



**November 17, 2020**

**To:** Consensus Standards Approval Committee (CSAC)  
**From:** Patient Experience and Function (PEF) Project Team  
**Re:** PEF Fall 2019 Track 2 Measures<sup>a</sup>

## **COVID-19 Updates**

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the fall 2019 cycle.

Commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

### **Track 1: Measures that Remained in Fall 2019 Cycle**

**Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations** moved forward to the CSAC for review and discussion during its meeting on July 28-29, 2020.

- **Exceptions**

Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation fall 2019 meetings.

### **Track 2: Measures Deferred to Spring 2020 Cycle**

**Fall 2019 measures that required further action or discussion from a Standing Committee were deferred to the spring 2020 cycle.** This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review retained endorsement during that time. Track 2 measures will be reviewed by the CSAC in November.

During the CSAC meeting on November 17-18, 2020, the CSAC will review fall 2019 measures assigned to Track 2. Evaluation summaries for measures in Track 2 have been described in this memo and related PEF draft report. A list of measures assigned to Track 1 can be found in the Executive Summary section of the PEF draft report for tracking purposes and can also be found in a separate report.

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<sup>a</sup> This memo is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-000601 Task Order HHSM-500-T0001.

## CSAC Action Required

The CSAC will review recommendations from the PEF project at its November 17-18, 2020 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. **PEF 2019 Track 2 Draft Report.** The draft report includes measure evaluation details on all measures that followed Track 2. The complete draft report and supplemental materials are available on the [project webpage](#). Measures that followed Track 1 have already been reviewed during the CSAC's meeting in July.
2. **Comment Table.** This [table](#) lists four comments received during the post-meeting comment period.

## Background

Over the past decade, there have been increasing efforts to change the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers individuals to participate actively in their care.<sup>1-3</sup> Healthcare treatments can be tailored to individual patients in terms of patient preferences and individual clinical factors when the patient voice is captured as part of routine care. Capturing patient experience and evaluating patient function are two important components of patient-centered measurement.<sup>4</sup> The Centers for Medicare and Medicaid Services (CMS) Meaningful Measures Initiative includes the identification of measures that capture patients' experiences with clinicians and providers—one of 19 measurement areas for focusing our healthcare quality improvement efforts as a country.<sup>5</sup> This falls under the measurement priority associated with strengthening person and family engagement as partners in their care. Ensuring that each person and family is engaged within a care partnership is critical to achieving better patient outcomes.<sup>6</sup>

Patient Experience and Function is a NQF measure topic area encompassing patient functional status, satisfaction, and experience of care, as well as issues related to care coordination. Central to the concepts associated with patient experience with their overall care is the patient's health-related quality of life and many factors that influence it, including communication, care coordination, transitions of care, and use of health information technology.<sup>7-9</sup>

The care coordination measures within the Committee portfolio represent a fundamental component for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes.<sup>10-12</sup> Well-coordinated care encompasses effective communication between patients, caregivers, and providers, and facilitates linkages between communities and healthcare systems. It also ensures that accountable structures and processes are in place for communication and integration of comprehensive plans of care across providers and settings that align with patient and family preferences and goals.<sup>13-15</sup>

The NQF PEF Committee was established to evaluate measures within this topic area for NQF endorsement. NQF has endorsed over 50 measures addressing patient experience of care, patient functional status, mobility and self-care, shared decision making, patient activation, and care coordination. The majority of measures within this portfolio are patient-reported outcomes performance measures.

During this cycle, the Committee's discussion remained primarily focused on the measures under consideration for maintenance review, but this led to broader measurement discussions related to NQF evidence and scientific acceptability submission requirements. During the discussion of the scientific acceptability of the measures considered for maintenance of endorsement, the Committee noted an important dependence of score-level reliability upon strong data element-level reliability. They also noted an important distinction between outcome measures and other measure types as it pertains to the evidence submission requirement and discussed when it may be necessary to grant an exception to evidence for non-outcome measures.

## Draft Report

The PEF Fall 2019 Track 2 draft report presents the results of the evaluation of one measure considered under the Consensus Development Process (CDP). The measure was recommended for endorsement.

The measures were evaluated against the 2019 version of the [measure evaluation criteria](#).

	Maintenance	New	Total
Measures under consideration	1	0	1
Measures recommended for endorsement	0	0	0
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for endorsement or trial use	1	0	1
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	Importance - 0 Scientific Acceptability - 1 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure - 0	

## CSAC Action Required

Pursuant to the CDP, the CSAC is asked to review one candidate consensus measure that was not recommended for endorsement. For the Committee's votes and rationale

## Measures Not Recommended for Endorsement

(See [Appendix B](#) for the Committee's votes and rationale.)

- [NQF 0291](#) Emergency Transfer Communication Measure ((University of Minnesota Rural Health Research Center (UMRHRC))

## Comments and Their Disposition

NQF received four comments from developers, future measure stewards, and two member organizations pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the NQF responses to each comment, is posted to the Patient Experience and Function [project webpage](#).

### Comments Received and NQF's Response

#### *Measure-Specific Comments*

#### **NQF 0291 Emergency Transfer Communication Measure (University of Minnesota Rural Health Research Center)**

Commenters noted that the observed agreement of the two raters was over 85% in the measure submission. However, the Kappa statistics were notably low. This resulted in a low vote on reliability from the Standing Committee. The paradox is due to a disproportionate distribution of responses, given that both reviewers responded “yes” most of the time. An additional Max Kappa analysis was conducted to address the disproportionate distribution. The Max Kappa adjustment increased the Kappa value to 0.42 and the element range to (0.2 to 0.73) with a range of increases between 0% and just over 900%. The developer noted that though the adjusted overall Kappa value is increased, there is significant variability within the elements. Elements six and eight have what can be considered high agreement, while elements one, five, and seven have fair agreement.

Additional comments outlined potential approaches to improving overall reliability in the future and expressed support for the Committee's decision to remove endorsement for the measure due to its low rating on reliability.

#### **Committee Response**

The Committee thanked the developer for providing additional analysis and agreed that the measure is both valuable and relevant. The Committee believes the measure should be considered in the future and encourages the developer to provide more information around the measure's reliability.

## Member Expression of Support

Throughout the continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expression of non-support. [Appendix C](#) details the expression of non-support.

## Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	N/A	NQF 0291 was not recommended for endorsement, therefore no related or competing measures were discussed by the Committee concerning the measure.
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

## Appendix B: Measures Not Recommended for Endorsement

The table below lists the Committee's vote and rationale for measures not recommended for endorsement.

Legend: H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
0291 Emergency Transfer Communication Measure (University of Minnesota Rural Health Research Center)	<p><b>Evidence</b> M-2; L-5; I-10</p> <p><b>Insufficient Evidence with Exception</b> Yes-13; No-4</p> <p><b>Gap</b> H-0; M-15; L-2; I-0</p> <p><b>Reliability</b> H-0; M-4; L-13; I-0</p> <p><b>Validity</b> The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</p> <p><b>Feasibility</b> The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</p> <p><b>Usability and Use</b> <i>Use</i> The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</p> <p><i>Usability</i> The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</p>	<p>The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion. This measure was discussed during the February 26 post-measure evaluation meeting, which did not achieve quorum. Therefore, voting was completed asynchronously after the call. Measure 0291 is a maintenance measure assessing the percentage of all patients transferred from an emergency department (ED) to another healthcare facility whose medical record documentation indicated that all required information be sent to the receiving facility within 60 minutes of the transfer. The Committee noted that this maintenance measure was granted an exception to evidence on the previous review. The Committee observed that this is because the evidence to support the connection between positive patient outcomes and the transfer of information with the patient within 60 minutes from the emergency room has not been well-studied and that it is difficult to design a study that makes a clear, empirical connection between this process and desirable outcomes. Nonetheless, the Committee noted that there is strong expert opinion that suggests that this is an industry best practice for better coordination of care. Committee members also expressed that measure 0291 is a particularly important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers, and that it would be very difficult to assess causation of an important outcome such as mortality and morbidity as evidence of the need for this type of measure. The Committee noted that it is also uncertain if public reporting and payment could be conducted</p>

Measure	Voting Results	Standing Committee Rationale
		<p>fairly without substantial bias and lack of adjustment for between-facility variation around technology. Related to performance gap, the Committee initially expressed concern that the data and analyses presented were from the revised measure, but that they were otherwise comfortable with the measure gap once the developer clarified that the testing was done according to the new specifications. The Standing Committee did not pass the measure on reliability due to concerns that the interrater reliability at the data element level produced low results. The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision. The Committee noted that the data element reliability testing for the measure produced fair to moderate crude agreement for interrater reliability between abstractors for the eight items in the measure. However, the results using Cohen's kappa statistics produced mostly low results for the eight items. The Committee also noted that while the score-level reliability results were good, they were produced using the beta-binomial methodology, which assumes that error is random. Because the interrater reliability is low, this implies that the error is systematic.</p>

## Appendix C: NQF Member Expression of Support Results

Two NQF members provided their expression of non-support for the measure under consideration. Results for the measure are provided below.

### **0291 Emergency Transfer Communication Measure (University of Minnesota Rural Health Research Center)**

Member Council	Support	Do Not Support	Total
Provider Organization	0	1	1
Supplier/Industry	0	1	1



## Appendix D: Details of Measure Evaluation

**Rating Scale:** H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

### Measures Not Recommended

0291 Emergency Transfer Communication Measure
<p><u>Submission</u></p> <p><b>Description:</b> Percentage of all patients transferred from an Emergency Department to another healthcare facility whose medical record documentation indicated that all required information was communicated (sent) to the receiving facility within 60 minutes of transfer. For all data elements, the definition of 'sent' includes the following:</p> <ul style="list-style-type: none"> <li>• Hard copy sent directly with the patient, or</li> <li>• Sent via fax or phone within 60 minutes of patient departure, or</li> <li>• Immediately available via shared Electronic health record (EHR) or Health Information Exchange (HIE) (see definition below)</li> </ul> <p>For purposes of this measure, a shared electronic health record (EHR) is defined as one where data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a Health Information Exchange (HIE) cannot assume immediate access by the receiving facility to the transferred patient's record.</p> <p><b>Numerator Statement:</b> Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:</p> <ul style="list-style-type: none"> <li>• Home Medications</li> <li>• Allergies and Reactions</li> <li>• Medications Administered in ED</li> <li>• ED Provider Note</li> <li>• Mental Status and Orientation Assessment</li> <li>• Reason for Transfer and Plan of Care</li> <li>• Tests and/or Procedures Performed</li> <li>• Tests and/or Procedures Results</li> </ul> <p><b>Denominator Statement:</b> Denominator Statement: Transfers from an ED to another healthcare facility Included Population: All transfers from an ED to another healthcare facility Excluded Populations: Patients observation status.</p> <p><b>Exclusions:</b> All emergency department patients not discharged to another healthcare facility. Those admitted, sent home, left AMA, those on observations status, etc.</p> <p><b>Adjustment/Stratification:</b> No risk adjustment or risk stratification</p> <p><b>Level of Analysis:</b> Facility</p> <p><b>Setting of Care:</b> Emergency Department and Services, Inpatient/Hospital, Outpatient Services</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records</p> <p><b>Measure Steward:</b> University of Minnesota Rural Health Research Center</p> <p><b>STANDING COMMITTEE MEETING 02/12/2020, 02/26/2020</b></p> <p><b>1. Importance to Measure and Report:</b> <u>The measure meets the Importance criteria</u> (1a. Evidence, 1b. Performance Gap) 1a. Evidence: <b>M-2; L-5; I-10</b>; 1b. Performance Gap: <b>H-0; M-15; L-2; I-0</b>; Evidence Exception: <b>Yes-13; No-4</b></p> <p><b>Rationale:</b></p> <ul style="list-style-type: none"> <li>• The Committee noted that the developer has added additional evidence of the need for better care transitions since the last submission.</li> </ul>

<b>0291 Emergency Transfer Communication Measure</b>
<ul style="list-style-type: none"> <li>• The Committee noted that this maintenance measure was granted an exception to evidence on the previous review.</li> <li>• Committee members expressed that this is an important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers, and that it would be very difficult to assess causation of an important outcome such as mortality and morbidity as evidence of the need for this type of measure.</li> <li>• The Committee noted that it is also uncertain if public reporting and payment could be done fairly without substantial bias and lack of adjustment for between-facility variation around technology.</li> <li>• The Committee felt that there was an adequate performance gap. <ul style="list-style-type: none"> <li>○ Results provided suggest a mean emergency department transfer communication (EDTC) performance rate of 0.75 and 0.79 in quarters 1 and 4 of 2017.</li> <li>○ The interquartile range was approximately 0.65-0.97 for both quarters, indicating good spread and continued opportunity for improvement.</li> </ul> </li> </ul>
<p><b>2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u></b></p> <p>(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)</p> <p>2a. Reliability: <b>H-0; M-4; L-13; I-0</b>; 2b. Validity: <b>H-X; M-X; L-X; I-X</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>• The Committee noted that the data element-level interrater reliability testing produced a low kappa statistic score.</li> <li>• Score-level reliability using beta binomial was high.</li> <li>• The Committee felt that the data element reliability was truly a concern due to the fact that the beta binomial methodology used for score-level reliability testing is based on the assumption that error is random, but low interrater reliability would be systematic error.</li> <li>• The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision.</li> <li>• The Committee did not pass the measure on reliability.</li> </ul>
<p><b>3. Feasibility: <u>The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</u></b></p> <p>(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified; 3d. Data collection strategy can be implemented)</p>
<p><b>4. Usability and Use: <u>The Standing Committee did not vote on these criteria since the measure did not pass Scientific Acceptability</u></b></p> <p>(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)</p>
<p><b>5. Related and Competing Measures</b></p> <ul style="list-style-type: none"> <li>• No related or competing measures noted.</li> </ul>
<p><b>6. Standing Committee Recommendation for Endorsement: Yes-X; No-X</b></p> <p><u>Rationale</u></p> <ul style="list-style-type: none"> <li>• The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion.</li> </ul>
<p><b>7. Public and Member Comment</b></p> <p>Comments received outlined concerns with the data element reliability results, approaches to improving reliability, and expressions of support for the Committee's endorsement decision. The Committee agreed that the measure is both valuable and relevant and should be considered in the future. The Committee encouraged the developer to improve the measure's overall reliability testing result in future submissions.</p>
<p><b>8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b></p>
<p><b>9. Appeals</b></p>



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# Patient Experience and Function Fall 2019 Review Cycle

## CSAC Review and Endorsement

*November 17, 2020*

*Funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.*



## Standing Committee Recommendations

- One measure reviewed for Fall 2019 Track 2
  - ▣ Not reviewed by the Scientific Methods Panel (SMP)
- One measure not recommended for endorsement
  - ▣ **NQF 0291** Emergency Transfer Communication Measure (Maintenance Measure)



## Overarching Issues

- Score Level and Data Element Level Reliability
  - ▣ Committee noted an important dependence of score-level reliability upon strong data element-level reliability.
    - » The Committee noted that for most measure types, NQF's current measure evaluation criteria do not require testing at both data element and score levels
    - » Most measure types may submit either data element-level or score-level testing according to the developer's discretion and access to data.
  - ▣ Score-level reliability may be dependent upon data element-level reliability, meaning that it is possible to achieve a score-level result that appears good inaccurately because it is significantly confounded by issues at the data element level.



## Public and Member Comment and Member Expressions of Support

- Four comments received
  - ▣ Two NQF member expressions of non-support received



## Questions?

- Project team:
  - ▣ Samuel Stolpe, PharmD, MPH, Senior Director
  - ▣ Oroma Igwe, MPH, Manager
  - ▣ Udobi Onyeuku, MSHA, Analyst
  - ▣ Yemsrach Kidane, PMP, Project Manager
- Project webpage:  
[http://www.qualityforum.org/Project Pages/Patient Experience and Function.aspx](http://www.qualityforum.org/Project_Pages/Patient_Experience_and_Function.aspx)
- Project email address: [patientexperience@qualityforum.org](mailto:patientexperience@qualityforum.org)

# THANK YOU.

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# Patient Experience and Function, Fall 2019 Cycle Track 2: CDP Report

**DRAFT REPORT FOR CSAC REVIEW  
NOVEMBER 17, 2020**

This report is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001

**<http://www.qualityforum.org>**

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## Executive Summary

Over the past decade, there have been increasing efforts to change the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers individuals to participate actively in their care.<sup>1-3</sup> Healthcare treatments can be tailored to individual patients in terms of patient preferences and individual clinical factors when the patient voice is captured as part of routine care. Capturing patient experience and evaluating patient function are two important components of patient-centered measurement.<sup>4</sup> The Centers for Medicare and Medicaid Services (CMS) Meaningful Measures Initiative includes the identification of measures that capture patients' experiences with clinicians and providers—one of 19 measurement areas for focusing our healthcare quality improvement efforts as a country.<sup>5</sup> This falls under the measurement priority associated with strengthening person and family engagement as partners in their care. Ensuring that each person and family is engaged within a care partnership is critical to achieving better patient outcomes.<sup>6</sup>

Patient Experience and Function (PEF) is a National Quality Forum (NQF) measure topic area encompassing patient functional status, satisfaction, and experience of care, as well as issues related to care coordination. Central to the concepts associated with patient experience with their overall care is the patient's health-related quality of life and many factors that influence it, including communication, care coordination, transitions of care, and use of health information technology.<sup>7-9</sup>

The care coordination measures within the Committee portfolio represent a fundamental component for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes.<sup>10-12</sup> Well-coordinated care encompasses effective communication between patients, caregivers, and providers, and facilitates linkages between communities and healthcare systems. It also ensures that accountable structures and processes are in place for communication and integration of comprehensive plans of care across providers and settings that align with patient and family preferences and goals.<sup>13-15</sup>

The NQF PEF Committee was established to evaluate measures within this topic area for NQF endorsement. NQF has endorsed over 50 measures addressing patient experience of care, patient functional status, mobility and self-care, shared decision making, patient activation, and care coordination. The majority of the measures within this portfolio are patient-reported outcomes performance measures.

During this cycle, the Committee's discussion focused primarily on the measures under consideration for maintenance review, but this led to broader measurement discussions related to NQF evidence and scientific acceptability submission requirements. During the discussion of the scientific acceptability of the measures considered for maintenance of endorsement, the Committee noted an important dependence of score-level reliability upon strong data element-level reliability. They also noted an important distinction between outcome measures and other measure types as it pertains to the evidence submission requirements and discussed when it may be necessary to grant an exception to evidence for non-outcome measures.

For this project, the Standing Committee evaluated two measures undergoing maintenance review against NQF's standard evaluation criteria. The Committee recommended one measure for endorsement, and the Committee did not recommend one measure for continued endorsement. The recommended measure is:

- **NQF 0425** Functional Status Change for Patients with Low Back Impairments (Focus on Therapeutic Outcomes (FOTO))

The Committee did not recommend the following measure:

- **NQF 0291** Emergency Transfer Communication Measure (University of Minnesota Rural Health Research Center)

Due to circumstances around the COVID-19 global pandemic, commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: measures that remained in fall 2019 Cycle:

- **NQF 0425** Functional Status Change for Patients with Low Back Impairments

Track 2: measures deferred to spring 2020 Cycle:

- **NQF 0291** Emergency Transfer Communication Measure

This report contains details of the evaluation of measures assigned to Track 2 and moved to the spring 2020 cycle. Detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in [Appendix A](#). The detailed evaluation summary of measures assigned to Track 1 and remained in the fall 2019 cycle were included in a separate report.

## Introduction

Patient experience, function, and coordination of care are key elements to patient-centered measurement. Patient-centered measurement aids in the delivery of high-quality care that aims to engage patients and families, leading to improved health outcomes, better patient and family experiences, and lower costs. The implementation of patient-centered measures is one of the most important approaches to ensure that the healthcare that Americans receive reflects the goals, preferences, and values of care recipients. Patient- and family-engaged care is planned, delivered, managed, and continually improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and healthcare goals, preferences, and values.<sup>16</sup> As such, effective engaged care must adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and socioeconomic backgrounds.<sup>4</sup>

The coordination of care is an essential component to the improvement of patient experiences and outcomes. Poorly coordinated and fragmented care not only compromises the quality of care patients receive, but may also lead to negative, unintended consequences, including medication errors and preventable hospital admissions.<sup>7</sup> For patients living with multiple chronic conditions—including more than two-thirds of Medicare beneficiaries—poor care transitions between different providers can contribute to poor outcomes and hospitalizations.<sup>1</sup> Nearly 15 percent of Medicare beneficiaries discharged from the hospital are readmitted within 30 days, with half of the patients not having yet seen an outpatient doctor for follow-up, and most of these readmissions occur through an emergency department (ED).<sup>2,9</sup> The existing evidence suggests that care in the United States (U.S.) is largely uncoordinated, even though evidence also suggests that quality improvement strategies within care can improve performance.<sup>11</sup> Care coordination is positively associated with patient- and family-reported receipt of family-centered care, resulting in greater satisfaction with services, lower financial burden, and fewer ED visits.<sup>1,3,6,12,15</sup>

A variety of tools and approaches can promote effective patient-provider communication, increase coordination of care, and improve patient experience and engagement. Electronic health records (EHRs) and interoperable health information can ensure that current and useful information follows the patient and is available across every setting and at each health interaction, which in turn reduces unnecessary and costly duplication of patient services. Patient education and the reconciliation of medication lists can also reduce costs by decreasing the number of serious medication events.<sup>13</sup> Shared decision making has been shown to promote better outcomes for patients and to support patients in choosing less costly, more effective interventions.<sup>14,15</sup> Innovative care models such as patient-centered medical homes (PCMHs), which invest in care coordination infrastructure, have led to sustained decreases in the number of ED and primary care visits.<sup>16</sup>

## NQF Portfolio of Performance Measures for Patient Experience and Function Conditions

The Patient Experience and Function Standing Committee ([Appendix C](#)) oversees NQF's portfolio of Patient Experience and Function measures ([Appendix B](#)) that includes measures for functional status,

communication, shared decision making, care coordination, patient experience, and long-term services and supports. This portfolio contains 51 measures: three process measures, one composite measure, and 47 outcome measures, of which 29 are patient-reported outcome performance measures (see table below).

**Table 1. NQF Patient Experience and Function Portfolio of Measures**

	Process	Outcome/Patient-Reported Outcome	Composite
<b>Functional status change and assessment</b>	1	23	0
<b>Shared decision making</b>	0	3	0
<b>Care coordination</b>	2	5	0
<b>Patient experience</b>	0	12	1
<b>Long-term services and supports</b>	0	4	0
<b>Total</b>	3	47	1

The remaining measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Resource Use), and a variety of condition- or procedure-specific outcome measures (Cardiovascular, Cancer, Renal, etc.).

## Patient Experience and Function Measure Evaluation

On February 12 and February 26, 2020, the Patient Experience and Function Standing Committee evaluated two measures undergoing maintenance review against NQF's [standard measure evaluation criteria](#).

**Table 2. Patient Experience and Function Measure Evaluation Summary, Fall 2019 Track 2**

	Maintenance	New	Total
Measures under consideration	1	0	1
Measures recommended for endorsement	0	0	0
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures where consensus is not yet reached	0	0	0
Measures not recommended for endorsement	1	0	1
Measure recommendation deferred	0	0	0
Measures withdrawn from consideration	0	0	0

	Maintenance	New	Total
Reasons for not recommending	Importance - 0 Scientific Acceptability - 1 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure - 0	

### Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 5, 2019 and closed on May 24, 2020. Pre-meeting commenting closed on January 28, 2020. As of that date, no comments were submitted ([Appendix F](#)).

### Comments Received After Committee Evaluation

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

#### **Track 1: Measures Remained in Fall 2019 Cycle**

**Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations** moved forward to the CSAC for review and discussion during its meeting on July 28-29, 2020.

- **Exceptions**

Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

#### **Track 2: Measures Deferred to Spring 2020 Cycle**

**Fall 2019 measures that required further action or discussion from a Standing Committee were deferred to the spring 2020 cycle.** This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review retained endorsement during that time.

During the spring 2020 CSAC meeting on November 17-18, the Consensus Standards Approval Committee (CSAC) will review all measures assigned to Track 2. A list of measures assigned to Track 1

can be found in the [Executive Summary](#) section of this report for tracking purposes, but these measures were reviewed during the July 28-29, 2020 CSAC meeting.

The extended public commenting period with NQF member support closed on May 24, 2020. Following the Committee's evaluation of the measures under consideration, NQF received four comments from developers, future measure stewards, and two member organizations pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration have been summarized in [Appendix A](#).

Throughout the extended public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expression of non-support.

## Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

### *Score Level and Data Element Level Reliability*

During the discussion of the scientific acceptability of the measures considered for maintenance of endorsement, the Committee noted an important dependence of score-level reliability on strong data element-level reliability because the tests have shown low data element-level reliability but strong score-level reliability. The Committee noted that for most measure types, NQF's current measure evaluation criteria do not require testing at both data element and score levels; instrument-based measures are the only measure type that requires both score-level and data element-level testing. While composite measures require score-level testing, data element level is optional. All other measure types may submit either data element-level or score-level testing according to the developer's discretion and access to data. The Committee discussed that this may be problematic considering that score-level reliability may be dependent upon data element-level reliability, meaning that it is possible to achieve a score-level result that inaccurately appears good because it is significantly confounded by issues at the data element-level. One very common methodology for score-level reliability testing was outlined by John Adams in a 2009 Rand Health Technical Report titled "*The Reliability of Provider Profiling*." The beta binomial signal-to-noise analysis assumes a provider's score is a binomial random variable conditional on the physician's true value that comes from the beta distribution. The modeling for this score also assumes that errors are random and not systematic. The Committee noted that it is possible to have high score-level reliability that is potentially biased by systematic error at the data element level (as a result of poor interrater reliability for measures that depend on abstraction from medical records, for example).

## Summary of Measure Evaluation: Fall 2019 Measures Track 2

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in [Appendix A](#).



## 0291 Emergency Transfer Communication Measure (University of Minnesota Rural Health Research Center): Not Recommended

**Description:** Percentage of all patients transferred from an Emergency Department to another healthcare facility whose medical record documentation indicated that all required information was communicated (sent) to the receiving facility within 60 minutes of transfer. For all data elements, the definition of “sent” includes the following:

- Hard copy sent directly with the patient, or
- Sent via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or health information exchange (HIE) (see definition below)

For purposes of this measure, a shared EHR is defined as one where data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a HIE cannot assume immediate access by the receiving facility to the transferred patient’s record; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Emergency Department and Services, Inpatient/Hospital, Outpatient Services; **Data Source:** Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records

The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion. This measure was discussed during the February 26 post-comment call, which did not achieve quorum. Therefore, voting was completed asynchronously after the call. NQF 0291 is a maintenance measure assessing the percentage of all patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all required information be sent to the receiving facility within 60 minutes of the transfer. The Committee noted that this maintenance measure was granted an exception to evidence on the previous review. The Committee observed this due to the fact that the evidence to support the connection between positive patient outcomes and the transfer of information with the patient within 60 minutes from the emergency room has not been well-studied, and that it is difficult to design a study that makes a clear and empirical connection between this process and desirable outcomes. Nonetheless, the Committee noted that there is strong expert opinion that suggests that this is an industry best practice for better coordination of care. Committee members also expressed that NQF 0291 is a particularly important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers, and that it would be very difficult to assess causation of an important outcome such as mortality and morbidity as evidence of the need for this type of measure. The Committee noted that it is also uncertain if public reporting and payment could be conducted fairly without substantial bias and lack of adjustment for between-facility variation around technology. Related to performance gap, the Committee initially expressed concern that the data and analyses presented were from the revised measure, but that they were otherwise comfortable with the measure gap once the developer clarified that the testing was done according to the new specifications.

The Standing Committee did not pass the measure on reliability due to concerns that the interrater reliability at the data element level produced low results. The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision. The Committee noted that

the data element reliability testing for the measure produced fair to moderate crude agreement for interrater reliability between abstractors for the eight items in the measure. However, the results using Cohen's kappa statistics produced mostly low results for the eight items. The Committee also noted that while the score-level reliability results were good, they were produced using the beta-binomial methodology, which assumes that error is random. Since the interrater reliability is low, this implies that the error is systematic.

## References

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## Appendix A: Details of Measure Evaluation

**Rating Scale:** H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

### Track 2 – Measures Not Recommended

0291 Emergency Transfer Communication Measure
<p><u>Submission</u></p> <p><b>Description:</b> Percentage of all patients transferred from an Emergency Department to another healthcare facility whose medical record documentation indicated that all required information was communicated (sent) to the receiving facility within 60 minutes of transfer. For all data elements, the definition of ‘sent’ includes the following:</p> <ul style="list-style-type: none"> <li>• Hard copy sent directly with the patient, or</li> <li>• Sent via fax or phone within 60 minutes of patient departure, or</li> <li>• Immediately available via shared Electronic health record (EHR) or Health Information Exchange (HIE) (see definition below)</li> </ul> <p>For purposes of this measure, a shared electronic health record (EHR) is defined as one where data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a Health Information Exchange (HIE) cannot assume immediate access by the receiving facility to the transferred patient’s record.</p> <p><b>Numerator Statement:</b> Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:</p> <ul style="list-style-type: none"> <li>• Home Medications</li> <li>• Allergies and Reactions</li> <li>• Medications Administered in ED</li> <li>• ED Provider Note</li> <li>• Mental Status and Orientation Assessment</li> <li>• Reason for Transfer and Plan of Care</li> <li>• Tests and/or Procedures Performed</li> <li>• Tests and/or Procedures Results</li> </ul> <p><b>Denominator Statement:</b> Denominator Statement: Transfers from an ED to another healthcare facility</p> <p>Included Population: All transfers from an ED to another healthcare facility</p> <p>Excluded Populations: Patients observation status.</p> <p><b>Exclusions:</b> All emergency department patients not discharged to another healthcare facility. Those admitted, sent home, left AMA, those on observations status, etc.</p> <p><b>Adjustment/Stratification:</b> No risk adjustment or risk stratification</p> <p><b>Level of Analysis:</b> Facility</p> <p><b>Setting of Care:</b> Emergency Department and Services, Inpatient/Hospital, Outpatient Services</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records</p> <p><b>Measure Steward:</b> University of Minnesota Rural Health Research Center</p> <p><b>STANDING COMMITTEE MEETING 02/12/2020, 02/26/2020</b></p> <p><b>1. Importance to Measure and Report:</b> <u>The measure meets the Importance criteria</u> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>M-2; L-5; I-10</b>; 1b. Performance Gap: <b>H-0; M-15; L-2; I-0</b>; Evidence Exception: <b>Yes-13; No-4</b></p> <p><u>Rationale:</u></p>

<b>0291 Emergency Transfer Communication Measure</b>
<ul style="list-style-type: none"> <li>• The Committee noted that the developer has added additional evidence of the need for better care transitions since the last submission.</li> <li>• The Committee noted that this maintenance measure was granted an exception to evidence on the previous review.</li> <li>• Committee members expressed that this is an important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers, and that it would be very difficult to assess causation of an important outcome such as mortality and morbidity as evidence of the need for this type of measure.</li> <li>• The Committee noted that it is also uncertain if public reporting and payment could be done fairly without substantial bias and lack of adjustment for between-facility variation around technology.</li> <li>• The Committee felt that there was an adequate performance gap. <ul style="list-style-type: none"> <li>○ Results provided suggest a mean emergency department transfer communication (EDTC) performance rate of 0.75 and 0.79 in quarters 1 and 4 of 2017.</li> <li>○ The interquartile range was approximately 0.65-0.97 for both quarters, indicating good spread and continued opportunity for improvement.</li> </ul> </li> </ul>
<p><b>2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u></b></p> <p>(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)</p> <p>2a. Reliability: <b>H-0; M-4; L-13; I-0</b>; 2b. Validity: <b>H-X; M-X; L-X; I-X</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>• The Committee noted that the data element-level interrater reliability testing produced a low kappa statistic score.</li> <li>• Score-level reliability using beta binomial was high.</li> <li>• The Committee felt that the data element reliability was truly a concern due to the fact that the beta binomial methodology used for score-level reliability testing is based on the assumption that error is random, but low interrater reliability would be systematic error.</li> <li>• The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision.</li> <li>• The Committee did not pass the measure on reliability.</li> </ul>
<p><b>3. Feasibility: <u>The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability</u></b></p> <p>(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified; 3d. Data collection strategy can be implemented)</p>
<p><b>4. Usability and Use: <u>The Standing Committee did not vote on this criteria since the measure did not pass Scientific Acceptability</u></b></p> <p>(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)</p>
<p><b>5. Related and Competing Measures</b></p> <ul style="list-style-type: none"> <li>• No related or competing measures noted.</li> </ul>
<p><b>6. Standing Committee Recommendation for Endorsement: Yes-X; No-X</b></p> <p><u>Rationale</u></p> <ul style="list-style-type: none"> <li>• The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion.</li> </ul>
<p><b>7. Public and Member Comment</b></p> <p>Comments received outlined concerns with the data element reliability results, approaches to improving reliability, and expressions of support for the Committee’s endorsement decision. The Committee agreed that</p>

<b>0291 Emergency Transfer Communication Measure</b>
the measure is both valuable and relevant and should be considered in the future. The Committee encouraged the developer to improve the measure's overall reliability testing result in future submissions.
<b>8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>9. Appeals</b>

## Appendix B: Patient Experience and Function Portfolio—Use in Federal Programs<sup>a</sup>

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Merit-based Incentive Payment System (MIPS) Program (Implemented) Physician Compare (Implemented)
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Medicaid (Implemented)
0166	HCAHPS	Hospital Compare (Implemented) Hospital Inpatient Quality Reporting (IQR) (Implemented) Hospital Value-Based Purchasing (HVBP) (Implemented) Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) (Implemented)
0258	CAHPS In-Center Hemodialysis Survey	End-Stage Renal Disease Quality Incentive Program (Implemented)
0291	Emergency Transfer Communication Measure	None
0422	Functional status change for patients with Knee impairments	MIPS Program (Implemented)
0423	Functional status change for patients with Hip impairments	MIPS Program (Implemented)
0424	Functional status change for patients with Foot and Ankle impairments	MIPS Program (Implemented)
0425	Functional status change for patients with lumbar impairments	MIPS Program (Finalized)
0426	Functional status change for patients with Shoulder impairments	MIPS Program (Implemented)
0427	Functional status change for patients with elbow, wrist and hand impairments	MIPS Program (Implemented)
0428	Functional status change for patients with General orthopedic impairments	MIPS Program (Implemented)
0517	CAHPS® Home Health Care Survey (experience with care)	Home Health Quality Reporting Program (HH QRP) (Implemented) Home Health Value Based Purchasing (HHVBP) (Implemented)

<sup>a</sup> Per CMS Measures Inventory Tool as of 01/13/2020



NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	None
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) <sup>®</sup> Surgical Care Survey	None
2286	Functional Change: Change in Self Care Score	None
2287	Functional Change: Change in Motor Score	None
2321	Functional Change: Change in Mobility Score	None
2483	Gains in Patient Activation (PAM) Scores at 12 Months	None
2548	Child Hospital CAHPS (HCAHPS)	None
2612	CARE: Improvement in Mobility	None
2613	CARE: Improvement in Self Care	None
2614	CoreQ: Short Stay Discharge Measure	None
2615	CoreQ: Long-Stay Resident Measure	None
2616	CoreQ: Long-Stay Family Measure	None
2631	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Long-Term Care Hospital Quality Reporting Program (LTCHQRP) (Implemented)
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	LTCHQRP (Implemented)
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) (Implemented)
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2643	Average change in functional status following lumbar spine fusion surgery	MIPS Program (Finalized)
2653	Average change in functional status following total knee replacement surgery	MIPS Program (Finalized)
2769	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	None
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	None
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities	None
2776	Functional Change: Change in Motor Score in Long Term Acute Care Facilities	None
2777	Functional Change: Change in Self Care Score for Long Term Acute Care Facilities	None
2778	Functional Change: Change in Mobility Score for Long Term Acute Care Facilities	None
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery	None
2962	Shared Decision-Making Process	Medicare Shared Savings Program (MSSP) (Implemented)
2967	CAHPS® Home- and Community-Based Services Measures	Medicaid (Implemented)
3227	CollaboRATE Shared Decision-Making Score	None
3420	CoreQ: AL Resident Satisfaction Measure	None
3422	CoreQ: AL Family Satisfaction Measure	None
3455	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	None
3461	Functional Status Change for Patients with Neck Impairments	MIPS Program (Finalized)
3477	Discharge to Community-Post Acute Care Measure for Home Health Agencies	None

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
3479	Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities	IRF QRP (Implemented)
3480	Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals	LTCHQRP (Implemented)
3481	Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities	Skilled Nursing Facility Quality Reporting Program (SNF QRP) (Implemented)

## Appendix C: Patient Experience and Function Standing Committee and NQF Staff

### STANDING COMMITTEE

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## **Appendix D: Measure Specifications**

The Standing Committee did not recommend the candidate measure for endorsement; therefore, specifications are not required to be listed.

## **Appendix E: Related and Competing Measures**

No related or competing measures were identified.



## **Appendix F: Pre-Evaluation Comments**

Pre-meeting commenting closed on January 28, 2020. As of that date, no comments were submitted.

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