

THE NATIONAL QUALITY FORUM

TO: Consensus Standards Approval Committee

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SU: Appeals on Nursing Homes Measures

DA: April 8, 2011

This memo responds to the appeals submitted by four organizations during the 30-day appeals period in March 2011, regarding measures included in the draft report *National Voluntary Consensus Standards for Nursing Homes: A Consensus Report*. These measures were recommended by the Steering Committee, approved by voting of the NQF Membership, recommended by the CSAC for endorsement, and endorsed by the Board on February 28, 2011. Appendix A contains a list of all measures endorsed in the project.

Letters of appeal were submitted by the American Health Care Association (AHCA); the Continuing Care Leadership Coalition (CCLC); Kindred Healthcare Inc; and the Uniform Data System for Medical Rehabilitation (UDSMR). The complete memos containing responses to the appeals from each of the measure developers are included in Appendix A. Appendix B contains the full text of each appeal.

During the comment period, NQF received 243 comments on the measures from 30 organizations. Two of the appeal-submitting organizations commented on issues related to the content of their appeals during commenting but did not submit comments during voting.

The 30-day voting period for the Nursing Homes measures closed on November 16, 2010. Please see attached original CSAC memo for the voting results (Appendix C).

The NQF Consensus Development Process version 1.8 states that “*anyone may register a request for reconsideration of an endorsed voluntary consensus standard by notifying the NQF in writing within 30 days of public notification that the voluntary consensus standard had been approved by the CSAC. For an appeal to be considered, the notification letter to the NQF must include information clearly demonstrating that the appellant has interests that are directly and materially affected by the NQF-endorsed voluntary consensus standard(s), and that the NQF decision has had (or will have) an adverse effect on those interests. Appeals will be reviewed by NQF staff and management, who may consult with the project’s technical advisors, Steering Committee, and/or other sources, as appropriate, before a recommendation is provided to the CSAC and BoD. Following consultation with the CSAC, the BoD shall act on an appeal within seven calendar days of the CSAC’s recommendation to BoD regarding the appeal. The result of this BoD action shall be promulgated in the same manner as the original decision. NQF will maintain a record of all appeals, as well as post them on the web site.*”

Specific appeals were received on 10 out of the 21 measures endorsed; one appeal relates to the entire project. Table 1 provides a list of all the measures endorsed with those endorsed with time-limited status at the end. The measures with specific appeals are identified and the specific comments and responses follow the table.

Measure-Specific Appeals

- Kindred Healthcare, Inc.
- Continuing Care Leadership Coalition

Non-Measure Specific Appeals

- The American Health Care Association has submitted an appeal of the entire project.
- The Uniform Data System for Medical Rehabilitation submitted comments on the project.

Table 1. Measures Approved by the NQF Board for Endorsement

Measure Steward	Project Measure Number/Endorsed Number and Title	Appeal Received? (Yes/No)
RAND	NH-003-10/0673: Physical therapy or nursing rehabilitation/restorative care for long-stay patients with new balance problem	Yes
CMS	NH-014-10/0680: Percent of residents who were assessed and appropriately given the seasonal influenza vaccine during the flu season (short stay)	Yes
CMS	NH-015-10/0681: Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (long stay)	Yes
CMS	NH-016-10/0682: Percent of residents who were assessed and appropriately given the pneumococcal vaccine (short stay)	No
CMS	NH-017-10/0683: Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long stay)	No
CMS	NH-018-10/0684: Percent of residents with a urinary tract infection (long stay)	No
CMS	NH-019-10/0685: Percent of low-risk residents who lose control of their bowels or bladder (long stay)	No
CMS	NH-020-10/0686: Percent of residents who have/had a catheter inserted and left in their bladder (long stay)	No
CMS	NH-021-10/0687: Percent of residents who were physically restrained (long stay)	No
CMS	NH-022-10/0688: Percent of residents whose need for help with daily activities has increased (long stay)	Yes
CMS	NH-024-10/0689: Percent of residents who lose too much weight (long stay)	Yes
AHRQ	NH-027-10/0692: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	Yes

Measure Steward	Project Measure Number/Endorsed Number and Title	Appeal Received? (Yes/No)
AHRQ	NH-028-10/0693: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument	Yes
Measures with Time-Limited Endorsement		
CMS	NH-008-10/0674: Percent of residents experiencing one or more falls with major injury (long stay)	No
CMS	NH-009-10/0675: The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay)	Yes
CMS	NH-010-10/0676: Percent of residents who self-report moderate to severe pain (short stay)	No
CMS	NH-011-10/0677: Percent of residents who self-report moderate to severe pain (long stay)	No
CMS	NH-012-10/0678: Percent of residents with pressure ulcers that are new or worsened (short stay)	No
CMS	NH-013-10/0679: Percent of high-risk residents with pressure ulcers (long stay)	Yes
CMS	NH-025-10/0690: Percent of residents who have depressive symptoms (long stay)	No
AHRQ	NH-026-10/0691: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument	Yes

Subject of the Appeals

Ten specific measures received appeals:

NH-003-10/673: Physical therapy or rehabilitation/restorative care for long-stay patients with new balance problem

Subject of appeal (Kindred): *RAND did not fully explain how they were going to be able to capture those patients who meet the denominator definition of a balance problem and received physical therapy in the prior 4 months to one month after paid by funds not recorded or submitted to CMS. Private pay patients, private insurance, many managed health care organizations and in some cases, State Medicaid programs, do not provide their therapy billing to CMS. If a patient received therapy in the administrative data look-back period paid by funds not reported to CMS, these patients would meet the requirement to be included in the numerator but would not be included in the measure. This would result in a false lower percentage being published. I strongly urge NFQ, CMS and RAND to research the variances in the percentage reported verses actual prior to making this measure public and provide information to the industry on how all applicable therapy billing for this measure will be captured. This will lessen*

the burden to the nursing homes to have to explain the actual percentage verses the percentage reported on Nursing Home Compare.

Response: This appeal was forwarded to the developer. They provided the following information:

RAND RESPONSE: The concern was expressed that physical therapy that had been received that was paid by sources not submitted to CMS (e.g., self pay, private insurance, some managed care organizations, and some Medicaid programs) would not be recognized and therefore, not credited to the NH and falsely lower the quality score for this measure.

The appeal is concerned that physical therapy received in the nursing home will not be available in Part A or Part B claims. We were unable to find data on the proportion of physical therapy provided to nursing home residents from non-Medicare sources, but we believe this proportion to be very small. An OIG report from 2001 entitled “Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients Medical Necessity, Cost, and Documentation Under the \$1500 Caps” (OEI-09-99-00560) found, among Medicare beneficiaries, minimal need for physical therapy that exceeded Medicare caps, suggesting that the need for private pay physical therapy for a new balance problem would be low.

Subject of appeal (CCLC): *CCLC members indicate that this measure lacks sensitivity to transient balance problems (caused by medications, for example) that may not be resolved by physical therapy or restorative nursing care. Additionally, the measure does not capture a resident’s refusal of offered services. CCLC recognizes that researchers found such refusals to be minimal in the 10/4/2010 draft report comments; however, CCLC members question the populations studied (e.g., were HIV/AIDS facilities or other specialty population facilities included in this study), and contend that the measure should be risk-adjusted for even small numbers of refusals.*

Response: This appeal was forwarded to the developer. They provided the following information:

RAND RESPONSE: The concerned party noted that the methodology used for identifying a new balance problem may not identify all new eligible cases. The methodology is based on MDS 3.0 item G3a (Balance during transitions and walking: moving from seated to standing position) with response category codes of 0=steady at all times; 1=not steady, but able to stabilize without human assistance; 2=not steady, only able to stabilize with human assistance. A new balance problem is identified as an increase in the numeric code in the current assessment compared to the prior assessment. Ms. Tena-Nelson correctly notes that patients who already have the most severe level of balance problem (code 2) on the first assessment cannot possibly receive a “worse” (increased) code on the subsequent assessment. A subsequent code of “2” in that case could indicate the continuation of the same balance problem OR a new and equally destabilizing balance problem. A code of “1” could indicate an improvement in the old balance problem OR a new but less destabilizing balance problem. While the methodology for this measure would not identify these cases (with an initial G3a code of “2”), it would identify those cases with an initial code of “0” or “1” that had a higher

code on the next assessment. These cases would, by definition, be patients with balance problems that are new OR problems that have worsened---either circumstance making them appropriate candidates for physical therapy or rehabilitation/restorative care. While the measure has the potential for missing some eligible cases, it identifies other patients whose balance problems were absent or less severe at the start and are now present or worse.

Ms. Tena-Nelson notes that some patients with a new/worsened balance problem will refuse offered PT/rehabilitation/restorative services, and these offers will not be credited to the NH by this measure. We previously responded to this concern that in our experience with this measure, we have found such refusals to be rare. Ms Tena-Nelson asks if special populations have been studied (e.g., HIV/AIDS and other specialty populations) and requests that the measure be risk-adjusted for even small numbers of refusals.

We would like to point out that patients are excluded from the denominator for this measure if they have advanced dementia or poor prognosis (less than 6-month life expectancy or receiving hospice care). Perhaps these exclusions address some of the HIV/AIDS and other “specialty populations” that Ms. Tena-Nelson mentions.

NH-009-10/675: The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short-stay) [time limited]

Subject of appeal (CCLC): *For facilities that have frequent unscheduled transfers to emergency departments (e.g., facilities caring for high acuity patients), this measure does not accurately reflect the residents who might have experienced an improvement in pain, as this measure relies on the MDS discharge assessment. CCLC recommends that NQF use an alternative to the MDS discharge assessment as the basis for the denominator for this measure.*

Response: NQF is not the measure steward and so cannot alter measure specifications. This measure received time-limited endorsement. Measure testing results are due to NQF by February 28, 2012, at which time they will be posted on our website and reviewed by CSAC to ensure that the measure meets the validity and reliability requirements. This appeal was also forwarded to the developer. They provided the following information:

CMS RESPONSE: This pain management QM does not rely solely on the MDS discharge assessments. The measure is constructed to use the most recently available assessment for an active resident. It is expected that the provider will be able to capture pain intensity and change in pain level on any assessment particularly where the resident is on a pain regimen; there is no reason to consider pain on discharge any differently from pain assessment at any other time during the resident’s stay. For residents on a pain medication regimen staff assessment of pain should be a part of the regimen and available at any discharge unscheduled or not. It is assumed that facility staff use chart reference medical records in examining the efficacy of pain regimen and that this should allow the assessment of pain on discharge. Finally, the ability to use the discharge assessment allows the measure to be applied to a broader sample of short-stay residents; that is, for 45 % of Part A residents there was only one assessment present on MDS 2.0—the use of the discharge assessment allows these residents to be included in calculating the measure.

In addition to analyses examining the report-ability, variability, stability, validity of this measure, analyses will include an investigation of the impact of including discharge assessments in the definition of this QM. These will include evaluating the change in sample size of assessments eligible to be included in the denominator, evaluating completeness of responses on items comprising the QM by assessment type, and comparing the relative positioning of facilities across the distribution of the QM when calculating the measure with and without discharge assessments in the sample.

NH-013-10/679: Percent of high risk residents with pressure ulcers (long stay) [time limited]

Subject of appeal (Kindred): *I appreciate CMS recognizing the need to examine the comments to include ICD-9 codes for Malnutrition in I8000 in the calculation of the denominator and hope this information will be provided to the industry prior to the measures becoming public record.*

Response: This measure received time-limited endorsement. Measure testing results are due to NQF by February 28, 2012, at which time they will be posted on our website and reviewed by CSAC to ensure that the measure meets the validity and reliability requirements. The appeal was also forwarded to the developer to provide more information regarding ICD-9 codes. They provided the following information:

CMS RESPONSE: The MDS 3.0 has implemented an item specifically to address malnutrition (item I5600). This item will be used in the calculation of the quality measure. Malnutrition is one of the markers used to identify residents at high-risk for pressure ulcers. The denominator details in the current NQF submission provide the specification details.

Analyses will include examining the number and stage of pressure ulcers on admission. (We received comments suggesting that it would be helpful to stratify this quality measure by whether the pressure ulcers were present on admission, especially Stage IV pressure ulcers that were acquired in the community and could take 100 days or more to heal [e.g., community-acquired or facility-acquired].) We will explore the relationship of pressure ulcers present on admission with prevalence on the target assessment to address stakeholder concerns of residents' being admitted with pressure ulcers and the nursing facilities' being held responsible.

CMS will analyze how community-acquired pressure ulcers affect facility-level quality measures scores and report-ability. For example, with regard to report-ability, CMS will examine the percentage of facilities that have sufficient residents in the denominator to report the long-stay measure, then see how that percentage changes if residents who had pressure ulcers present on admission were excluded. CMS will examine the percentage of facilities that would have sufficient residents in the denominator to report quality measure scores based on only community-acquired or only facility-acquired pressure ulcers, compared with report-ability of the existing quality measure.

To determine the impact of community-acquired pressure ulcers on the quality measure scores themselves, we will calculate the percentage of facilities whose quality measure scores would increase, decrease, or stay the same if quality measure were calculated separately for residents with community-acquired pressure ulcers and for residents with facility-acquired pressure ulcers.

NH-014-10/680: Percent of nursing home residents who were assessed and appropriately given the seasonal influenza vaccine (short stay)

NH-015-10/681: Percent of nursing home residents who were assessed and appropriately given the seasonal influenza vaccine (long stay)

Subject of appeal (Kindred): *The current title remains unclear to the consumer based upon the specifications of the measure. The measure includes in the numerator and denominator residents who refuse and resident who are medically ineligible to receive the vaccine. Adding the word “appropriately” to the title does not make the percentage clearer. When consumers see “appropriately given” – their first reaction is that the percentage represents the percentage actually given. Would the NQF and CMS ever consider handling the influenza vaccine measures like the pneumococcal vaccine measures – reporting each of the areas as separate measures to reduce confusion?*

Response: The original recommendation endorsement was conditional upon the developer changing the measure specifications to report out the rates (for vaccination, refusal, and contraindication) separately to be consistent with the NQF standard specifications for influenza immunization and the prior nursing home measure. This change appears to have not been made in the final measure specifications. The developer agreed to update the specifications and will do so by April 15, 2011. Regarding the title, commenters suggested adding “appropriately” to the title of these measures to clarify that the vaccine is only given to those eligible but that percentages are reported for those who are not vaccinated due to contraindications or because they declined. The Committee and developers agreed this was more clear than the original title. This appeal was also forwarded to the developer, who provided the following response:

CMS RESPONSE: The numerator and denominator will be harmonized with NQF standards for endorsed measures (calculating and reporting three numerator components separately: residents who were vaccinated; residents who refused vaccination; and residents for whom vaccination is contraindicated). The NQF measure specification details will be revised to reflect this methodology and be available to NQF on 4/15/11. Preliminary analytic results based on MDS 3.0 data are expected to be completed in Fall 2011 with analytic refinements available in Winter 2011. In our continued efforts to maintain transparency, detailed reporting of the approved measure, will be made available to the public after NQF endorsement, expected in early Winter 2012.

CMS will analyze the both the short-stay and long-stay quality measures. The public noted that “inability to obtain vaccine due to a declared shortage” is not considered to be a valid reason for excluding residents from the denominator. Their concern is that this would artificially decrease a facility’s score on these quality measures for reasons beyond the facility’s control. CMS will determine the impact that this has on facilities’ quality measure scores by identifying the percentage of assessments that indicate that a vaccine was not received because of inability to obtain the vaccine. CMS will analyze the percentage of facilities that would no longer have sufficient residents in the denominator to calculate this quality measure if assessments in which the vaccine was not received because of the facility’s inability to obtain the vaccine were excluded from the denominator. In addition, CMS will analyze the percentage of facilities whose quality measure scores for both the short-stay and long-stay measures would increase, decrease,

or stay the same if assessments where the vaccine was not received because of the facility's inability to obtain the vaccine were excluded from the denominator, compared with quality measures calculated using the current definition.

NH-022-10/688: Percent of residents whose need for help with activities of daily living has increased (long stay)

Subject of appeal (Kindred): *CMS failed to explain in their responses their rationale in not providing any risk adjustments for late loss ADL loss based upon geriatric aging syndrome. Commenters referenced Katz, who indicated that late loss ADLS are lost in opposite order from which they are acquired from infancy. Late loss functional decline is considered a component of geriatric aging syndrome and there is no evidence that late loss ADLS can be prevented. Considering that the purpose of the measure is to measure decline as a measure relating to quality, CMS should research and recognize risk adjustments based upon the aged aging. Although the exclusions recognize when a resident is totally dependent in all 4 late loss ADLS, there is no risk adjustment for the aged aging during the ADL loss cycle.*

Response: The issues of risk adjustment and exclusions were discussed by the Steering Committee for this measure and several others; ultimately the Committee decided to recommend the measures for endorsement. This appeal was forwarded to the developer. They provided the following information:

CMS RESPONSE: This QM and risk adjustment strategy is based on MDS 2.0 data analyses. No covariates were included in the prior QM because none were identified with sufficient predictive power in the analysis. Exclusions were defined however, as cited in the comment, which is a strategy for risk adjustment. CMS will continue research in aged aging syndromes and continue to evaluate new refinements and potential additional risk adjusters and measures in the future. Immediate analyses include examining whether acute illness (active diagnoses) could increase residents' need for help with activities of daily living and whether the residents who trigger this quality measure are more likely to have a diagnosis of dementia or to be in the end stage of an illness (such as renal disease, congestive heart failure, or other condition that makes the residents eligible for hospice care). To address the impact of acute illnesses on the quality measure, CMS will examine the percentage of residents who trigger this quality measure and who have an acute illness listed on their most recent MDS assessment. This acute illness, which would be indicated in the active diagnoses section of the MDS 3.0, may include stroke or coronary artery disease. CMS will calculate the percentage of facilities that would no longer have sufficient residents in the denominator if residents with these active diagnoses were excluded from the quality measure calculation. To analyze whether residents who trigger this quality measure are more likely to have a diagnosis of dementia, CMS will compare the proportion of residents who trigger this quality measure both across all residents whose most recent assessment includes a diagnosis of dementia and across all residents whose most recent assessment does not include a diagnosis of dementia. We will use these rates to determine whether a diagnosis of dementia is associated with triggering this quality measure. Moreover, we will calculate the percentage of facilities that would no longer have sufficient residents in

their denominator for this quality measure if residents with a dementia diagnosis were excluded.

NH-024-10/689: Percent of residents who lose too much weight (long stay)

Subject of appeal (Kindred): *I appreciate CMS response to the comments regarding the omission of the discharge assessment in the specifications – however – the specifications posted with the October 2010 responses to the public comment still did not address that the discharge assessment would be included in the measure.*

Response: The changes to the specifications should have been made. These specifications will be updated by April 15, 2011. This issue was referred to the developer, who provided the following response:

CMS RESPONSE: The current measure specification for public reporting includes the discharge assessment. The NQF measure specification will be revised to clarify this inclusion is part of the current definition.

Subject of appeal (Kindred): *Many comments were submitted regarding including hospice and “life expectancy of less than 6 months” as an exclusion for this measure....CMS responded that a prognosis in J1400 of having less than 6 months to live is likely subject to substantial measurement error given it is very difficult to predict when someone will die. Since this MDS item requires physician documentation in order to code and hospice services must have supporting physician documentation, it is not a subjective decision of center clinicians. The exclusion of hospice/end of life residents has been part of the prior Quality Measure # 13 and it revised Quality Measure 7.1. for years. CMS stated in their response that they plan “to analyze the MDS 3.0 data regarding refinement in the measures and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live”. I appreciate this response and look forward to having to opportunity along with the industry to review any revisions prior to the measure becoming public record.*

Response: The hospice exclusion was discussed extensively, during both measure review and commenting. Several commenters raised concerns about unintended consequences of excluding hospice patients. Ultimately, the Steering Committee decided to recommend the measure for endorsement. This issue was referred to the developer, who provided the following response:

CMS RESPONSE: While residents receiving hospice care and those with a prognosis of less than six months to live were excluded from the MDS 2.0 measure, these residents are not excluded from the MDS 3.0 measure. CMS acknowledges the controversy over the biological and disease basis for weight loss among older people in nursing facilities, which may limit the effectiveness of interventions designed purely to increase resident nutritional intake as a method of maintaining weight. CMS also recognizes that hospice and other end-of-life experts argue that weight loss is a normal part of the dying process and contentions that efforts to maintain weight during this period are not consistent with a palliative care approach. These issues were raised and discussed in detail during the technical expert panel (TEP). The exclusion was dropped from the QM definition because the majority of TEP members believed that hospice and prognosis items will not

capture many residents who are dying as a result of reluctance to identify individuals who are actively dying and difficulty in accurately estimating prognosis for non-cancer residents. When sufficient MDS 3.0 data are available we will examine the impact of including these residents in the measure. In addition to analyses examining the reportability, variability, stability, validity of this measure, analyses will include investigating facility level variation in the distribution of hospice and residents with a prognosis of less than 6 months to live among residents triggering this QM. Differences in facility QM score when calculating the measure with and without hospice and residents with a prognosis of less than 6 months will also be done, specifically looking at whether facilities change relative positions across the distribution of the QM. Analyses will also investigate the relationship between facility QM score and the proportion of residents with other markers of end-of-life and predictors of weight loss such as dementia.

NH-026-10/691: CAHPS Nursing Home Survey: Discharged Resident Instrument [time limited]

Subject of appeal (Kindred): *I appreciate AHRQ analyzing the questions “how often did you feel worried”; “how often did you feel happy” and “Think about how you felt about your life when you were in the nursing home, Use any number from 0-10 where 0 is the worst possible and 10 is the best possible, what number would you use to rate your life then?” and their impact as potential case mix adjusters. I believe it will be very important to involve the nursing home industry in their review of the data and consideration of the impact of these questions to the survey. I believe it will be very important to involve the nursing home industry in their review of the data and consideration of the impact of these questions to the survey.*

Response: This measure received time-limited endorsement. Measure testing results are due to NQF by February 28, 2012, at which time they will be posted on our website and reviewed by CSAC to ensure that the measure meets the validity and reliability requirements. The appeal was also forwarded to the developer to provide more information. They provided the following information:

AHRQ Response: Several mood related questions like “how often did you feel worried”; “how often did you feel happy” were added as potential case mix adjusters (based on CMS sponsored research by Dr. Rosalie Kane) and are being analyzed for that purpose; this analysis is underway. They are placed at the end of the core set of questions so as not to influence a resident’s response to the core set of questions.

NH-026-10/691: CAHPS Nursing Home Survey: Discharged Resident Instrument [time limited]

NH-027-10/692: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

NH-028-10/693: CAHPS Nursing Home Survey: Family Member Instrument

Subject of appeal (CCLC): *CCLC strongly urges the NQF to clarify how providers and States may use alternative satisfaction surveys, pursuant to AHRQ’s response to concerns about the Federal government’s survey tool as the only tool eligible to meet requirements. Whether a provider can use an existing satisfaction survey and what the parameters are surrounding the*

threshold number of required returned surveys will have a significant impact on the cost of administering satisfaction surveys, which could potentially become overburdensome for financially fragile providers.

Response: NQF is a national voluntary consensus standards setting body. NQF endorses measures that are submitted for consideration. The CAHPS measures were the only experience of care measures that were submitted for consideration under this project. Other patient experience of care measures can be submitted for consideration under future projects. The appeal was also forwarded to the developer to provide more information. They provided the following information:

AHRQ response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone who desires to use them. AHRQ recommends that the long stay resident survey only be administered as in-person survey by a third party because of concern based on previous research that staff administration biases the results (see Hodlewsky, R. and Decker, F. “The Problem of Bias When Nursing Facility Staff Administer Customer Satisfaction Surveys” Journal on Quality Improvement 2002:546-554). The family member survey is a mail survey (which is less expensive to implement than the long stay resident survey) and is intended for family members of cognitively impaired residents. The discharged (short stay) resident (who tend to have better cognitive capacity) survey is also administered by mail.

The three CAHPS nursing home surveys are included as several possible surveys for the Advancing Excellence in America’s Nursing Homes Campaign at

http://www.nhqualitycampaign.org/files/Resident_Satisfaction_Survey_Tools.pdf

This Campaign website also lists “Considerations in Survey Selection and Implementation and Special Issues for Nursing Home Surveys” at

http://www.nhqualitycampaign.org/files/Considerations_in_Satisfaction_Survey_Selection.pdf

AHRQ does not have legal authority to mandate these surveys. The Centers for Medicare & Medicaid Services (CMS) has no current plan to implement these surveys but does desire that these surveys are in the public domain. The sponsor implementing a resident or family experience survey may be other entities besides the federal government, such as a state agency or even a provider itself either for public reporting or for quality improvement. There are at least 3 examples where states (Ohio, Rhode Island and Georgia) have provided funds for either the resident or family member surveys and/or charged a modest fee to the nursing home in return for providing comparative information to all providers as well as the public.

General Appeals of the Project

AHCA submitted a general appeal of the project, and UDSMR submitted a general comment. These can be grouped into two categories: concerns about the testing of the measures, and concerns about the lack of measures in certain subjects.

Subject of appeal (AHCA): *The announcement for the appeal is premature. Since the definition of “short-stay” and “long-stay” measures has been newly defined, AHCA believes that NQF must designate all the measures with provisional approval. It is difficult to appeal any measure*

until testing is completed and measure performance results have been analyzed, validated and published. By signifying all the MDS 3.0 measures as having time-limited approval, this will allow NQF the opportunity to reexamine the performance of the quality measures when they are actually used and calculated using the MDS 3.0 data. AHCA recommendation: NQF request that CMS offer a second appeal opportunity this Fall after testing is completed and when all the needed measure changes and refinements have been made.

Subject of appeal (AHCA): *We also urge NQF to work with CMS to ensure that all MDS measures are tested after all changes and refinements are made, that a second public appeal is offered, measure exclusions are considered, and measure construction does not hamper public reporting.*

Response: In the transition from MDS 2.0 to 3.0, some items did not change. Therefore, the developer submitted measures based on unchanged data items with testing results and the Committee agreed with the assessment that the measures met the reliability and validity testing criteria. After endorsement, measures are evaluated on all criteria on a regular basis (generally every three years for endorsement maintenance). Several measures were given time-limited status based on the need to complete testing for reliability and validity. This testing data is due by February 28, 2012, at which time it will be posted on NQF's site and reviewed by CSAC to ensure that the measure meets the validity and reliability requirements. This appeal was forwarded to CMS, who provided the following response:

CMS RESPONSE: The short-stay and long-stay definitions have been made more explicit. The changes are an improvement in the definitions. The effectiveness of these definitions will be examined with further MDS 3.0 data analysis and be made available to the public. In a continuing effort to be transparent, findings will be shared with the public subsequent to the NQF review in February 2012. Analyses will include correlation between pairs of long and short-stay measures where the definitions are the same except for sample selection (e.g. 014 and 015 Influenza Vaccine). CMS will compare facility results using MDS 3.0 measures with their quality measure performance on the basis of MDS 2.0 data. For quality measures whose underlying items did not change significantly from the MDS 2.0 to MDS 3.0—for example, physical restraints—it is expected that facilities will have similar results. Analyses will also include comparisons of QM scores calculated based on assessments of residents that were discharged within 100 days, as compared with QM scores calculated using assessments of residents that were in the early part of a greater than 100 day stay.

Additional CMS Comments on Testing:

While some analyses mentioned are specific to an individual quality measure, as part of the NQF submission process requiring measures be fully specified and tested for reliability and validity we will include general analyses as follows:

- Evaluate variability, stability, validity, and risk adjustment.
- Impact of missing data and skip patterns on the quality measure.
- Impact of short-stay and long-stay definitions on the quality measure.
- Prepare reliability and validity summary report.
- Prepare risk adjustment methodology report.
- Summarize quality measure testing.

Analyses using first quarter MDS 3.0 have begun. Until six months of MDS 3.0 data are available analyses will focus on detailed measure specification and preliminary descriptive statistics. When six months of MDS 3.0 data are available issues related to measure reliability, variability, stability, validity and risk adjustment coefficients will be undertaken. These analyses will address issues and questions raised by technical expert panel members, NQF board and public comments received by NQF. This second phase of data analysis is expected to begin May 2011 and continue through Winter 2011, with preliminary results available late Fall 2011.

Subject of appeal (AHCA): *The number of measures for the Medicare Program is inadequate. Among the 21 endorsed measures, only 5 measures are directly intended for the Medicare, short stay, patient population. If Medicare funding leads to better quality and yet there is an inadequate number of Medicare Program quality measures, are nursing facility quality and policy decisions unintentionally being negatively biased by the predominance of the long-stay (underfunded Medicaid population) measures? Are MDS-based quality measures, currently categorized by long-stay and short-stay patients (Medicaid and Medicare), in reality measuring the quality of the nursing facility payment systems? AHCA recommendation: Work with CMS to identify and test additional measures for the Medicare Program and include those measures and their testing findings in a second public appeal opportunity.*

Subject of appeal (UDSMR): *We merely question the absence of functional measures in a quality tool used when medical rehabilitation is predominant. We recommend you strongly consider adding functional measures beyond pain and incidence of vaccination.*

Response: Committees are limited to reviewing and recommending measures that are submitted to NQF. During the project's start-up phase, staff did an environmental scan and reached out to organizations to encourage them to submit measures. We encourage interested parties to suggest measures for review. Upcoming projects in 2011 that could review measures related to the nursing home population include:

- Renal disease
- Care coordination
- Palliative & end of life care
- Pulmonary

The Committee identified a long list of gap areas for future measure development. This list begins on page 39 of the voting report and includes a number of areas that are related to both short-stay and long-stay populations. This appeal was also forwarded to CMS, who provided the following response:

CMS RESPONSE: This is incorrect, it is not appropriate to equate the long- and short-stay measures with Medicaid and Medicare residents respectively. The quality measure calculations use all assessments for residents in certified beds regardless of payer type. Furthermore, data from the MDS 2.0 quality measures suggest that the majority of short-stay residents in the measures will be non Part A Medicare residents. The definition of short-stay and long-stay is no longer defined on the basis of a PPS and OBRA

assessment, but on how long the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode.

Subject of appeal (AHCA): *Privacy of information is an issue that restrains the development of quality measures for the Medicare Program. Measuring structure, process and outcomes is impacted by the numbers of managed care, private insurance and self-pay patients receiving care in the facility. Patient information is withheld from Federal and State agencies when the payer of the nursing facility services is not Medicare and Medicaid. The purpose of the restriction relates to the need to protect patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a result, managed care, private insurance and self-pay patient data is excluded from the reported measures. Adding to this problem, more and more nursing facilities are admitting managed care patients.*

Response: This appeal was forwarded to the developer. They provided the following information:

CMS RESPONSE: Federal access and use of MDS data is based on whether the resident is in a Medicare Medicaid certified bed and is not tied to the payer source. It is not true that managed care residents are excluded.

Subject of appeal (AHCA): *MDS 3.0 coding addresses the information exclusions in Section A, 0410, Submission Requirement.*

An important outcome resulting from the MDS Submission Requirements is the reduction in the number of assessment files used in the calculation of the nursing facility's quality measures that mostly impacts the short-stay patient population. This means the measure's denominator size is reduced and may be too small to produce a valid result, resulting in a measure not appropriate for public reporting. This situation further restricts the availability and use of short-stay measures and inadvertently may lead to a biased assessment of nursing facility quality.

Response: This appeal was forwarded to the developer. They provided the following information:

CMS RESPONSE (to both bullets above): Item A0410 has not changed since MDS 2.0 which also allowed federal access to submissions so will in no way effect the denominator size in the QMs.

Subject of appeal (AHCA): *As previously discussed, long-stay patients are those predominantly paid by Medicaid and short-stay patient are those patients funded by Medicare.*

Response: This appeal was forwarded to the developer. They provided the following information:

CMS RESPONSE: The definition of short-stay and long-stay is no longer defined on the basis of PPS and OBRA assessments, but on how long the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in

the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode. As such the short-stay measures take into account long-stay residents in the initial part of their stay.

Subject of appeal (UDSMR): *After careful consideration, we have concluded that the proposed nursing home measures are predisposed to long-term patients and do not adequately address clinical and rehabilitative objectives for short-stay patients. Given the propensity of Medicare payments to nursing homes for skilled nursing and therapy services, it seems appropriate that the Centers for Medicare and Medicaid Services (CMS) would be most interested in quality and efficacy data related to the patient population it is ultimately financially responsible for. The recommended measures do not allow facilities to substantiate the quality of their short-term restorative care program to CMS.*

Response: This appeal was forwarded to the developer. They provided the following information:

CMS RESPONSE: The definition of short-stay and long-stay is no longer defined on the basis of PPS and OBRA assessments, but on how long the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode. As such the short-stay measures take into account long-stay residents in the initial part of their stay. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Finally, the availability of the discharge assessment will allow further analyses to explore possible new short-stay functional measures.

Subject of appeal (AHCA): *Existing measures may not be sensitive enough to the various patient populations being served in nursing facility care centers. AHCA recommendation: CMS and NQF members must work together with stakeholders to explore other methodologies that improve the current quality measurement framework and recommend an alternative approach that is patient-focused and not care setting or payment focused.*

Response: As a voluntary consensus standards setting organization that endorses quality performance measures, NQF does not develop the measures. However, the appellant may be interested to note that NQF is interested in quality measures that apply to patients regardless of setting. Future endorsement projects will focus on clinical topics or cross-cutting topics. We encourage interested parties to suggest measures for review. Upcoming projects in 2011 that could review measures related to the nursing home population include:

- Renal disease
- Care coordination
- Palliative & end of life care
- Pulmonary conditions

The Steering Committee identified a long list of gap areas for future measure development relevant to quality care in nursing homes. This list begins on page 39 of the voting report and includes a number of areas that are related to both short-stay and long-stay populations. This appeal was also forwarded to the developer. They provided the following information:

CMS RESPONSE: When sufficient MDS 3.0 data become available analyses will explore new short-stay and cross setting measures. That said, note that the current measures are intentionally constructed to be resident-focused and the definitions of short-stay and long-stay not linked to payer source (see comments above).

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**AGENCY FOR HEALTHCARE RESEARCH AND QUALITY: RESPONSE TO
NURSING HOME APPEALS**

AHRQ Response to NQF Appeals on NH Measures April 7, 2011

1. Comment from Darlene A. Thompson, Kindred Healthcare Inc.

“I appreciate AHRQ analyzing the questions “how often did you feel worried”; “how often did you feel happy” and “Think about how you felt about your life when you were in the nursing home, Use any number from 0-10 where 0 is the worst possible and 10 is the best possible, what number would you use to rate your life then?” and their impact as potential case mix adjusters. I believe it will be very important to involve the nursing home industry in their review of the data and consideration of the impact of these questions to the survey.”

AHRQ Response: Several mood related questions like “how often did you feel worried”; “how often did you feel happy” were added as potential case mix adjusters (based on CMS sponsored research by Dr. Rosalie Kane) and are being analyzed for that purpose; this analysis is underway. They are placed at the end of the core set of questions so as not to influence a resident’s response to the core set of questions.

2. Comment from Roxanne Tena-Nelson, Continuing Care Leadership Coalition (CCLC)

“NH-026-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Discharged Resident Instrument (Agency for Healthcare Research and Quality).
NH-027-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Long-Stay Resident Instrument (Agency for Healthcare Research and Quality).
NH-028-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Family Member Instrument (Agency for Healthcare Research and Quality).

As a strong proponent of person-centered care, CCLC recognizes the value of a standard satisfaction survey; however, CCLC strongly urges the NQF to clarify how providers and States may use alternative satisfaction surveys, pursuant to AHRQ’s response to concerns about the Federal government’s survey tool as the only tool eligible to meet requirements. CCLC also recognizes the difficulty involved with obtaining results from cognitively impaired nursing home residents and the resources needed to seek feedback from them and their loved ones. Whether a provider can use an existing satisfaction survey and what the parameters are surrounding the threshold number of required returned surveys will have a significant impact on the cost of administering satisfaction surveys, which could potentially become overburdensome for financially fragile providers.”

AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone who desires to use them. AHRQ recommends that the long stay resident survey only be administered as in-person survey by a third party because of concern based on previous research that staff administration biases the results (see Hodlewsky, R. and

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Decker, F. “The Problem of Bias When Nursing Facility Staff Administer Customer Satisfaction Surveys” Journal on Quality Improvement 2002:546-554). The family member survey is a mail survey (which is less expensive to implement than the long stay resident survey) and is intended for family members of cognitively impaired residents. The discharged (short stay) resident (who tend to have better cognitive capacity) survey is also administered by mail.

The three CAHPS nursing home surveys are included as several possible surveys for the Advancing Excellence in America’s Nursing Homes Campaign at http://www.nhqualitycampaign.org/files/Resident_Satisfaction_Survey_Tools.pdf

This Campaign website also lists “Considerations in Survey Selection and Implementation and Special Issues for Nursing Home Surveys” at http://www.nhqualitycampaign.org/files/Considerations_in_Satisfaction_Survey_Selection.pdf

AHRQ does not have legal authority to mandate these surveys. The Centers for Medicare & Medicaid Services (CMS) has no current plan to implement these surveys but does desire that these surveys are in the public domain. The sponsor implementing a resident or family experience survey may be other entities besides the federal government, such as a state agency or even a provider itself either for public reporting or for quality improvement. There are at least 3 examples where states (Ohio, Rhode Island and Georgia) have provided funds for either the resident or family member surveys and/or charged a modest fee to the nursing home in return for providing comparative information to all providers as well as the public.

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**CENTERS FOR MEDICARE AND MEDICAID SERVICES: RESPONSE TO NURSING
HOME APPEALS**

DATE: April 07, 2011

TO: Suzanne C. Theberge, MPH
Project Manager, Performance Measures
National Quality Forum

FROM: Cheryl Wiseman, (CMS, OCSQ), Government Project Officer

RE: Response to Nursing Home Quality Measure Appeals

CMS appreciates the opportunity to respond to the comments received from Kindred, American Health Care Association, Continuing Care Leadership Coalition and Uniform Data System for Medical Rehabilitation on April 6, 2011. This report contains CMS' responses to comments including planned analyses for each identified QM. Please note that they are not all inclusive; we will be open to analyzing other pertinent questions of interest to CMS.

While some analyses mentioned below are specific to an individual quality measure, as part of the NQF submission process requiring measures be fully specified and tested for reliability and validity we will include general analyses as follows:

- Evaluate variability, stability, validity, and risk adjustment.
- Impact of missing data and skip patterns on the quality measure.
- Impact of short-stay and long-stay definitions on the quality measure.
- Prepare reliability and validity summary report.
- Prepare risk adjustment methodology report.
- Summarize quality measure testing.

Analyses using first quarter MDS 3.0 have begun. Until six months of MDS 3.0 data are available analyses will focus on detailed measure specification and preliminary descriptive statistics. When six months of MDS 3.0 data are available issues related to measure reliability, variability, stability, validity and risk adjustment coefficients will be undertaken. These analyses will address issues and questions raised by technical expert panel members, NQF board and public comments received by NQF. This second phase of data analysis is expected to begin May 2011 and continue through Winter 2011, with preliminary results available late Fall 2011.

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Kindred Healthcare

NH-013-10 Percent of high-risk residents with pressure ulcers (long stay)

- “[We] appreciates that the measure includes the ICD-9 codes for malnutrition in I1800 in the calculation of the denominator and hope this information will be provided to the industry prior to the measures becoming public record.”

CMS RESPONSE: The MDS 3.0 has implemented an item specifically to address malnutrition (item I5600). This item will be used in the calculation of the quality measure. Malnutrition is one of the markers used to identify residents at high-risk for pressure ulcers. The denominator details in the current NQF submission provide the specification details.

Analyses will include examining the number and stage of pressure ulcers on admission. (We received comments suggesting that it would be helpful to stratify this quality measure by whether the pressure ulcers were present on admission, especially Stage IV pressure ulcers that were acquired in the community and could take 100 days or more to heal [e.g., community-acquired or facility-acquired].) We will explore the relationship of pressure ulcers present on admission with prevalence on the target assessment to address stakeholder concerns of residents’ being admitted with pressure ulcers and the nursing facilities’ being held responsible.

CMS will analyze how community-acquired pressure ulcers affect facility-level quality measures scores and report-ability. For example, with regard to report-ability, CMS will examine the percentage of facilities that have sufficient residents in the denominator to report the long-stay measure, then see how that percentage changes if residents who had pressure ulcers present on admission were excluded. CMS will examine the percentage of facilities that would have sufficient residents in the denominator to report quality measure scores based on only community-acquired or only facility-acquired pressure ulcers, compared with report-ability of the existing quality measure.

To determine the impact of community-acquired pressure ulcers on the quality measure scores themselves, we will calculate the percentage of facilities whose quality measure scores would increase, decrease, or stay the same if quality measure were calculated separately for residents with community-acquired pressure ulcers and for residents with facility-acquired pressure ulcers.

NH-014-10: Percent of nursing home residents who were assessed and appropriately given the seasonal influenza vaccination (short-stay)

AND

NH-015-10: Percent of residents assessed and appropriately given the seasonal influenza vaccination (long-stay)

- “Would the NQF and CMS ever consider handling the influenza vaccine measures like the pneumococcal vaccine measures – reporting each of the areas as separate measures to reduce confusion.”

CMS RESPONSE: The numerator and denominator will be harmonized with NQF standards for endorsed measures (calculating and reporting three numerator components separately: residents

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who were vaccinated; residents who refused vaccination; and residents for whom vaccination is contraindicated). The NQF measure specification details will be revised to reflect this methodology and be available to NQF on 4/15/11. Preliminary analytic results based on MDS 3.0 data are expected to be completed in Fall 2011 with analytic refinements available in Winter 2011. In our continued efforts to maintain transparency, detailed reporting of the approved measure, will be made available to the public after NQF endorsement, expected in early Winter 2012.

CMS will analyze the both the short-stay and long-stay quality measures. The public noted that “inability to obtain vaccine due to a declared shortage” is not considered to be a valid reason for excluding residents from the denominator. Their concern is that this would artificially decrease a facility’s score on these quality measures for reasons beyond the facility’s control. CMS will determine the impact that this has on facilities’ quality measure scores by identifying the percentage of assessments that indicate that a vaccine was not received because of inability to obtain the vaccine. CMS will analyze the percentage of facilities that would no longer have sufficient residents in the denominator to calculate this quality measure if assessments in which the vaccine was not received because of the facility’s inability to obtain the vaccine were excluded from the denominator. In addition, CMS will analyze the percentage of facilities whose quality measure scores for both the short-stay and long-stay measures would increase, decrease, or stay the same if assessments where the vaccine was not received because of the facility’s inability to obtain the vaccine were excluded from the denominator, compared with quality measures calculated using the current definition.

NH-022-10: Percent of residents whose need for help with activities of daily living has increased (long stay)

- “CMS should research and recognize risk adjustments based upon the aged aging. Although the exclusions recognize when a resident is totally dependent in all 4 late loss ADLS, there is no risk adjustment for the aged aging during the ADL loss cycle.”

CMS RESPONSE: This QM and risk adjustment strategy is based on MDS 2.0 data analyses. No covariates were included in the prior QM because none were identified with sufficient predictive power in the analysis. Exclusions were defined however, as cited in the comment, which is a strategy for risk adjustment. CMS will continue research in aged aging syndromes and continue to evaluate new refinements and potential additional risk adjusters and measures in the future. Immediate analyses include examining whether acute illness (active diagnoses) could increase residents’ need for help with activities of daily living and whether the residents who trigger this quality measure are more likely to have a diagnosis of dementia or to be in the end stage of an illness (such as renal disease, congestive heart failure, or other condition that makes the residents eligible for hospice care). To address the impact of acute illnesses on the quality measure, CMS will examine the percentage of residents who trigger this quality measure and who have an acute illness listed on their most recent MDS assessment. This acute illness, which would be indicated in the active diagnoses section of the MDS 3.0, may include stroke or coronary artery disease. CMS will calculate the percentage of facilities that would no longer have sufficient residents in the denominator if residents with these active diagnoses were excluded from the quality measure calculation. To analyze whether residents who trigger this quality measure are more likely to have a diagnosis of dementia, CMS will compare the

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proportion of residents who trigger this quality measure both across all residents whose most recent assessment includes a diagnosis of dementia and across all residents whose most recent assessment does not include a diagnosis of dementia. We will use these rates to determine whether a diagnosis of dementia is associated with triggering this quality measure. Moreover, we will calculate the percentage of facilities that would no longer have sufficient residents in their denominator for this quality measure if residents with a dementia diagnosis were excluded.

NH-024-10: Percent of residents who lose too much weight (long stay)

- “I appreciate CMS response to the comments regarding the omission of the discharge assessment in the specifications – however – the specifications posted with the October 2010 responses to the public comment still did not address that the discharge assessment would be included in the measure.”

CMS RESPONSE: The current measure specification for public reporting includes the discharge assessment. The NQF measure specification will be revised to clarify this inclusion is part of the current definition.

- “Many comments were submitted regarding including hospice and “life expectancy of less than 6 months” as an exclusion for this measure. The exclusion of hospice/end of life residents has been part of the prior Quality Measure # 13 and its revised Quality Measure 7.1 for years. CMS stated in their response that they plan “to analyze the MDS 3.0 data regarding refinement in the measures and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live”. I appreciate this response and look forward to having to opportunity along with the industry to review any revisions prior to the measure becoming public record.”

CMS RESPONSE: While residents receiving hospice care and those with a prognosis of less than six months to live were excluded from the MDS 2.0 measure, these residents are not excluded from the MDS 3.0 measure. CMS acknowledges the controversy over the biological and disease basis for weight loss among older people in nursing facilities, which may limit the effectiveness of interventions designed purely to increase resident nutritional intake as a method of maintaining weight. CMS also recognizes that hospice and other end-of-life experts argue that weight loss is a normal part of the dying process and contentions that efforts to maintain weight during this period are not consistent with a palliative care approach. These issues were raised and discussed in detail during the technical expert panel (TEP). The exclusion was dropped from the QM definition because the majority of TEP members believed that hospice and prognosis items will not capture many residents who are dying as a result of reluctance to identify individuals who are actively dying and difficulty in accurately estimating prognosis for non-cancer residents. When sufficient MDS 3.0 data are available we will examine the impact of including these residents in the measure. In addition to analyses examining the report-ability, variability, stability, validity of this measure, analyses will include investigating facility level variation in the distribution of hospice and residents with a prognosis of less than 6 months to live among residents triggering this QM. Differences in facility QM score when calculating the

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measure with and without hospice and residents with a prognosis of less than 6 months will also be done, specifically looking at whether facilities change relative positions across the distribution of the QM. Analyses will also investigate the relationship between facility QM score and the proportion of residents with other markers of end-of-life and predictors of weight loss such as dementia.

American Health Care Association

Appeal Is Premature

- “Since the definition of “short-stay” and “long-stay” measures has been newly defined, AAHCA believes that NQF must designate all the measures with provisional approval.”

CMS RESPONSE: The short-stay and long-stay definitions have been made more explicit. The changes are an improvement in the definitions. The effectiveness of these definitions will be examined with further MDS 3.0 data analysis and be made available to the public. In a continuing effort to be transparent, findings will be shared with the public subsequent to the NQF review in February 2012. Analyses will include correlation between pairs of long and short-stay measures where the definitions are the same except for sample selection (e.g. 014 and 015 Influenza Vaccine). CMS will compare facility results using MDS 3.0 measures with their quality measure performance on the basis of MDS 2.0 data. For quality measures whose underlying items did not change significantly from the MDS 2.0 to MDS 3.0—for example, physical restraints—it is expected that facilities will have similar results. Analyses will also include comparisons of QM scores calculated based on assessments of residents that were discharged within 100 days, as compared with QM scores calculated using assessments of residents that were in the early part of a greater than 100 day stay.

Inadequate Measures for the Medicare Program

- “If Medicare funding leads to better quality and yet there is an inadequate number of Medicare Program quality measures, are nursing facility quality and policy decisions unintentionally being negatively biased by the predominance of the long-stay (underfunded Medicaid population) measures?”
- “Are MDS-based quality measures, currently categorized by long-stay and short-stay patients (Medicaid and Medicare), in reality measuring the quality of the nursing facility payment systems? “

CMS RESPONSE (to both bullets above): This is incorrect, it is not appropriate to equate the long- and short- stay measures with Medicaid and Medicare residents respectively. The quality measure calculations use all assessments for residents in certified beds regardless of payer type. Furthermore, data from the MDS 2.0 quality measures suggest that the majority of short-stay residents in the measures will be non Part A Medicare residents. The definition of short-stay and long-stay is no longer defined on the basis of a PPS and OBRA assessment, but on how long

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the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode.

- “Privacy of information is an issue that restrains the development of quality measures for the Medicare Program. Measuring structure, process and outcomes is impacted by the numbers of managed care, private insurance and self-pay patients receiving care in the facility. Patient information is withheld from Federal and State agencies when the payer of the nursing facility services is not Medicare and Medicaid. The purpose of the restriction relates to the need to protect patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a result, managed care, private insurance and self-pay patient data is excluded from the reported measures. Adding to this problem, more and more nursing facilities are admitting managed care patients.”

CMS RESPONSE: Federal access and use of MDS data is based on whether the resident is in a Medicare Medicaid certified bed and is not tied to the payer source. It is not true that managed care residents are excluded.

- “MDS 3.0 coding addresses the information exclusions in Section A, 0410, Submission Requirement.”
- “An important outcome resulting from the MDS Submission Requirements is the reduction in the number of assessment files used in the calculation of the nursing facility’s quality measures that mostly impacts the short-stay patient population. This means the measure’s denominator size is reduced and may be too small to produce a valid result, resulting in a measure not appropriate for public reporting. This situation further restricts the availability and use of short-stay measures and inadvertently may lead to a biased assessment of nursing facility quality.”

CMS RESPONSE (to both bullets above): Item A0410 has not changed since MDS 2.0 which also allowed federal access to submissions so will in no way effect the denominator size in the QMs.

- “As previously discussed, long-stay patients are those predominantly paid by Medicaid and short-stay patient are those patients funded by Medicare.”

CMS RESPONSE: The definition of short-stay and long-stay is no longer defined on the basis of PPS and OBRA assessments, but on how long the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode. As such the short-stay measures take into account long-stay residents in the initial part of their stay.

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- “CMS and NQF members must work together with stakeholders to explore other methodologies that improve the current quality measurement framework and recommend an alternative approach that is patient-focused and not care setting or payment focused.”

CMS RESPONSE: When sufficient MDS 3.0 data become available analyses will explore new short-stay and cross setting measures. That said, note that the current measures are intentionally constructed to be resident-focused and the definitions of short-stay and long-stay not linked to payer source (see comments above).

Continuing Care Leadership Coalition

NH-009-10: The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Report a Decrease in Pain Intensity or Frequency (short stay)

- “For facilities that have frequent unscheduled transfers to emergency departments (e.g., facilities caring for high acuity patients), this measure does not accurately reflect the residents who might have experienced an improvement in pain, as this measure relies on the MDS discharge assessment. CCLC recommends that NQF use an alternative to the MDS discharge assessment as the basis for the denominator for this measure.”

CMS RESPONSE: This pain management QM does not rely solely on the MDS discharge assessments. The measure is constructed to use the most recently available assessment for an active resident. It is expected that the provider will be able to capture pain intensity and change in pain level on any assessment particularly where the resident is on a pain regimen; there is no reason to consider pain on discharge any differently from pain assessment at any other time during the resident’s stay. For residents on a pain medication regimen staff assessment of pain should be a part of the regimen and available at any discharge unscheduled or not. It is assumed that facility staff use chart reference medical records in examining the efficacy of pain regimen and that this should allow the assessment of pain on discharge. Finally, the ability to use the discharge assessment allows the measure to be applied to a broader sample of short-stay residents; that is, for 45 % of Part A residents there was only one assessment present on MDS 2.0—the use of the discharge assessment allows these residents to be included in calculating the measure. In addition to analyses examining the report-ability, variability, stability, validity of this measure, analyses will include an investigation of the impact of including discharge assessments in the definition of this QM. These will include evaluating the change in sample size of assessments eligible to be included in the denominator, evaluating completeness of responses on items comprising the QM by assessment type, and comparing the relative positioning of facilities across the distribution of the QM when calculating the measure with and without discharge assessments in the sample.

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Uniform Data System for Medical Rehabilitation

- “After careful consideration, we have concluded that the proposed nursing home measures are predisposed to long-term patients and do not adequately address clinical and rehabilitative objectives for short-stay patients. Given the propensity of Medicare payments to nursing homes for skilled nursing and therapy services, it seems appropriate that the Centers for Medicare and Medicaid Services (CMS) would be most interested in quality and efficacy data related to the patient population it is ultimately financially responsible for. The recommended measures do not allow facilities to substantiate the quality of their short-term restorative care program to CMS.”

CMS RESPONSE: The definition of short-stay and long-stay is no longer defined on the basis of PPS and OBRA assessments, but on how long the resident is in the facility. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Based on MDS 2.0 data a large proportion of short-stay residents are potential long-stay residents who are in the initial part of their episode. As such the short-stay measures take into account long-stay residents in the initial part of their stay. The short-stay definition captures actual short-stay residents as well as other residents in the initial part of their stay. Finally, the availability of the discharge assessment will allow further analyses to explore possible new short-stay functional measures.

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RAND COROPORATION: RESPONSE TO NURSING HOME APPEALS

To: Suzanne C. Theberge, MPH
Project Manager, Performance Measures
National Quality Forum

FROM: Neil Wenger, MD
Carol Roth, RN MPH
RAND Corporation

DATE: April 7, 2011

RE: Appeals on NQF Nursing Homes Project
NH-003-10 Physical Therapy or Rehabilitation/Restorative Care for
Long-Stay Patients with New Balance Problem

Comment from Darlene Thompson, RN, CCRN, NE-BC; Kindred Healthcare, Inc.: PT payment billing not submitted to CMS

The concern was expressed that physical therapy that had been received that was paid by sources not submitted to CMS (e.g., self pay, private insurance, some managed care organizations, and some Medicaid programs) would not be recognized and therefore, not credited to the NH and falsely lower the quality score for this measure.

The appeal is concerned that physical therapy received in the nursing home will not be available in Part A or Part B claims. We were unable to find data on the proportion of physical therapy provided to nursing home residents from non-Medicare sources, but we believe this proportion to be very small. An OIG report from 2001 entitled “Physical, Occupational, and Speech Therapy for Medicare Nursing Home Patients Medical Necessity, Cost, and Documentation Under the \$1500 Caps” (OEI-09-99-00560) found, among Medicare beneficiaries, minimal need for physical therapy that exceeded Medicare caps, suggesting that the need for private pay physical therapy for a new balance problem would be low.

Comment from Roxanne Tena-Nelson, JD, MPH, Continuing Care Leadership Coalition (CCLC): Potential lack of capture of new balance problem

The concerned party noted that the methodology used for identifying a new balance problem may not identify all new eligible cases. The methodology is based on MDS 3.0 item G3a (Balance during transitions and walking: moving from seated to standing position) with response category codes of 0=steady at all times; 1=not steady, but able to stabilize without human assistance; 2=not steady, only able to stabilize with human assistance. A new balance problem is identified as an increase in the numeric code in the current assessment compared to the prior assessment.

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Ms. Tena-Nelson correctly notes that patients who already have the most severe level of balance problem (code 2) on the first assessment cannot possibly receive a “worse” (increased) code on the subsequent assessment. A subsequent code of “2” in that case could indicate the continuation of the same balance problem OR a new and equally destabilizing balance problem. A code of “1” could indicate an improvement in the old balance problem OR a new but less destabilizing balance problem. While the methodology for this measure would not identify these cases (with an initial G3a code of “2”), it would identify those cases with an initial code of “0” or “1” that had a higher code on the next assessment. These cases would, by definition, be patients with balance problems that are new OR problems that have worsened---either circumstance making them appropriate candidates for physical therapy or rehabilitation/restorative care. While the measure has the potential for missing some eligible cases, it identifies other patients whose balance problems were absent or less severe at the start and are now present or worse.

Comment from Roxanne Tena-Nelson, JD, MPH, Continuing Care Leadership Coalition (CCLC): Patient refusal of PT/rehabilitation/ restorative services

Ms. Tena-Nelson notes that some patients with a new/worsened balance problem will refuse offered PT/rehabilitation/restorative services, and these offers will not be credited to the NH by this measure. We previously responded to this concern that in our experience with this measure, we have found such refusals to be rare. Ms Tena-Nelson asks if special populations have been studied (e.g., HIV/AIDS and other specialty populations) and requests that the measure be risk-adjusted for even small numbers of refusals.

We would like to point out that patients are excluded from the denominator for this measure if they have advanced dementia or poor prognosis (less than 6-month life expectancy or receiving hospice care). Perhaps these exclusions address some of the HIV/AIDS and other “specialty populations” that Ms. Tena-Nelson mentions.

March 14, 2011

National Quality Forum

Re: National Voluntary Consensus Standards for Nursing Homes

To the Committee:

First I want to thank the NQF for their efforts to endorse quality measures for the nursing home industry that are consistent across the industry utilizing standard data for comparison. The nursing home industry has always supported methods to present their quality standards.

I was privileged to be a member of the National Quality Forum's Steering Committee for the National Voluntary Consensus Standards for Nursing Homes project that had the opportunity to review and comment on the proposed quality measures as a representative of my profession and my peers. I feel that even though I did express my concerns during the meetings and during the public comment period, I feel I must comment one more time on some of the measures that the NQF has approved for endorsement or for time limited endorsement.

In the responses to the comments posted on the NQF website, many of the responses from CMS indicated that the comments will be considered as they analyze the MDS 3.0 data as well as for further refinement of the quality measures. My hope is that this consideration and refinement will occur prior to the measures becoming public record and allow the industry to fully understand and prepare for the publishing of the quality measures.

NH-003-10 Physical Therapy or Rehabilitation/Restorative Care for Long-Stay Patients with New Balance Problem.

I appreciate RAND's response to the comments received in correcting the original title to recognize long stay patients and for their addition of the BIMS in the definition of "advanced dementia" for exclusion from the measure.

RAND did not fully explain how they were going to be able to capture those patients who meet the denominator definition of a balance problem and received physical therapy in the prior 4 months to one month after paid by funds not recorded or submitted to CMS. Private pay patients, private insurance, many managed health care organizations and in some cases, State Medicaid programs, do not provide their therapy billing to CMS. If a patient received therapy in the administrative data look-back period paid by funds not reported to CMS, these patients would meet the requirement to be included in the numerator but would not be included in the measure. This would result in a false lower percentage being published.

As an example – 100 patients meet the denominator requirement. 20 patients meet the physical therapy administrative data in the 4 month look-back, 10 patients meet the numerator from O5f of the MDS 3.0, and 20 patients received physical therapy in the administrative data look back period but from private or insurance payors. According to the specifications for this measure – the reportable percentage would be 30% rather than the actual 50%.

I strongly urge NFQ, CMS and RAND to research the variances in the percentage reported versus actual prior to making this measure public and provide information to the industry on how all applicable therapy billing for this measure will be captured. This will lessen the burden to the nursing homes to have to explain the actual percentage versus the percentage reported on Nursing Home Compare.

NH-013-10 Percent of High Risk Residents with Pressure Ulcers (Long Stay)

I appreciate CMS recognizing the need to examine the comments to include ICD-9 codes for Malnutrition in I8000 in the calculation of the denominator and hope this information will be provided to the industry prior to the measures becoming public record.

NH-014-10 and NH-015-10 Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (Long Stay)

I appreciate NQF noting the concern regarding the accuracy of the title from the original title; however, I still feel the current title remains unclear to the consumer based upon the specifications of the measure. The measure includes in the numerator and denominator residents who refuse and resident who are medically ineligible to receive the vaccine. Adding the word “appropriately” to the title does not make the percentage clearer. When consumers see “appropriately given” – their first reaction is that the percentage represents the percentage actually given.

For example; 100 patients meet the denominator, if that number 20 received the vaccine, 20 declined the vaccine and 40 were medically ineligible. The measure would be presented as 80% of residents were assessed and appropriately given the influenza vaccine when in actuality – only 20% of the residents actually received the vaccine.

Would the NQF and CMS ever consider handling the influenza vaccine measures like the pneumococcal vaccine measures – reporting each of the areas as separate measures to reduce confusion?

NH-022-10 Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)

I appreciate CMS responses to the comments and excluding the discharge assessment from the denominator and also recognizing an ADL score of 7 will equate to a score of 4 in the numerator.

CMS failed to explain in their responses their rationale in not providing any risk adjustments for late loss ADL loss based upon geriatric aging syndrome. Commenters referenced Katz, who indicated that late loss ADLS are lost in opposite order from which they are acquired from infancy. Late loss functional decline is considered a component of geriatric aging syndrome and there is no evidence that late loss ADLs can be prevented. Considering that the purpose of the measure is to measure decline as a measure relating to quality, CMS should research and recognize risk adjustments based upon the aged aging. Although the exclusions recognize when a resident is totally dependent in all 4 late loss ADLS, there is no risk adjustment for the aged aging during the ADL loss cycle.

NH-024-10 Percent of Residents Who Lose Too Much Weight (Long Stay)

I appreciate CMS response to the comments regarding the omission of the discharge assessment in the specifications – however – the specifications posted with the October 2010 responses to the public comment still did not address that the discharge assessment would be included in the measure.

Many comments were submitted regarding including hospice and “life expectancy of less than 6 months” as an exclusion for this measure. No clinician has a goal for a resident who is end of life and/or receiving hospice services to lose weight and I agree that it is not associated with all residents who are at end of life but it is an outcome of many end of life residents. CMS responded that a prognosis in J1400 of having less than 6 months to live is likely subject to substantial measurement error given it is very difficult to predict when someone will die. Since this MDS item requires physician documentation in order to code and hospice services must have supporting physician documentation, it is not a subjective decision of center clinicians. The exclusion of hospice/end of life residents has been part of the prior Quality Measure # 13 and it revised Quality Measure 7.1. for years.

CMS stated in their response that they plan “to analyze the MDS 3.0 data regarding refinement in the measures and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live”. I appreciate this response and look forward to having to opportunity along with the industry to review any revisions prior to the measure becoming public record.

NH—026-10 CAHPS Nursing Home Survey: Discharged Resident Instrument

I appreciate AHRQ analyzing the questions “how often did you feel worried”; “how often did you feel happy” and “Think about how you felt about your life when you were in the nursing home, Use any number from 0-10 where 0 is the worst possible and 10 is the best possible, what number would you use to rate your life then?” and their impact as potential case mix adjusters. I believe it will be very important to involve the nursing home industry in their review of the data and consideration of the impact of these questions to the survey.

Again, I appreciate the efforts of the NQF in assisting the nursing home industry with their quality standards and the collaborative efforts to identify consistent and meaningful quality measures for the community.

Thank you

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Kindred Healthcare Inc.

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March 24, 2011

Ms. Suzanne Theberge
Project Manager, Performance Measures
National Quality Forum
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Washington, DC 20005

Re: National Voluntary Consensus Standards for Nursing Homes – Appeal

Dear Ms. Theberge,

The American Health Care Association (AHCA) appreciates the work of the National Quality Forum (NQF) on the National Voluntary Consensus Standards for Nursing Homes Steering Committee's work in identifying measures for quality improvement and public reporting. As the nation's leading long term care organization, AHCA and our members agree that measures are needed to monitor and improve care. However, we are concerned that the quality measures most recently approved by the board fall short in their ability to measure processes and outcomes for all our patients and thus we are appealing the measures. Our appeal is based on the following issues:

1. The announcement for the appeal is premature,
2. The number of measures for the Medicare Program is inadequate; and
3. Existing measures may not be sensitive enough to the various patient populations being served in nursing facility care centers.

Appeal is Premature

While we appreciate the opportunity to appeal some or all of the measures, we believe this offer is premature since the measures will not be available to the public (blacked-out) for one year. Currently, one third of the measures have been given provisional approval; meaning that CMS will, during the black-out period, test the measure definitions and the performance of the provisional measures. These measures have not been previously tested or validated. Since the definition of "short-stay" and "long-stay" measures has been newly defined, AHCA believes that NQF must designate all the measures with provisional approval. It is difficult to appeal any measure until testing is completed and measure performance results have been analyzed, validated and published. By signifying all the MDS 3.0 measures as having time-limited approval, this will allow NQF the opportunity to reexamine the performance of the quality measures when they are actually used and calculated using the MDS 3.0 data.

Recommendation: NQF request that CMS offer a second appeal opportunity this Fall after testing is completed and when all the needed measure changes and refinements have been made.

Inadequate Measures for Medicare Program

Among the 21 endorsed measures, only 5 measures are directly intended for the Medicare, short-stay, patient population. These measures include:

1. The percent of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency;
2. Percent of residents who report moderate to severe pain;
3. Percent of residents with pressure ulcers that are new or worsening;
4. Percent of residents assessed and appropriately given the seasonal influenza vaccine;
5. Percent of residents assessed and appropriately given the pneumococcal vaccine; and,
6. CAHPS Discharge Resident Instrument.

It is apparent that the short-stay measures for pain, pressure ulcer, influenza, pneumonia and experience of care survey do not cover the care issues experienced by the Medicare patient and the scope of care provided by nursing facility care centers. These measures also fall short in measuring quality associated with the growing short-stay population. In 2004, Grabowski published a study entitled *Medicaid Payment and Risk-Adjusted Nursing Home Quality Measures*. The researchers looked at the relationship between payment rates and quality outcomes for pressure ulcers, physical restraints and pain, and they found that higher payment was associated with lower incidents of pressure ulcers and physical restraints. The researchers concluded that nursing facility care may suffer as a result of State Medicaid budget shortfalls. The study also found that higher payment rates were associated with higher quality.¹

This study leads to questions and concerns about nursing facility care funding adequacy and the quality measures currently being proposed. Two questions that need to be raised and considered include:

- If Medicare funding leads to better quality and yet there is an inadequate number of Medicare Program quality measures, are nursing facility quality and policy decisions unintentionally being negatively biased by the predominance of the long-stay (underfunded Medicaid population) measures?
- Are MDS-based quality measures, currently categorized by long-stay and short-stay patients (Medicaid and Medicare), in reality measuring the quality of the nursing facility payment systems?

Privacy of information is an issue that restrains the development of quality measures for the Medicare Program. Measuring structure, process and outcomes is impacted by the numbers of managed care, private insurance and self-pay patients receiving care in the facility. Patient information is withheld from Federal and State agencies when the payer of the nursing facility services is not Medicare and Medicaid. The purpose of the restriction relates to the need to protect patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

¹ Grabowski, David C., Joseph, J., Angelelli and Vincent Mor, *Health Affairs*, 23(5):243-252 (2004).

As a result, managed care, private insurance and self-pay patient data is excluded from the reported measures. Adding to this problem, more and more nursing facilities are admitting managed care patients.

MDS 3.0 coding addresses the information exclusions in Section A, 0410, Submission Requirement. This section lists the following instructions:

Code 1, neither Federal nor State required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for residents on this unit. If the record is submitted, it will be rejected and all information from that record will be purged.

Code 2, State but not Federal required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or other requirements, to collect MDS information for these residents.

Code 3, Federal required submission: if the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.²

An important outcome resulting from the MDS Submission Requirements is the reduction in the number of assessment files used in the calculation of the nursing facility's quality measures that mostly impacts the short-stay patient population. This means the measure's denominator size is reduced and may be too small to produce a valid result, resulting in a measure not appropriate for public reporting. This situation further restricts the availability and use of short-stay measures and inadvertently may lead to a biased assessment of nursing facility quality. As previously recommended, having a second appeal will allow the quality measure performance to be evaluated during the black-out period and will help better understand the impact of the denominator size, exclusions, and reliability (which could not be adequately tested since MDS 3.0 was not in use when the measures were developed.) This latter point is demonstrated by the fact that the NQF panel asked the measure developers for a number of changes to the measure specifications during the NQF review process.

Fixing quality measures for the Medicare Program is not simple and the previously cited Grabowski study findings beg the question of whether the current framework for measuring nursing facility quality is the most appropriate approach. More analysis is needed. In the interim, Medicare Program quality measurement remains a necessity and efforts are needed to develop, as best as possible, more measures that are accurate and valid and that can be implemented with the rest of the quality measures. Having an equal number of measures for both the Medicaid and Medicare Programs will help eliminate the unintended biased and negative care setting impression conveyed to consumers and others about the quality of nursing facility care.

Recommendation: Work with CMS to identify and test additional measures for the Medicare Program and include those measures and their testing findings in a second public appeal opportunity.

² MDS 3.0 RAI Manual, December 2010. MDS 3.0 Chapter 3, Section A, *available at* http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

Long Term Care Patient Populations

As previously discussed, long-stay patients are those predominantly paid by Medicaid and short-stay patient are those patients funded by Medicare.

In an article entitled *Using Population Segmentation to Provide Better Health Care for All: The “Bridges to Health” Model*, the authors Lynn, Straube, Bell, Jencks and Kambic divide the population into eight groups; people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty. They propose that each group has its own definitions of optimal health and its own priorities among services. The authors interpreted what they called “population-focused priorities” in the context of the Institute of Medicine’s (IOM), *Crossing the Quality Chasm* report. The report identified six goals of quality (safety, effective, efficient, patient centered, timely and equitable) and from this framework recognize that a better approach to care arrangements, resource planning and services could be realized.³

AHCA finds the *Bridges to Health Model* discussion enlightening with regard to its potential use in providing the framework for the next generation of healthcare quality measurements. At least half of the identified population groups are currently found in nursing care facilities. Since each patient needs different services for the attainment of optimal health; building a measurement system based on population segments, not funding approaches, may allow for measures to be used across provider settings and compared. This approach potentially offers a more appropriate method to measure quality for like-patients across care settings, tie payment to quality, and in implementing a bundled or value-based purchasing payment system.

NQF has incorporated the IOM’s *Crossing the Quality Chasm* work in the National Priority Partnership initiative. It is logical, if not already underway, that NQF look at patient classification methodologies and test all-setting quality measures based on a patient classification system.

Recommendation: CMS and NQF members must work together with stakeholders to explore other methodologies that improve the current quality measurement framework and recommend an alternative approach that is patient-focused and not care setting or payment focused.

AHCA understands that the NQF is an independent CMS contractor in the endorsement of MDS 3.0 quality measures for quality improvement and public reporting and that any organization whether Federal, State, Insurance, etc. can use the measures. Being the CMS designated entity to recommend the measures, in essence bounds CMS to use the NQF measures. It also infers that NQF is an acting arm of CMS. Therefore, a premature approval of the NQF endorsed measures results in the possible release of less than optimal measures. In fact, some States are currently using NQF MDS endorsed measures for their serious reportable event payment programs. CMS also is recommending the adoption of NQF hospital, healthcare acquired conditions (HAC) for consideration for use in other settings. It is important to note that a HAC or never-event program can be crafted for long term care if it is done in an appropriate fashion with specific nursing facility criteria and measures and not warmed-over hospital never-events.

³ Lynn, J., Straube, B., Bell, K., Jencks, S., Kambic, R. Using Population Segmentation to provide Better Health Care for All: The “Bridges to Health” Model. *The Milbank Quarterly*, Vol. 85(2):185-208 (2007).

Payment policy initiatives cannot just adopt the hospital never event program and expect it to work properly or work at all in nursing facilities. Due to the open use of NQF adopted measures, we strongly urge the NQF to consider how other groups are using or proposing to use NQF products. We also urge NQF to work with CMS to ensure that all MDS measures are tested after all changes and refinements are made, that a second public appeal is offered, measure exclusions are considered, and measure construction does not hamper public reporting.

Again, AHCA appreciates the opportunity to appeal the nursing home quality measures and to offer our thoughts and recommendations.

Sincerely,



Sandra Fitzler
Senior Director of Clinical Services

April 1, 2011

Suzanne Theberge, MPH
Project Manager, Performance Measures
National Quality Forum
601 13th Street NW
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Washington, D.C. 20005

Re: Endorsed Quality Measures for Nursing Homes

Dear Ms. Theberge:

On behalf of more than 100 not-for-profit and public long term care organizations that make up the membership of Continuing Care Leadership Coalition (CCLC), an affiliate of the Greater New York Hospital Association (GNYHA), we appreciate the opportunity to comment upon the National Quality Forum endorsed quality measures for nursing homes.

CCLC strongly supports the use of quality measures for quality improvement and quality assurance activities in long-term care. CCLC appreciates the ability to represent our deeply engaged members in this opportunity for comments on these quality measures.

The following issues have been identified as problematic for our members:

NH-003-10: Physical therapy or nursing rehabilitation/restorative care for long-stay patients with new balance problem (RAND).

CCLC members indicate that this measure lacks sensitivity to transient balance problems (caused by medications, for example) that may not be resolved by physical therapy or restorative nursing care. In using MDS 3.0 assessments, this measure has potential to miss capturing certain new balance problems that normally respond to physical therapy or restorative nursing care.

For example, an initial quarterly MDS might have captured in the 7-day lookback period transient balance problems previously noted for which a resident was coded as "2". During the next quarter, the resident exhibits a new balance problem, which normally responds to physical therapy or restorative nursing care, coded in the second quarterly MDS as "2" or "1." As a result, this case would incorrectly capture a "new balance" problem under this measure.

Additionally, the measure does not capture a resident's refusal of offered services. CCLC recognizes that researchers found such refusals to be minimal in the 10/4/2010 draft report comments; however, CCLC members question the populations studied (e.g., were HIV/AIDS facilities or other specialty population facilities included in this study), and contend that the measure should be risk-adjusted for even small numbers of refusals.

NH-009-10: The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay).

For facilities that have frequent unscheduled transfers to emergency departments (e.g., facilities caring for high acuity patients), this measure does not accurately reflect the residents who might have experienced an improvement in pain, as this measure relies on the MDS discharge

assessment. CCLC recommends that NQF use an alternative to the MDS discharge assessment as the basis for the denominator for this measure.

NH-026-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Discharged Resident Instrument (Agency for Healthcare Research and Quality).

NH-027-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Long-Stay Resident Instrument (Agency for Healthcare Research and Quality).

NH-028-10: Consumer Assessment of Health Providers and Systems (CAHPS) Nursing Home Survey: Family Member Instrument (Agency for Healthcare Research and Quality).

As a strong proponent of person-centered care, CCLC recognizes the value of a standard satisfaction survey; however, CCLC strongly urges the NQF to clarify how providers and States may use alternative satisfaction surveys, pursuant to AHRQ's response to concerns about the Federal government's survey tool as the only tool eligible to meet requirements. CCLC also recognizes the difficulty involved with obtaining results from cognitively impaired nursing home residents and the resources needed to seek feedback from them and their loved ones. Whether a provider can use an existing satisfaction survey and what the parameters are surrounding the threshold number of required returned surveys will have a significant impact on the cost of administering satisfaction surveys, which could potentially become overburdensome for financially fragile providers.

If you would like to follow up, please do not hesitate to contact me (212-506-5412 or tena-nelson@cclcnyc.org) or Kathryn Santos, Manager of Quality Improvement Initiatives (212-506-5413 or ksantos@cclcnyc.org), at CCLC.

Sincerely,



Roxanne Tena-Nelson, JD, MPH
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April 4, 2011

Dear NQF Nursing Home Group,

Uniform Data System for Medical Rehabilitation (UDSMR) appreciates the opportunity to submit comments on the National Quality Forum's (NQF) proposed nursing home measurers.

UDSMR offers post-acute care providers a range of products and services they can use to document the severity of patient disability and the results of medical rehabilitation. Since 1994, we have maintained a national database for short-term rehabilitation programs in skilled nursing facilities and have provided severity-adjusted benchmark data to our subscribers.

After careful consideration, we have concluded that the proposed nursing home measures are predisposed to long-term patients and do not adequately address clinical and rehabilitative objectives for short-stay patients. Given the propensity of Medicare payments to nursing homes for skilled nursing and therapy services, it seems appropriate that the Centers for Medicare and Medicaid Services (CMS) would be most interested in quality and efficacy data related to the patient population it is ultimately financially responsible for. The recommended measures do not allow facilities to substantiate the quality of their short-term restorative care program to CMS.

The average length of stay in short-term rehabilitation programs, coupled with the expectation for a community-based discharge, results in a concentrated effort to maintain or restore function. In 2010, the average length of stay in UDSMR's skilled nursing database was 23 days. The mix and intensity of services provided in this abbreviated time frame differ greatly from those of the long-term patient population. The emphasis on restoration or maintenance of function affected by the patient's illness or injury is paramount in this episode of care. Yet the proposed measures do not adequately capture function or functional improvement. The result is an incomplete picture of the short-term episode that doesn't help purchasers. The measures would be much improved if they identified the burden of care at admission, the functional improvement achieved, and the percentage of patients returned to community settings.

Our most respected instrument, the FIM[®] instrument, is used across the post-acute care continuum. The FIM[®] instrument has a high overall internal consistency, captures significant functional gains during rehabilitation, has high discriminative capabilities for rehabilitation patients, and is a good indicator of the patient's burden of care. Measures of effectiveness, efficiency, timeliness, resource use, and safety are integral parts of the FIM[®] instrument. CMS endorses the FIM[®] instrument as part of the Inpatient Rehabilitation Facility Prospected Payment System (IRF PPS) used to capture functional health in patients seen at IRFs—a patient set similar to, yet with differing severity than, the patients seen at skilled nursing facilities.



University at Buffalo
The State University of New York

Although incorporating the FIM[®] instrument into your measures would certainly be a valid approach, UDSMR does not necessarily advocate it. We merely question the absence of functional measures in a quality tool used when medical rehabilitation is predominant. We recommend that you strongly consider adding functional measures beyond pain and incidence of vaccination.

We thank NQF for the opportunity to share our comments on this important initiative. If you have any questions about these comments, please contact us at 716-817-7800.

Sincerely,

A handwritten signature in black ink that reads "Carl V. Granger". The signature is written in a cursive style with a large initial "C".

Carl V. Granger, MD
Executive Director, UDSMR

NATIONAL QUALITY FORUM

TO: Consensus Standards Approval Committee

FR: Suzanne Theberge, MPH

RE: Results of Voting for *National Voluntary Consensus Standards for Nursing Homes*

DA: December 1, 2010

The CSAC will review the draft report *National Voluntary Consensus Standards for Nursing Homes* during the December 9, 2010, conference call. This memo includes summary information about the project, the recommended measures, and the Member voting results. The complete [voting draft report](#) and supplemental materials are available on the [project webpage](#).

CSAC ACTION REQUIRED

Pursuant to the Consensus Development Process (CDP), the CSAC may consider approval of 21 candidate consensus standards (eight are eligible for time-limited endorsement only) as specified in the “voting draft” of *National Voluntary Consensus Standards for Nursing Homes*. This project followed the National Quality Forum’s (NQF’s) version 1.8 of the CDP. All CDP steps were adhered to, and no concerns regarding the process were received.

BACKGROUND

Despite past efforts to address quality in nursing homes, and some evidence of improvement in care, evidence still remains that the quality of care experienced by the 1.4 million Americans currently residing in nursing homes often remains inadequate.^{1,2} Moreover, quality measurement has failed to describe clearly the state of healthcare in the nursing home setting, providing mixed results that can confuse both providers and consumers.³

Efforts by the federal government to address the quality of care within nursing homes and long-term care facilities have evolved over time through initiatives such as the Nursing Home Quality Initiative and the mandatory collection of Minimum Data Set (MDS) information. The MDS originated as part of a 1997 decision by the Centers for Medicare & Medicaid Services (CMS) to establish guidelines for collecting nursing home data to provide information about residents’ physical and mental health status, as well as to compare trends over time using more detailed resident-level statistics.⁴ In 2004, CMS asked NQF to identify a set of voluntary consensus

¹Centers for Disease Control and Prevention (CDC), *Nursing Home Care*, Atlanta, GA: CDC; 2010. Available at www.cdc.gov/nchs/fastats/nursingh.htm. Last accessed December 2010.

² Stone RI, Emerging issues in long-term care, In: Binstock R, George L, eds., *Handbook of Aging and the Social Sciences*, 6th ed., New York: Academic Press; 2006; pp. 397-417.

³ American Healthcare Association (AHCA), Alliance for Quality Nursing Home Care, *2009 Annual Quality Report*, Washington, DC; AHCA; 2009. Available at www.ahcancal.org/research_data/quality/Documents/2009AnnualQualityReport.pdf. Last accessed May 2010.

⁴ Commonwealth of Massachusetts, Office of Health and Human Services (EOHHS), *Minimum Data Set; 2010*, Boston, MA: EOHHS. Available at <http://www.mass.gov/?pageID=eohhs2terminal&L=7&L0=Home&L1=Provider&L2=Certification%2C+Licensure%2C+and+Registration&L3=Facilities&L4=Health+Care+Facilities+and+Programs&L5=Long+Term+Care+Facilit>

NATIONAL QUALITY FORUM

standards based on the MDS 2.0 for assessing the quality of care in both long-term residents and short-stay (subacute and post-acute) residents. When the current project is completed, the 18 previously endorsed nursing home measures will be retired. In some instances, the old measures will be replaced by new ones based on the MDS version 3.0, which was implemented in October 2010.

COMMENTS AND THEIR DISPOSITION

NQF received 243 comments from 30 organizations on the second draft report of the Nursing Homes project. Similar comments were received from multiple organizations. All measure-specific comments were forwarded to the measure developers, who were invited to respond. A [table](#) of detailed comments submitted during the review period, with responses and actions taken by the Steering Committee, is posted on the NQF voting webpage.

General Comments

There were many comments in support of the report's recommendations and many comments raised issues that the Steering Committee had previously discussed in detail. Public and member comment also raised additional concerns that were discussed by the Committee on the post comment call. The primary concerns included 1) missing data; 2) the lack of risk-adjustment for particular outcome measures; and 3) exclusion criteria (whether or not particular populations should be excluded).

The Steering Committee had discussed the issue of missing data in its original deliberations. Several comments asked further questions about this issue and the developer's responses provided information from the measure developer on how the missing data would be coded.

Action taken: The measure developers have provided information about missing data where requested; this is detailed in the comment table.

The Steering Committee reviewed several comments pertaining to risk adjustment and exclusion criteria.

Action taken: The Steering Committee re-reviewed the appropriate measures and decided in all cases that the rationales for not risk adjusting the measures and for the original exclusions were adequate. No changes to the measures were made. Further information on specific measures is detailed below.

Many of the comments sought further details or clarifications of the measure specifications. A large number of comments also suggested areas that the measure developers should examine when testing the measures. These were referred to the measure developers for a response and are detailed in the comments table.

Action taken: The measure developers have responded in detail to the comments seeking clarification or further details. This information is included in the comment table.

[ies&L6=Nursing+Homes&sid=Eeohhs2&b=terminalcontent&f=dph_quality_healthcare_p_ltc_minimum_data_set&csid=Eeohhs2](#). Last accessed May 2010.

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Other comments offered recommendations for needed measures to fill gaps in nursing home and geriatric care. There were also several recommendations to retitle measures to clarify the measure's intent, and the developers agreed to all of these changes.

Action taken: NQF staff have added new recommendations for measure development to the list at the end of the report.

Measure-Specific Comments

NH-009-10: Percent of short stay residents with effective pain management (time-limited)

Comments were primarily concerned with standardization of pain measurement scales, the time of assessment, and the differences in individuals' tolerance of pain levels.

Action taken: The measure developer agreed to examine these issues as they review the MDS 3.0 data and continue to test the measure.

NH-012-10: Percent of short-stay residents with new or not improved pressure ulcers (time-limited)

There were multiple comments about this measure, primarily focused on two issues: that the measure does not allow a realistic amount of time for pressure ulcers to heal, and that combining new pressure ulcers and pressure ulcers that fail to improve is confusing and does not reflect the true quality of care in a facility.

Action taken: After extensive discussion, the Steering Committee suggested a title change that reflects MDS 3.0 item M0800, "Worsening in pressure ulcer status since prior assessment (OBRA, PPS, or Discharge)", and that also reflects the lack of evidence about the degree to which pressure ulcers can improve during a short time. The developer agreed to this title change. The new title is "Percent of residents with pressure ulcers that are new or worsened (short stay)".

NH-013-10: Percent of high risk residents with pressure ulcers (long stay) (time limited)

Comments raised concerns about the lack of risk adjustment for this outcome measure. The measure developer explained that it had decided to not risk-adjust the measure at this time because it needs to complete further testing with the new MDS 3.0 definition of pressure ulcers before the need for risk adjustment can be determined. The measure developer expressed concern over risk-adjusting away incidents that should be reported and agreed to examine this in further detail during testing (the measure was recommended for time-limited endorsement). The Steering Committee agreed with this rationale.

Action taken: None necessary.

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Several comments also requested that the measure developer consider an exclusion for a vaccine shortage or for when a facility is unable to obtain vaccines.

Action taken: Although the measure developer agreed to consider this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; it affects all providers, and the measure should not be reported or the shortage should be noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages because of a lack of vaccine programs or inadequate planning or ordering of vaccine, which indicate quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed.

NH-018-10: Percent of long-stay residents with a urinary tract infection

This measure received a number of comments addressing two primary concerns: the lack of risk-adjustment and whether the measure is truly an appropriate quality measure for nursing home care. In the Committee call after the commenting period, the measure developer explained that there are no obvious conditions related to urinary tract infections (UTIs) appropriate for risk adjustment. The Committee agreed with the measure developer that risk adjustment was not needed, but expressed additional concerns based on the other issues raised by commenters. In response to the comments, the Committee reexamined whether this measure truly assesses quality. Several Committee members pointed to the sparse literature supporting interventions to avoid UTIs apart from avoidance of catheterizations and to the lack of an accurate definition of a UTI. They also suggested that variability in this measure across nursing homes could very well be the result of prevalence of testing for UTIs rather than quality of care. In light of these concerns, the Steering Committee requested that the measure developer provide for additional information, and called for a re-vote on this measure.

Action taken: After review of the developer's responses, the Committee voted on to recommend endorsement of this measure with the condition that it be paired with measure NH-020-10, Percent of long-stay residents who have/had a catheter inserted and left in their bladder.

NH-022-10: Percent of residents whose need for help with daily activities of living has increased (long stay)

Comments raised concerns about the lack of risk-adjustment for this outcome measure. The measure developer requested that the Steering Committee consider the detailed list of exclusion criteria related to this measure in its discussion of risk adjustment. The Steering Committee reviewed the following exclusion criteria:

- 1) OBRA admission or PPS assessment
- 2) Resident is comatose
- 3) Resident has life expectancy of less than six months
- 4) Resident in hospice care
- 5) Resident does not meet the criteria for decline in late-loss ADLs
- 6) Missing data on items 2-6

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Action taken: After review of the exclusion criteria, the Steering Committee agreed that it was appropriate for this measure to proceed without risk adjustment.

The comments were concerned about the lack of exclusion or risk adjustment for patients with dementia and about the impact of active diagnoses such as a stroke or other acute illness, which can lead to functional decline but are beyond the control of a nursing home.

Action taken: The measure developer agreed to look at these issues for future iterations of this measure.

NH-024-10: Percent of residents who lose too much weight (long stay)

Several comments raised concerns about the inclusion of hospice patients and individuals with dementia in this measure, particularly because it may lead to an increased use of feeding tubes. In the post-comment period conference call, some members of the Steering Committee felt that this issue of exclusion criteria had already been discussed at length and did not require further attention. Others were concerned about the unintended consequences this measure may have for hospice and dementia patients, given that the MDS does account for patient preference. This led to an extensive discussion of the merits of this measure, with the primary dissention coming from the Steering Committee members who thought that hospice patients needed to be excluded from the measure and were concerned about the unintended consequences of their inclusion.

According to the developer, CMS, its Technical Expert Panel (TEP) discussed this issue in detail and decided against excluding the hospice population and/or population having a prognosis of less than six months to live because it is subject to substantial measurement error given that it is very difficult to predict when someone will die. In addition, the CMS TEP believed that substantial weight loss is not necessarily associated with the last six months of life or with residents receiving hospice care. The measure developer also stated that it plans to analyze the MDS 3.0 data regarding refinements related to this quality measure, and in particular, for residents receiving hospice care and those with a prognosis of less than six months to live. The proposed weight loss quality measure is the percentage of long-stay residents who had a weight loss of 5 percent or more in the last month or 10 percent or more in the last six months, which is considered unhealthful and significant.

Action taken: Because the Steering Committee was unable to reach consensus on the call, it decided that they would re-vote on this measure after reviewing the additional materials from the measure developer. During the re-vote, the Steering Committee voted to recommend this measure for endorsement.

NH-026-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged resident instrument (time limited)

NH-27-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-stay resident instrument

NH-028-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family member instrument

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There were numerous questions and comments about the three survey measures, covering measure specifications, the development and testing of the measure, and concerns about implementation. The measure developer responded to each of them within the comment table.

Action taken: The measure developer updated the specifications to match the MDS 3.0 and responded to specific questions and concerns within the comment table.

Although the Steering Committee discussed the issue extensively, many comments were still concerned about the cost of implementation for the CAHPS surveys.

Action taken: The Steering Committee decided that this issue had been adequately addressed during its meetings and did not need to be discussed again. Endorsement of the measures does not mean that facilities are required to implement them at this time, and the Committee agreed that CMS should address the cost implications if they decide to require use of these surveys.

Measures Not Recommended for Endorsement

NH-001-10: Assessment of dementia on admission to a long-term care facility

The measure developer, the American Medical Directors Association (AMDA) requested a review of this measure.

Action taken: The group unanimously agreed that the measure was important but that it did not meet NQF's evaluation criteria when it was reviewed during the April 2010 in-person Steering Committee meeting. NQF staff and the Steering Committee encouraged the representatives from AMDA to resubmit the measure at a later date, when the measure specifications and testing are more complete.

NQF MEMBER VOTING

The 30-day voting period for the Nursing Homes project closed on November 16, 2010. Thirty-two Member organizations voted; no votes were received from the Supplier/Industry Council. The American Association of Nurse Assessment Coordinators (AANAC) submitted comments on 10 measures, the Association for Professionals in Infection Control and Epidemiology (APIC) submitted comment on 6 measures, and the St. Louis Area Business Health Coalition submitted a comment on 1 measure. The comments received are included under the voting results for each measure.

Voting Results

Voting results for the 21 candidate consensus standards are provided below.

NH-003-10: Physical therapy or nursing rehabilitation/restorative care for long stay patients with new balance problem

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%

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Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	3	1	1	5	75%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	3	1	0	4	75%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	26	2	4	32	93%
Percentage of councils approving (<50%)					100%
Average council percentage approval					93%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comments:

- Are there going to be any exclusion such as impaired leg function r/t CVA, Cast, etc. Or due to a medical condition such as Normal Pressure Hydrocephal. This measure would be very aggressive to the whole industry.
- The MDS 3.0 collects information about therapy only in the 7 days prior to and including the ARD. A resident's new balance problem may be identified during the observation window resulting in a therapy screen and treatment which may not be able to be started before the ARD. Also, it is not possible to note from the MDS whether Physical therapy is being provided for walking or balance. Any PT treatment would be noted on the MDS if provided during the look-back window.

NH-008-10: Percent of residents experiencing one or more falls with major injury (long stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	0	3	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

NH-009-10: The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay) (time-limited endorsement)

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Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	1	2	11	89%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	1	2	32	97%
Percentage of councils approving (<50%)					100%
Average council percentage approval					98%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comment:

- I would recommend this measure should also address long stay. I would take short stay off and just not address whether long or short stay?

NH-010-10: Percent of residents who self-report moderate to severe pain (short stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	0	3	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comment:

- I think that would be better to use the 30-day PPS assessment for this measure. Residents admitted following a surgical procedure, or fracture receiving therapy and/or encouraged to move will likely experience at least some moderate pain sometime in the 5-day look-back window of the 14-day assessment. It would be expected that pain should be managed after the first 2 weeks. Day 21 would open the look-back of the 30-day. The 5-day look-back window would be 17-21.

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NH-011-10: Percent of residents who self-report moderate to severe pain (long stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	0	3	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

NH-012-10: Percent of residents with pressure ulcers that are new or worsened (short-stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	0	3	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comments:

- If it is a short stay then how much time exactly can a facility have to show improvement or prevention. This seems likely to show little if any chance of being a measurement that would be statistically relevant. It would seem more relevant to not restrict this to short stay residents. It would also seem prudent from a best practice standpoint to have this measure show the percentage of residents with existing PU

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that improved while in the facility.

- I would recommend this measure should also address long stay.
- Using the 14-day PPS assessment (or discharge assessment if discharged prior to the completion of the 14-day MDS) and comparing it to the answers on the 5-day PPS assessment for improvement of pressure ulcers does not seem realistic. I agree that new pressure ulcers identified on the 14-day assessment is a good measure. However, residents admitted with a stage 2, 3, or 4 pressure ulcer will not likely have the ulcer completely heal prior to the lookback window for the 14-day MDS. The ARD for the 14-day PPS assessment is usually set on day 11, so the lookback window includes days 5-11. Pressure ulcers would not likely heal within that short of a time. Any ulcer present anytime during the lookback window would be included on the MDS. Although the measure discusses short stay as less than 100 days, the measure is said to use the 14 day PPS assessment or the discharge assessment, whichever comes first. It is unrealistic to expect that pressure ulcers would heal in that short of a time. Since there is no back staging of Pressure ulcers on MDS 3.0, it will not be possible for the QMs to note if the ulcers are actually improving or not.

NH-013-10: Percent of high risk residents with pressure ulcers (long stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	7	2	2	11	78%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	28	2	2	32	93%
Percentage of councils approving (<50%)					100%
Average council percentage approval					97%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC did not support this measure and submitted the following comments:

- It would seem that this measure gives little credence to quality. It would be important to know if a facility prevented these and a percentage would overtime perhaps show that. A better, more positive, measure would be to track improvement of pressure ulcers present in high risk residents that improved.
- I am concerned that this measure would count against a facility who has a strong wound care program and admits residents specifically for wound care. The measure shows that it counts against the facility if any pressure ulcers are present at stage 2-4 on the

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MDS. Since there is no longer backstaging of pressure ulcers with MDS 3.0, it is not possible to determine if ulcers are actually improving from the MDS coding. Once a stage 3 always a stage 3 until completely healed. I believe it would be a much better criteria to include only ulcers that were NOT present on admission. This way, ulcers that deteriorated during a hospitalization would not count against a good performing facility. And, likewise, pressure ulcers that were present on admission and being correctly treated would not count against a facility. If using the “present on admission” criteria, ulcers that develop in the facility would count against the facility.

NH-014-10: Percent of short stay residents assessed and appropriately given the seasonal influenza vaccine

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	3	1	1	5	75%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	28	1	3	32	97%
Percentage of councils approving (<50%)					100%
Average council percentage approval					96%

*equation: Yes/(Total - Abstain)

Voting Comment: APIC supported this measure and submitted the following comment:

- APIC supports the revised NQF Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay). APIC further believes future measure development should identify residents included in the numerator that actually received the vaccine to determine the rate of immunization versus the rate of compliance with offering the vaccine.

NH-015-10: Percent of long stay residents assessed and appropriately given the seasonal influenza vaccine

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	

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All Councils	29	1	2	32	97%
Percentage of councils approving (<50%)					100%
Average council percentage approval					97%

*equation: Yes/(Total - Abstain)

Voting Comment: APIC supported this measure and submitted the following comment:

- APIC supports the revised NQF Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay). APIC further believes future measure development should identify residents included in the numerator that actually received the vaccine to determine the rate of immunization versus the rate of compliance with offering the vaccine.

NH-016-10: Percent of short-stay residents assessed and appropriately given the pneumococcal vaccine

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	3	1	1	5	75%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	28	1	3	32	97%
Percentage of councils approving (<50%)					100%
Average council percentage approval					96%

*equation: Yes/(Total - Abstain)

Voting Comment: APIC supported this measure and submitted the following comment:

- APIC supports the revised NQF Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (short stay). APIC further believes future measure development should identify residents included in the numerator that actually received the vaccine to determine the rate of immunization versus the rate of compliance with offering the vaccine.

NH-017-10: Percent of long-stay residents assessed and appropriately given the pneumococcal vaccine

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%

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Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	1	2	32	97%
Percentage of councils approving (<50%)					100%
Average council percentage approval					97%

*equation: Yes/ (Total - Abstain)

Voting Comment: APIC supported this measure and submitted the following comment:

- APIC supports the revised NQF Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (long stay). APIC further believes future measure development should identify residents included in the numerator that actually received the vaccine to determine the rate of immunization versus the rate of compliance with offering the vaccine.

NH-018-10: Percent of long stay residents with a urinary tract infection (to be paired with measure NH-020-10)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	2	1	11	80%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	28	3	1	32	90%
Percentage of councils approving (<50%)					100%
Average council percentage approval					94%

*equation: Yes/(Total - Abstain)

Voting Comment: APIC did not support this measure and submitted the following comment.

- APIC does not support the revised NQF measure: NH-018-10 Percent of Residents with a Urinary Tract Infection (Long Stay). A resident with an in-dwelling urinary catheter has the highest risk of acquiring a urinary tract infection. At this time, with the exception of removing the catheter, there are no proven sustainable interventions available to prevent or reduce urinary tract infections in the elderly. This measure includes residents with, and without, a urinary catheter. There is no risk stratification of this metric. Additionally, a urinary tract infection is not well defined by the MDS 3.0 definition and it can be subjective in identifying a urinary tract infection for the person filling out the MDS resident assessment. To remove some of the subjectivity, APIC recommends waiting to reconsider this measure when the CDC updates the UTI Long

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Term Care definition that was originally published in 1991 by the McGeer group.

NH-019-10: Percent of low risk residents who lose control of their bowel or bladder (long stay) (to be paired with measure NH-020-10)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	29	0	3	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

NH-020-10: Percent of residents who have/had a catheter inserted and left in their bladder (long stay)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	30	0	2	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comments:

- I would recommend this measure for short stay.
- The measure discusses how many residents have had catheters inserted in the last 5 days. The look back window for MDS 3.0 is 7 days. I believe the measure is reporting how the item performed on the MDS 3.0 validation testing tool which only had a 5-day assessment window. Language should be updated to show the correct (7-day) MDS look-back window.

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Voting Comment: APIC supported this measure and submitted the following comments:

- APIC supports the proposed NQF measure: NH-020-10 Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)
- APIC supports this measure but believes that the exclusion criteria should not be limited only to neurogenic bladder and obstructive uropathy. There are other exclusion criteria that are cited by the CDC that should be considered for inclusion in the criteria. They are: residents who require a urinary catheter to assist in healing of open sacral or perineal wounds and are incontinent, and to improve the comfort of the resident for end of life care if needed. CDC (2009) Guideline for Prevention of Catheter-Associated Urinary Tract Infections.

Measure NH-021-10: Percent of residents who were physically restrained (long stay)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	9	0	2	11	100%
Provider Organizations	5	0	0	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	30	0	2	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

NH-022-10: Long stay residents with increased need for help with activities of daily living (ADLs)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	3	1	1	5	75%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	27	1	4	32	96%
Percentage of councils approving (<50%)					100%
Average council percentage approval					96%

*equation: Yes/(Total - Abstain)

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NH-024-10: Percent of residents who lose too much weight (long stay)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	1	2	11	89%
Provider Organizations	3	1	1	5	75%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	27	2	3	32	93%
Percentage of councils approving (<50%)					100%
Average council percentage approval					95%

*equation: Yes/(Total - Abstain)

NH-025-10: Percent of residents who have depressive symptoms (long stay) (time-limited endorsement)

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	7	0	0	7	100%
Health Plan	1	0	0	1	100%
Health Professional	8	0	3	11	100%
Provider Organizations	4	0	1	5	100%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	28	0	4	32	100%
Percentage of councils approving (<50%)					100%
Average council percentage approval					100%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC supported this measure and submitted the following comment:

- Symptoms could vary and this measure does not sound like a very precise measurement. Rather than measure the mere presence of symptoms it would be a better performance measure to determine what percentage of residents who had symptoms or a depression score on a previous assessment showed improvement on the current assessment. In other words, measure success rather than status quo

Measure NH-026-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: discharged resident instrument (time-limited endorsement)

NATIONAL QUALITY FORUM

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	6	1	0	7	86%
Health Plan	1	0	0	1	100%
Health Professional	7	0	4	11	100%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	26	2	4	32	93%
Percentage of councils approving (<50%)					100%
Average council percentage approval					95%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC abstained from voting on this measure and submitted the following comment:

- Nursing homes have enough “instruments” to deal with already. These measures can be sampled by PRO or other Quality measurement organizations WITHOUT burdening facilities with more work.

NH-027-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-stay resident instrument

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	6	1	0	7	86%
Health Plan	1	0	0	1	100%
Health Professional	7	1	3	11	88%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	26	3	3	32	90%
Percentage of councils approving (<50%)					100%
Average council percentage approval					93%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC abstained from voting on this measure and submitted the following comment:

- Nursing homes have enough “instruments” to deal with already. These measure can be sampled by PRO or other Quality measurement organizations WITHOUT burdening facilities with more work

NATIONAL QUALITY FORUM

NH-028-10: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family member instrument

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	6	1	0	7	86%
Health Plan	1	0	0	1	100%
Health Professional	7	0	4	11	100%
Provider Organizations	4	1	0	5	80%
Public/Community Health Agency	1	0	0	1	100%
Purchaser	4	0	0	4	100%
QMRI	3	0	0	3	100%
Supplier/Industry	0	0	0	0	
All Councils	26	2	4	32	93%
Percentage of councils approving (<50%)					100%
Average council percentage approval					95%

*equation: Yes/(Total - Abstain)

Voting Comment: AANAC abstained from voting on this measure and submitted the following comment:

- Nursing homes have enough “instruments” to deal with already. These measure can be sampled by PRO or other Quality measurement organizations WITHOUT burdening facilities with more work

Voting Comment: St. Louis Area Business Health Coalition supported this measure and submitted the following comment:

- Employee turnover should be measured and made public.