

NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for Nursing Homes Summary of the Second Steering Committee Follow-up Call

June 7, 2010

Committee Members Present: David Gifford, MD, MPH (co-chair); Christine Mueller, PhD, RN (co-chair); Alice Bell, PT, GCS; Bruce Boissonnault, MBA; Heidi Gil, NHA, CCM; Tomas Griebing, MD, MPH; Mary Rose Heery, RN; Mary Jane Koren, MD, MPH; Bill Kubat, MS; Betty MacLaughlin Frandsen, RN, NHA, MHA, C-NE; Naomi Naierman, MPA; Kathleen Niedert, PhD, MBA, RD, NHA; Diana Ordin, MD, MPH; Patricia Rosenbaum, RN, CIC; Ronald Schumacher, MD, CMD; Robert Zorowitz, MD, MBA, CMD

NQF Staff Present: Helen Burstin, MD, MPH; Del Conyers, MPH; Emma Nochomovitz, MPH; Karen Pace, PhD, RN; Suzanne Theberge, MPH

Additional Participants: Shula Bernard, PhD, Research Triangle Institute (RTI) International; Ann Clancy, RN, MBA, CPHQ, Health Services Advisory Group; Roberta Constantine, PhD, RTI International; Toby Edelman, EdM, JD, Center for Medicare Advocacy; Mary Fermazin, MD, MPA, Health Services Advisory Group; Sandra Fitzler, RN, American Health Care Association (AHCA); Peter Gruhn, MA, AHCA; Stella Mandl, BSN, BSW, RN, Centers for Medicare and Medicaid Services (CMS); Jane Pederson, MD, MS, Stratis Health; Marilyn Reiersen, Stratis Health; Carol Roth, MPH, BSN, RAND Corporation; Judith Tobin, MBA, PT, CMS; Janet Wells, JD, National Citizens' Coalition for Nursing Home Reform; Neil Wenger, MD, MPH, RAND Corporation

INTRODUCTION

Ms. Theberge, Nursing Homes project manager, outlined the main goals of the call, which included discussing the measures revised by RAND and CMS in response to the Steering Committee's original recommendations from their meeting on April 21-22, 2010. The NQF measure evaluation criteria were briefly reviewed, and the Steering Committee was asked to consider the following voting options in response to the revisions prepared by RAND and CMS:

- a. recommend for endorsement;
- b. recommend for time-limited endorsement (applies to untested measures only); and
- c. do not recommend for endorsement.

The Steering Committee was informed that voting via Survey Monkey would occur after the call. Steering Committee members who were unavailable to participate on the call are also able to vote on the measures, following their review of the call summary.

RAND MEASURE REVIEW

NH-003-10: *Nursing home resident with a new balance problem should receive physical therapy*

Committee Co-Chair Dr. Mueller described the conditions the Committee recommended during its April in-person meeting and asked RAND to respond accordingly. The conditions for endorsement included:

- remove assistive devices as a treatment modality;
- update measure specifications to reflect MDS version 3.0; and
- modify denominator to include advanced dementia patients.

Dr. Wenger and Ms. Roth responded on behalf of RAND Corporation and explained that the measure has been revised to comply with all the conditions. Dr. Wenger explained that the removal of assistive devices from the numerator had little effect on the results of the measure, given that almost all patients who received an assistive device also received physical therapy. RAND submitted updated specifications for the measure's numerator, denominator, and calculation algorithm, reflecting the revisions corresponding to MDS version 3.0. Although the developer agreed to include advanced dementia patients in the denominator, further discussion regarding the scientific evidence for exclusion led to the consensus among RAND and the Committee that the exclusion of advanced dementia patients, as originally outlined in the measure submission, was indeed appropriate and would remain in the measure. RAND submitted these references in support of the exclusion:

- Shaw FE, Bond J, Richardson DA, et al., Multifactorial intervention after a fall in older people with cognitive impairment and dementia presenting to the accident and emergency department: randomized controlled trial, *BMJ*, 2003;326:73.
- Shaw FE, Prevention of falls in older people with dementia, *J Neural Transm*, 2007;114:1259-1264.
- Hauer K, Becker C, Lindemann U, et al., Effectiveness of physical training on motor performance and fall prevention in cognitively impaired older persons: a systematic review, *Am J Phys Med Rehab*, 2006;85:847-857.

During further discussion, the Committee raised concerns about the scientific acceptability of how the measure's numerator is defined. These concerns included whether the measure accounts for residents who refuse physical therapy and individuals who receive restorative nursing care. In response to issue of refusal, the developer suggested that MDS 3.0 may code an offer for physical therapy as equivalent to having received it. However, following the call, RAND clarified that the MDS 3.0 does not currently allow for the capture of refusals, and, therefore, refusals are likely not counted within the measure's numerator. They also explained that how refusals are handled is not completely straightforward, given that a refusal may occur either before or during treatment and may be documented in medical records, even if the MDS does not provide a place for this type of documentation. Post-call clarifications also included verification that nursing rehabilitation/restorative care is part of the numerator and must have occurred within the last seven calendar days prior to the date describing the new balance problem to be counted. The MDS 3.0 requires that therapy must occur for at least 15 minutes on any given day to count as a "day" of therapy.

This measure was recommended for endorsement in post-call voting.

CMS/RTI MEASURE REVIEW

RTI submitted 18 measures to the Nursing Homes project on behalf of CMS. During the in-person meeting the Committee requested revisions and additional information for 16 of these measures. Following RTI's response, NQF staff determined that several of the measures did not require further discussion because all conditions clearly had been met. The Committee was asked to vote on those measures using an online survey system, basing their decisions on RTI's written response to their questions. This call was planned to focus on the measures that did not clearly meet the conditions.

Overarching Issues

During the Committee's in-person meeting discussion, RTI was asked to respond to two overarching issues:

- clarify the definition of long-stay and short-stay residents; and
- address the concern that residents with missing MDS data should be included in the measure denominator.

Defining Length of Stay

RTI agreed to clarify their definitions for long-stay and short-stay residents. The denominator for short-stay residents will be defined as "all residents whose length of stay (LOS) in the facility is less than or equal to 100 days from the date of admission," and the definition for long-stay residents will be defined as "all residents whose length of stay is greater than 100 days." Furthermore, the LOS of residents who return to the nursing home following a hospital discharge will not reset to zero upon return to the facility.

Missing Data

Regarding missing data, RTI requested the opportunity to conduct more extensive reliability testing for the measures to be discussed on the call before making a decision about the including or excluding missing data. The rationale for this request from the measure developer stemmed from:

- previous testing with MDS version 2.0 demonstrating very small amounts of missing data and the similarity between MDS version 2.0 and 3.0 for a number of items (for example, of 5,242,022 nonadmission target assessments for calendar year 2009, 2,796 assessments were missing the catheterization data required for measure 020);
- effort for continuity in measure methodology: previous measures excluded missing data, serves as a precedent for continued measurement in this manner; and
- avoidance of forcing nursing homes to provide inaccurate information rather than allowing a "dash" (i.e., not providing an answer).

The Committee discussion also clarified that "missing data" refers to data specific to a given quality measure and the algorithm used to compute that measure.

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)**

*Please note title change. This measure was previously titled *Effective pain management (short stay)*.

The Committee originally advised resolution of the following conditions before recommending the measure for time-limited endorsement:

- evaluate cognitive status (i.e., severe dementia) when assessing the patient's report of pain levels;
- modify the denominator to include residents with missing MDS data;
- consider patient preference regarding pain management; and
- modify definition of pain management to include either decreased frequency or intensity.

The Committee suggested, but did not require, that the developer change the title of the measure to be more specific about what is being measured.

Ms. Constantine represented the measure developer, RTI, in responding to these concerns.

Measure Title

Based on the Committee's recommendation, the developer agreed to change the title and explained that the new title aims to limit the broad scope of pain management the measure's original title suggested.

Cognitive Status

While the developer agreed it is important to capture residents' cognitive status when measuring pain, the MDS currently does not allow for such combined assessment. The MDS 3.0 includes questions on cognitive status and pain, respectively, but not concurrently. The change from MDS 2.0 to MDS 3.0 for this topic means a switch to a resident interview rather than a staff assessment to measure pain. The MDS 3.0 includes an observational pain assessment for individuals who are unable to complete the self-report pain assessment interview, but these pain measures exclude residents who are unable to answer the relevant questions. Dr. Constantine explained that validity testing showed that 89 percent of a nationally representative sample of nursing home residents was able to complete the pain interview, and evidence suggests that residents experiencing varying levels of cognitive impairment are still able to complete the self-report pain assessment. RTI expressed interest in expanding its measure testing efforts in the future to include consideration of severely cognitively impaired individuals who are unable to self-report pain.

Missing Data

The measure developer reiterated its preference to complete further testing and analysis in order to observe the “pattern of missingness,” or how missing data will affect the measure, before making a decision about whether to include them.

Defining Pain Management

The steward informed the Committee that it plans to examine the change, lack of change, and direction of change and patterns for both frequency and intensity as part of ongoing measure testing. The steward also clarified that individuals who are on a pain management regimen but are not experiencing any pain upon admission are not included in the measure.

Defining Length of Stay

RTI agreed to clarify the definition of long-stay residents to include all residents whose length of stay (LOS) is longer than 100 days.

The Committee recommended this measure for time-limited endorsement in post-call voting.

NH-010-10: *Percent of residents with moderate to severe pain (short stay)*

NH-011-10: *Percent of residents with moderate to severe pain (long-stay)*

The developer explained that the specifications for these measures have remained the same in the update from MDS 2.0 to MDS 3.0. The developer also clarified that the title of measure NH-010-10 was incorrectly listed in the memo provided to NQF for distribution to the Steering Committee.

The Committee discussed a number of concerns, similar to those for NH-009-10, including evaluation of resident’s cognitive status, exclusion of missing data, consideration of patient preference, and the definition of effective pain management.

The developer requested more details about how the Committee envisioned the incorporation of cognitive status evaluation into the measure and stressed its intention to examine the results of this measure in light of those produced by independent measures solely focused on cognitive status (i.e., Brief Interview of Mental Status [BIMS]) or resident ability to complete the MDS self-report pain assessment at a later date. The developer emphasized that these measures are intended for time-limited endorsement, given the need for measure testing. CMS explained it plans to delay public reporting on these measures until early 2012, at which point testing will have been completed.

Defining Length of Stay

RTI agreed to clarify the definition of short-stay residents to include all residents whose LOS in the facility is less than or equal to 100 days from the date of admission, and long-stay residents to include all residents whose LOS is longer than 100 days.

Missing Data

The measure developer reiterated its preference to complete further testing and analysis in order to observe the “pattern of missingness,” or how missing data will affect the measure, before making a decision about whether to include the missing data. It will examine the extent, distribution, and impact of missing data on the measures during reliability testing.

The Committee recommended both measures for time-limited endorsement during post-call voting.

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

The Committee requested resolution of the following conditions before recommending this measure for time-limited endorsement:

- modify definition of falls to include both minor and major injuries or provide literature to justify the exclusion of minor injuries; and
- provide additional literature to support the exclusion of comatose patients.

Defining Falls

The Committee’s recommendation to include both major and minor falls was based on the variability in how falls are classified and the use of similar interventions to treat different types of falls. Despite these concerns, the developer disagreed with the recommendation to combine major and minor injuries into a single measure, due to the differences in the after affects of major or minor fall injuries. The developer plans to examine rates for both types of fall injuries during measure testing. The information the developer provided convinced the Committee to recommend the measure for time-limited endorsement despite the original request to broaden the scope to all falls.

Comatose Patients

The developer said the technical experts who advised the measure development presented conflicting evidence regarding the exclusion of comatose patients. Ultimately, the developer agreed to include comatose patients, based on the rationale that any fall is a negative outcome that should be prevented and for which nursing homes should be held accountable.

The Committee recommended this measure for time-limited endorsement during the post-call vote.

NH-019-10: *Percent of low-risk residents who lose control of their bowel or bladder (long-stay)*

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

For these two measures, the Committee discussed the overarching issues described above, including the definition of long-stay residents and the exclusion of missing data. In addition, the Committee discussed the pairing of the two measures and how to implement this move.

Defining Length of Stay

RTI agreed to clarify the definition of long-stay residents to include all residents whose LOS is longer than 100 days.

Missing Data

The measure developer reiterated its preference to complete further testing and analysis in order to observe the “pattern of missingness,” or how missing data will affect the measure, before making a decision about whether to include them. The Committee agreed that further testing and analysis based on missing data is needed but found this problematic since the measure was labeled as having been completely tested in terms of reliability and validity. Following the call, RTI provided information on the missing data for the earlier versions of these two measures to support its request to consider these measures for full endorsement. For 5,242,022 non-admission target assessments for calendar year 2009:

The low-risk bowel/bladder incontinence measure is based on two fields:

H1A_BOWEL_CONTRL and H1B_BLADDER_CONTRL.

390 had dash for H1A = 0.0074%.

371 had dash for H1B = 0.0071%.

727 had dash for one or both = 0.014%.

The catheter measure is based on one field, H3D_INDWELL_CATH.

2,769 had dash for H3D = 0.053%.

Measure Pairing

Representatives from CMS and RTI were willing to pair these measures. However, the steward explained that the way in which measures are displayed on the CMS website and used for public reporting does not fall within the jurisdiction of the Office of Clinical Standards and Quality. Follow-up will occur with the CMS unit responsible for approving measure pairing.

The Committee ultimately recommended both measures for full endorsement during the post-call vote.

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

The measure developer agreed to revise this measure to clarify the definition of “long-stay residents” and provide documentation on how MDS 3.0 defines “activities of daily living.”

The Committee recommended this measure for endorsement during the post-call vote.

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

The only condition the Committee offered for this measure was the potential inclusion of missing data. As noted previously, the developer intends to maintain the exclusion of missing data until further analysis of the “pattern of missingness” has been completed. RTI provided the following data to demonstrate how infrequently missing data occurs for the items related to this measure:

The restraints measure is based on three fields: P4C_TRUNK_REST, P4D_LIMB_REST and P4E_CHR_PRVNT_RISE.

533 had dash for P4C = 0.010%.

542 had dash for P4D = 0.010%.

581 had dash for P4E = 0.011%.

629 had dash for one or more of the three fields = 0.012%

This information is based on all the non-admission target assessments for calendar year 2009. Although these data pertain to MDS 2.0 items, the developer predicts the completion rates for the MDS 3.0 items will be the same, given the similarity between the two versions.

Based on this information, RTI requested the Committee consider this measure for full endorsement, even though the possibility of time-limited endorsement was discussed during the conference call. During the post-call vote, the Committee recommended this measure for endorsement.

NH-025-10: *Percent of residents who have symptoms of major depression*

The Committee had requested resolution of the following conditions before recommending this measure for time-limited endorsement:

- clarify the definition of long-stay residents; and
- clarify the numerator calculation.

Defining Length of Stay

RTI agreed to clarify the definition of long-stay residents to include all residents whose LOS is longer than 100 days.

Numerator

The measure developer cited the following reference as the basis for the numerator definition:

- Kroenke K, RL Spitzer, J Williams, The PHQ-9: Validity of a brief depression severity measure, *J Gen Intern Med*, 2001;16:606-613.

The developer cited a study finding that 88 percent of patients with major depression scored a 10 or higher from either the Total Severity Score (MDS 3.0 item D0300), which is calculated based on the resident response to the PHQ-9 (Patient Health Questionnaire, depression module), or the Staff Assessment Measure (MDS 3.0 item D0500).¹ Thus, the measure numerator was explained in terms of residents who scored a 10 or above on either the Total Severity Score assessment or the Staff Assessment Measure.

Following the call, the measure developer clarified that The Staff Assessment of mood (item D0500) should be used if a long-stay resident is missing data for three or more of the sub items of data elements D0200 for the Resident Assessment AND has valid data for seven or more of subitems A through I of item D0500 for the Staff Assessment, as described below. Furthermore, when the Staff Assessment is necessary, the resident must have a score of two or greater for either D0200A or D0200B AND a score of two or more for five of the items D0200A-I within the MDS. Inclusion in the numerator based on the Resident Assessment was described as dependent on a score of two or greater for either D0200A or D0200B AND a score of two or more for five of the following items D0200A-I.

In the post-call vote, the Committee voted to recommend this measure for time-limited endorsement.

NH-012-10: *Percent of residents with pressure ulcers that are new or have not improved (short stay)*

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

One Committee member raised the concern that the MDS coding requirement, as utilized by CMS, conflicts with recommendations of relevant expert groups. The CMS definition of a deep tissue injury (DTI) wound with a blood-filled blister as a Stage 2 pressure ulcer differs from the definition used by the National Pressure Ulcer Advisory Panel, which defines a Stage 2 pressure ulcer as “partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.”

The Committee originally voted on these measures at the in-person meeting and recommended them for time-limited endorsement.

PUBLIC COMMENT

The majority of the public comment period addressed concerns related to the two pressure ulcer measures and the PHQ-9 assessment included in measure NH-025-10: Percent of residents who have symptoms of major depression. The details of these comments are outlined below.

¹ Kroenke K, RL Spitzer, J Williams, The PHQ-9: validity of a brief depression severity measure, *J Gen Intern Med*, 2001;16:606-613.

Pressure Ulcers

Ms. Fitzler supported a Committee member's concern pertaining to CMS' recent change to its definition of a DTI wound with a blood-filled blister as a Stage 2 pressure ulcer. Ms. Fitzler emphasized that this definition inappropriately identifies a facility as providing poor quality based on the fact that the DTI blood-filled blister will become a Stage 3 or 4 pressure ulcer once it ruptures. Ms. Fitzler urged CMS to reconsider its definition.

PHQ-9 Assessment

In addition to her comments on the pressure ulcer measures, Ms. Fitzler also raised a concern about the scientific acceptability of measure NH-025-10: Percent of residents who have symptoms of major depression (long-stay). She questioned the validity of the PHQ-9, which serves as the basis for the Total Severity Index described in the measure numerator. Ms. Fitzler expressed her concern that the validity of the PHQ-9 may suffer as the result of a more frequent assessment schedule than that which was used during measure testing. The developer explained that the current assessment schedule allows for up to six separate assessments for the average short-term stay nursing home resident. Ms. Mandl from CMS suggested that that more frequent assessment can be beneficial, rather than detrimental, to the measure's validity, since there is a time lag between the beginning of depression or suicidal thoughts and the point at which they show up in responses to the assessment. Despite this comment, Ms. Fitzler expressed continued concern that frequent assessment using the PHQ-9 might force inaccurate responses from nursing home residents.

The discussion of the PHQ-9 led to a question from a Committee member regarding which MDS 3.0 assessments include it. After the call, RTI explained that the PHQ-9 is included in the following MDS 3.0 assessments: Comprehensive, Discharge, Quarterly, PPS, OMRA Start of Therapy and Discharge, OMRA Other, OMRA-Other and Discharge, Swing-Bed PPS, Swing-Bed Start of Therapy and Discharge, Swing-Bed OMRA Other, Swing-Bed OMRA Other and Discharge, Swing-Bed OMRA Discharge.

CARE TRANSITION MEASURE

In continued follow-up to the May 21, 2010 conference call, Ms. Theberge noted that the NQF Board of Directors has endorsed the Care Transition Measure (CTM-3) at the facility level by. The Nursing Homes Steering Committee was asked to consider whether the measure, as specified for nursing homes, should be included in the set of recommended measures. Several Committee members emphasized the importance of measuring transitions. One Committee member also commented that the measure is user friendly, simple, and useful. Despite the positive comments on the measure, Committee members raised a few concerns regarding its scientific acceptability and feasibility, including the need to:

- correct a misleading typo in the form as submitted;
- clarify the method of administering the tool; and

- determine whether the CTM-3 could be connected with the Nursing Homes CAPHS discharge measure.

Although Dr. Coleman, the representative of the measure developer, was unable to join the call to discuss the CTM-3 measure, he was able to respond to these concerns during post-call follow-up.

Specification to Nursing Homes

During the call, the Committee noticed that question #1 of the CTM-3 survey had not been properly specified to the nursing home setting. It was clarified that the materials the Committee previously received included a typo, and question #1 is intended to read: “The nursing facility staff took my preferences and those of my family or caregiver into account in deciding *what* my health care needs would be when I left the nursing facility.”

Methodology for Administration

The developer clarified that the tool can be administered via mail or telephone, based on previous testing demonstrating that either option is acceptable to the target population. The survey can be administered by an external third party or by the care provider (e.g., the nursing home), as long as the survey is not administered by a health professional who has cared for the patient, as this effectively inflates the CTM-3 score due to the social desirability influence.

Connected to the CAHPS Discharge Instrument

The Committee had expressed interest in having the CTM-3 added to the Nursing Homes CAPHS discharge measure. Dr. Coleman responded that no formal efforts have been made to add the CTM-3 to a Nursing Home CAHPS instrument at this time. However, including the CTM-3 as part of Hospital CAHPS has been discussed before. This issue also was addressed during the Steering Committee call on May 21, during which Judy Sangl, ScD, from the Agency for Healthcare Research and Quality, explained that the Nursing Home CAHPS measures allow for questions to be added to supplement the original instrument.

In the post-call vote, the Committee recommended that this measure be included in the Nursing Homes measure set.