NATIONAL QUALITY FORUM
Driving measurable health improvements together

Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup: 2022 Measure Set Review Meeting

Meeting Summary
July 19, 2022

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-T0003, Option Year 3.

Contents

Meeting Summary

Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup 2022 Measure Set Review (MSR) Meeting

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup on June 30, 2022. The purpose of the meeting was to discuss the measures under review within the PAC/LTC programs for the 2022 Measure Set Review (MSR). There were 51 attendees at this meeting including MAP PAC/LTC Workgroup members, NQF staff, government representatives, and members of the public.

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

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP PAC/LTC Workgroup 2022 MSR meeting and reviewed housekeeping reminders, meeting ground rules and the meeting agenda. She then invited NQF leadership and the workgroup co-chairs to provide opening remarks.

Dr. Tricia Elliott, senior managing director, NQF, welcomed everyone to the PAC/LTC Workgroup MSR meeting. She continued saying NQF was honored to partner with CMS, in bringing together representatives from quality measurement, research and improvement, purchasers, public community health agencies, health professionals, health plans, consumers and suppliers. Dr. Elliott explained last year was the pilot year for the MSR process. The MAP Coordinating Committee provided a final set of recommendations and rationale for measure removal. Dr. Elliott then explained this year the MSR process has been expanded to all three workgroups and both advisory groups. The PAC/LTC Workgroup has focused on measures under review from the Hospice Quality Reporting Program and the Home Health Quality Reporting Program. Dr. Elliott noted the workgroup's discussions will navigate to what extent each measure contains challenges regarding data collect for PAC/LTC providers, methodological problems calculating performance, or any negative consequences of removal from the specified program.

Dr. Elliot then thanked the workgroup members, federal liaisons and CMS program leads for their time. In addition, she thanked the workgroup in advance for providing the necessary feedback to help hone the MSR process going forward. Lastly, Dr. Elliot thanked the co-chairs for their dedication and leadership, with a special thanks to Gerri Lamb for her thoughtful facilitation and engagement, as this was her last meeting serving as a co-chair.

Co-chair Dr. Gerri Lamb then welcomed everyone to the meeting and thanked everyone for their attendance, and for their preparation. Dr. Lamb continued saying the MSR is a different type of review, so tapping into the workgroup's expertise and advice is critical. Dr. Lamb then encouraged active participation and the free sharing of ideas from workgroup members throughout the MSR meeting, Lastly, Dr. Lamb thanked NQF and CMS.

Co-chair Dr. Kurt Merkelz was unable to attend the meeting. Ms. Williams-Bader noted NQF staff would support Dr. Lamb in the facilitation of the meeting due to Dr. Merkelz's absence.

Ms. Williams-Bader then introduced Susanne Young, manager, NQF to perform roll call and disclosures of interest (DOI).

Of the fourteen organizational members, eleven attended the meeting. In addition, there was one co-chair, and two subject matter experts, totaling fourteen voting members. Fourteen members was the minimum quorum for voting. There were no recusals from any voting organizational members or SME's. The full attendance details are available in Appendix A. Ms. Young also introduced the nonvoting federal government liaisons.

Ms. Williams-Bader then recognized the NQF team, including Dr. Taroon Amin, an NQF consultant, and CMS staff supporting the MSR meeting activities. She then reviewed the meeting objectives:

1. Review the 2022 MSR process and measure review criteria (MRC)
2. Provide MAP members with an opportunity to discuss and recommend measures for potential removal
3. Seek feedback from the workgroup on the MSR process.

CMS Opening Remarks

Dr. Michelle Schreiber, deputy director of the Centers for Clinical Standards & Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS) and the group director for the Quality Measurement and Value-Based Incentives Group (QMVIG) welcomed the PAC/LTC Workgroup and thanked everyone for their time. Dr. Schreiber explained the MSR process is closing the cycle where committees get to recommend to CMS which measures to remove from CMS programs. Dr. Schreiber noted this process shapes value-based programs to be more meaningful for the community. Dr. Schreiber continued that leading up to this meeting the Rural Health and Health Equity Advisory Groups have reviewed all measures and provided comments. Dr. Schreiber explained she looked forward to the comments from the group convened for PAC/LTC.

Dr. Schreiber then introduced the CMS program leads and gave a special note of thanks to Dr. Alan Levitt, an expert in post-acute care. She explained he is retiring, and his absence will be felt. She then thanked Gerri Lamb for co-chairing the meeting solo and the great deal of work it takes to lead the workgroup discussions. Dr. Schreiber once more thanked the workgroup for their time.

Review of MSR Process and Measure Review Criteria (MRC)

Ms. Young reviewed the MSR process by stating CMS and NQF together prioritized programs to include for the 2022 measure set review. Ms. Young explained there are several programs falling under MAP's purview. Since there were too many to discuss at once, the NQF team divided the programs into groups. She stated NQF refined the list of measures by program and created a survey that advisory group and workgroup members completed. From this survey, members reviewed the criteria, provided rationale, and nominated measures for removal. Ms. Young explained NQF staff selected measures to discuss based on the number of MAP members who nominated the measure for discussion. That narrowed list was then posted for public comment. Ms. Young noted all measures to be discussed at the meeting were from the Home Health Quality Reporting Program and there were no measures from the Hospice Quality Reporting Program to be discussed as they did not receive enough nominations.

Ms. Young noted NQF staff took the narrowed list and prepared measure summary sheets (MSS). The measure summary sheets provide members detailed information including reporting information, performance data, endorsement history and whether the measure was previously reviewed by MAP. Ms. Young explained throughout the meeting, NQF staff will provide a summary of Rural Health and Health Equity Advisory Groups' discussions for each measure. She explained the Coordinating Committee meets in August to review the workgroup's recommendations.

Ms. Young then presented the ten measure review criteria (MRC) the workgroup uses to evaluate the measures. Ms. Young detailed the four 2022 MSR decision criteria categories. The four categories were support for retaining, conditional support for retaining, conditional support for removal, and support for removal. Ms. Young explained the quorum and key voting principles. Quorum is 66 percent of the voting members present virtually for live voting to take place. A consensus threshold is set at 60 percent of voting, and every measure under review during the meeting received a recommendation.

Ms. Young explained each measure set begins with a review of the program by NQF staff and then co-chairs offer a public comment period on the program. Following the public comment, the workgroup reviews each measure, led by the lead discussants and the co-chairs. After workgroup discussions, the co-chairs put forward a decision category based on the review criteria, and NQF staff facilitate a vote on the measure. If a measure does not reach a consensus of 60% the category of "Support for Retaining" will be applied.

Ms. Young opened the call to questions on the MSR process and meeting overview. There were no questions from the workgroup. Ms. Young then ran a test vote for all workgroup members.

Home Health Quality Reporting Program (HH QRP)

Ms. Williams-Bader provided an overview of the HH QRP, including program type, incentive structure, and program goals. For complete details of the program, please refer to the MAP PAC/LTC Workgroup MSR meeting slides (PDF). Ms. Williams-Bader turned the meeting to Dr. Lamb to open public comment on the measures for review within the HH QRP.

Opportunity for Public Comment on HH QRP Measures

Dr. Lamb opened the meeting for public comment on the HH QRP measures. No public comments were presented during the commenting period.

HH QRP Measures

00187-C-HHQR: Improvement in Dyspnea

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS program and measure leads to provide any further clarification. A CMS program lead stated the medium performance score is 83.5, the mean is 78.4, and the measure's trend data is still improving over time. The program lead noted there is no exclusion for a terminal diagnosis. The program lead noted the endorsement was removed by the NQF Pulmonary and Critical Care Steering Committee due to consideration for a stronger quality measure. The program lead also noted there is no other measure currently addressing dyspnea and it is an important outcome to monitor.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure leads to a high level of reporting burden for reporting entities

- Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure

A Rural Health Advisory Group volunteer noted the group's polling results in which one member supported retaining the measure in the program, five members did not support retaining the measure, and one member was unsure. The rural health volunteer noted there was much discussion in the advisory group around the measure's lost endorsement. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). A Health Equity Advisory Group volunteer stated the advisory group was concerned there are inequities in referrals to home health and the group recommended stratifying the measure in order to evaluate inequities. Dr. Amin also noted the Health Equity Advisory Group discussion included challenges with functional status measures in general and disadvantaged populations' access to home health. The health equity volunteer agreed with Dr. Amin's comments regarding the advisory group's discussion. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

A lead discussant asked for clarity regarding the measure's data collection timeframe and exactly what is being measured. The measure developer noted the patient is evaluated by a licensed home health clinician at the start of care, the end of care, and at other time points throughout care. The measure developer further noted the clinician is using their clinical judgement based on the patient's diagnosis.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. The co-chair asked for information about the measure's endorsement removal in 2012 due to inadequate evidence on outcomes. The CMS program lead turned to the measure developer for clarity. The developer noted other non-related measures have been resubmitted for endorsement and cross-setting measures have been a focus, so the developer has not circled back to this measure yet. Another representative from the measure developer stated one of the challenges in 2012 was the lack of publications in home health that could be pulled into the endorsement process and this challenge continues today. A workgroup member asked for further clarity on the data utilized for the measure, whether it was a physical assessment, subjective or objective. The developer noted the measure is based on items within the Outcome and Assessment Information Set (OASIS). There were workgroup questions about the subjectivity of answers, whether these items were self-reported by patients, and if there was reporting burden. The developer noted the answers were gathered by clinicians and there is no self-reporting. A workgroup member noted there does not appear to be reporting burden. Another workgroup member stated there is some subjectivity to the measure. The member asked if this measure is captured in the readmissions measure and the developer stated that it is not totally captured in the readmissions measure.

The co-chair summarized the measure discussion to this point and asked the workgroup about a vote starting with conditional support for retaining the measure. There were support statements and reactions in the chat. A workgroup member noted there can be subjectivity in the measure as scores can be established by observation only. Another member suggested measurement based on the same structured activity for a more valid and objective way to evaluate patients. Another member noted home health is not always provided by the same clinician so there are objectivity concerns.

Dr. Lamb stated the PAC/LTC Workgroup vote would start with "conditional support for retaining" measure 00187-C-HHQR in the program. The conditions were based on CBE endorsement, reassessing the measurement components within OASIS, and reevaluating the measure's reliability and how dyspnea is reported. There were technical difficulties during the voting process. Voting was paused and votes were cleared from the electronic platform. After a scheduled break, the meeting circled back to vote "conditional support for retaining" measure 00187-C-HHQ in the program. There were not enough

responses via the electronic survey for the quorum threshold. After the following measure's discussion and vote, the meeting circled back to vote "conditional support for retaining" measure 00187-C-HHQR in the program. Voting results were as follows: Yes – 12, No – 2. Complete voting results are in Appendix B.

00196-C-HHQR: Timely Initiation of Care

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

A lead discussant questioned why the measure developer did not submit for measure endorsement maintenance. The lead discussant noted there is a disconnect between the science and the measure as there is evidence timely home health care matters and that there are gaps in care; however, the measure performance indicates the measure is topped out. The lead discussant noted part of the issue is that the measure is contingent on the receipt of a valid referral. This lead discussant further noted a challenge with the definition of this valid referral, how to capture the real amount of time, and how to code this referral.

Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. A CMS program lead stated the research consistently shows outcomes have improved and the measure represents an important aspect of the continuity of care. The lead acknowledged there is currently no available process to conduct data validation of this program. The program lead turned to the measure developer for clarity on the measure endorsement. The developer noted the measure was due for maintenance in 2016 but it had limited variability and the developer agreed it would most likely fail endorsement based on the performance gap. A lead discussant responded there appears to be slight differences in the data presented from 2016 for dual eligible, Hispanic, and Black individuals. Another lead discussant noted the confusion around the valid referral and questioned how that definition could be clarified. This lead discussant stated that timeliness of initiation of care is important, especially for adverse events. This lead discussant further noted the importance to decipher whether the measure is measuring what it is intended to measure. The CMS program lead noted they had not heard these concerns previously when conducting OASIS trainings. The program lead further stated now that CMS is aware, resources and education can be shared during provider trainings to ensure providers are clear what represents a valid referral.

A Rural Health Advisory Group volunteer noted during the advisory group meeting there was a long discussion about endorsement and the group stated the measure was topped out. The rural health volunteer noted 78 percent of the Rural Health Advisory Group did not support retaining this measure in the program. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). A Health Equity Advisory Group volunteer noted the advisory group's

comments were like the prior measure and there is a lack of home health referrals in largely marginalized populations. The health equity volunteer noted there are differences with Black patients compared to White patients and from a health equity standpoint it is important to explore these and other differences. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. There was agreement among workgroup members regarding the challenges with finding home health agencies to provide services, especially during the COVID-19 public health emergency (PHE). Dr. Lamb questioned the workgroup regarding a decision category. Dr. Lamb asked if the group agreed with conditional support for retaining because the benefits outweigh the problems or conditional support for removal because removal would bring a gap. A member posed a process question to whether there would be faster resolution around clarifying the definition if the group voted conditional support for retaining or conditional support for removal. Ms. Williams-Bader stated that while the vote matters, CMS looks to the workgroup comments and discussion. Ms. Williams-Bader further explained the difference between the conditional categories is the fit of the measure for the program.

There was agreement among workgroup members with conditional support for retaining. A member questioned if valid results would occur if the valid referral portion were refined. The member asked for clarification regarding the MSR cycle and when the workgroup would revisit this program again. Dr. Schreiber acknowledged the intended cycle is every three years. Another member asked for clarification regarding what happens when agencies do not accept a home health patient. The measure developer confirmed that for a patient to be in the measure, the home health agency must complete the OASIS assessment, which a home health agency would not do for patients they refuse to accept. The member noted delay between hospital discharge and home health initiation would not be reported in this situation. Dr. Lamb noted it is helpful to look at access issues and a need for short term metrics.

Dr. Lamb stated the PAC/LTC Workgroup vote would start with “conditional support for retaining” measure 00196-C-HHQR in the program. The conditions were based on clarifying the definition of a valid referral and referral start time and CBE endorsement. Voting results were as follows: Yes – 14, No – 0. Complete voting results are in Appendix B.

00185-C-HHQR: Improvement in Bathing

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as “endorsed,” and the number of survey votes received during the nomination process by MAP advisory and workgroup members.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Performance or improvement on the measure does not result in better patient outcomes
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

A Rural Health Advisory Group volunteer noted the advisory group’s polling results in which 25 percent polled in support of retaining the measure, 63 percent not in support, and 13 percent unsure. The rural health volunteer stated the advisory group’s main concern was whether this was an adequate measure

that would show improvement over time. The rural health volunteer noted advisory group concern that patients discharged into the rural setting may not have the skill at hospital discharge and may never have that skill at home health discharge. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF).

Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS program lead noted the 2019 overall performance score was 83 percent and the 2021 overall performance score was 85 percent. The program lead stated the performance scores have improved over time, yet the scores are low enough to show room for improvement. The program lead further stated functional quality measures are important to CMS. The program lead noted CMS is currently developing a cross-setting outcome measure to address functional status in post-acute care settings with a discharge score appropriate for the maintenance population.

A lead discussant asked the measure developer if the 83 or 85 percent compliance of the measure is compliance to the documentation of the measure. The measure developer agreed that is documentation compliance. The lead discussant noted bathing is just one part of a whole functional assessment, and this measure has a potential for many exclusions. The lead discussant further stated an individual may have poor mobility, poor cognition, or things that are never going to improve so it may be a difficult measure to isolate.

A Health Equity Advisory Group volunteer noted the advisory group's discussion was like previous measures and the volunteer reiterated the concern for access along with referrals to home health for historically marginalized populations. The health equity volunteer stated the advisory group's suggestion to stratify the measure by race and/or characteristics of the patient. The health equity volunteer noted the importance of stratification in regard to equity. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. A workgroup member asked for clarification about the 80 percent comment earlier and if that meant 80 percent show improvement in bathing from admission to discharge. The measure developer stated the 83 percent was an episode level number and it corresponds to the home health agency level scores. There were several members who reiterated prior comments about expectations of patients who may not be able to show improvement. These members further commented on improvement versus maintenance and the need for exclusions. There was discussion among the group about CMS' development of the cross-setting measure and the inclusion of patients where the goal would be maintenance rather than improvement. The measure developer stated the cross-setting functional measure has not been finalized yet. Dr. Lamb stated potential conditions for retaining the measure including addressing the concern of maintenance versus improvement in certain populations and the understanding CMS will review once respecifications are completed. Ms. Williams-Bader clarified the respecifications are for the new cross-setting measure. There was agreement among workgroup member comments that this measure is important, but there is a need to assess the measure with reference to patient maintenance and exclusions. Another member suggested the condition that once the cross-setting measure is added CMS will review whether this measure is redundant. There was agreement within the group for the noted conditions. Ms. Williams-Bader confirmed there were not enough members present for the quorum threshold at this point in the meeting. Ms. Williams-Bader noted the meeting would circle back for a vote once quorum was reached.

Once quorum was reached later in the meeting, Dr. Lamb stated the PAC/LTC Workgroup vote would start with "conditional support for retaining" measure 00185-C-HHQR in the program. The conditions were addressing patients where maintenance is the goal rather than improvement, potentially with exclusions for certain populations, and reviewing the measure for redundancy once the cross-setting

functional measure is finalized. Voting results were as follows: Yes – 14, No – 0. Complete voting results are in Appendix B.

00189-C-HHQR: Improvement in Management of Oral Medications

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS program lead noted the measure is important to reduce hospitalizations in acute care, especially for the underserved and rural populations.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure leads to a high level of reporting burden for reporting entities
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

A lead discussant noted this measure is important for quality, safety, adherence, and activities of daily living (ADLs). The discussant noted a question for the measure developer and asked if the original concept of the measure was intended for adherence or for ADLs.

A Rural Health Advisory Group volunteer referenced the polling results of this measure at an earlier time in the meeting. The rural health volunteer noted the advisory group's polling of 75 percent in favor of retaining this measure in the program. Dr. Amin added a comment regarding the Rural Health Advisory Group in which the group questioned whether there are patients with whom management of oral medications may not be a goal. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). A Health Equity Advisory Group volunteer noted similar comments to prior measures including lack of home health referrals and access for historically marginalized patients. The health equity volunteer noted the group suggested stratifying the measure and looking at unintended consequences from a health equity perspective. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Dr. Amin asked the measure developer to respond to the lead discussant's question about the measure's original concept and the developer stated it was not necessarily for either adherence or ADLs, but more of a patient safety issue.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. Dr. Lamb restated what was presented during the discussion including measure importance and the potential for disparities. Dr. Lamb noted the question about burden was responded to by the measure developer and noted data collection utilizes OASIS. A workgroup member asked for measure developer clarification of whether the measure assesses if the patient can physically take medications or if it assesses medication knowledge or access. The developer confirmed the measure assesses whether the patient can physically take the medication. The member also asked if there are other measures in home health that address medication administration and the measure developer confirmed there are no other measures. Dr. Lamb noted medication administration may be something to add to the gaps discussion later in the meeting. Another member stated this discussion is similar to discussion about the measure assessing bathing in

regard to patients with limitations and the expectation there may not be an improvement during home health. Dr. Lamb clarified if the workgroup had potential changes to the measure the voting would start with conditional support for retaining. The measure developer noted there are not exclusions for cognitive decline, but there are risk factors for cognitive decline, confusion, anxiety, and depression. Dr. Lamb asked for further clarification about the decision category of conditional support for retaining and the process for noting conditions is expressing what the group would like reviewed. Ms. Williams-Bader, Dr. Amin, and Dr. Scheiber agreed the process for noting conditions is stating those during the voting process. A member noted the group keeps struggling with the concept of sustainability as a goal of care. The member further noted risk adjustment may not address this issue, but instead the patient's goal would be improvement or sustainability. Dr. Amin noted the main emphasis of the workgroup has been captured in regard to patients who are not able to improve. Ms. Williams-Bader confirmed there were not enough members present for the quorum threshold at this point in the meeting. Ms. Williams-Bader noted the meeting would circle back for a vote once quorum was reached.

Once quorum was reached later in the meeting, Dr. Lamb stated the PAC/LTC Workgroup vote would start with "conditional support for retaining" measure 00189-C-HHQR in the program. The condition was addressing patient populations who would not exhibit improvement, potentially through exclusions. Voting results were as follows: Yes – 13, No – 1. Complete voting results are in Appendix B.

01000-C-HHQR: Improvement in Bed Transferring

Dr. Amin introduced the measure for review and provided an overview of the measure description, noting the measure endorsement status as "endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. The CMS program lead noted that the measure is reported on Care Compare and is part of the Home Health Star Ratings and the Home Health Value-Based Purchasing Model. The measure does not exist elsewhere in the HH QRP. The program lead also noted the measure performance has improved over time citing performance of 81.2 percent in 2019, 82.5 percent in 2020 and 84 percent in 2021, with demonstrated room for improvement by home health agencies (HHAs).

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is duplicative of other measures within the same program
- Performance or improvement on the measure does not result in better patient outcomes
- Measure does not reflect current evidence
- Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

The first lead discussant then provided comments and noted that the previously discussed upcoming changes in crosscutting measures would also apply to this measure. The discussant then noted there were no issues with variability of data, but there were differences in overall outcomes indicating there may be disparities for patients who are non-White, younger, lower income, and living in the western United States. The discussant concluded by indicating there is room for improvement with this measure.

An additional lead discussant then explained that the previously discussed exclusion criteria hold true for this measure as well as far as functional impairment and cognitive impairment. The discussant then brought up access to physical therapy, rehab medicine, or appropriate equipment in the home as a

contributor to non-improvement in this measure and the ability to get equipment to assist with transfers.

The final lead discussant referenced the scoring for this measure that was provided in the chat. The scoring is a zero to five scale, with one being *Able to independently transfer* and five being *Bedfast, unable to transfer and is unable to turn and position self*. The discussant questioned the thought process for improvement in bed transferring related to improving outcomes and for having a threshold or a goal for bed transferring. The discussant gave an example of goal setting for a patient's home health plan, if the patient was score four or score five, they are still bedfast. From score five to four/three it may look like improvement but depending on the goal for the patient there may not be improvement. The lead discussant encouraged connecting this measure to outcomes.

The CMS program lead addressed this comment around scoring by saying if this measure was to continue in the program and be opt-out, they would be looking at some type of adjustment. The program lead noted the feedback from the committee was important to making those adjustments.

A Rural Health Advisory Group volunteer noted the group's main concern was regarding the correct standard for an individual with a disability. A Health Equity Advisory Group volunteer did not provide any additional comments.

A workgroup member then offered that patients who were bedfast were at risk for worse outcomes, or pressure injuries, and tracking pressure injuries is a secondary benefit to this measure as well. The co-chair asked if the measure was duplicative of other measures in the measure and the program lead answered it was not. An additional member then commented the improved function of bed mobility movement is very important for patients, and also indicated it is important to address the maintenance issues as well.

The co-chair then summarized the discussion and noted it was similar to the discussion around functional assessment. The co-chair noted the workgroup's concerns over the potential for disparities but indicted there was room for improvement. The co-chair reiterated the measure was endorsed, not duplicative and there remained questions about populations as well as issues related to mitigation and to maintenance. With this the co-chair put forward the category of conditional support to retain.

Ms. Williams-Bader invited a member to elaborate on their comment made in the chat. The workgroup member questioned if it was the goal to improve functional status and mobility, because having access to home physical therapy can facilitate improvement. Another workgroup member confirmed that HHAs are required to provide necessary physical therapy and occupational therapy. An additional member agreed this standard is important but there is a different issue when the services are understaffed or unavailable. The workgroup agreed it was important to capture this discussion but since it is a standard, it was not included by the workgroup as a condition. There were not enough members present for the quorum threshold at this point in the meeting.

Once quorum was reached later in the meeting, Dr. Lamb stated the vote would start with "conditional support for retaining" measure 01000-C-HHQR. The condition for support was to evaluate populations where there would not be expectations of improvement, but rather maintenance. Voting results were as follows: Yes - 14 No - 0. Full voting results can be accessed in Appendix B.

00212-C-HHQR: Influenza Immunization Received for Current Flu Season

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS

program and measure leads to provide further clarification on the measure. The CMS program lead noted this measure does not exist anywhere else in the home health program. The program lead stated this measure has important public health implications, especially considering the COVID-19 PHE. The program lead further stated there was a decision to harmonize this measure with the minor specification changes to the influenza measures utilized in other post-acute care settings, but this was bumped by priorities from the IMPACT Act.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

A lead discussant stated that for mature programs this is one of the measures that has topped out, but the Home Health Quality Reporting Program is a young program so there is support to keep it in the program.

A Rural Health Advisory Group volunteer noted the group's polling results in which 63 percent polled to support retaining the measure in the program, 25 percent did not support retaining the measure, and 13 percent were unsure. The rural health volunteer also noted comments from the advisory group meeting about including other vaccines, such as the COVID-19 vaccine, that might not be accessible in rural settings. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). A Health Equity Advisory Group volunteer stated nothing to add to the previous comments besides issues with consent. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. A workgroup member stated that vaccines are important but wondered if this is the right measure. The member questioned whether the measure should be that the home health agency has confirmed vaccination status or offered the vaccine. The measure developer noted this measure could be viewed as a "back stop" measure. Another member asked for clarification of whether the home health agency is dinged if the patient refused, and the developer confirmed the agency is not dinged. Dr. Lamb questioned if the measure was topped out but noted looking at the documentation that there is still room for improvement with the percentages in the 70's. Dr. Lamb stated the vote would start with conditional support for retaining and noted the first condition as endorsement. There was workgroup discussion around reviewing how the measure addresses patients who do not receive the vaccine (for example, due to patient refusal), as covered by items 4, 5 and 7 in the survey, and the workgroup agreed to add this as a second condition. Ms. Williams-Bader confirmed there were not enough members present for the quorum threshold at this point in the meeting. Ms. Williams-Bader noted the meeting would circle back for a vote once quorum was reached.

Once quorum was reached later in the meeting, Dr. Lamb stated the PAC/LTC Workgroup vote would start with "conditional support for retaining" measure 00212-C-HHQR in the program. The conditions were CBE endorsement and review how the measure addresses patients who do not receive the vaccine, as covered by items 4, 5 and 7 in the survey. Voting results were as follows: Yes – 14, No – 0. Complete voting results are in Appendix B.

02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) HHQRP

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "not endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS program lead noted this measure is required by statute. The program lead acknowledged the 2020 NQF Cost and Efficiency Standing Committee did not recommend this measure for endorsement, but noted this measure brings value to the program. The program lead further noted strong support from NQF's Scientific and Acceptability panel review on rigorous criteria for validity, reliability, reportability and usability.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

A lead discussant noted support for removal due to concerns about adverse selection and premature discharge. This discussant stated the NQF Cost and Efficiency Standing Committee voted the measure did not meet scientific acceptability criteria. The discussant referenced the standing committee's notes that the assumption of the measure is to be spending less, not more. This discussant further referenced the committee's notes that those home health agencies spending more had patient populations with more functional improvement and spending was heavily driven by rehospitalization. This discussant mentioned the exclusion of social risk factors and noted dual eligible patients had less spending than non-dual eligible patients. Dr. Amin noted the item related to spending less on certain populations came up during the Health Equity Advisory Group meeting discussion. Another lead discussant concurred with the first lead discussant's comments. This lead discussant noted the biggest challenge is around negative unintended consequences.

A Rural Health Advisory Group volunteer noted the advisory group was split on this measure with five (56 percent) members supporting to retain the measure, three (33 percent) not supporting to retain, and one (11 percent) unsure. The rural health volunteer noted the advisory group's concern about the validity of the measure and the small sample size in rural populations. A Health Equity Advisory Group volunteer had no additional comments.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. A workgroup member stated a challenge with this measure is hospitalizations are a primary driver of cost. The member further stated it is redundant in a sense as data is already captured for rehospitalizations. A member asked if there were any other measures under development that assess cost. The program lead responded that there is no development of any different types of cost or spending measures, yet acknowledged the comments provided during discussion are similar to what CMS has heard in the past. A member noted clinicians or caregivers may feel discomfort when there are discussions about how much it costs to care for a particular patient. This member suggested connecting the cost with outcomes. The measure developer clarified that the measure does not assess how much is spent, but how much is spent relative to national median. Another member concurred with the prior comment about connecting cost with outcomes and this member further noted a suggestion of a cost per outcome achieved metric. Dr. Lamb responded stating that it sounds like moving towards a value-based metric. There was agreement with Dr. Lamb's statement from the workgroup. The measure developer noted the measure is an efficiency

measure and the outcome is an episode of care. A member asked about variation in geographic cost and the developer responded that the measure is risk standardized and cost adjusted for geographic payment variation. Dr. Lamb summarized the workgroup comments identifying concerns with the measure including no endorsement, scientific acceptability, exclusion of social risk factors, unintended consequences related to lower costs, problems with small sample sizes, inability of home health agencies to impact, and redundancy with higher cost services (e.g, hospitalizations and emergency rooms). There was one member who voiced they were not in support of removal. The member noted the measure in isolation is problematic, but programmatically it is a reasonable way to meet the statute and assess value and efficiency. Ms. Williams-Bader confirmed there were not enough members present for the quorum threshold at this point in the meeting. Ms. Williams-Bader noted the meeting would circle back for a vote once quorum was reached.

Once quorum was reached later in the meeting, Dr. Lamb stated the PAC/LTC Workgroup vote would start with "support for removal" for measure 02943-C-HHQR in the program. Voting results were as follows: Yes – 12, No – 2. Complete voting results are in Appendix B.

02944-C-HHQR: Discharge to Community – Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status is "endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS lead stated this measure is required by statute. The program lead noted this is a claims-based measure and noted the data originally provided was from a separate discharge to community measure.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is duplicative of other measures within the same program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure does not reflect current evidence
- Measure leads to a high level of reporting burden for reporting entities
- Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

A lead discussant noted it was helpful to know the number of exclusions and that it was consistent across other levels of care. This discussant noted the concern about burden did not apply to this claims-based measure. This discussant noted the measure was risk adjusted but asked if the data could be divided into dual eligible patients and non-dual eligible patients. Another lead discussant noted the importance of transitions of care and discharges across the continuum of care.

A Rural Health Advisory Group volunteer noted there was minimal discussion with this measure. The rural health volunteer noted 67 percent of the Rural Health Advisory Group supported retaining the measure and 33 percent were not in favor of retaining. The rural health volunteer also noted the importance of the measure when there is a long distance for patients to travel. A Health Equity Advisory Group volunteer noted no additional comments at this time.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. A member stated there is value in having this measure across post-acute care settings and it is in line with the IMPACT Act's intent to create a standard measure that is interoperable across post-acute settings. A workgroup member asked for clarification if this is the same measure across all post-acute settings. The measure developer responded that the measure is not the same as there are some exclusions that will not apply to home health care. Ms. Williams-Bader confirmed there were not enough members present for the quorum threshold at this point in the meeting. Ms. Williams-Bader noted the meeting would circle back for a vote once quorum was reached.

Once quorum was reached later in the meeting, Dr. Lamb stated the PAC/LTC Workgroup vote would start with "support for retaining" measure 02944-C-HHQR in the program. Voting results were as follows: Yes – 14, No – 0. Complete voting results are in Appendix B.

03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status is "not endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin stated this measure is required by statute. Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS program lead had no additional statement or comments to add.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes

A lead discussant noted concern with the use of a measure developed in a setting where patients have 24-hour care but transferring the measure for use in the home health setting. The discussant stated this could present challenges in data accuracy. This discussant also questioned if the goal is to identify a major fall, would this be duplicative with an emergency department visit measure. This discussant acknowledged falls are significant, 33 to 50 percent of community dwelling older adults will fall, with large dollar and human costs. The discussant questioned whether this is the right measure for home health. Another lead discussant echoed what the prior discussant stated. This lead discussant also stated the challenge with the measure relying on a self-report. This discussant also noted the data does not indicate much change in performance over time. Dr. Amin acknowledged the concern of self-report was a component of the Health Equity Advisory Group discussion. A third discussant noted a fall rate measure is required per the IMPACT Act, but this measure is the rate of patients that fall and it is not the same as other post-acute fall rate measures (for example, falls per 1,000 patient days).

A Rural Health Advisory Group volunteer noted the advisory group's poll with 33 percent in favor of retaining the measure, 44 percent not in favor, and 22 percent unsure. The rural health volunteer noted much of the group's discussion was already noted by the lead discussants. A Health Equity Advisory Group volunteer noted the group's discussion points were individuals living alone may not have social systems for support and there may be equity concerns with the self-report nature of the measure.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. Dr. Lamb summarized the workgroup's discussion including the concern of applying the measure to home care, the lack of control home care has over the environment compared to other settings, and the low rate of reporting. Dr.

Lamb noted without this measure there would be a gap in the program. The measure developer noted this measure has not been brought for endorsement due to the COVID-19 PHE and delays in measure implementation due to the PHE. The developer also noted a relationship between this measure and readmissions. A workgroup member noted a fall with major injury is the "ultimate fail" in regards to fall risk and its management. The CMS program lead noted the evaluation of this data is part of ongoing monitoring of measures. Dr. Lamb restated the member comment about the ultimate fail and questioned whether the measure could address prevention and factors that could be mitigated. There was further workgroup discussion about whether this is the right measure and whether it was capturing the right data. Another member noted from a macro perspective the need for fall rates to improve patient safety. A member noted concern that the measure is not risk adjusted and questioned whether a claims-based measure may decipher better data. This member also questioned whether the measure should be indicated as a rate per thousand as it is in other post-acute settings. The CMS program lead acknowledged recent conversations regarding these measures across programs and recent evaluations of the data. A member questioned if a patient had a fall would it be captured in the home health readmission measure. The measure developer noted it depends on whether the patient had an emergency department visit only or if there was a hospital admission. The developer noted there is a current assessment of that scenario.

Dr. Lamb stated the PAC/LTC Workgroup vote would start with "conditional support for removal" for measure 03493-C-HHQR in the program. The condition was based on removal creating a measure gap, and the need to replace the measure with a better measure when available. Voting results were as follows: Yes – 13, No – 1. Complete voting results are in Appendix B.

05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Dr. Amin introduced the measure for review with an overview of the measure description, noting the measure endorsement status is "not endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Dr. Amin turned to the CMS program and measure leads to provide further clarification on the measure. The CMS program lead noted this measure is required by statute and is unique to the Home Health Quality Reporting Program. The program lead noted CMS is currently developing a cross-setting outcome measure to address functional status in post-acute care settings with a discharge score. The program lead further noted the measure would be appropriate for the maintenance population.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is duplicative of other measures within the same program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

A lead discussant noted the performance scores are high, lack variation, and may have topped out. This discussant noted there would be a gap without this measure. Another lead discussant concurred with the topped-out comment.

The Rural Health Advisory Group volunteer noted the advisory group's polling with 89 percent not in support of retaining and 11 percent unsure. The rural health volunteer noted the advisory group discussed that this measure is duplicative and topped out. Dr. Amin provided a summary of the Health Equity Advisory Group discussion including similar concerns of self-report, populations missing from the measure data, and difficulties in access for disparities.

Ms. Williams-Bader opened the meeting for PAC/LTC Workgroup discussion. Dr. Lamb asked if the measure is duplicative. The CMS program lead noted there are no other measures in the home health program that address admission, discharge, and care plan. The measure developer concurred there is no other measure that addresses functional goals in the program. The developer noted it is a unique measure to the home health program. Dr. Lamb recapped the group's discussion including duplicative, topped out, and lacks variation. The CMS program lead reminded the workgroup this is the measure where CMS is planning to move to an outcome measure that would allow for the capture of maintenance patients as discussed earlier in the meeting. The measure developer concurred this is the same measure that was mentioned during the bathing or bed transferring measure discussions earlier in the meeting.

Dr. Lamb stated the PAC/LTC Workgroup vote would start with "support for removal" for measure 05853-C-HHQR in the program. Voting results were as follows: Yes – 13, No – 1. Complete voting results are in Appendix B.

Public Comment

Dr. Lamb opened the meeting to public comment. There was no public comment provided.

Discussion of Gaps in PAC/LTC MSR Programs

Dr. Lamb provided an overview from the day regarding gaps in the programs discussed. Dr. Lamb mentioned alignment across measures for PAC/LTC, related to function and symptoms as with dyspnea), to systematic issues associated with care initiation, to prevention as with flu immunization, and assessing the relevance across all PAC/LTC settings. Dr. Lamb also noted discussions about what functional measures had the strongest relationship to outcomes and to fill in those areas across the programs. Dr. Lamb then raised discussions around stabilization; without disregarding improvement, she noted there are some populations where the goal is stabilization or risk mitigation to reduce the rate of decline. Dr. Lamb then described that for measures about symptoms, in this case dyspnea, it was important to identify which symptoms are the most problematic. Dr. Lamb noted identifying these gap areas is important for CMS to obtain the most meaningful measure set across PAC/LTC settings.

Dr. Lamb then mentioned it was important to identify when social determinants of health are important as risk adjusters, and what measures best capture disparities. Dr. Lamb raised a broader issue around systemic barriers when accessing home health, as measuring impact cannot happen if people cannot access the service. She mentioned there could also be disparities in access to care. Dr. Lamb also talked about access to medication and people's ability to self-care with medications. She then mentioned measures that assess longer processes of care, such as initiation of care, and specifically the measure of timely initiation of care discussed earlier. For this type of measure, she noted the discussion around the start of care and what happens before a home health agency accepts a referral. Dr. Lamb summarized the discussion of cost measures and trying to link those to outcomes, in order to measure value.

A workgroup member then raised that a gap topic relevant to home health and PAC was dwindling fee-for-service data. The member stressed that data is important to understanding what good quality is. The

member also mentioned that when evaluating the quality being delivered, quality should be measured in both the fee-for-service and Medicare Advantage plans.

Dr. Schreiber from CMS then offered to the group that clinician and hospital MSR programs have measures for promoting interoperability and noted meaningful use dollars did were not available for PAC settings. Dr. Schreiber asked the workgroup for their feedback on electronic clinical quality measures and measures of interoperability.

Many workgroup members agreed that interoperability is especially important. One workgroup member mentioned the use of electronic health records (EHRs) for more consistent measures and the United States Core Data for Interoperability (USCDI). They agreed there needed to be more attention on this topic as the workgroup has not yet looked at it and it is important to get familiar with the USCDI.

Two other workgroup members expanded on this point. One member agreed this was a gap area, especially for prevention of errors and being able to keep people at home in rural areas. A different member expressed they believed interoperability was important for streamlining information, but they believed it would take the enforcement of a system, as this would not happen on its own.

A workgroup member then mentioned there needed to be a better understanding of EHRs in home health. The member mentioned how a tiered approach had helped gain traction for EHRs in hospitals, and suggested home health EHRs could be encouraged through a tiered, mandated approach with funding. A member mentioned in the chat that interoperability is difficult because in home health and in Skilled Nursing Facilities (SNFs), therapy and nursing utilize different EHRs, making coordination challenging.

Members in the chat also noted caregivers' needs and training as a gap and noted the importance around mental health such as depression and social isolation and the need for psychiatric nurse practitioners across PAC settings. Another chat commented that a challenge for interoperability in rural areas is broadband access. A final comment from the chat discussed the importance of having functional measures in acute hospital care assess function or changes in function across the continuum.

MAP PAC/LTC Workgroup Feedback on MSR Process

Ms. Williams-Bader moved to hold a poll and a discussion among workgroup members regarding feedback on the MSR process. There were three poll questions, and the full results are detailed in Appendix C.

A workgroup member expanded on the topic of materials in preparation for the survey and then for the meeting. The member recognized the importance of narrowing the list of measures down through the survey but suggested the possibility of more measure specific information being available at the time of survey completion. NQF staff explained concerns with feasibility of creating the measure summary sheets for approximately seventy measures and expecting the workgroup to have the capacity to review all the information. There was then a suggestion from the workgroup members to divide the measures for review by workgroup members and then propose measures from the set for to the group to review. Ms. Williams-Bader offered that a smaller number of measures, with more opportunity to review, would be helpful. She then suggested this could come from the survey being a more narrowed list created by NQF and CMS, allowing the opportunity for more in-depth review by the workgroup. The idea of a narrowed list with further details provided was supported by workgroup members, as was consistency in the measures reviewed.

Dr. Schreiber from CMS then proposed asked the workgroup about covering MSR and MUC processes in a two-day meeting. The workgroup said they thought that would be a lot of information to evaluate and prepare for, and that they supported keeping the meetings separate. Ms. Williams-Bader agreed, but also echoed CMS's idea for more holistic review of measure sets, when either removing or adding measures.

Next Steps

Ms. Williams-Bader summarized the next steps in the MSR process. Ms. Williams-Bader noted that the MAP Coordinating Committee MSR meeting will take place in late August, following a second public commenting period between July 22 and August 5, 2022. All MAP events can be accessed through the relevant project pages. The final Recommendations Report will be published on September 22, 2022.

Ms. Williams-Bader then thanked the workgroup for their participation in the meeting and for their feedback. Dr. Lamb echoed thanks to the workgroup for a thoughtful discussion and for all their work, adding additional thanks to NQF, CMS and the measure developers. She concluded it was an honor and pleasure to be a co-chair and she will stay on the workgroup as a subject matter expert.

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

The following members of the MAP PAC/LTC Workgroup were in attendance:

Co-chairs

- Gerri Lamb, PhD, RN, FAAN

Organization Members

- AMDA – The Society for the Post-Acute and Long-Term Care Medicine
- American Geriatrics Society
- American Occupational Therapy Association
- American Physical Therapy Association
- Encompass Health Corporation
- LeadingAge
- National Hospice and Palliative Care Organization
- National Partnership for Healthcare and Hospice Innovation
- National Pressure Injury Advisory Panel
- National Transitions of Care Coalition
- SNP Alliance

Individual Subject Matter Experts

- Dan Andersen, PhD
- Paul Mulhausen, MD, MHS

Appendix B: Full Voting Results

Some MAP PAC/LTC members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained during voting periods.

Measure	Program	Decision Category	Yes (N/%)	No (N/%)	Total (N/%)
00187-C-HHQR: Improvement in Dyspnea	HH QRP	Conditional Support for Retaining	12 (86)	2 (14)	14 (100)
00196-C-HHQR: Timely Initiation of Care	HH QRP	Conditional Support for Retaining	14 (100)	0 (0)	14 (100)
00185-C-HHQR: Improvement in Bathing	HH QRP	Conditional Support for Retaining	14 (100)	0 (0)	14 (100)
00189-C-HHQR: Improvement in Management of Oral Medications	HH QRP	Conditional Support for Retaining	13 (93)	1 (7)	14 (100)
01000-C-HHQR: Improvement in Bed Transferring	HH QRP	Conditional Support for Retaining	14 (100)	0 (0)	14 (100)
00212-C-HHQR: Influenza Immunization Received for Current Flu Season	HH QRP	Conditional Support for Retaining	14 (100)	0 (0)	14 (100)
02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) HHQRP	HH QRP	Support for Removal	12 (86)	2 (14)	14 (100)
02944-C-HHQR: Discharge to Community – Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	HH QRP	Support for Retaining	14 (100)	0 (0)	14 (100)
03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	HH QRP	Conditional Support for Removal	13 (93)	1 (7)	14 (100)
05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	HH QRP	Support for Removal	13 (93)	1 (7)	14 (100)

Appendix C: MSR Process Feedback Polling Results

Some MAP PAC/LTC members were unable to attend the entire meeting. The polling totals reflect members present and eligible to vote.

Poll Question	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	Total
The MSR survey to nominate measures for discussion worked well	0	1	2	7	2	12
I had what I needed to respond to the MSR survey	0	3	1	5	1	10
The advisory group review of the measures under review worked well	0	0	1	5	5	11