NATIONAL QUALITY FORUM

Measure Applications Partnership

PAC-LTC Workgroup In-Person Meeting

December 13, 2017

Welcome, Introductions, Disclosures of Interest and Review of Meeting Objectives

MAP Post-Acute Care/Long-Term Care Workgroup Membership

Workgroup Chairs (voting)	
Gerri Lamb, PHD	
Paul Mulhausen, MD, MHS	
Organizational Members (voting)	**Organizational Representative**
AMDA – The Society for Post-Acute and Long-Term Care Medicine	Dheeraj Mahajan, MD, FACP, CMD, CIC, CHCQM
American Academy of Physical Medicine & Rehabilitation	Kurt Hoppe, MD
American Geriatrics Society	Deb Saliba
American Occupational Therapy Association	Pamela Roberts, PhD, OTR/L, SCRES, CPHQ, FAOTA
American Physical Therapy Association	Heather Smith, PT, MPH
Centene Corporation	Michael Monson
Compassus	Kurt Merkelz, MD
HealthSouth Corporation	Lisa Charbonneau, DO, MS
Families USA	Frederick Isasi, JD, MPH
Kindred Healthcare	Sean Muldoon, MD
National Association of Area Agencies on Aging	Sandy Markwood, MA
National Consumer Voice for Quality Long-Term Care	Robyn Grant, MSW
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Partnership for Hospice Innovation	Theresa Schmidt
National Pressure Ulcer Advisory Panel	Arthur Stone, MD
National Transitions of Care Coalition	James Lett, II, MD, CMD
Visiting Nurses Association of America	Danielle Pierottie, RN, PhD, CENP, AOCN, CHPN

MAP Post-Acute Care/Long-Term Care Workgroup Membership

Individual Subject Matter Experts (voting)	
Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN	
Kim Elliott, PhD, CPH	
Caroline Fife, MD, CWS, FUHM	
Eugene Nuccio, PhD	
Thomas von Sternberg, MD	
Ashish Trivedi, Pharm. D.	
Federal Government Members (non-voting)	
Centers for Medicare & Medicaid Services (CMS)	Alan Levitt, MD
Office of the National Coordinator for Health Information Technology (ONC)	Elizabeth Palena Hall, MIS, MBA, RN

MAP PAC/LTC Workgroup
Staff Support Team

- Erin O'Rourke: Senior Director
- Jean-Luc Tilly: Senior Project Manager
- Miranda Kuwahara: Project Analyst

- Project Email: MAPPAC-LTC@qualityforum.org

Agenda (Morning):

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- CMS Opening Remarks and Review of Meaningful Measures Framework
- Overview of Pre-Rulemaking Approach
- Pre-Rulemaking Input:
  - *Skilled Nursing Facility QRP*
  - *Hospice QRP*
  - *Long-Term Care Hospital QRP*
  - *Inpatient Rehabilitation Facility QRP*
  - *Home Health QRP*

Agenda (Afternoon):

- Lunch
- Update on Implementation of the IMPACT Act
- Review of NQF's Attribution Work and Guidance on Attribution Challenges in PAC/LTC Settings
- Update on Equity Program
- Input on Measure Removal Criteria
- Opportunity for Public Comment
- Summary of Day and Next Steps

Meeting Objectives

Review and provide input on measures under consideration for use in federal programs

Finalize input to the MAP Coordinating Committee on measures for use in federal programs

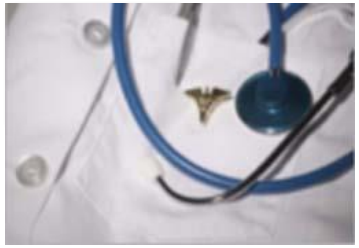
Identify gaps in measures for federal PAC-LTC quality programs

CMS Opening Remarks

Pierre Yong, CMS

CMS Opening Remarks and Review of Meaningful Measures Framework

Meaningful Measures



November 28, 2017

Jean Moody-Williams, RN, MPP
Pierre Yong, MD, MPH, MS
Theodore G Long, MD, MHS

A New Approach to Meaningful Outcomes

Empower patients and doctors to make decision about their health care

Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

Meaningful Measures Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help:

- *Address high impact measure areas that safeguard public health*
- *Patient-centered and meaningful to patients*
- *Outcome-based where possible*
- *Relevant for and meaningful to providers*
- *Minimize level of burden for providers*
  - *Remove measures where performance is already very high and that are low value*
- *Significant opportunity for improvement*
- *Address measure needs for population based payment through alternative payment models*
- *Align across programs and/or with other payers (Medicaid, commercial payers)*

Meaningful Measures Framework

Meaningful Measure Areas Achieve:

- ✓ *High quality healthcare*
- ✓ *Meaningful outcomes for patients*

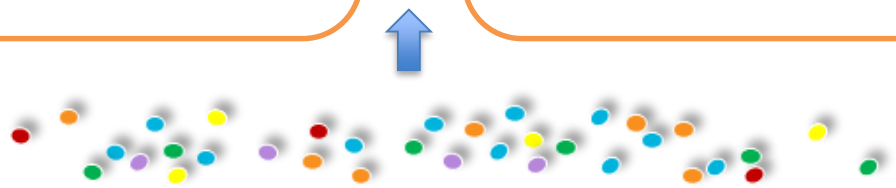
Criteria meaningful for patients and actionable for providers

Draws on measure work by:

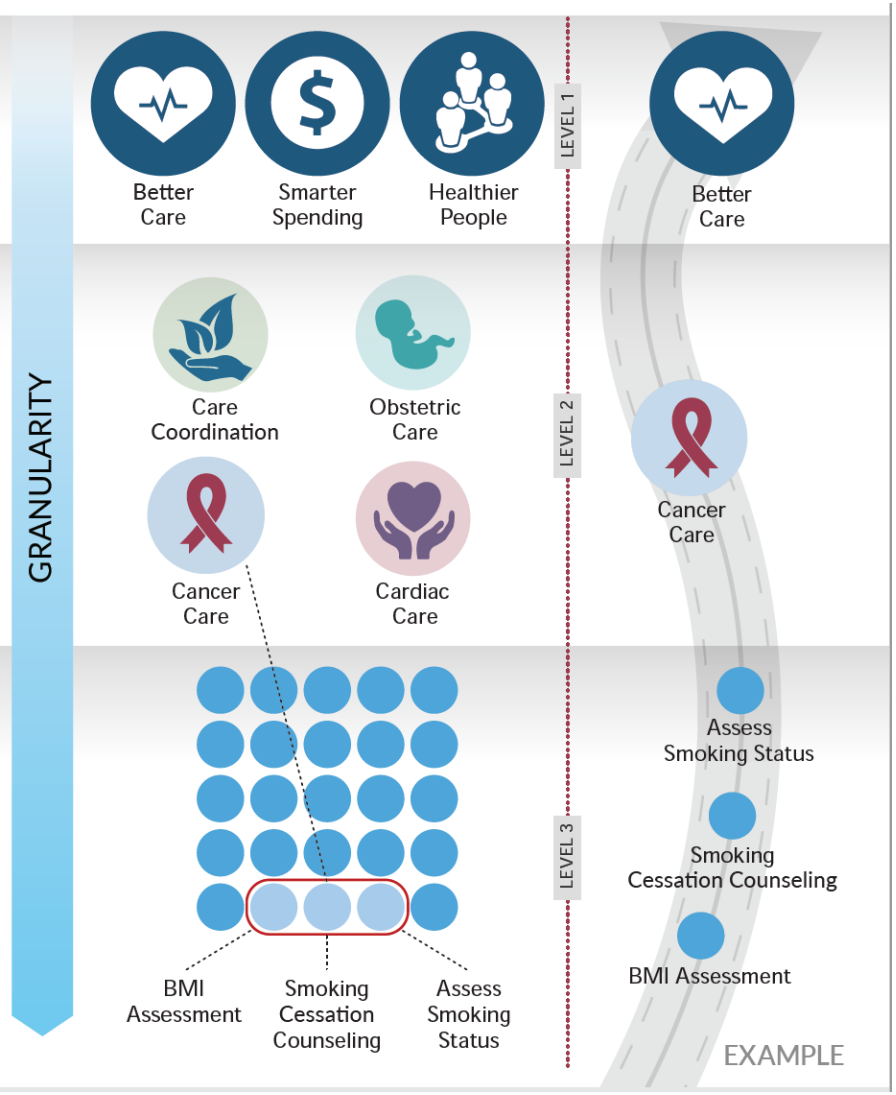
- Health Care Payment Learning and Action Network
- National Quality Forum – *High Impact Outcomes*
- National Academies of Medicine – *IOM Vital Signs Core Metrics*

Includes perspectives from experts and external stakeholders:

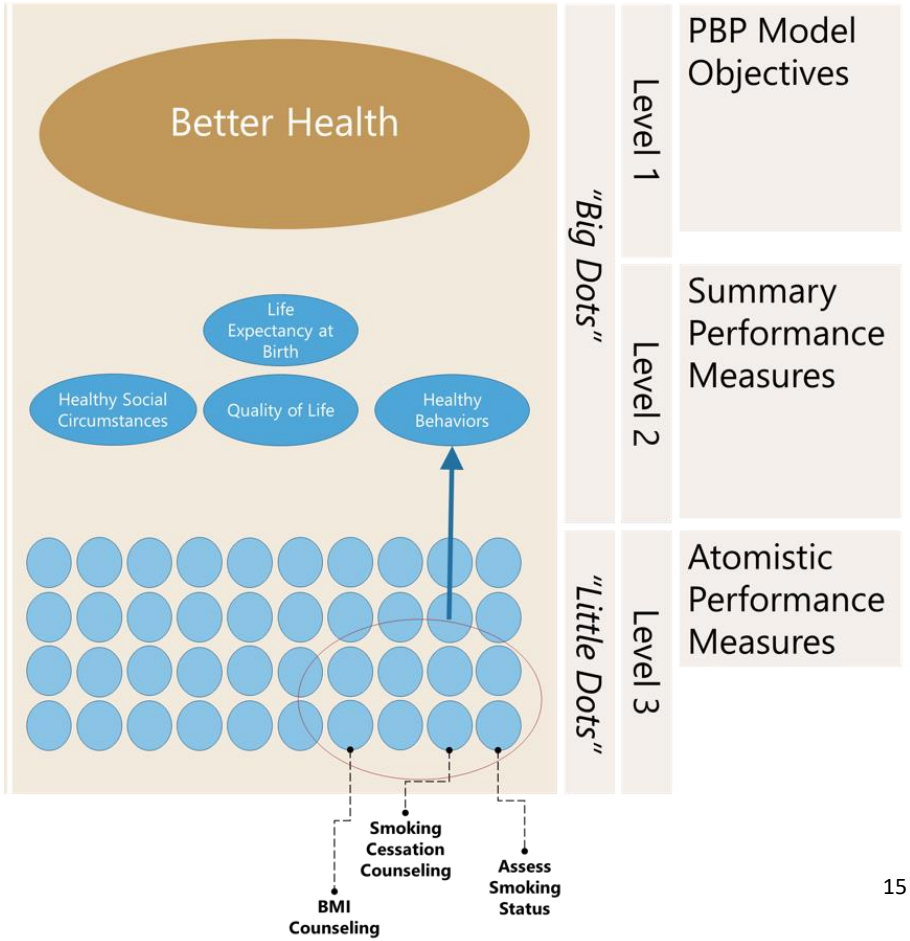
- Core Quality Measures Collaborative
- Agency for Healthcare Research and Quality
- Many other external stakeholders



Use Meaningful Measures to Achieve Goals, while Minimizing Burden



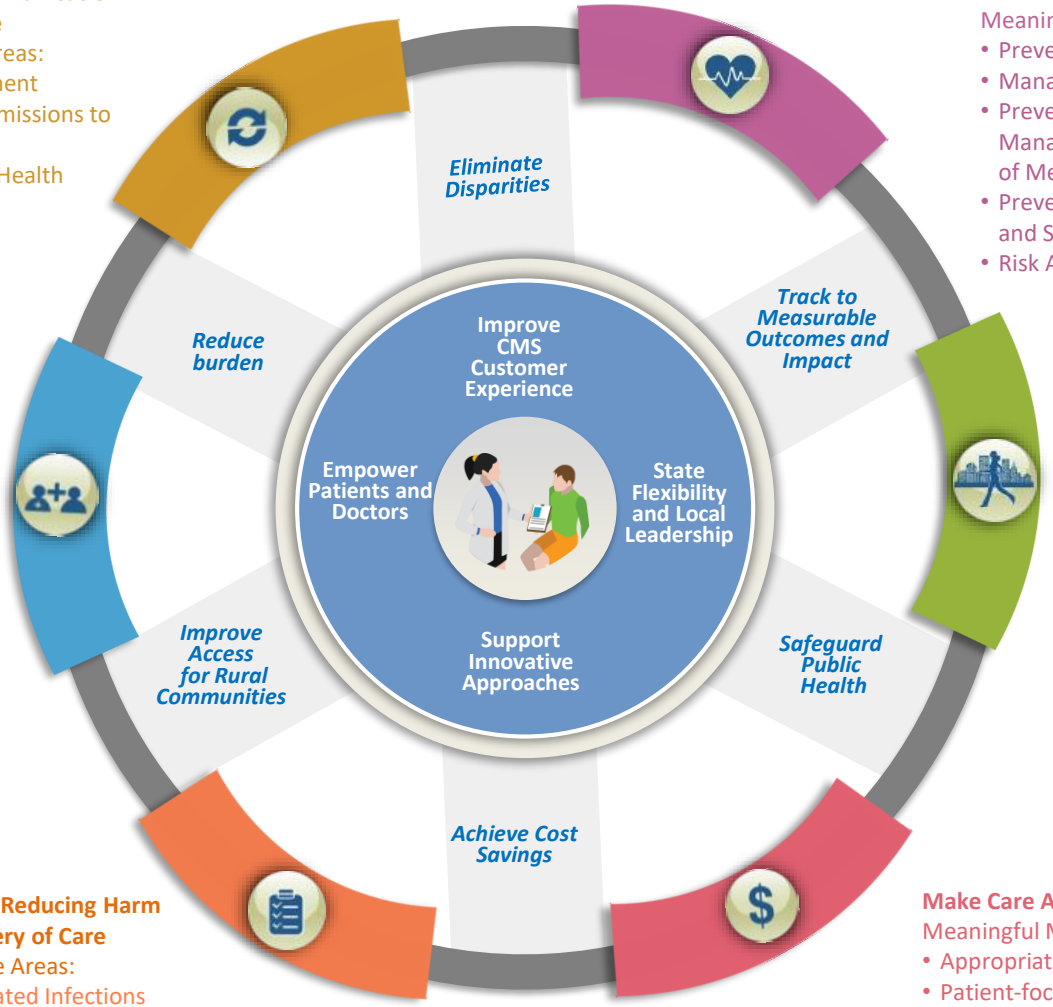
Drawing from the HCP LAN "Big Dot" Work



Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Seamless Transfer of Health Information

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality



Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience and Functional Outcomes

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Make Care Affordable
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Patient Safety

Healthcare-Associated Infections

Preventable Healthcare Harm

Meaningful Measure Areas

Central Line-Associated Bloodstream Infection (CLABSI) HACRP, LTCH QRP, Medicaid & CHIP, QIO

Surgical Site Infections (SSI) IQR

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure LTCH QRP, IRF QRP

Catheter-Associated Urinary Tract Infection (CAUTI) IRF QRP, LTCH QRP, QIO

Early Elective Delivery Medicaid & CHIP

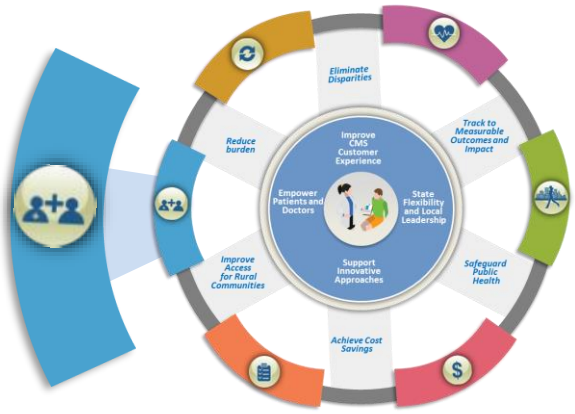
Percent of Patients or Residents with Pressure Ulcers that are New or Worsened IRF QRP, LTCH QRP, SNF QRP, HH QRP

Measures

Programs Using Illustrative Measures

Hospital-Acquired Condition Reduction Program (HACRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Hospital Inpatient Quality Reporting (IQR) Program
Home Health Quality Reporting Program (HH QRP)
Quality Improvement Organization (QIO)

Strengthen Person & Family Engagement as Partners in their Care



Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

Patient's Experience and Functional Outcomes

Meaningful Measure Areas

The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function IRF QRP, LTCH QRP, SNF QRP, HH QRP

Care plan QPP

Hospice Visits while Death is Imminent HQRP

CAHPS® Hospice Survey: Getting Emotional and Religious Support HQRP

CAHPS In-Center Hemodialysis Survey ESRD QIP

Home and Community Based Services CAHPS Medicaid & CHIP

Functional Status Assessment for Total Hip Replacement QPP

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Hospice Quality Reporting Program (HQRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Home Health Quality Reporting Program (HH QRP)

Promote Effective Communication & Coordination of Care

Effective Communication and Care Coordination

Medication Management

Admissions and Readmissions to Hospitals

Seamless Transfer of Health Information

Meaningful Measure Areas

- Use of High Risk Medications in the Elderly QPP
- Medication Reconciliation Post-Discharge MSSP
- Drug Regimen Review Conducted with Follow-Up for Identified Issues IRF QRP, LTCH QRP, SNF QRP, HH QRP
- Standardized Readmission Ratio (SRR) ESRD QIP
- Plan All-Cause Readmissions Medicaid & CHIP
- Use of an Electronic Health Record IPFQR, QIO

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Medicare Shared Savings Program (MSSP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Home Health Quality Reporting Program (HH QRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Quality Improvement Organization (QIO)

Promote Effective Prevention & Treatment of Chronic Disease

Prevention and Treatment of Leading Causes of Morbidity and Mortality

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Meaningful Measure Areas

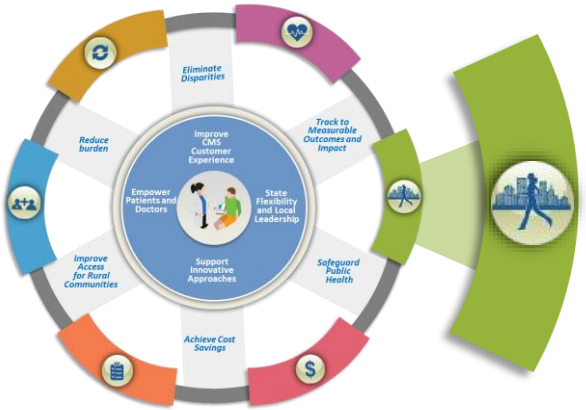
- Influenza Immunization Received for Current Flu Season HH QRP
- Timeliness of Prenatal Care (PPC) Medicaid
- Osteoporosis Management in Women who Had a Fracture QPP
- Follow-up after hospitalization for Mental Illness IPFQR
- Alcohol Use Screening IPFQR
- Use of Opioids at High Dosage Medicaid & CHIP
- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization HVBP

Measures

Programs Using Illustrative Measures

Home Health Quality Reporting Program (HH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Quality Payment Program (QPP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Hospital Value-Based Purchasing (HVBP) Program

Work with Communities to Promote Best Practices of Healthy Living

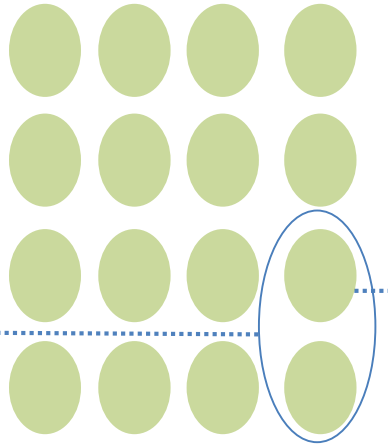


Health and Well-Being

Equity of Care

Community Engagement

Meaningful Measure Areas



Measures

Discharge to Community-Post Acute Care HH QRP, LTCH QRP, IRF QRP, SNF QRP

Programs Using Illustrative Measures

Home Health Quality Reporting Program (HH QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Make Care Affordable

Affordable Care

Appropriate Use of Healthcare

Patient-focused Episode of Care

Risk Adjusted Total Cost of Care

Meaningful Measure Areas

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis QPP

Caesarean Section Medicaid & CHIP

Spinal Fusion Clinical Episode-Based Payment (Sfusion Payment) Measure IQR

Medicare Spending Per Beneficiary IRF QRP, LTCH QRP, SNF QRP, HH QRP

Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Heart Failure (HF) HVBP

Oncology Care Model CMMI

Total Per Capita Costs for All Attributed Beneficiaries VM

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Hospital Inpatient Quality Reporting (IQR) Program
Hospital Value-Based Purchasing (HVBP) Program
Center for Medicare and Medicaid Innovation (CMMI)
Value Modifier (VM) Program
Home Health Quality Reporting Program (HH QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Meaningful Measures Next Steps

- Get stakeholder input to further improve the Meaningful Measures framework
- Work across CMS components to implement the framework
- Evaluate current measure sets and inform measure development

Meaningful Measures Summary

Meaningful Measure Areas

Guiding CMS's efforts to achieve better health and healthcare for the patients and families we serve

Give us your feedback!

Pierre.Yong@cms.hhs.gov
Theodore.Long@cms.hhs.gov

Meaningful Measures

Question & Answer

To ask a question, please dial:

1-877-388-2064

MAP Rural Health Introduction and Presentation

2015 Rural Project: Purpose and Objectives

- To provide multistakeholder information and guidance on performance measurement issues and challenges for rural providers
  - *Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians*
  - *Make recommendations to help mitigate measurement challenges for rural providers, including the low-case volume challenge*
  - *Identify measurement gaps for rural hospitals and clinicians*

Key Issues Regarding Measurement of Rural Providers

- Geographic isolation
- Small practice size
- Heterogeneity
- Low case-volume

Previous Rural Work: Overarching Recommendation

- Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and explicitly address low-case volume

Previous Rural Work: Supporting Recommendations for Measure selection

- Use guiding principles for selecting quality measures that are relevant for rural providers
- Use a core set of measures, along with a menu of optional measures, for rural providers
- Consider measures that are used in Patient-Centered Medical Home models
- Create a Measures Applications Partnership (MAP) workgroup to advise CMS on the selection of rural-relevant measures

Objectives for 2017-2018 MAP Rural Health Workgroup

- Advise MAP on selecting performance measures that address the unique challenges, issues, health care needs and other factors that impact of rural residents
  - *Develop a set of criteria for selecting measures and measure concepts*
  - *Identify a core set(s) of the best available (i.e., "rural relevant") measures to address the needs of the rural population*
  - *Identify rural-relevant gaps in measurement*
  - *Provide recommendations regarding alignment and coordination of measurements efforts across programs, care settings, specialties, and sectors (both public and private)*
  - *Address a measurement topic relevant to vulnerable individuals in rural areas*

Interaction With Other MAP Workgroups and Coordinating Committee

- NQF staff will introduce the Rural Workgroup and represent rural perspective at Nov-Dec 2017 Workgroup and Coordinating Committee meetings
- The MAP Coordinating Committee will consider input from the MAP Rural Health Workgroup during pre-rulemaking activities
- MAP Coordinating Committee will review and approve the Rural Health Workgroup's recommendations before finalizing (August 2018)

Progress to date

- Seated the Workgroup
  - *18 organizational members*
  - *7 subject matter experts*
  - *3 federal liaisons*
- Convened orientation meeting on November 29
- Obtained initial guidance on criteria for identifying core set measures
  - *NQF endorsement*
  - *Addresses low case volume*
  - *Cross-cutting*
  - *Several "must-have" topic areas/conditions*

Discussion Questions: Your Advice to the Rural Health MAP Workgroup

- What are the key issues measurement for PAC/LTC programs that you want to RH WG to keep in mind?
- Does the initial guidance from the RH WG concerning core measures (e.g., cross-cutting, etc.) ring true? Any concerns? Any additions?
- Going forward, what information/guidance/input from the RH WG be helpful to your work on MAP?
- What advice can you give this new WG vis-à-vis serving on a MAP Workgroup?

Update on Implementation of the IMPACT Act

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

- Passed on September 18, 2014, and signed into law October 6, 2014.
- **The Act requires the submission of <u>standardized</u> patient assessment data elements by:**
  - *Long-Term Care Hospitals (LTCHs): LCDS*
  - *Skilled Nursing Facilities (SNFs): MDS*
  - *Home Health Agencies (HHAs): OASIS*
  - *Inpatient Rehabilitation Facilities (IRFs): IRF-PAI*

- **Requires Standardized Patient Assessment Data that will enable:**
  - Quality care and improved outcomes
  - Data Element uniformity
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordinated care
  - Inform payment models

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Requirements for Standardized Assessment Data

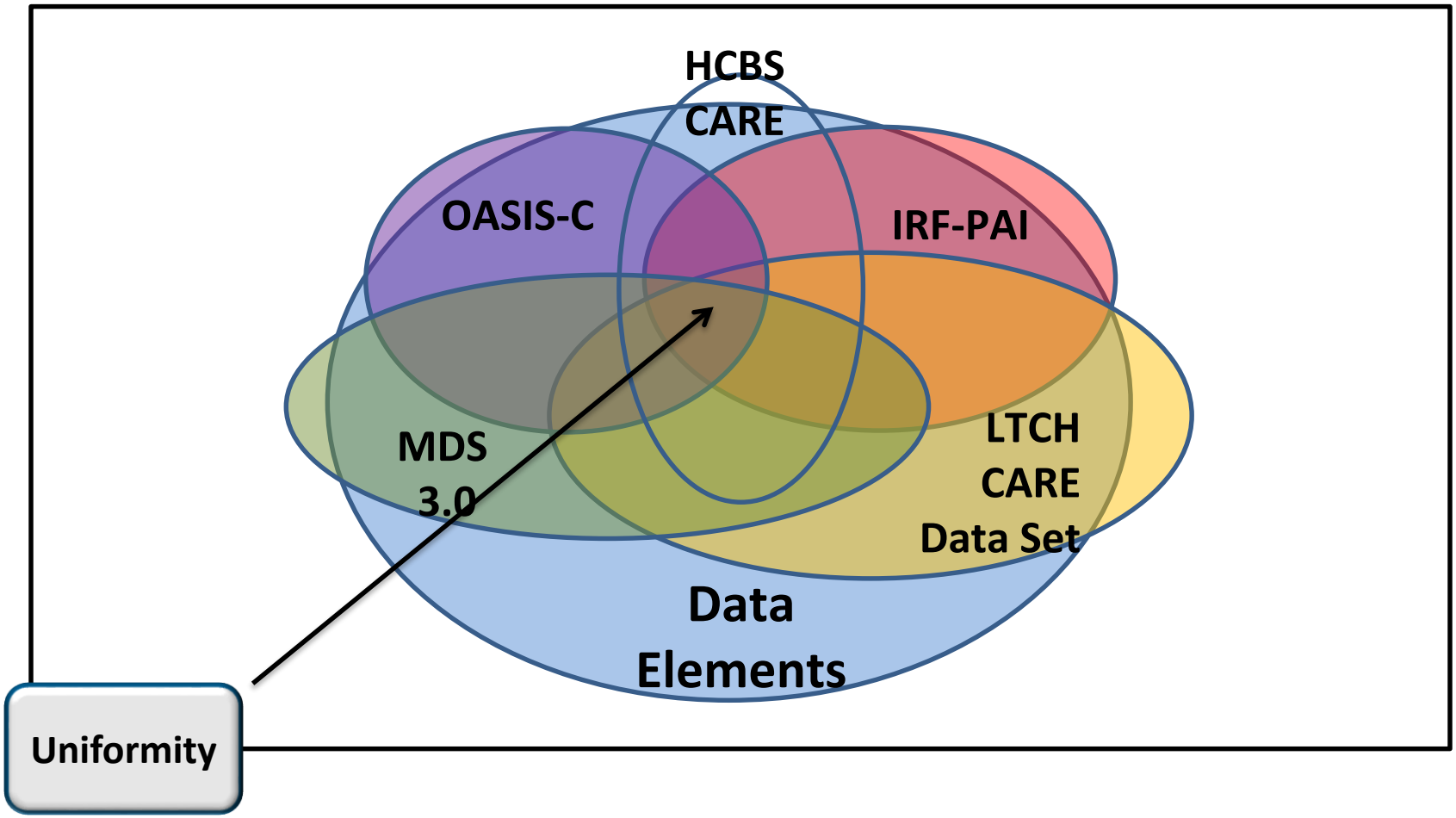
IMPACT Act added new section 1899(B) to Title XVIII of the Social Security Act (SSA)

- **Post-Acute Care (PAC) providers must report:**
  - Standardized assessment data
  - Data on quality measures
  - Data on resource use and other measures

- **The data must be standardized and interoperable to allow for the:**
  - Exchange of data using common standards and definitions
  - Facilitation of care coordination
  - Improvement of Medicare beneficiary outcomes

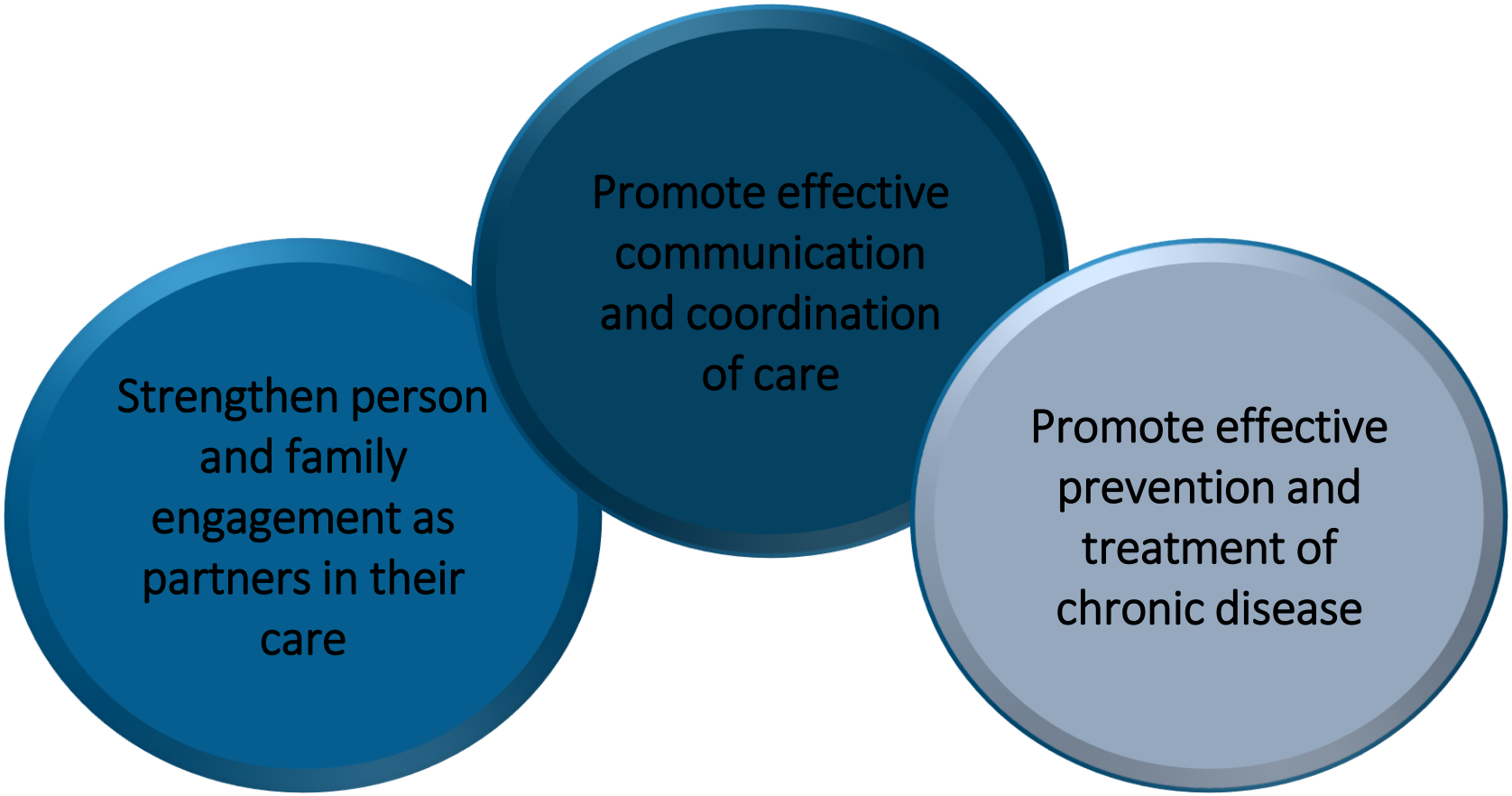
- **PAC assessment instruments must be modified to:**
  - Enable the submission of standardized data
  - Compare data across all applicable providers

Data Elements: Standardization



Addressing Critical Gaps: The IMPACT Act

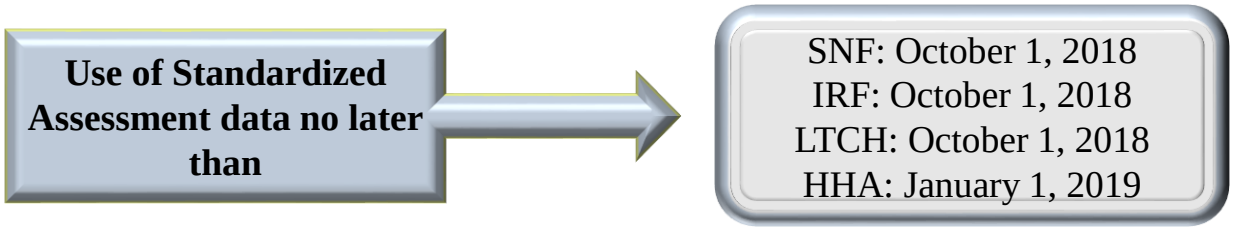
An opportunity to address complex goals



The IMPACT Act: Standardized Patient Assessment Data

Requirements for reporting assessment data:

- Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions



- The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

Data categories:

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions
- Medical conditions and co-morbidities
- Impairments
- Other categories required by the Secretary

Standardized Assessment Data Elements

One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

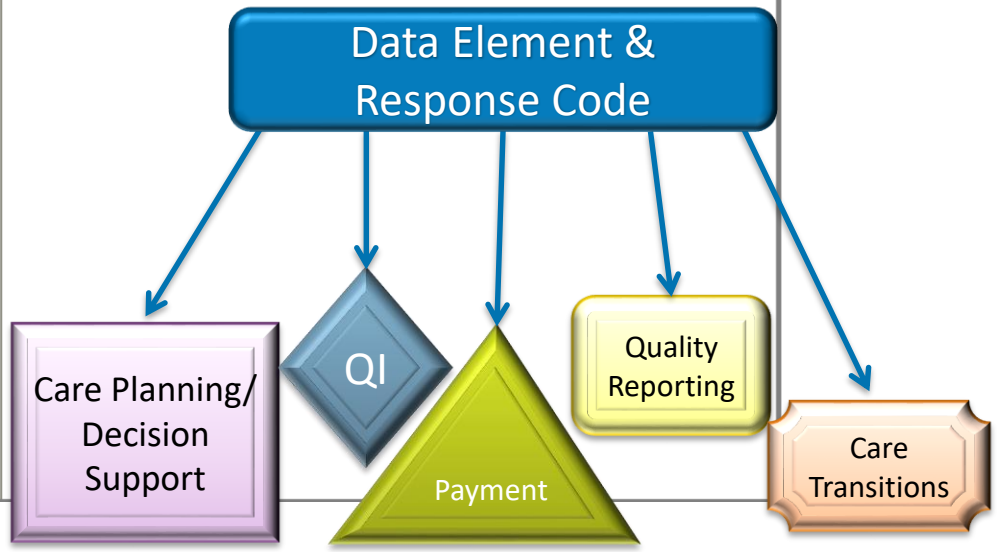
Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

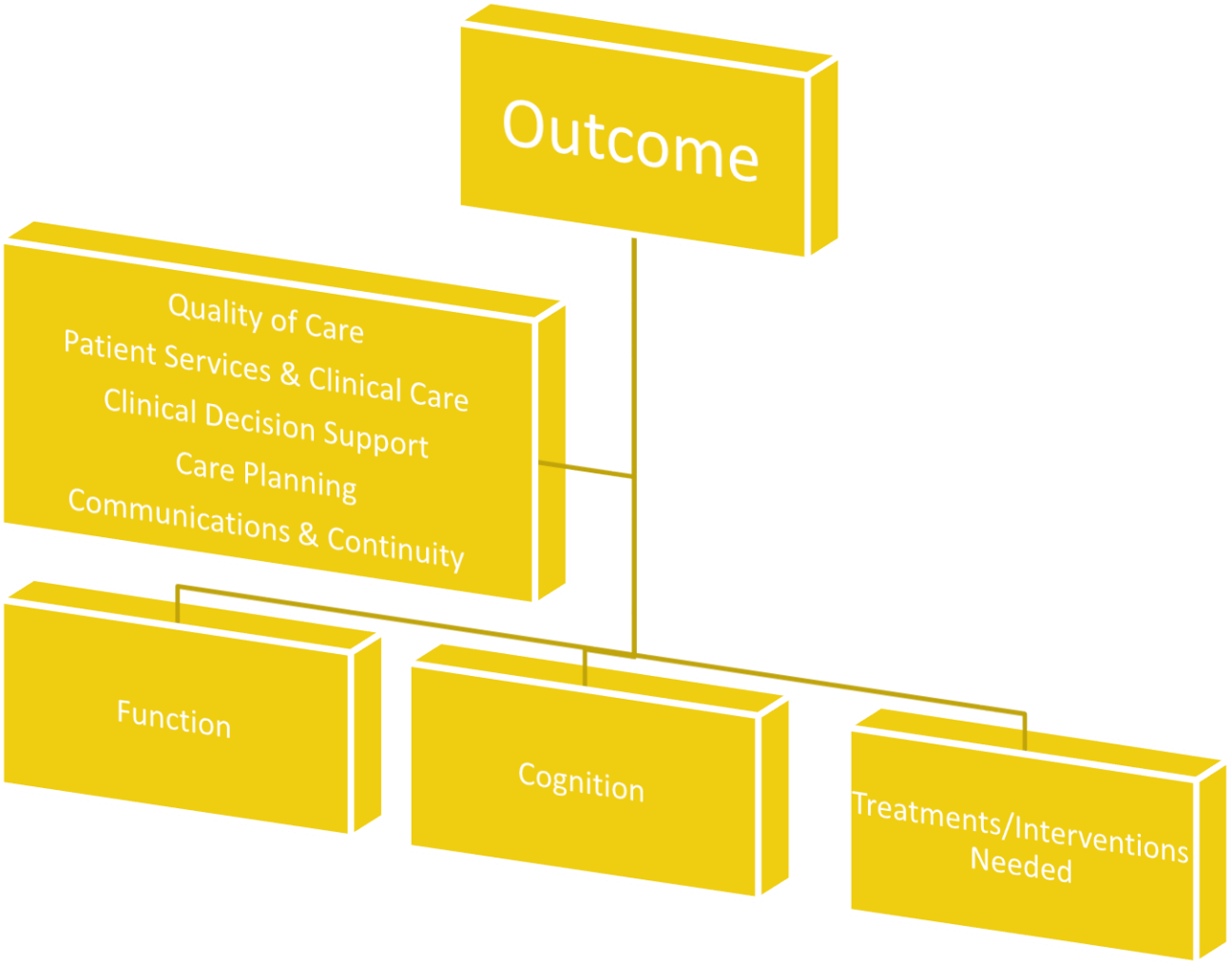
07. **Patient refused**
09. **Not applicable**

If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

Enter Codes in Boxes	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.



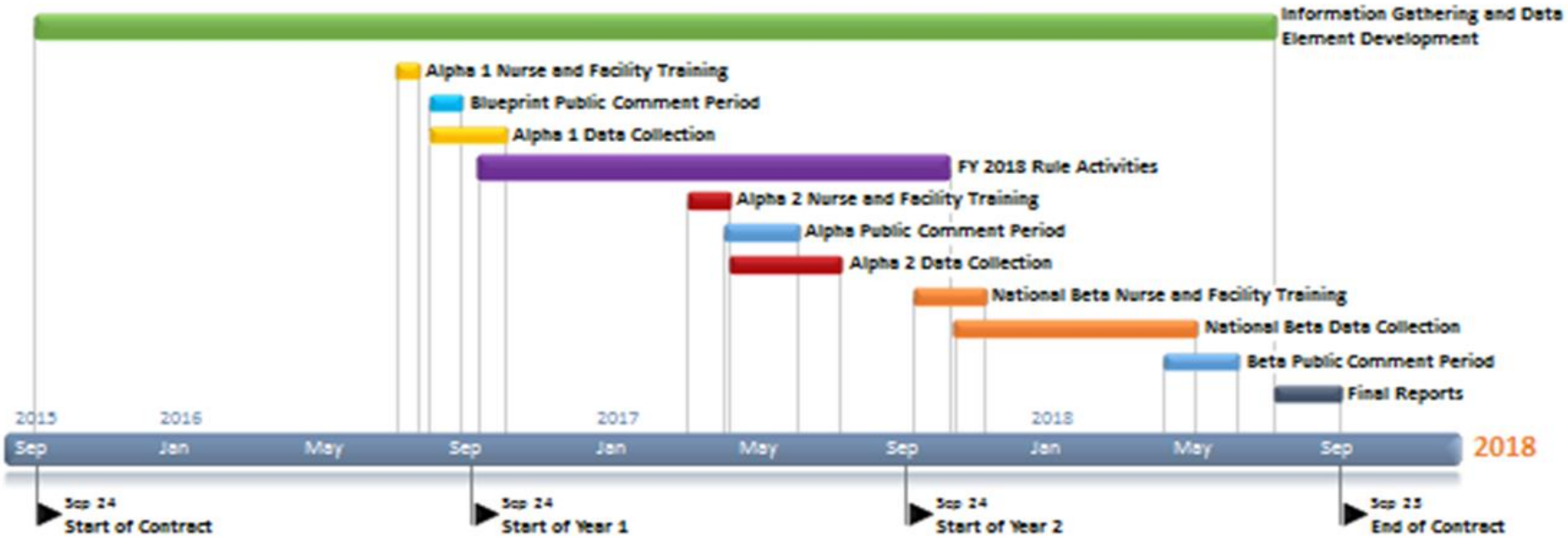
Medical Complexity, Quality, and Outcome



Overview of the RAND Contract

- Project goal is to develop, implement, and maintain standardized PAC patient assessment data
- Project phases:
  1. *Information Gathering: Sep 2015 – Apr 2016*
  2. *Pilot Testing (Alpha 1 and Alpha 2): Aug 2016 – July 2017*
  3. *National Beta Testing: Begins Fall 2017*

Standardized Assessment Categories: General Timeline



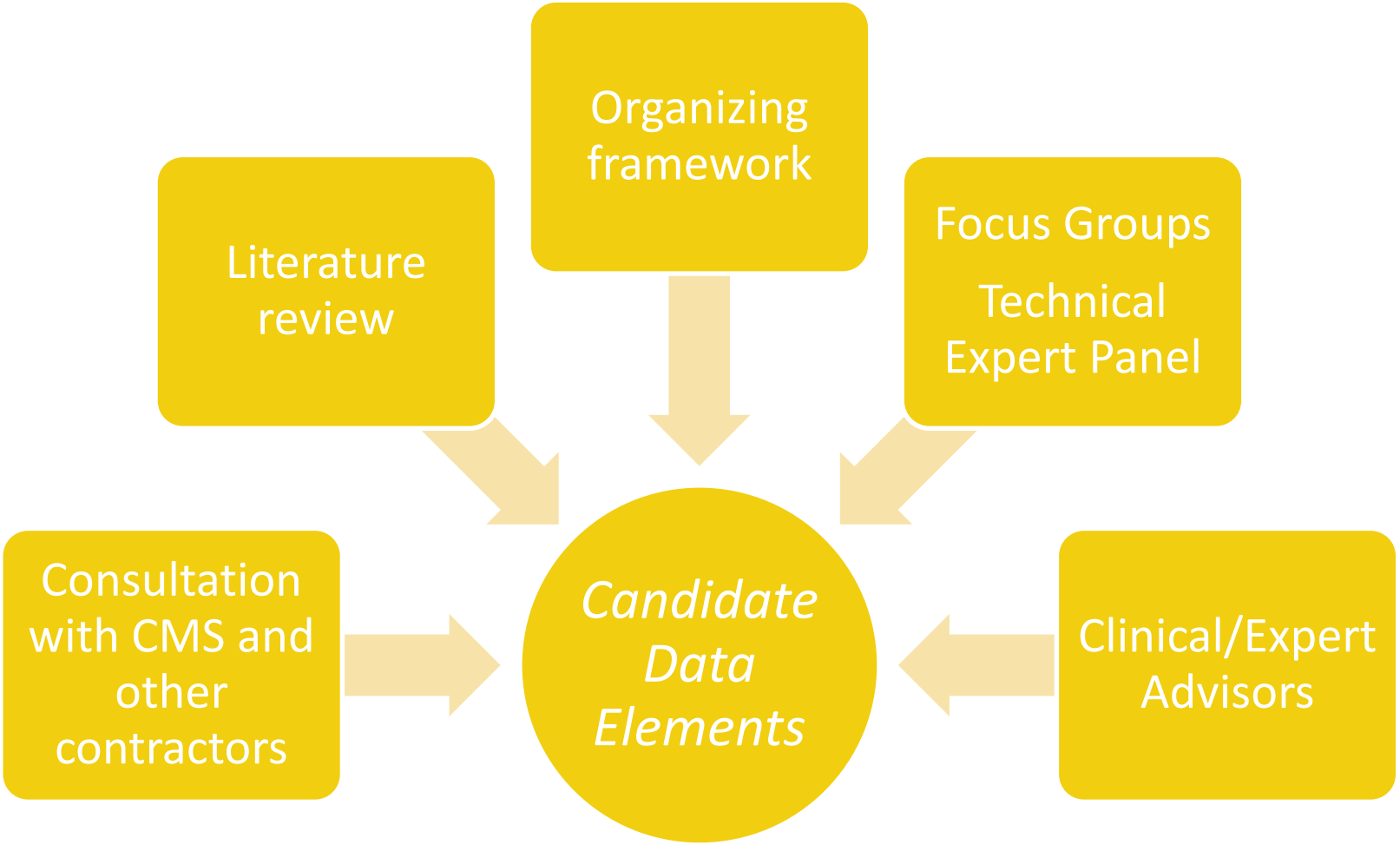
The IMPACT Act Data Element Development and Activities

Date	Event	Activity Type
Sept 28, 2017	September SODF	Stakeholder Engagement
Oct 2017	National Data Element Testing (Beta) - Research nurse in-person training	National Field Test
Nov 2017	National Data Element Testing (Beta) - Begin field trainings in 14 markets	National Field Test
Nov 2017	National Data Element Testing (Beta) - All facilities recruited (est.)	National Field Test
Nov 2017	National Data Element Testing (Beta) - Data collection begins (through May 2018)	National Field Test
Dec 2017	Public Comment Report published to CMS website	Stakeholder Engagement
Dec 2017	Data Collection Protocols for National Data Element Testing (Beta) published to CMS website	National Field Test
Dec 2017	Data Element Standardization FAQ page posted to CMS website	Stakeholder Engagement
Dec 2017	December SODF	Stakeholder Engagement
Winter 2017-2018	Alpha 2 Provider Debrief	Alpha Testing
Jan 2018	Pilot Data Element Testing (Alpha) - Final report	Alpha Testing
Mar 2018	SODF; Stakeholder webinar series	Stakeholder Engagement
Mar 2018	Beta participant survey	National Field Test
May-June 2018	Public Comment Period	Stakeholder Engagement
Jun 2018	SODF; Stakeholder webinar series	Stakeholder Engagement
Summer 2018	Beta participant focus groups	Stakeholder Engagement
Sep 2018	TEP	Stakeholder Engagement
Fall 2018	Public Comment Period report published to CMS website	Stakeholder Engagement
Winter 2018-2019	National Data Element Testing (Beta) summary report	National Field Test

Standardized Patient Assessment Data Elements: The Framework

- Testing for standardized patients assessment data elements are for the clinical categories outlined in IMPACT Act:
  - *Cognitive function*
  - *Mental status (e.g., mood)*
  - *Medical conditions (e.g., pain)*
  - *Impairments (e.g., incontinence and sensory impairments)*
  - *Special services, treatments and interventions (e.g., dialysis)*
  - *Other clinical topics (e.g., care preferences, medication reconciliation and global health)*

Information Gathering Identified Candidate Data Elements for Standardization



Evaluation of Candidate Data Elements

Potential for improving quality	• Improve care transitions, person-centered care and care planning • Improve care practices and patient safety • Use for quality comparisons, including value based payment models • Supports clinical decision making and care coordination
Validity and reliability	• Inter-rater reliability (consensus in ratings by two or more assessors) • Validity (captures the construct being assessed)
Feasibility for use in PAC	• Potential to be standardized and made interoperable across settings • Clinically appropriate • Relevance to work flow
Utility for describing case mix	• Potential use for payment models • Measures differences in severity levels related to resource needs

Two Tracks of Work for Candidate Data Elements

- Track 1 – data elements with prior evidence
  - *Existing evidence for cross-setting feasibility and performance (mostly from PAC PRD)*
    - Cognitive Function and Mental Status
    - Special Services, Treatments and Interventions
    - Sensory Impairments
- Track 2 – feasibility testing
  - *Data elements that fill gaps but require more feasibility and performance testing*
    - Cognition (executive functioning), pain, continence, care preferences, medication reconciliation

Track 1 Status

- Data elements identified for FY 2018 proposed rule (cognitive function and mental status, special services, treatments and interventions, impairments) were not finalized
- Reasons for this decision:
  - *To be responsive to stakeholders' comments that the addition of standardized data elements "are too much, too soon."*
  - *To enable greater "recovery" for providers between major releases as expressed*
  - *To allow for additional reliability and validity testing, including testing on time points used in data collection*
  - *To allow more time with stakeholders and TEPs to build additional consensus on elements*

Track 2 Status

- The majority of data elements were feasible to administer and showed adequate to excellent agreement between raters
- Some data elements did not perform well in alpha 1 and were modified and re-tested in alpha 2
- Qualitative feedback from assessors was used to help evaluate and improve training instructions and data element specifications
- Both qualitative and quantitative information was used to identify data elements that may be problematic or overly burdensome across PAC settings

Next Steps

- Identify data elements from both tracks for national field testing (beta test)
- Outreach and consensus building activities for data elements being tested
  - *Feedback sessions with facility staff and administrators participating in beta field test to gain understanding of workflow constraints and issues and identify ways to mitigate burden*
  - *Stakeholder webinars to report interim findings from beta test*

National Beta Test

- Test reliability and validity of candidate data elements from both tracks of work in a national sample of PAC providers
- Field test taking place over a span of six months starting in November 2017
- 14 geographic/metropolitan areas were randomly selected and eligible providers have been randomly selected from within these 14 areas
- Eligible providers are being contacted and invited to participate
- Participation is voluntary

Beta Patient/Resident Participants

- Beneficiaries selected will be Medicare only or dually eligible (Medicare-Medicaid) that are admitted to participating providers during the field period

PAC setting	Target number of patients per facility	Target number of facilities	Target number of admission assessments	Target number of discharge assessments
LTCH	30	28	840	579
IRF	30	28	840	772
SNF	25	84	2100	1491
HHA	25	70	1750	1103
TOTAL	----	210	5530	4055

Beta Data Collection

- Completed electronically on handheld tablets provided to the facilities
- Protocol includes patient interviews, patient observation and record review items
- A subset of assessments will be coded by both facility staff and a project research nurse to evaluate inter-rater reliability
- Research nurses will also conduct repeat assessments on a subset of patients to identify optimal lookback for items

Beta Assessment Categories

- **Assessment will focus on:**
  - *Cognitive status*
  - *Mental status*
  - *Pain*
  - *Impairments*
  - *Special services, treatments and interventions*

  - *Other categories*
    - Care preferences
    - PROMIS: Global health
    - Medication reconciliation

Beta Data Elements by Category: Cognitive Status

Data Element	Data Element Activities	Beta Test Considerations
Expression and Understanding	PC1	Two versions will be tested; included in Day 3,5,7 test
Brief interview for mental status (BIMS)	PC1, draft rule	Included in Day 3,5,7 test
Signs and symptoms of delirium (CAM)	PC1, draft rule	Included in Day 3,5,7 test
Behavioral signs and symptoms	PC1, draft rule; Alpha 2, PC2	Included in Day 3,5,7 test
Staff assessment of mental status	Alpha 2, PC2	For patients/ residents unable to communicate

Beta Data Elements by Category: Mental Status

Data Element	Data Element Activities	Beta Test Considerations
PHQ-2 to 9	PC1, draft rule; alpha 1	
PROMIS Depression	TEP/stakeholder review	Two versions tested in beta
PROMIS Anxiety	Alpha 2, PC2	Two versions tested in beta
Staff assessment of mood (PHQ-9 OV)	Alpha 2, PC2	For patients/ residents unable to communicate

Beta Data Elements by Category: Pain

Data Element	Data Element Activities	Beta Test Considerations
Pain interview: presence, frequency, severity, effect on sleep, interference with therapy and non-therapy related activities, relief	PC1; alpha 1, PC2	Two versions will be tested; included in Day 3,5,7 test
Staff assessment of pain or distress	Alpha 2, PC2	For patients/ residents unable to communicate

Beta Data Elements by Category: Impairments

Data Element	Data Element Activities	Beta Test Considerations
Ability to hear, ability to see	PC1, draft rule	
Continence (bladder and bowel): Patient/resident perceived problem	Alpha 1, PC2	
Continence (bladder and bowel): Appliance use, frequency of events	Alpha 1, PC2	Will be recorded on admission Days 1, 3, 5 and 7; discharge date and discharge date -2

Beta Data Elements by Category: Special services, treatments and interventions

Data Element	Data Element Activities	Beta Test Considerations
Services and treatments: Cancer, respiratory, other	PC1, draft rule	Will be recorded on admission Days 1, 3, 5 and 7; discharge date and discharge date -2
Nutritional approaches: IV or feeding tube, diet	PC1, draft rule	Will be recorded on admission Days 1, 3, 5 and 7; discharge date and discharge date -2

Beta Data Elements by Category: Other

Data Element	Data Element Activities	Beta Test Considerations
Care preferences: Decision making preferences, designated health care agent	Alpha 1, Alpha 2, PC2	
PROMIS Global health	PC2, TEP2	Two versions will be tested
Medication reconciliation	Alpha 1, Alpha 2, PC2	

Update on the PROMIS Tool

Patient-Reported Outcomes and Information System (PROMIS)

- NIH and CMS staff participated in meetings to discuss capabilities and use of PROMIS.
- Project goals included to test PROMIS item domains of most interest for PAC assessment.
- PROMIS items from domains considered:
  - *Cognitive Function*
  - *Anxiety*
  - *Physical Function and Mobility*
  - *Fatigue*
  - *Sleep Disturbance*
  - *Social Role Functioning*
  - *Depression*
  - *Pain*
- TEP, expert/consumer survey, interviews of patients on item clarity, and, public comment.

PROMIS: TEP, Cognitive Testing, and Public Comment

- Public comment and SME input on the PROMIS items suitability.
- Results used to create smaller item sets, which were subjected to cognitive testing with patients.
- Small-scale patient interviews on the clarity of PROMIS items.
  - *Indicated variability in "time-frame" patients had in mind when evaluating different health concepts.*
- Overall Public Comment on PROMIS, very brief summary:
  - *Support: anxiety can improve person-centered care and prevention of readmission.*
  - *Concern: validity of PROMIS generally in PAC (patients unlike those with chronic conditions), increased burden, staff reluctance to diagnose mood, overlap with MDS/OASIS.*

PROMIS: The National Beta Test

- Beta Test will include:
  - *PROMIS Global 10*
  - *Depression*
  - *Anxiety*
- Global 10: Half of the national sample assessment protocols will include the following 10-item PROMIS® Global Health Assessment, while half of the national sample will include a slightly modified 10-item PROMIS® Global Health Assessment, which uses a reference period of 'in the past 3 days'.
- Depression and Anxiety: Half of the national sample assessment protocols will include PROMIS® Depression and PROMIS® Anxiety item sets that ask about mood over the past 3 days, and the other half will ask over the past 7 days.

PROMIS: The OASIS Field Test

- Abt Associates, Inc. conducted a comprehensive mixed methods field test of OASIS
  - *12 Medicare-certified home health agencies in four states*
  - *Total 213 participants enrolled (Aug 2016-Jul 2017)*

- Testing included proof of concept study for patient reported outcomes
  - *PROMIS® Global Health Survey v1.1*
  - *Among 213 field test participants: 56 completed PROMIS survey at both start/resumption of care (SOC/ROC) and at discharge (DC)*

PROMIS quantitative results

Survey Respondents (n=56)		
Age 65+	White race	Female
76.9%	79.8%	60.6%

- Compared to US reference population subgroup (age 65 +) survey respondents reported significantly worse global physical and mental health (GPH, GMH).
- A majority reported improvement in GPH (62%) and GMH (59%) from SOC/ROC to DC.
- Most notable improvements reported in pain, and ability to carry out physical activities.
- Completion of PRO survey feasible among cognitively intact home health patients.

Applications of MIPS in PAC-LTC

MIPS Overview

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (Advanced APMs)

MIPS Overview

- MIPS combined legacy programs into a single program:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VM)
  - Medicare EHR Incentive Program (EHR) for Eligible Professionals

MIPS Overview

- Comprised of four performance categories in 2018:
  - Quality
  - Cost
  - Improvement Activities
  - Advancing Care Information

MIPS Overview

- Who is included:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
- ***Change*** *to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Workgroup Discussion

- What are the challenges PAC/LTC clinicians face to participate in MIPS?
- Are there gaps in the measure set that prevent PAC/LTC clinicians from being able to participate?
- Does the Workgroup have any guidance on ways to improve the measures to facilitate participation for PAC/LTC providers?

MAP Pre-Rulemaking Approach

Jean-Luc Tilly, Senior Project Manager, NQF

Approach

The approach to the analysis and selection of measures is a three-step process:

- Provide program overview
- Review current measures
- Evaluate MUCs for what they would add to the program measure set

Evaluate Measures Under Consideration

- MAP Workgroups must reach a decision about every measure under consideration
  - *Decision categories are standardized for consistency*
  - *Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached*

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process, NQF staff will conduct a preliminary analysis of each measure under consideration.

The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was:

- Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee, to evaluate each measure
- Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions

MAP Measure Selection Criteria

1	NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. MAP will provide a rationale that outlines the conditions (e.g., NQF endorsement) based on assessments 4-7 (reference Table 2 below) that should be met. Ideally the conditions specified by MAP would be met before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified conditions without resubmitting the measure to MAP prior to rulemaking.
Refine and Resubmit for Rulemaking	The measure meets assessments 1-3, but needs modifications. A designation of this decision category assumes at least one assessment 4-7 (slide 29) is not met. MAP will provide a rationale that outlines each suggested refinement (e.g., measure is not fully developed and tested OR there are opportunities for improvement under evaluation). Ideally the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to the MAP prior to rulemaking. CMS may informally, without deliberations and voting, review these refinements via the "feedback loop" with the MAP. These updates may occur during the web meetings of the MAP workgroups scheduled annually in the fall.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of assessments 1-3.

Guidance on Refine and Resubmit

- Concerns were raised about this category during the fall web meetings
- The Coordinating Committee created this category with the thought that MUCs receiving this designation would be brought back to MAP before implementation.
- HHS Secretary has statutory authority to propose measures after considering MAP's recommendations.
- The feedback loop was implemented to provide MAP members updates on measures on prior MUC lists.
- The Coordinating Committee will review the decision categories at their January meeting.

Guidance on Refine and Resubmit

- The Coordinating Committee discussed the concerns raised by the Workgroups during its 11/30 meeting
  - *Reiterated the intent of the decision was to support the concept of a measure but recognize a potentially significant issue that should be addressed before implementation*
- The Committee suggested this category should be used judiciously
  - *The Coordinating Committee recommended that the Workgroups use this decision when a measure needs a substantive change*
  - *The Committee also noted the need for Workgroups to clarify the suggested refinement to the measure*

Lunch

MAP Voting Instructions

Key Voting Principles

- MAP has established a consensus threshold of greater than 60 percent of participants.
  - *Multiple stakeholder groups would need to agree to reach this threshold.*
  - *Abstentions do not count in the denominator.*
- Every measure under consideration receives a decision, either individually or as part of a slate of measures.
  - *All measures are voted on or accepted as parted of the consent calendar.*
- Workgroups and will be expected to reach a decision on every measure under consideration. There will not be a category of "split decisions" that would mean the Coordinating Committee decides on that measure. However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy.

Key Voting Principles

- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.
- The in-person meeting Discussion Guide will organize content as follows:
  - *Measures under consideration will be divided into a series of related groups for the purposes of discussion and voting. The groups are likely to be organized around programs (Hospital and PAC/LTC) or condition categories (Clinician/Medicaid).*
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
  - *The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support, refine and resubmit) and provide rationale to support how that conclusion was reached.*

Voting Procedure

Step 1. Staff will review a Preliminary Analysis Consent Calendar

- Staff will present each group of measures as a consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives

Voting Procedure

Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion. Workgroup members are asked to identify any MUCs to be pulled off for individual discussion prior to the in-person meeting, if possible.
- Workgroup members should clarify if they are pulling a measure for discussion only or if they disagree with the preliminary analysis and would like to vote on a new motion.
- Measures pulled for discussion will focus on resolving clarifying questions.
  - *If during the course of discussion, a workgroup member determines the discussion has shown the need for a new vote a workgroup member can put forward a motion.*
- Potential reasons members can pull measures:
  - *Disagreement with the preliminary analysis*
  - *New information is available that would change the results of the algorithm*
- Once all measures that the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If a measure is not removed from the consent calendar the associated recommendations will be accepted without discussion

Voting Procedure

Step 3. Discussion and Voting on Measures Identified for a New Motion

- Workgroup member(s) who identified the need for discussion describe their perspective on the use of the measure and how it differs from the preliminary recommendation in the discussion guide.
  - *If a motion is for conditional support or refine and resubmit the member making the motion should clarify and announce the conditions or suggested refinements.*
- Workgroup member(s) assigned as lead discussant(s) for the relevant group of measures will be asked to respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
- The co-chair will then open for discussion among the Workgroup. Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
- After the discussion, the Workgroup member who made the motion has the option to withdraw the motion. Otherwise, the Workgroup will be asked to vote on the motion.
  - *If the motion is for conditional support or refine and resubmit the chair can accept additional conditions or suggested refinement based on the Workgroup's discussion.*
  - *If the named conditions or refinements directly contradict each other, the chair should ask for a separate motion after the original motion has been subject to a vote.*

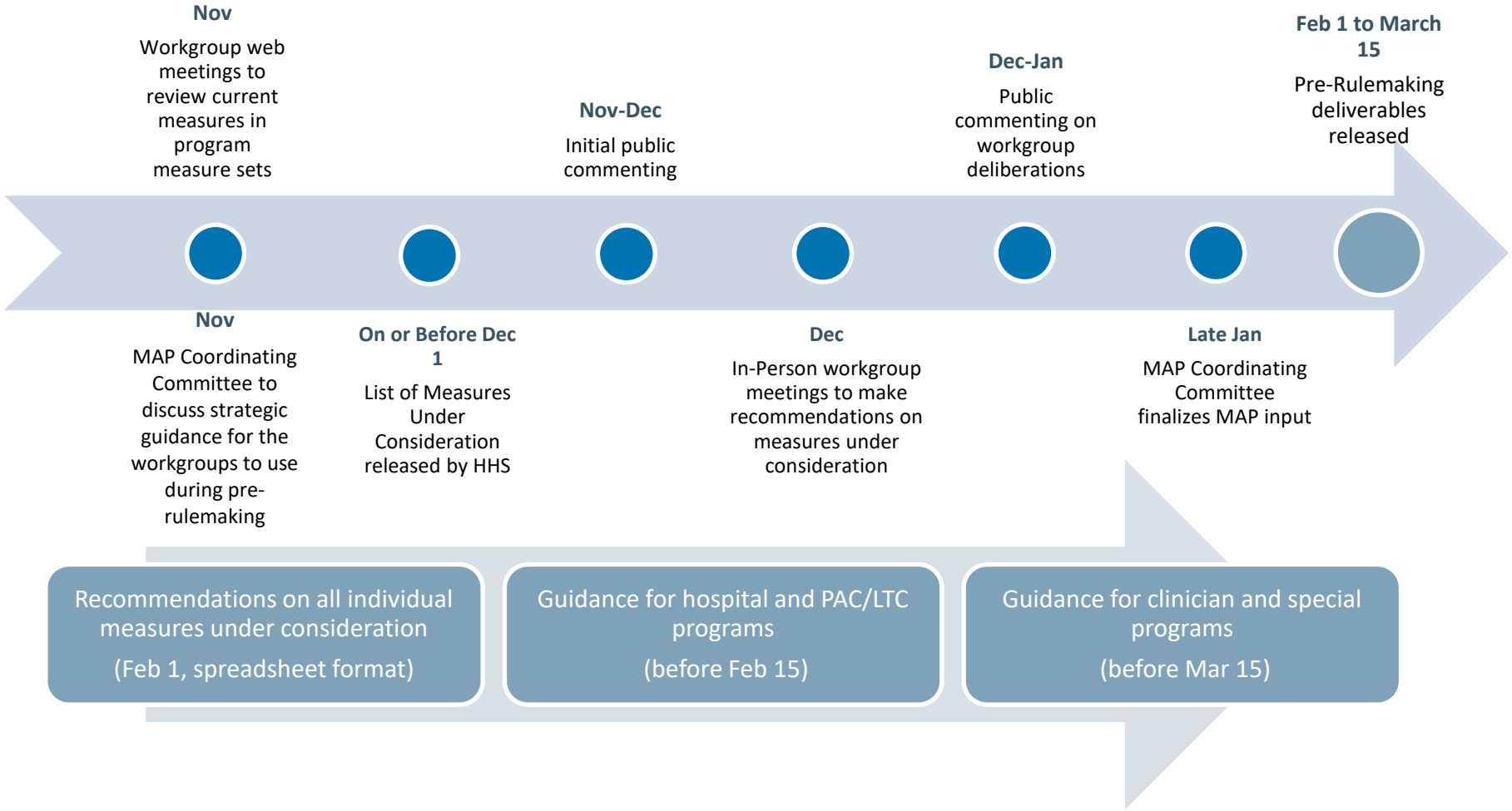
Voting Procedure
Step 4: Tallying the Votes

- If the motion put forward by the workgroup member receives greater than 60% of the votes, the motion will pass and the measure will receive that decision.
- If the motion does not receive greater than 60% of the votes, the co-Chairs will resume discussion to develop another motion. To start discussion, the co-chairs will ask for another motion. If that motion receives greater than 60% of the votes, the motion will pass. If not, discussion will resume.
- If a no motion put forward by the Workgroup achieves greater than 60% the preliminary analysis decision will stand.
- Abstentions are discouraged but will not count in the denominator

Commenting Guidelines

- Comments from the early public comment period have been incorporated into the discussion guide
- There will be an opportunity for public comment before the discussion on each program.
  - *Commenters are asked to limit their comments to that program and limit comments to **two minutes.***
  - *Commenters are asked to make any comments on MUCs or opportunities to improve the current measure set at this time*
- There will be a global public comment period at the end of each day.
- Public comment on the Workgroup recommendations will run from December 21st 2016—January 11th, 2017.
  - *These comments will be considered by the MAP Coordinating Committee and submitted to CMS.*

MAP Approach to Pre-Rulemaking: A look at what to expect



Pre-Rulemaking Input

Skilled Nursing Facility Quality Reporting Program

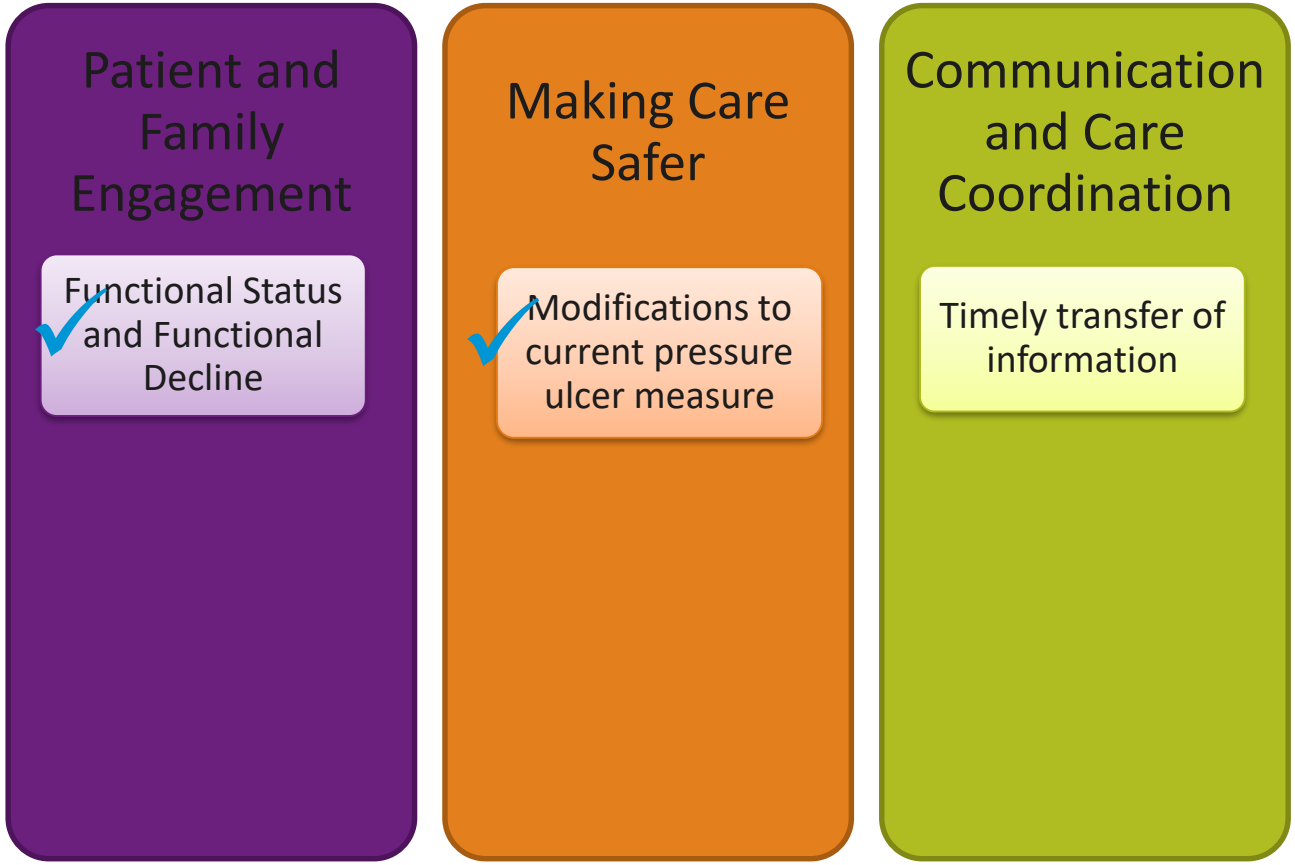
- **Program Type:** Penalty for failure to report
- **Incentive Structure:** Section 1888(e)(6)(A)(i) to the Social Security Act, as added by section 2(c)(4) of the IMPACT ACT, required CMS to reduce the annual payment update to SNFs that do not submit required quality data by two percentage points.
- **SNF QRP Information:**
  - *Facilities that submit data under the SNF PPS are required to participate in the SNF QRP, excluding units that are affiliated with critical access hospitals (CAHs).*
  - *Data sources for SNF QRP measures include Medicare FFS claims as well as Minimum Data Set (MDS) assessment data.*

SNF QRP: Current Program Measure Information

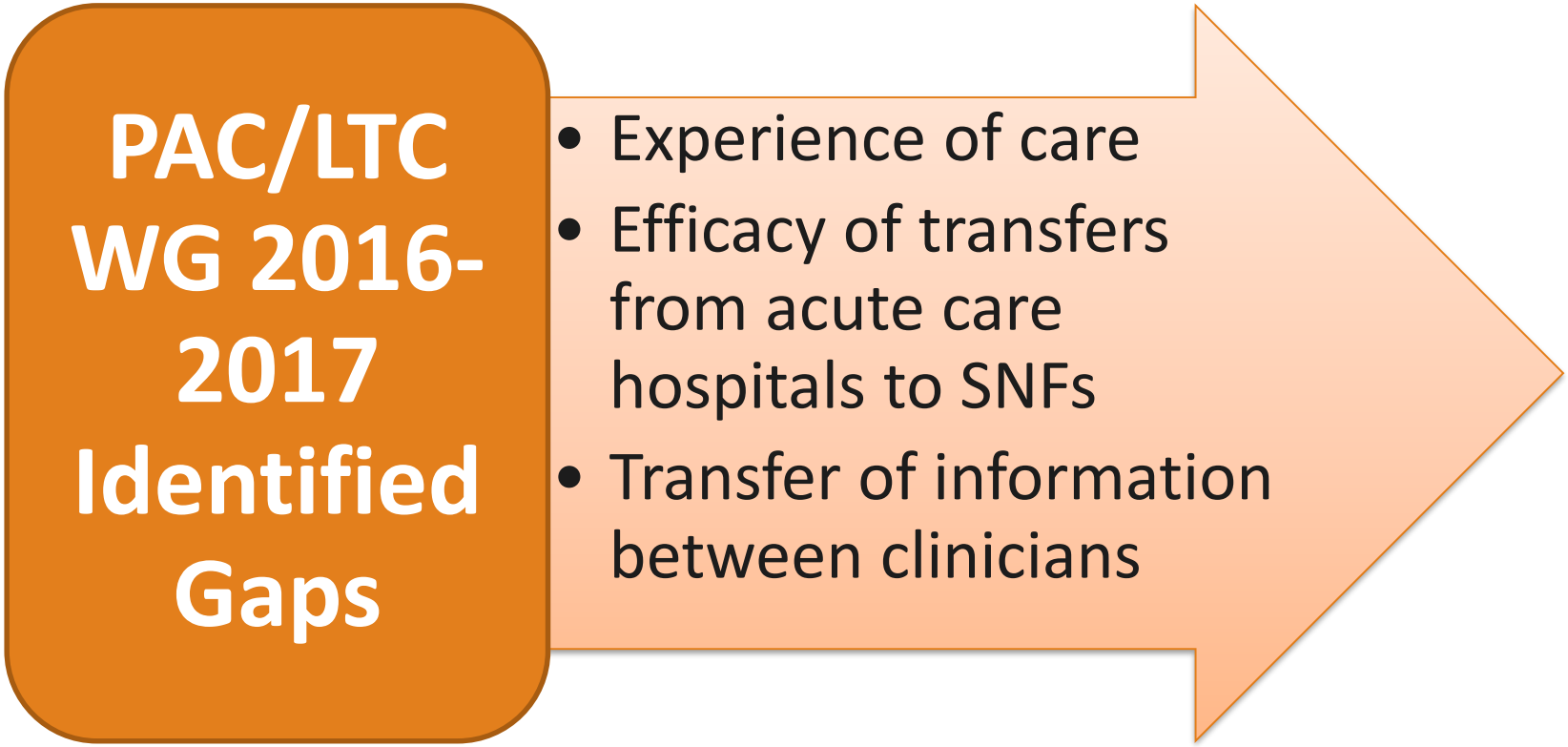
★ Finalized in FY 2018 SNF PPS Final Rule

Type	NQF ID	Measure Title	NQF Status
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Endorsed
Outcome	N/A	Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Not Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care Skilled Nursing Facility Quality Reporting Program	Not Endorsed
Cost/Resource	N/A	Total Estimated Medicare Spending per Beneficiary —Post-Acute Care Skilled Nursing Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program.	Not Endorsed
Outcome	0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (Removed effective 10/1/18 per FY 2018 SNF PPS Final Rule)	Endorsed
Outcome	Based on 2633	Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Endorsed ★
Outcome	Based on 2634	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Endorsed ★
Outcome	Based on 2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Endorsed ★
Outcome	Based on 2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Endorsed ★
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed ★

CMS High Priority Domains for Future Measure Consideration – SNF QRP



Previous Gaps Identified



Public Comment

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Consent Calendar:**
  - *MUC17-258: CoreQ: Short Stay Discharge Measure*

Workgroup Discussion

- Are there additional gap areas for this program?

Hospice Quality Reporting Program

- **Program Type:** Penalty for failure to report
- **Incentive Structure:** The Hospice QRP was established under the Affordable Care Act. Beginning in FY 2014, Hospices that fail to submit quality data will be subject to a 2.0 percentage point reduction to their annual payment update.
- **Hospice QRP Information**:.
  - *Data sources for Hospice QRP measures include the Hospice Item Set and Hospice CAHPS.*

Hospice QRP: Current Program Measure Information

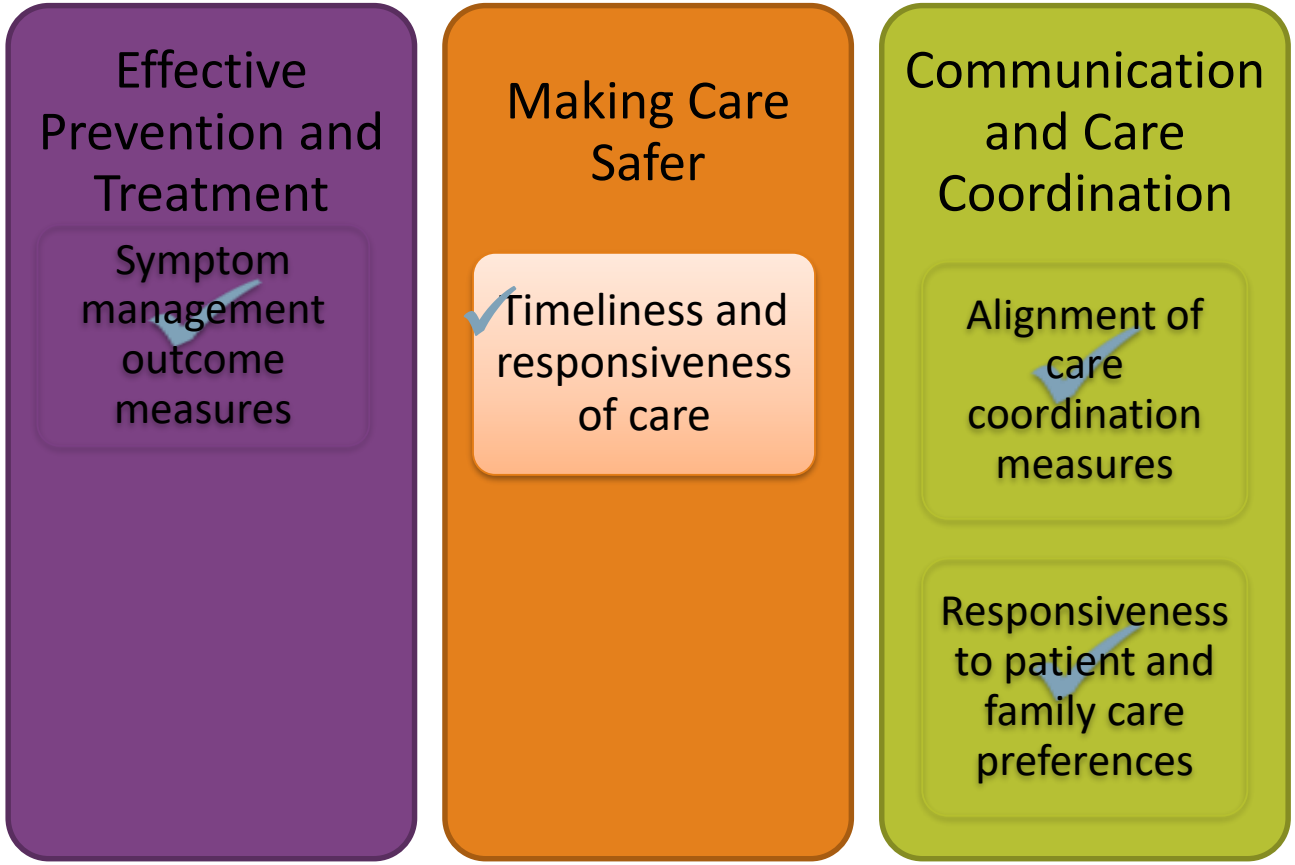
★ Finalized in FY 2018 Hospice PPS Final Rule

Type	NQF ID	Measure Title	NQF Status
Process	1638	Dyspnea Treatment	Endorsed
Process	1639	Dyspnea Screening	Endorsed
Process	1637	Pain Assessment	Endorsed
Process	1634	Pain Screening	Endorsed
Process	1641	Treatment Preferences	Endorsed
Process	1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Endorsed
Process	1647	Beliefs/Values Addressed (if desired by the patient)	Endorsed
Patient Reported Outcome	2651	CAHPS Hospice Survey	Endorsed ★
Process	9999	Hospice Visits When Death is Imminent Measure 1	Not Endorsed
Process	9999	Hospice Visits When Death is Imminent Measure 2	Not Endorsed
Composite	3235	Hospice and Palliative Care Composite Process Measure - Comprehensive Assessment at Admission	Endorsed

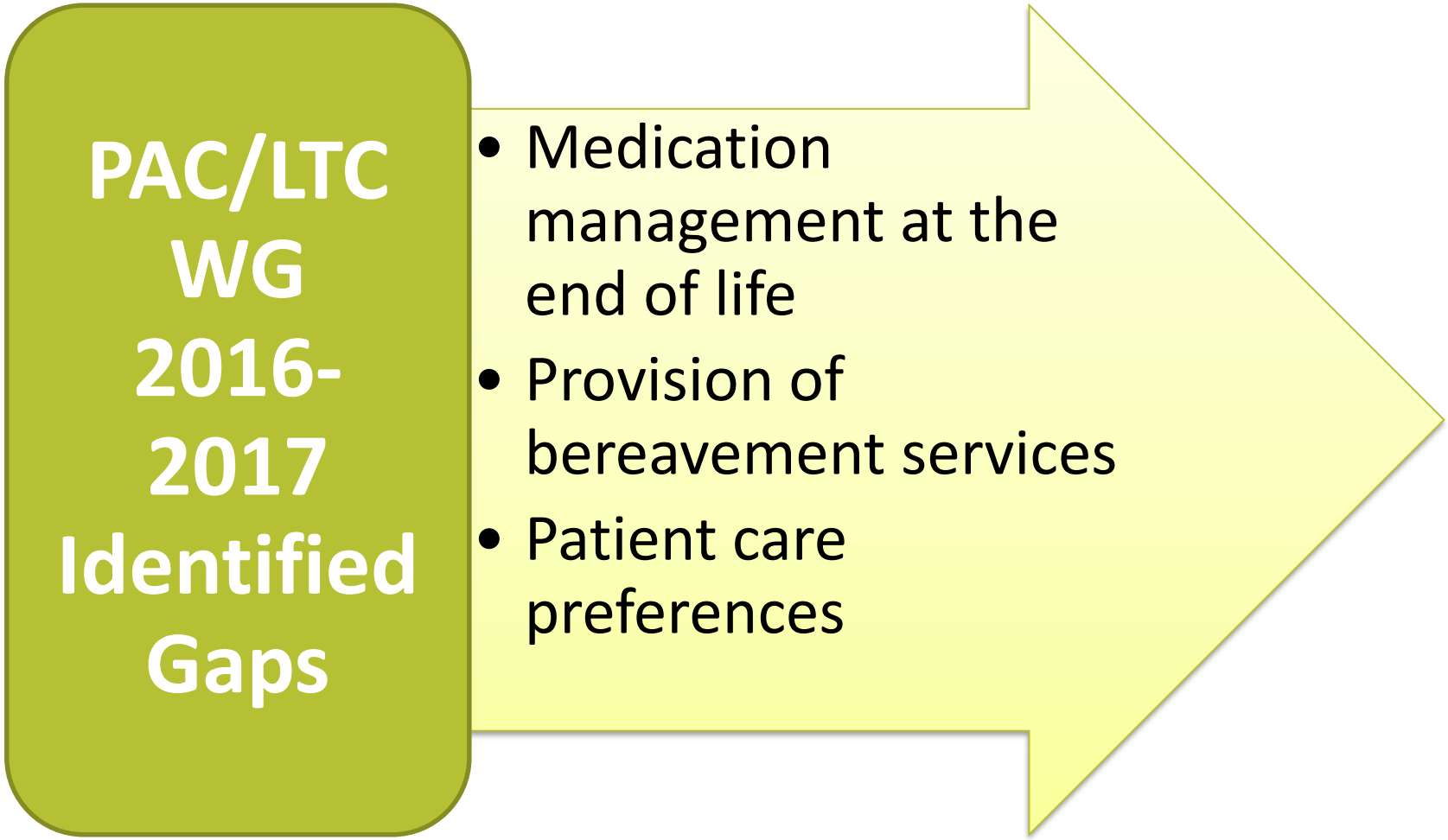
Current Measures by High Priority Areas

Hospice High Priority Areas for Measurement	Existing Measures in the Hospice QRP
Experience of care	-Hospice Experience of Care Survey
Comprehensive assessment	-Beliefs/Values Addressed (if desired by the patient) -Comprehensive Assessment at Admission
Physical aspects of care	-Dyspnea Treatment -Dyspnea Screening -Pain Assessment -Pain Screening -Patients Treated with an Opioid who are Given a Bowel Regimen
Care planning	-Treatment Preferences
Implementing patient/family/caregiver goals	-Beliefs/Values Addressed (if desired by the patient)
Avoiding Unnecessary hospital and ED admissions	
Psychological and psychiatric aspects of care	-Beliefs/Values Addressed (if desired by the patient) -Hospice Experience of Care Survey
Timeliness/responsiveness of care	-Hospice Experience of Care Survey -Hospice Visits When Death is Imminent Measure 1 -Hospice Visits When Death is Imminent Measure 1
Access to the healthcare team on a 24-hour basis	
Avoiding unwanted treatments	- Treatment preferences

CMS High Priority Domains for Future Measure Consideration – Hospice QRP



Previous Gaps Identified



Workgroup Discussion

- Are there additional gap areas for this program?

Long-Term Care Hospital (LTCH) Quality Reporting Program

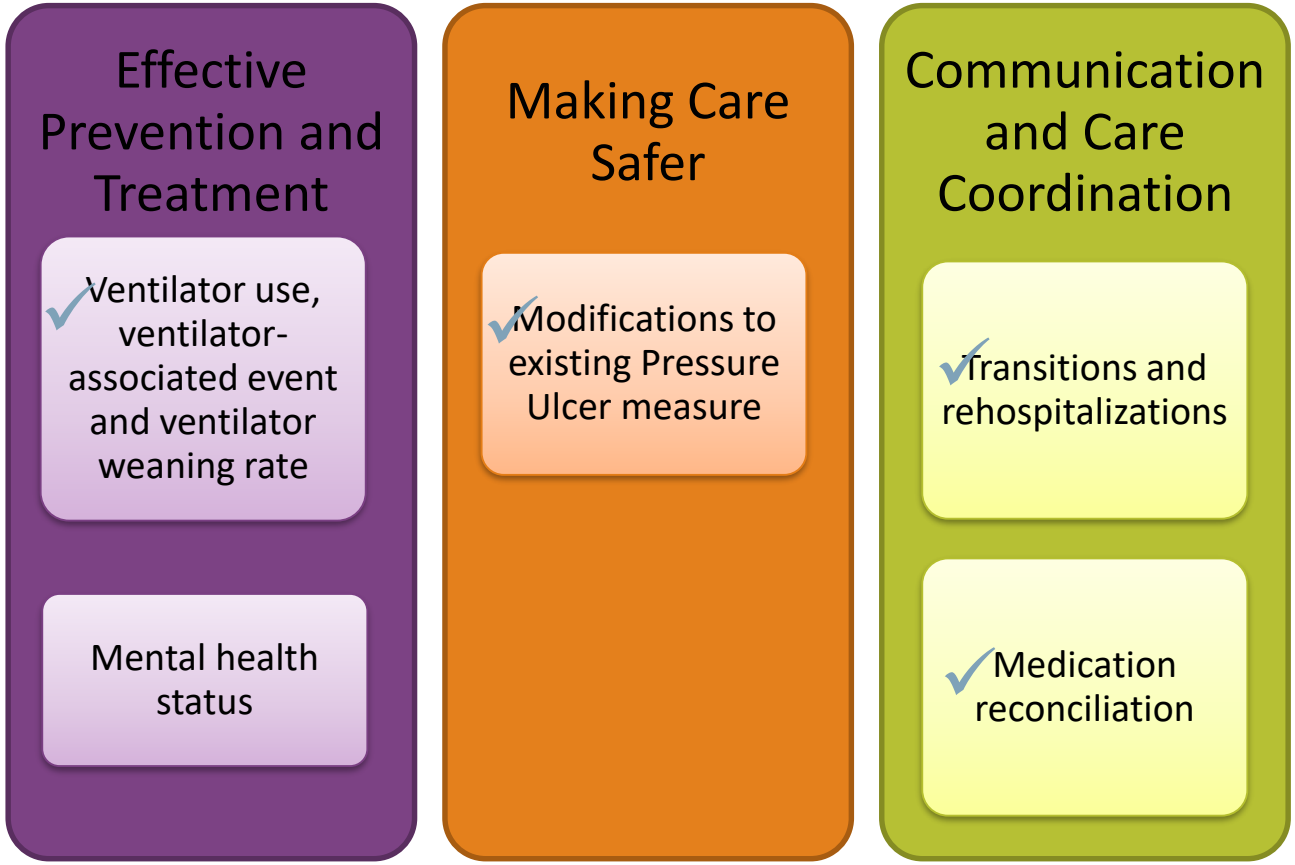
- **Program Type**: Penalty for failure to report
- **Incentive Structure**: The LTCH QRP was established under the Affordable Care Act. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable annual payment update (APU).
- **Program Information**:
  - ***Goal:*** *Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).*
  - *New LTCHs are required to begin reporting quality data under the LTCH QRP no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter*

LTCH QRP: Current Program Measure Information

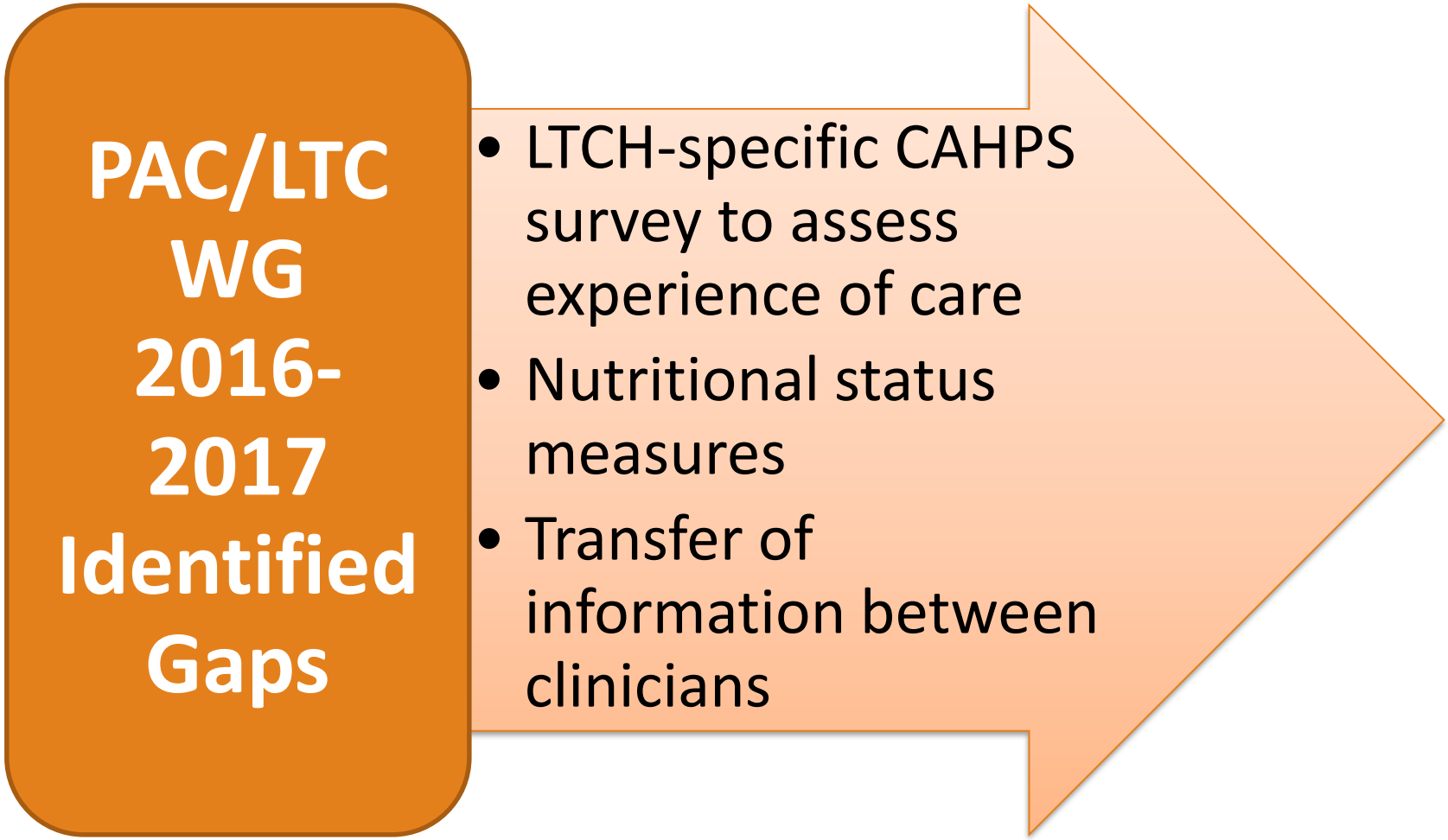
Type	NQF ID	Measure Title	NQF Status
Outcome	0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) Removed in FY 2018 IPPS Rule	Endorsed
Process	0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680).	Endorsed
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).*	Endorsed
Process	2631	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	Endorsed
Outcome	2632	Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support (NQF #2632).	Endorsed
Process	N/A	Drug Regimen Review Conducted With Follow-Up for Identified Issues—Post Acute Care (PAC) Long- Term Care Hospital (LTCH) Quality Reporting Program (QRP).*	Not Endorsed
Outcome	138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF #0138).	Endorsed
Outcome	139	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection Outcome Measure (NQF #0139).	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716).	Endorsed
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717).	Endorsed
Process	431	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431).	Endorsed
Outcome	N/A	National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure.*	Not Endorsed
Outcome	2512	All-Cause Unplanned Readmission Measure for 30-Days Post-Discharge from Long-Term Care Hospitals (LTCHs) (NQF #2512). Removed in FY 2018 IPPS Rule	Endorsed
Cost/Resource Use	N/A	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	Not Endorsed
Outcome	N/A	Discharge to Community—Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).*	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	Not Endorsed
Process	N/A	Compliance With Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	Not Endorsed
Outcome	N/A	Ventilator Liberation Rate	Not Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed

Finalized in FY 2018 IPPS Final Rule

CMS High Priority Domains for Future Measure Consideration – LTCH QRP



Previous Gaps Identified



Workgroup Discussion

- Are there additional gap areas for this program?

Inpatient Rehabilitation Facility Quality Reporting Program

- **Program Type:** Penalty for failure to report
- **Incentive Structure:** The IRF QRP was established under the Affordable Care Act. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update.
- **Program Information:**
  - ***Goal:*** *Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.*
  - *Applies to all IRF facilities that receive the IRF PPS (e.g., IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical access hospitals [CAHs]).*
  - *Data sources for IRF QRP measures include Medicare FFS claims, the Center for Disease Control's National Health Safety Network (CDC NHSN) data submissions, and Inpatient Rehabilitation Facility - Patient Assessment instrument (IRF-PAI) records.*

IRF QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Process	0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	Endorsed
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Outcome	2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (Removed in FY 2018 IRF PPS Final Rule)	Endorsed
Outcome	2634	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Endorsed
Outcome	2633	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	Based on 0674	An Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	Endorsed
Process	Based on 2631	An Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Endorsed
Outcome	2635	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	2636	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Endorsed
Outcome	N/A	Discharge to Community: Discharge to Community-Post Acute Care Inpatient Rehabilitation Facility Quality Reporting Program	Not Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues	Not Endorsed
Cost/Resource Use	N/A	Medicare Spending Per Beneficiary-Post Acute Care Inpatient Rehabilitation Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities	Not Endorsed
Outcome	0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (Removed in FY 2018 IRF PPS Final Rule)	Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury ★	Not Endorsed

★ Finalized in FY 2018 IRF PPS Final Rule

CMS High Priority Domains for Future Measure Consideration – IRF QRP

Making Care Safer

- ✓ Modifications to current Pressure Ulcer measure

Communication and Care Coordination

- ✓ Discharge to the community
- ✓ Potentially preventable readmissions
- ✓ Medication reconciliation

Previous Gaps Identified

PAC/LTC WG 2016-2017 Identified Gaps

- Experience of care measures related to patient and family engagement

Workgroup Discussion

- Are there additional gap areas for this program?

Home Health Quality Reporting Program

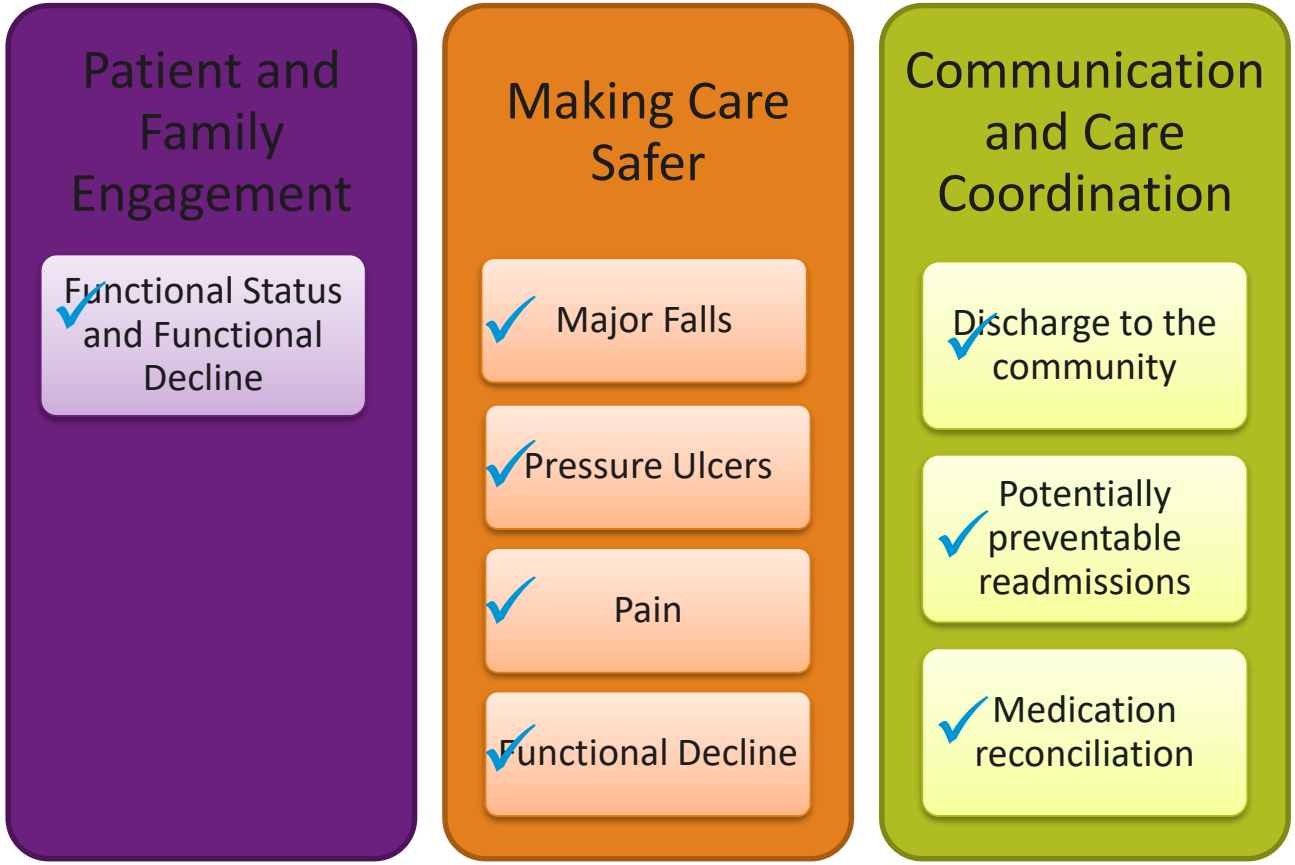
- **Program Type:** Penalty for failure to report; Data are reported on the Home Health Compare website.
- **Incentive Structure:** The HH QRP was established in accordance with section 1895 of the Social Security Act. Home health agencies (HHAs) that fail to submit quality data are subject to a 2 percentage point reduction in their annual HH market basket annual payment update.
- **Program Information:** Data sources for the HH QRP include the Outcome and Assessment Information Set (OASIS), the CAHPS survey, and Medicare FFS claims.

HH QRP: Current Program Measure Information

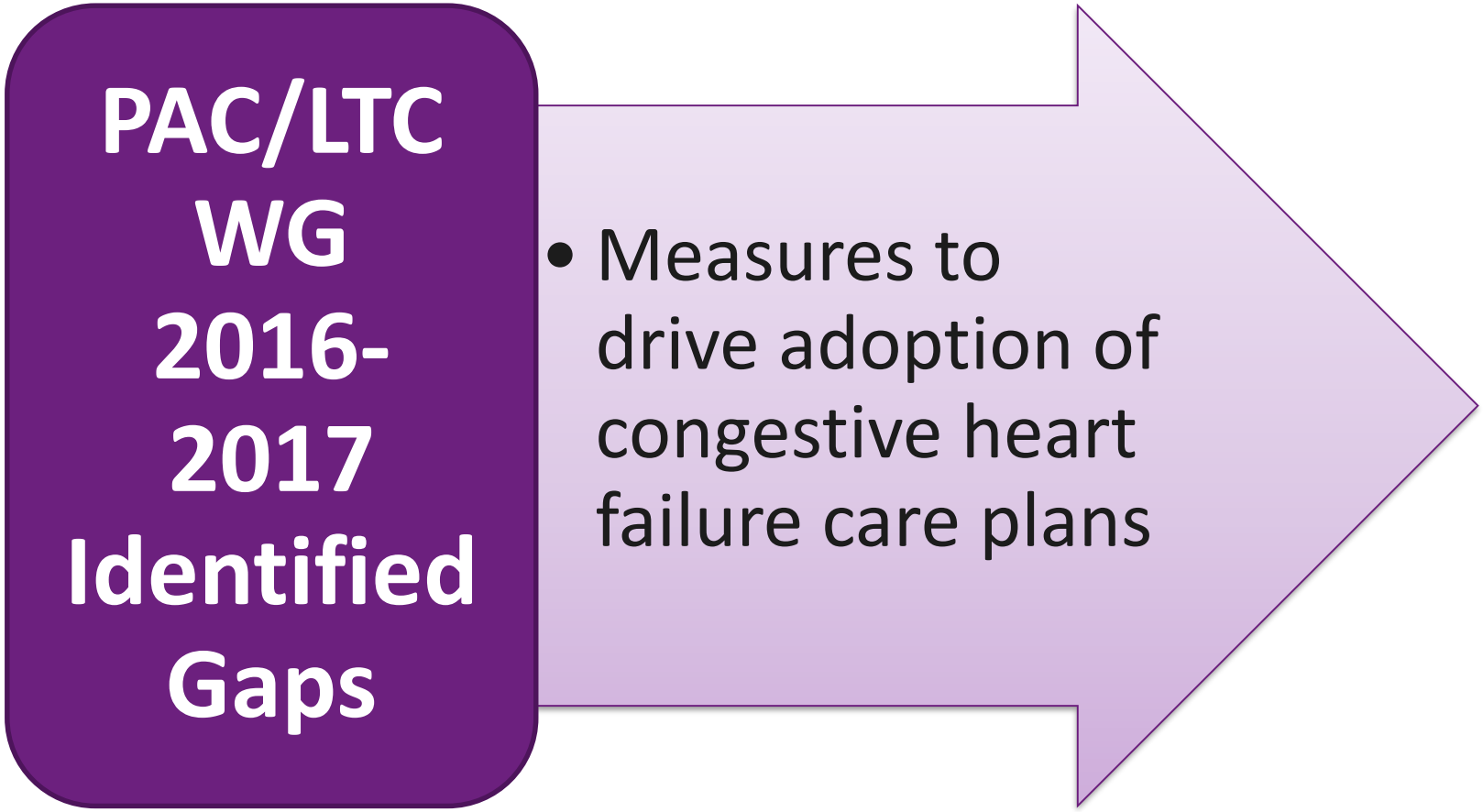
Type	NQF ID	Measure Title	NQF Status
Outcome	0171	Acute Care Hospitalization During the First 60 Days of Home Health	Endorsed
Outcome	0173	Emergency Department Use without Hospitalization During the First 60 Days of Home Health	Endorsed
Outcome	0167	Improvement in Ambulation/Locomotion	Endorsed
Outcome	0174	Improvement in Bathing	Endorsed
Outcome	0179	Improvement in Dyspnea	Endorsed
Outcome	0176	Improvement in Management of Oral Medication	Endorsed
Outcome	0177	Improvement in Pain Interfering with Activity	Endorsed
Outcome	0178	Improvement in Status of Surgical Wounds	Endorsed
Process	0526	Timely Initiation Of Care	Endorsed
Process	0518	Depression Assessment Conducted	Endorsed
Process	0522	Influenza Immunization Received for Current Flu Season	Endorsed
Process	0525	Pneumococcal Polysaccharide Vaccine Ever Received	Endorsed
Process	0537	Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate	Endorsed
Process	0519	Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care	Endorsed
Outcome	0175	Improvement in Bed Transferring	Endorsed
Outcome	2380	Rehospitalization During the First 30 Days of Home Health	Endorsed
Outcome	2505	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	Endorsed
PRO	0517	CAHPS Home Health Care Survey (experience with care)	Endorsed
Process	N/A	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	Not Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program	Not Endorsed
CRU	N/A	Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	Not Endorsed
Outcome	N/A	Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program	Not Endorsed
Outcome	0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (Removed in CY 2018 HH PPS Rule)	Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury ★	Not Endorsed
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury ★	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function ★	Endorsed

★ Finalized in CY 2018 HH PPS Final Rule

CMS High Priority Domains for Future Measure Consideration – HH QRP



Previous Gaps Identified



Workgroup Discussion

- Are there additional gap areas for this program?

Public Comment

Break

Input on Measure Removal Criteria

Considerations for Measure Removals

- **Meaningful to patients and providers**
  - *Patient-centered high priority quality measures current with clinical guidelines. May also need to meet specific statutory requirements.*
- **Measure Type**
  - *Outcome measures are preferred.*
- **Variation in performance**
  - *Measure should demonstrate variation in performance.*
- **Peformance trend**
  - *Should consider trends in performance.*

CMS Criteria for Measure Removals

- **Burden**
  - *Consider amount of burden associated with the measure.*
- **Unintended consequences**
  - *Consider unintended consequences from use of the measure.*
- **Operational issues**
  - *Consider operational issues that may impact the measure.*
- **Alignment**
  - *Consider alignment of similar measures with private payers, and across and within CMS programs while minimizing unnecessary duplication of measures and measure concepts.*

Workgroup Discussion

- What criteria should CMS consider as it reviews the measure sets for its quality reporting and value-based purchasing programs?

Review of NQF's Attribution Work and Guidance on Attribution Challenges in PAC/LTC Settings

Phase 1 Work

Current Landscape

- Recent legislation such as IMPACT and MACRA demonstrate the continued focus on value-based purchasing to drive improvements in quality and cost by re-aligning incentives.
- Implementing pay for performance models requires knowing who can be held responsible for the results of the quality and efficiency measures used to judge performance.
  - *Increasingly challenging as quality is assessed on outcome measures rather than process or structural measures.*
- Attribution can be defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.
  - *Attribution models help to identify a patient relationship that can be used to establish accountability for quality and cost.*
- Moving the system away from fee-for-service payment to alternative payment models has highlighted the need to better understand how patient outcomes and costs can be accurately attributed in a system increasingly built on shared accountability.

Environmental Scan Highlights

- Models categorized by:
  - Program stage
  - Type of provider attributed
  - Timing
  - Clinical circumstances
  - Payer/programmatic circumstances
  - Exclusivity of attribution
  - Measure used to make attribution
  - Minimum requirement to make attribution
  - Period of time for which provider is responsible
- 163 models in use or proposed for use
  - 17% currently in use
  - 89% use retrospective attribution
  - 77% attribute to a single provider, mainly a physician

Commissioned Paper Findings

- Best practices have not yet been determined
  - *Existing models are largely built off of previously used approaches*
  - *Trade-offs in the development of attribution models should be explored and transparent*
- No standard definition for an attribution model
- Lack of standardization across models limits ability to evaluate

Challenges

- Greater standardization among attribution models is needed to allow:
  - *Comparisons between models;*
  - *Best practices to emerge.*
- Little consistency across models but there is evidence that changing the attribution rules can alter results.
- Lack of transparency on how results are attributed and no way to appeal the results of an attribution model that may wrongly assign responsibility.

Addressing the Challenges

- To address these challenges the Committee:
  - *Developed guiding principles*
  - *Made recommendations*
  - *Created the Attribution Model Selection Guide*

- These products allow for greater standardizations, transparency, and stakeholder buy-in:
  - *Allow for evaluation of models in the future*
  - *Lay the groundwork to develop a more robust evidence base*

Guiding Principles Preamble

- Acknowledge the complex, multidimensional challenges to implementing attribution models as the models can change depending on their purpose and the data available.
- Grounded in the National Quality Strategy (NQS) as attribution can play a critical role in advancing these goals.
- Recognize attribution can refer to both the attribution of patients for accountability purposes as well as the attribution of results of a performance measure.
- Highlighted the absence of a gold standard for designing or selecting an attribution model; must understand the goals of each use case.
- Key criteria for selecting an attribution model are: actionability, accuracy, fairness, and transparency.

Guiding Principles

1. Attribution models should fairly and accurately assign accountability.
2. Attribution models are an essential part of measure development, implementation, and policy and program design.
3. Considered choices among available data are fundamental in the design of an attribution model.
4. Attribution models should be regularly reviewed and updated.
5. Attribution models should be transparent and consistently applied.
6. Attribution models should align with the stated goals and purpose of the program.

Attribution Model Selection Guide

- **Current state:**
  - *Tension between the desire for clarity about an attribution model's fit for purpose and the state of the science related to attribution*
  - *Desire for rules to clarify which attribution model should be used in a given circumstance, but not enough evidence to support the development of such rules at this time.*
- **Goals of the Attribution Model Selection Guide:**
  - Aid measure developers, measure evaluation committees, and program implementers on the necessary elements of an attribution that should be specified.
  - Represent the minimum elements that should be shared with the accountable entities

The Attribution Model Selection Guide

What is the context and goal of the accountability program?	• What are the desired outcomes and results of the program? • Is the program aspirational? • Is the program evidence-based? • What is the accountability mechanism of the program? • Which entities will participate and act under the accountability program?
How do the measures relate to the context in which they are being used?	• What are the patient inclusion/exclusion criteria? • Does the model attribute enough individuals to draw fair conclusions?
Who are the entities receiving attribution?	• Which units are eligible for the attribution model? • Can the accountable unit meaningfully influence the outcomes? • Do the entities have sufficient sample size to meaningfully aggregate measure results? • Are there multiples units to which the attribution model will be applied?
How is the attribution performed?	• What data are used? Do all parties have access to the data? • What are the services that drive assignment? Does the use of those services assign responsibility to the correct accountable unit? • What are the details of the algorithm used to assign responsibility? • Has the reliability of the model been tested using multiple methodologies? • What is the timing of the attribution computation?

Recommendations for Attribution Models

- Build on the principles and Attribution Model Selection Guide.
- Intended to apply broadly to developing, selecting, and implementing attribution models in the context of public and private sector accountability programs.
- Recognized the current state of the science, considered what is achievable now, and what is the ideal future state for attribution models.
- Stressed the importance of aspirational and actionable recommendations in order to drive the field forward.

Use the Attribution Model Selection Guide to evaluate the factors to consider in the choice of an attribution model

- No gold standard; different approaches may be more appropriate than others in a given situation.
- Model choice should be dictated by the context in which it will be used and supported by evidence.
- Measure developers and program implementers should be transparent about the potential trade-offs between the accountability mechanism, the gap for improvement, the sphere of influence of the accountable entity over the outcome, and the scientific properties of the measure considered for use.

Attribution models should be tested

- Attribution models of quality initiative programs must be subject to some degree of testing for goodness of fit, scientific rigor, and unintended consequences.
  - *Degree of testing may vary based on the stakes of the accountability program, attribution models would be improved by rigorous scientific testing and making the results of such testing public.*
- When used in mandatory accountability programs, attribution models should be subject to testing that demonstrates adequate sample sizes, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurate data sources to support the model in fairly attributing patients/cases to entities.

Attribution models should be subject to multistakeholder review

- Given the current lack of evidence on the gold standard for attribution models, perspectives on which approach is best could vary based on the interests of the stakeholders involved.
- Attribution model selection and implementation in public and private sectors, such as organizations implementing payment programs or health plans implementing incentive programs should use multistakeholder review to determine the best attribution model to use for their purposes.

Attribution models should attribute care to entities who can influence care and outcomes

- Attribution models can unfairly assign results to entities who have little control or influence over patient outcomes.
- For an attribution model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others.
- As care is increasingly delivered by teams and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control.

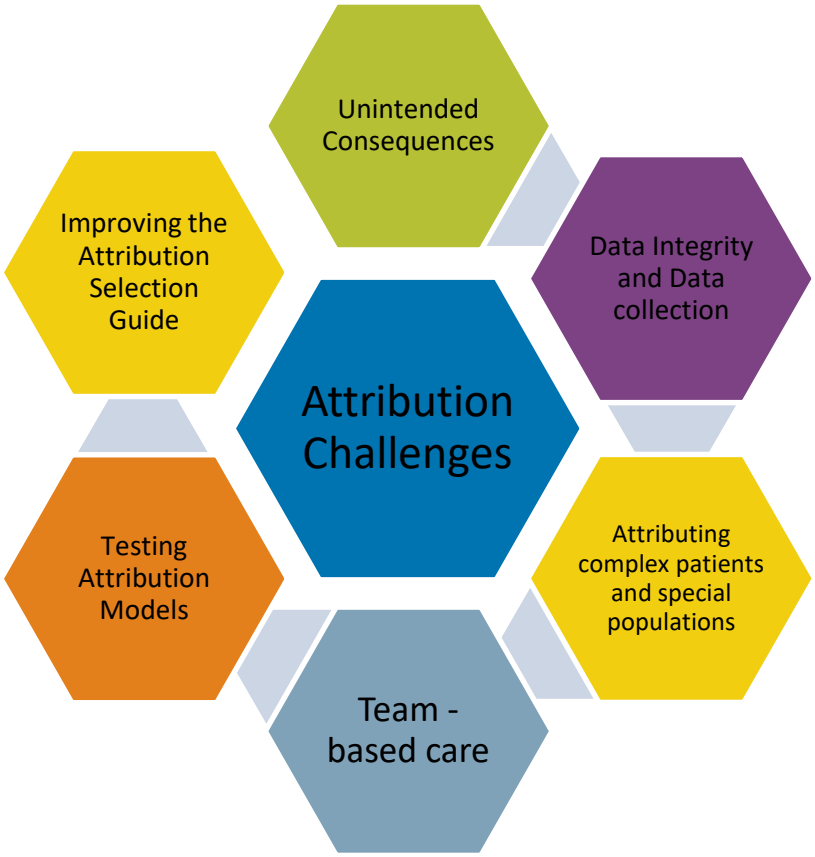
Attribution models used in mandatory public reporting or payment programs should meet minimum criteria

- In order to be applied to mandatory reporting or payment program attribution models should:
  - *Use transparent, clearly articulated, reproducible methods of attribution;*
  - *Identify accountable entities that are able to meaningfully influence measured outcomes;*
  - *Utilize adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed entities;*
  - *Undergo sufficient testing with scientific rigor at the level of accountability being measured;*
  - *Demonstrate accurate enough data sources to support the model in fairly attributing patients/cases to entities;*
  - *Be implemented with adjudication processes, open to the public, that allow for timely and meaningful appeals by measured entities.*

Current Phase

Project Purpose and Objectives

- Develop a white paper to provide continued guidance to the field on approaches to attribution



To accomplish these goals, NQF will:

1. Convene a multistakeholder advisory panel to guide and provide input on the direction of the white paper
2. Hold two webinars and four conference calls with the panel
3. Conduct a review of the relevant evidence related to attribution
4. Perform key informant interviews
5. Develop a white paper that summarizes the evidence review, interviews, and recommendations
6. Develop a blueprint for further development of the Attribution Selection Guide
7. Examine NQF processes for opportunities to address attribution in measure evaluation and selection

Workgroup Discussion

- Doe the Workgroup have any guidance for how to consider attribution issues in post-acute and long-term care settings?
- Are there special attribution challenges in home health that should be considered?

Update on Equity Program

NQF work on Health Equity, Disparities, and SDOH

Measure Selection and Endorsement	Measurement Frameworks	Principles and Best Practices	Implementation Guidance
▪ Healthcare Disparities & Cultural Competence ▪ Health and Wellbeing ▪ Prevention and Population Health ▪ MAP Adult and Child Core Sets ▪ Measure Prioritization	▪ Population Health ▪ Rural Health ▪ Home and Community-Based Services ▪ **Food Insecurity and Housing Instability** ▪ Cultural Competency	▪ Disparities-Sensitive Measure Criteria ▪ Guiding Principles for Culturally Competent Care ▪ Community Action Guide ▪ Risk Adjustment for Socioeconomic Status (SES)	▪ **Approach for Taking Action on Social Determinants of Health (SDOH)** ▪ Roadmap to Promote Health Equity and Eliminate Disparities

NQF's Health Equity Program

IDENTIFY disparities and at-risk populations

INFLUENCE performance measurement

INSPIRE implementation of best practices

INFORM payment

Identify Disparities and Those Affected by Health Inequity

NQF Will:

- Promote a common understanding and standardized language around health equity to address data and infrastructure challenges
- Gather innovative strategies for social risk factor data collection and use

Projects:

- Approaches to address data challenges
- Identification, showcase of innovative examples from the field
- SDOH measurement frameworks

Influence Performance Measurement

NQF Will:

- Facilitate development of needed measures to promote health equity and reduce disparities
- Drive toward the systematic approach laid out in the NQF Health Equity Roadmap for using measures to eliminate disparities and promote health equity

Projects:

- Measure concepts to fill measurement gaps
- Facilitation of measure development and testing
- Technical expertise on high priority measures

Inspire Implementation of Best Practices through Innovative Approaches

NQF Will:

- Lead and engage strategic partners to implement effective interventions and best practices
- Disseminate effective interventions, best practices, and lessons learned
- Facilitate use of innovative, successful interventions

Projects:

- Practical, applied implementation guidance
- Education and peer forums to share resources and solutions

Inform Payment

NQF Will:

- Convene experts to address the impact of payment on health equity
- Spur resource allocation to those meaningfully affecting change
- Create tools and resources to facilitate uptake of payment models that promote health equity
- Explore emerging issues related to risk adjusting performance measures for social risk factors

Projects:

- Continuing work on SDS Trial
- Convening experts to develop payment guidance

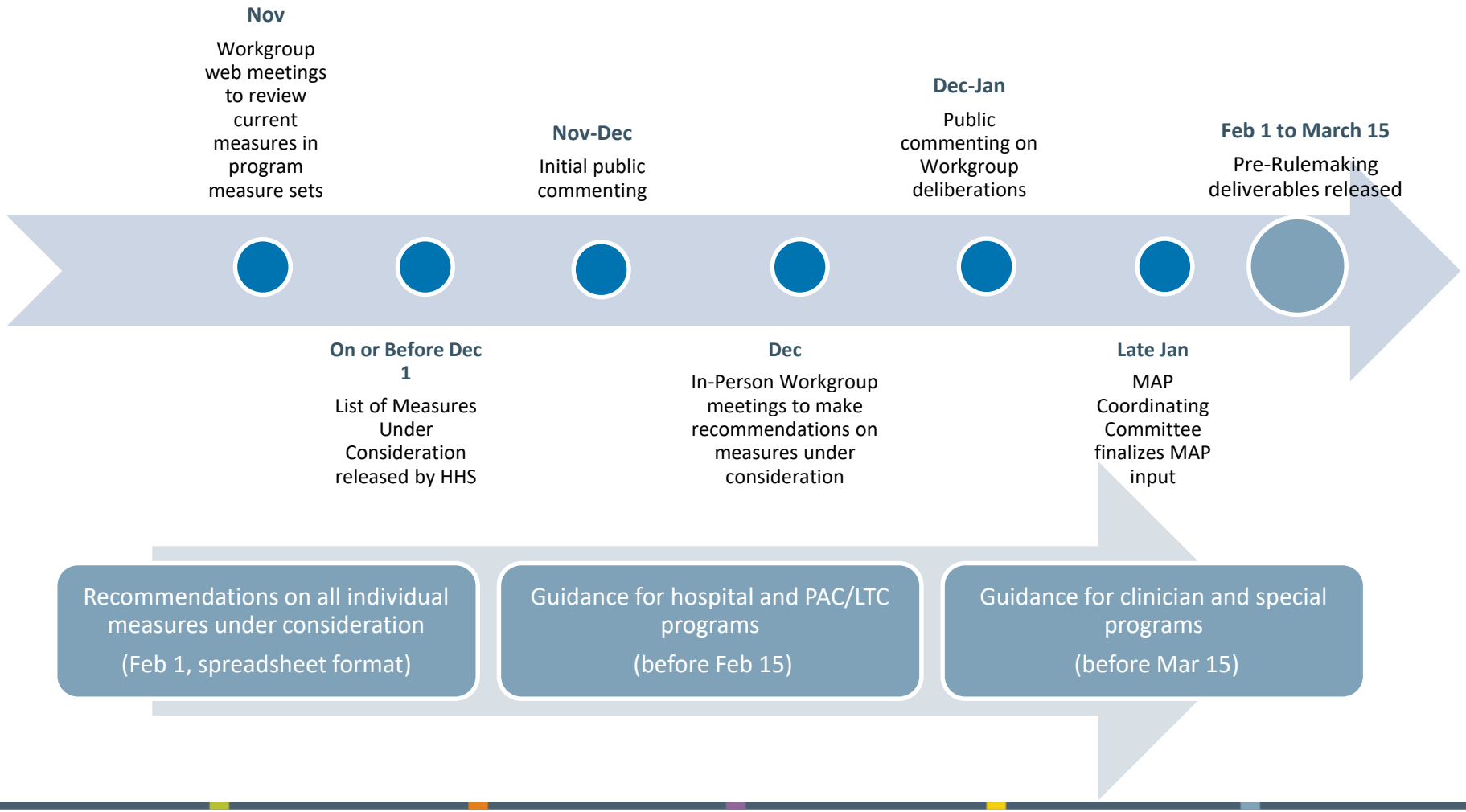
Questions?

Public Comment

Summary of Day and Next Steps

MAP Approach to Pre-Rulemaking

A look at what to expect



Next Steps: Upcoming Activities

In-Person Meetings

- Clinician Workgroup – **December 12**
- PAC/LTC Workgroup – **December 13**
- Hospital Workgroup – **December 14**
- Coordinating Committee – **January 25-26**

Public Comment Period #2: December 21st 2016—January 11th, 2017

Adjourn