e Dementia: Cognitive Assessment

Documentation of patient reason(s) for not assessing cognition

Exclusion Details

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Time Period for Data Collection: During the measurement period.

Submission Criteria 1 - Newly enrolled:

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. This measure has been developed using the PCPI exception methodology, which uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients, exceptions may include most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, it is recommended that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The UCSF, JHU School of Medicine, and the PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Exception 1 is determined by date(s) of encounter(s).

Submission Criteria 2 - Established patients:

Not applicable.

2872e Dementia: Cognitive Assessment

Time Period for Data Collection: 12 consecutive months

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Dementia: Cognitive Assessment, exceptions may include patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient

management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

Risk Adjustment

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

No risk adjustment or risk stratification

140560

140560

2872e Dementia: Cognitive Assessment

No risk adjustment or risk stratification

140560| 135810| 141015

140560| 135810| 141015

Stratification

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM (now the National Academies) and NQF, the University of California San Francisco, and Johns Hopkins University School of Medicine encourage collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

2872e Dementia: Cognitive Assessment

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Type Score

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

Rate/proportion better quality = higher score

2872e Dementia: Cognitive Assessment

Rate/proportion better quality = higher score

Algorithm

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Submission Criteria 1 (Newly enrolled) and

Submission Criteria 2 (Established patients), resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows:

Performance Rate = (Numerator 1 + Numerator 2)/ [(Denominator 1 – Denominator Exceptions 1) + (Denominator 2)]

To calculate performance rates for Submission Criteria 1 - Newly enrolled:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: most recent new patient encounter (with subsequent established patient encounter) occurs within the last 90 days of the measurement period; documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason); or documentation of patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

To calculate performance rates for Submission Criteria 2 - Established patients:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

If the patient does not meet the numerator, this case represents a quality failure. 140560

2872e Dementia: Cognitive Assessment

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 141015

Submission items

3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients

5.1 Identified measures: 2000 : Dementia: Cognitive Assessment

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: One measure was identified as conceptually related to the current measure. The related measure (NQF 2872e- Dementia: Cognitive Assessment) is intended to ensure an annual cognitive evaluation is completed on patients with an existing diagnosis of dementia. This is different from the current measure, which is intended to ensure an annual cognitive evaluation is completed for all patients enrolled in home-based primary care and palliative care, regardless of diagnosis.

2872e Dementia: Cognitive Assessment

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: Not applicable

Appendix F: Pre-evaluation Comments

No comments were received as of June 1, 2019.

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ISBN