NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership PAC/LTC Workgroup Virtual Review Meeting

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Post-Acute Care and Long-Term Care (PAC/LTC) Workgroup on January 11, 2021.

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

The MAP PAC/LTC Workgroup convened jointly with the MAP Hospital Workgroup for the morning session. Matt Pickering, NQF Senior Director, and Amy Moyer, NQF Director, welcomed participants to the virtual meeting. NQF leadership, including Interim President and CEO Chris Queram, Senior Vice President Sheri Winsper and Senior Managing Director Michael Haynie also provided a welcome to the Workgroup. MAP PAC/LTC Co-chairs, Gerri Lamb and Kurt Merkelz, then provided opening remarks. The MAP Hospital Co-chairs, Sean Morrison and Akin Demehin, followed with additional opening remarks. Dr. Pickering reviewed the meeting objectives, namely, to review and provide recommendations on quality measures under consideration for PAC/LTC, hospital, and facility programs, to discuss measurement gaps for these programs, and to provide input into the Centers for Medicare and Medicaid Services (CMS) Quality Action Plan.

CMS Opening Remarks and Meaningful Measure Update

Michelle Schreiber, CMS Deputy Director for Quality and Value, offered opening remarks and provided a presentation on the CMS Quality Action Plan. Dr. Schreiber discussed the vision of the action plan, namely, to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians. Dr. Schreiber reviewed the impact of Meaningful Measures 1.0 and 2.0 and outlined further goals for Meaningful Measures. Dr. Schreiber discussed CMS's intentions to use the Meaningful Measure Initiative to streamline quality measurement, drive value and outcome improvement, improve quality measures through use of digital measures and analytics, empower patients to make best healthcare choices through patient-directed quality measures and public transparency, and to leverage quality measure to highlight disparities and close performance gaps.

CMS's new paradigm features Person-Centered Care at the top of six other focus areas including Patient Safety, Chronic Conditions, Seamless Communication, Affordability and Efficiency, Wellness and Prevention, and Behavioral Health and Substance Use Disorders. Discussion began on the term "patient safety" where the recommendation was made that it be transitioned to a broader term to "person safety"; this was supplemented other comments suggesting that "patient safety" may be appropriate if additional language is added to include residents and healthcare personnel to include safety for all. There were also concerns expressed related to missing health care equity language. It was also suggested that "care coordination" be used in lieu of "seamless communication"; other words for CMS to consider instead of "seamless" included "effective" or "integrated".

MAP provided feedback on "digital measures", where CMS defined digital measures to include a broad definition for both electronic clinical quality measures (eCQMs) and other measures derived from digital

data sources. A concern was expressed that an emphasis on digital measures may discourage developers from building patient reported outcomes performance measures (PRO-PMs). MAP noted that there are no clear measures related to health equity such as food insecurity, income, and race. CMS notified that organizations are stratifying dual-eligible beneficiaries by social risk to address specialized needs. CMS noted that they are limited in the data that they have available but are consulting with other Department of Health and Human Services (HHS) offices on approach to incorporating social risk into measurement and stratification.

MAP also pointed out that indirect estimation presents problems in tailoring care. MAP suggested that imputation may not be the best approach and added that making the gathering of information a routine part of providing care may be more effective. It was noted that imputation introduces risk of getting the information. If personal patient data is to be used, MAP suggested that patients should be included in the dialogue around how their data is used.

Overview of Pre-Rulemaking Approach

Janaki Panchal, NQF Manager, and Udara Perera, NQF Senior Manager, provided an overview of the three-step approach to pre-rulemaking, which includes program overview, review of current measures, and evaluation of Measures Under Consideration for what they would add to the program measure set. Ms. Panchal and Dr. Perera then reviewed the four decision categories that MAP members could vote on following the discussion of each measure. Finally, Ms. Panchal and Dr. Perera briefly summarized the voting process and discussed the Rural Health Workgroup charge.

COVID-19 Measures Under Consideration

Dr. Schreiber and Alan Levitt from CMS and Dan Budnitz from the Centers for Disease Control (CDC) provided a presentation on the COVID measures. Dr. Budnitz reviewed the prevalence and incidence of the disease, current vaccines under emergency use authorization (EUA) by the Food and Drug Administration (FDA), the importance of vaccinating healthcare personnel, and early precedents for vaccination measurement. Dr. Budnitz reviewed the healthcare personnel modules within the National Health Safety Network (NHSN).

Dr. Levitt provided an overview of MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel. CMS noted that the measure is being considered to go into effect in 2022. CMS noted that there is no mandate for vaccination, but that it is essential to track vaccination rates.

MAP noted potential equity differences on both the workforce and patient side. CMS suggested that this may present an opportunity for both CMS and other organizations to stratify reporting for equity purposes.

Following the presentation on the COVID measures, MAP PAC/LTC and MAP Hospital reconvened separately to review their respective measures under consideration.

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure

MUC20-0044 was considered for multiple programs. Each program is outlined below.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) SARS-CoV-2 Measure

Dr. Lamb and Ms. Moyer welcomed MAP back and opened the floor for public comment. No public comments were received.

Ms. Moyer provided an overview of the measure and the staff preliminary analysis. MAP questioned which personnel would be included. CDC clarified that the measure includes all healthcare personnel (HCP) who were eligible to have worked at this healthcare facility for at least one day during the week of data collection, regardless of clinical responsibility or patient contact. This also includes HCP on sick leave, maternity leave, vacation, etc. as well as persons who worked full-time and part-time, and volunteers. CDC further noted that the number of doses required for full coverage will be accounted for in future versions of the NHSN module, which is currently tailored for the two-dose mRNA vaccines currently available.

MAP suggested that the rules associated with NHSN reporting should be clarified. MAP also noted that the premise of up to date on vaccination as the endpoint of the measure is an appropriate one.

MAP did not support the measure with potential for mitigation. The mitigation points for this measure prior to implementation are that the evidence should be well documented, and that the measure specifications should be finalized, followed by testing and NQF endorsement. The proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

Collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback to IRFs will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel will reduce transmission among patients and reduce instances of staff shortages due to illness.

Program Measure Gaps

Within the IRF QRP measure set, MAP identified several gaps, including care aligned with and meeting patient goals; care coordination and patient and caregiver involvement in care design; and pain management and impact on patient function. MAP also called on CMS to review how the measures in the program currently align with the CMS Quality Action Plan and Meaningful Measures 2.0.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP) SARS-CoV-2 Measure

Dr. Merkelz and Ms. Moyer opened the floor for public comment. No public comments were received.

It was noted by CMS that there is a penalty for not reporting on measures included in LTCH QRP and that patients and families can use the CMS Compare website to compare providers in this setting when selecting where they would like to receive care. Some workgroup members recommended CMS consider narrowing the denominator to frontline HCP only while other members affirmed that including the full range of HCP is appropriate and potentially less burdensome to facilities.

MAP did not support the measure with potential for mitigation. The mitigation points for this measure prior to implementation are that the evidence should be well documented, and the measure specifications should be finalized, followed by testing and NQF endorsement. The proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

Collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing

feedback to LTCHs will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel will reduce transmission among patients and reduce instances of staff shortages due to illness.

Program Measure Gaps

Within the LTCH QRP measure set, MAP identified several gaps, including care aligned with and meeting patient goals; care coordination and patient and caregiver involvement in care design; and availability of palliative care.

Skilled Nursing Facility Quality Reporting Program (SNF QRP) SARS-CoV-2 Measure

Ms. Moyer introduced the measure and Dr. Lamb opened the web meeting to allow for public comment. No public comments were received.

MAP suggested that non-employee, non-contracted hospice workers should also be considered for inclusion in the measure denominator. It was also noted that education around vaccination for the facilities would be helpful.

MAP did not support the measure with potential for mitigation. The mitigation points for this measure prior to implementation were identical to the previous two programs—that the evidence should be well documented and that the measure specifications should be finalized, followed by testing and NQF endorsement. The proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

Collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback to SNFs will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel will reduce transmission among patients and reduce instances of staff shortages due to illness.

MAP deferred discussion of gaps in the program until after they had considered all the measures proposed for inclusion in the SNF QRP.

Hospice Quality Reporting Program (HQRP) Measure

MUC20-0030: Hospice Care Index

Ms. Moyer introduced the measure and Dr. Merkelz opened the floor to allow for public comment. Two public comments were received. Janice Tufte provided a comment that supported hospice quality measures generally. The National Hospice and Palliative Care Organization (NHPCO) generally supports an index measure but offered a summary of their written comment asking for further clarification on the measure specifications and noting their general opposition to claims-based measures. They also disagreed with folding revocation into hospice discharge and stated that nursing visit length should be benchmarked against a gold standard for duration of nursing visits. In addition, they called for telehealth visits to be included.

Cindy Massuda from CMS and TJ Christian from Abt Associates provided an overview of the measure. Ms. Moyer then offered a review of the NQF staff preliminary analysis. The developer clarified that the indicator associated with transition and discharge to hospice was within two days. The developer further clarified that the nursing minutes indicator was based on the distribution nationally. Hospices earn a

point for the indicator if they meet the point criterion (a relative threshold of performance). The indicators were selected based on measure gaps identified by hospice service providers.

MAP noted that the measures seem to be a mix of program-integrity measures and quality-of-care measures, suggesting that the quality-of-care measures are more likely to be easily understood by patients and their families while the program-integrity measures might need more explanation for why they are significant. Furthermore, MAP felt that the spending per beneficiary measure is difficult to interpret when there may be significant patient case mix variation between hospice programs (for example, patients with a terminal diagnosis of cancer have different spending patterns than patients with a terminal diagnosis of dementia). CMS reinforced that the strength of the Hospice Care Index measure is in the combination of all of the indicators into the overall index score and that in studies with patients, patients understood the index and found it useful.

MAP recommended conditional support for rulemaking, contingent on NQF endorsement. The Hospice Care Index describes provider performance across a broad array of leading indicators of hospice service representing care throughout the hospice stay and represented by the multi-discipline team. The index augments the reporting program with new measurement domains that were either directly recommended for CMS to publicly report or identified as areas for improvement by the Office of Inspector General, MedPAC, and academic literature. The index design monitors 10 indicators simultaneously to best ensure the reliability of the providers it assigns as consistent outliers, which identifies hospices underperforming relative to expectations of the hospice philosophy. By identifying hospices which meet the thresholds across multiple areas, the index overcomes the limitations of single-outcome measures. More broadly, the Hospice Care Index monitors the performance for a broad and holistic set of indicators for hospice care processes not otherwise addressed within the current quality measures of CMS's Quality Reporting Program.

The Hospice Care Index will introduce new domains and measurement concepts to the Hospice Quality Reporting Program. Burdensome transfers/live discharges, and spending-per-beneficiary are new domains not currently covered by existing measures. Combining multiple indicators into one index is a new approach to measurement for this program. Patients may find a single indicator of care quality to be more useful than ten separate indicators.

Program Measure Gaps

MAP identified several measure gaps within HQRP including safety (in particular polypharmacy and medication reconciliation); patient-reported outcomes around symptom management; care aligned with and meetings patient goals; communication of patient's goals to the next site of care if patient leaves hospice; coordination of care especially with primary care and hospital staff; patient and family education; perceived caregiver burden and how caregiver burden is managed/impacted through hospice care; and capturing the quality of care provided for those who contribute to hospice care but may not be represented in claims data. MAP also encouraged CMS to continue working to maintain a portfolio of measures that show variation in performance across providers and to incorporate telehealth into the program measures. Workgroup members also noted that hospice is an area where the patient voice is not currently captured.

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Dr. Lamb opened with a call for public comments. None were received. Ms. Moyer provided a summary of the measure and the NQF staff preliminary analysis. Dr. Levitt and Casey Freeman with CMS provided

a detailed overview of the measure. Of note, Ms. Freeman presented new information demonstrating a correlation between the numerator (number of severe infections) of this measure and cases of COVID in SNFs. SNFs with higher healthcare-acquired infection (HAI) rates also have a higher number of COVID-19 cases. The SNF HAI measure could help predict those SNFs more likely to have COVID-19 outbreaks.

MAP had several questions regarding the measure results, which are calculated and reported as a single rate and not broken out by type of infection. They raised concerns that this would limit facilities' ability to improve quality based on their results. CMS responded that the quality improvement goal associated with the measure is for facilities to focus on foundational safety interventions, such as rates of hand washing that will reduce all instances of infection rather than focusing on interventions targeting a single infection. The measure is intended to reflect global infection control for a facility.

MAP recommended conditional support for rulemaking, contingent on NQF endorsement. This measure adds value to the program measure by adding one overall measurement of all HAIs acquired in SNFs that result in hospitalizations, information that is not currently available. This measure focuses on severe infections and captures several infection types in the SNF setting. There is variation in performance on this measure and SNFs can improve their performance.

Collecting information on severe HAIs and providing SNFs with information and feedback will encourage SNFs to assess processes and perform interventions to reduce the 1 in 4 adverse events among SNF residents that are due to HAIs, more than half of which are potentially preventable. Among 14,347 SNFs included in the 2018 sample, risk-adjusted measure scores ranged from 2.19% (min) to 19.83% (max) indicating that there is wide variation in HAI rates across SNFs, and opportunities for safer and more efficient patient care.

Program Measure Gaps

Within the SNF QRP measure set, MAP identified several gaps, including care aligned with and meeting patient goals; care coordination and patient and caregiver involvement in care design; bi-directional transfer of information; quality and safety of care transitions; and patient and family engagement.

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Dr. Levitt provided an overview of changes to this program resulting from the Consolidated Appropriations Act (CAA) of 2021. The CAA allows CMS to consider expansion of the program measures up to ten measures beginning on or after October 2023. Previously the program was limited to a single readmissions measure.

MAP strongly encouraged CMS to engage patients and caregivers in a discussion of what concepts or measures they would find most valuable. With a ten-measure limit, MAP discussed priorities and methodology. Some Workgroup members encouraged CMS to pursue a composite measure, similar to the Hospice Care Index, which would encompass the quality of care across the continuum of the patient stay. Other Workgroup members expressed concern that a composite could dilute the impact of any one measure. MAP expressed support for continued work in infection control, which they identified as one of the highest stake areas for patients. MAP also felt there was a need to assess value that may not be represented in claims data, including direct costs to patients and families such as co-pays, out of pocket costs, and parking. Finally, MAP reaffirmed the importance of measuring beyond the SNF stay, including referral to effective services after the stay; caregiver burden; and care coordination after the stay, noting that the ability to manage care and all of the services after discharge has a direct impact on patient readmissions.

Home Health Quality Reporting Program (HH QRP)

MAP identified several measure gaps within HH QRP, including care aligned with and meeting patient goals; care coordination and patient and caregiver involvement in care design; long-term tracking of functional status; healthcare acquired infections; telehealth; vaccination status (patient and HCP); and capturing wound care holistically. Two of the gap areas, long-term tracking of functional status and capturing wound care holistically were carried over from previous meetings and MAP asked NQF staff to review the meeting transcript to provide additional detail. Both gaps were originally raised during the November 14, 2018 MAP PAC/LTC Orientation Meeting. The holistic wound care gap was related to a lack of measures addressing whether all appropriate services and supplies were provided for patients with wounds. The long-term tracking of functional status gap recognized that current measures in the program addressed short-term improvements in activities of daily living (ADLs) such as bathing and dressing. MAP noted that for longer home health episodes, patients may have different functional goals, such as the ability to shop independently or to walk to the mailbox.

Public Comment

Dr. Lamb opened the web meeting to allow for public comment. No public comments were received.

Next Steps

Ms. Moyer summarized next steps. Workgroup recommendations for the five MAP PAC/LTC measures will be opened for public comment on January 15, 2021. The MAP Coordinating Committee will convene to finalize MAP recommendations for all measures on January 25, 2021.

Appendix A: MAP PAC/LTC Workgroup Attendance (Voting Only)

The following members of the MAP PAC/LTC Health Workgroup were in attendance during the roll call:

Co-chairs

- Gerri Lamb, PhD, RN, FAAN
- Kurt Merkelz, MD, CMD

Organization Members

- American Academy of Physical Medicine and Rehabilitation (AAPM&R)
- American Geriatrics Society
- American Occupational Therapy Association
- American Physical Therapy Association
- Kindred Healthcare
- LeadingAge
- National Partnership for Healthcare and Hospice Innovation
- National Pressure Injury Advisory Panel
- National Hospice and Palliative Care Organization
- SNP Alliance

Individual Subject Matter Experts

- Dan Andersen, PhD
- Terrie Black, DNP, MBA, CRRN, FAHA, FAAN
- Sarah Livesay, DNP, APRN, ACNP-BC, ACNS-BC
- Rikki Mangrum, MLS
- Eugene Nuccio, PhD

Appendix B: Full Voting Results

	Measure Name	Program	Yes	No	Total	Percent
1	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	IRF QRP	16	1	17	94%
2	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	LTCH QRP	16	1	17	94%
3	MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel Measure	SNF QRP	16	1	17	94%
4	MUC20-0030: Hospice Care Index	HQRP	16	2	18	89%
5	MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization	SNF QRP	17	0	17	100%