Patient Experience and Function, Spring 2018 Cycle: CDP Report

DRAFT REPORT CSAC REVIEW

October 23, 2018

NATIONAL QUALITY FORUM

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Patient Experience and Function, Spring 2018 Cycle

DRAFT REPORT FOR COMMENT

Executive Summary

Ensuring that every patient and family member is engaged as a partner in coordinated care is core to advancing the quality of our healthcare system. Often, healthcare is received in an asynchronous manner that does not support effective communication between participants in the process of care, or account for the preferences and goals of individuals and their families. Over the past decade, there have been 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. ~~Our~~ The United States' national priority, reflected in the Centers for Medicare and Medicaid's new Meaningful Measure Framework, of "*ensuring that each person and family is engaged as partners in their care*" emphasizes this approach. Care coordination is also 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. 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.

Patient Experience and Function is a newly formed National Quality Forum (NQF) measure topic area encompassing many of the measures previously assigned to the Person- and Family-Centered Care and Care Coordination topic areas. Measures included in this portfolio assess patient function and experience of care as they relate to health-related quality of life and many factors that influence it, including communication, care coordination, transitions of care, and use of health information technology.

For the spring 2018 cycle of work, the Standing Committee evaluated two newly submitted measures against NQF's standard evaluation criteria. The Committee recommended both of these measures for endorsement:

- 3420 CoreQ: AL Resident Satisfaction Measure
- 3422 CoreQ: AL Family Satisfaction Measure

A brief summary of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

In addition to evaluating the newly submitted measures, the Patient Experience and Function (PEF) Standing Committee also discussed measure prioritization, ~~and~~ care coordination measure priorities~~,~~ ~~and~~, and ~~also~~ continued to build on definitions for patient-centered coordinated care.

Introduction

Ensuring that every patient and family member is engaged as a partner in coordinated care is core to advancing the quality of our healthcare system. Patient and family engaged care is a key component in the delivery of high-quality care that aims to improve health outcomes, achieve better patient and family experiences, and lower costs. Patient and family engaged care is planned, delivered, managed, and continuously 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.[1] 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.[2]

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.[3,4] 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.[5] One in five Medicare beneficiaries discharged from the hospital is 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 the emergency department (ED).[6] The coordination of care is essential to reduce preventable hospitalizations, improve patient experiences and outcomes, and lower costs in today's healthcare system. Delivery of coordinated care necessarily brings together disparate sectors of the health and healthcare system, thus improving care coordination offers a potential opportunity for drastically improving care quality that could save $240 billion a year.[7]

The existing evidence suggests that care today in the U.S. is largely uncoordinated even though evidence also suggests that quality improvement strategies within care can improve performance.[8] 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 emergency department visits.[9] A variety of tools and approaches, when leveraged, can promote effective 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 patients 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.[10] Shared decision making has been shown to promote better outcomes for patients, and to support patients in choosing less costly, more effective interventions.[11,12] Innovative care models such as Patient Centered Medical Homes (PCMH), which invest in care coordination infrastructure, have led to sustained decreases in the number of ED and primary care visits, as well as increased screening for some types of cancer.[13]

NQF Prioritization of Patient Experience and Function Portfolio Measures

NQF has engaged in several strategic initiatives with the goal of evaluating redundancy in measurement, unnecessary burden, and measurement that is not adding value. As part of these efforts, NQF has launched an initiative on measure prioritization. To drive a meaningful dialogue at the national level, NQF has developed a set of prioritization criteria and a hierarchical framework that highlight the most significant measures and gaps. Together, they contribute to the identification of a set of measures that matter and motivate improvement.

The final measure prioritization criteria are based on an environmental scan of prioritization efforts across the United States and the world and include outcome-focused, improvable and actionable, meaningful to patients and caregivers, and support systemic/integrated view of care. NQF has developed a rubric based on the four prioritization criteria on which to evaluate measures. The rubric was introduced to the Committee, and members were offered an opportunity to comment and suggest revisions to the rubric on the basis of how the measures were ranked according to their prioritization scores.

The Committee shared feedback with NQF staff during the spring cycle 2018 post-evaluation meeting. Initial responses focused on how criteria such as "meaningful to patients" and "systemic/integrated view of care" are defined. Many of the Committee members agreed that including meaningful-to-patient metrics for all measure submissions would be a welcome addition to measure submission packets. Overall, the Committee agreed that the prioritization work was important and valuable.

Care Coordination Measure Priorities

Care coordination is foundational to an effective healthcare system, pivotal to patient experience, and an essential pillar of the national health strategy. More recently, care coordination has been prioritized by CMS' Meaningful Measures framework, and many state Medicaid programs are now requiring care coordination measures for high-risk populations. Despite these shared priorities, few new care coordination measures have come to NQF for evaluation over the last few years. Of the measures that have been submitted, they have not addressed the priorities outlined by the previous Care Coordination Committee. These priorities include measures that:

- reflect patient preferences as they move through the healthcare system;
- incorporate the care plan as the core document in the patient record, and are inclusive of the patient's voice and goals;
- encompass some of the practical and basic elements of transition (e.g., medication reconciliation); and
- are evidence-based.

During the spring 2018 cycle post-evaluation meeting, the Committee discussed the current state of care coordination measures and provided guidance to NQF on how the Committee may help to better evaluate and track care coordination measures in the NQF portfolio, and to advance the overall state of measurement of care coordination. The Committee agreed that effective care coordination must be patient-centered; otherwise, systems may report effective coordination, when in fact, the patient experience indicates otherwise. Measuring this will require an expansion of meaningful measures of the patient experience of care coordination. Many Committee members also noted that meaningful measurement of care coordination requires a balanced portfolio of structure, process, and outcome measures. One Committee member noted the tension between outcome and process measures, identifying significant barriers for measuring processes and structures due to gaps in reported data. It was also noted that often the most meaningful way to measure care coordination involves measuring the patient experience, which comes with a substantial cost. Patient-reported outcome (PRO) measures are expensive to administer, and the data collection process is often not feasible, lacking efficiencies needed to support effective measurement. In addition, attribution of care coordination outcomes to a single provider or unit was also cited as a stumbling block to advancing care coordination measurement. Accountability for care coordination is typically a collective responsibility that crosses settings, and it can be difficult to determine how responsibility should be shared across providers. Committee members commented that NQF's recent work on attribution should be incorporated into future discussions about advancing the care coordination measurement portfolio.

The Committee put forth a series of recommendations to guide the evaluation and tracking of care coordination measures across NQF portfolios and to encourage expansion of the care coordination measures portfolio:

1. Identify care coordination structures and processes that are standard across care delivery to demonstrate a balanced approach to measurement through structure, process, and outcome measures.
2. Expand the definition of care coordination beyond the medical system, emphasizing its use as a tool for facilitating positive health outcomes for the patient and caregiver across all settings.
3. Encourage submission of measures specific to patient experience of care coordination.
4. Centralize review of care coordination measures:
    a. Route all care coordination measures to the PEF Committee, or alternatively, provide a mechanism for the PEF Committee to provide input on evaluation of specific measures related to care coordination if not in the PEF portfolio.
    b. Allow for cross-disciplinary committee discussions to ensure internal alignment of evaluation of measures.
    c. Track all measures that touch on care coordination, care integration, and experience.
5. NQF should re-evaluate its decision to embed care coordination into patient experience and consider whether to re-establish a standing committee specific to care coordination.

NQF Portfolio of Performance Measures for Patient Experience and Function

NQF's portfolio of PEF measures include measures of functional status, communication, shared decision making, care coordination, patient experience, and long-term services and supports (see Appendix B). This portfolio contains 56 measures, including three process measures and 53 outcome measures, of which 18 are PRO performance measures (see table below).

Table 1. NQF Patient Experience and Function Portfolio of Measures

	Process	Outcome/Patient-Reported Outcome
Functional Status Change and Assessment	2	28
Communication	1	6

	Process	Outcome/Patient-Reported Outcome
Shared Decision Making	-	2
Care Coordination	-	1
Patient Experience	-	12
Long Term Services and Supports	-	4
Total	3	53

Additional measures related to PEF are assigned to other projects, including Cost and Efficiency (i.e., emergency department timing measures), Patient Safety (i.e., medication reconciliation measures), and Geriatric and Palliative Care (i.e., home health measures, advanced care plan measures, and family experience with hospice and end-of-life care measures).

Patient Experience and Function Measure Evaluation

On June 22, 2018 the Patient Experience and Function Standing Committee evaluated two new measures against NQF's standard evaluation criteria.

Table 2. Patient Experience and Function Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	0	2	2
Measures recommended for endorsement	-	2	2

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 May 8, 2018 and ~~will~~ closed on September 5, 2018. As of June 12, no comments were submitted and shared with the Committee prior to the measure evaluation meeting.

Comments Received After Committee Evaluation

~~The continuous 16-week public commenting period with NQF member support closed on September 5, 2018.~~ Following the Committee's evaluation of the measures under consideration, NQF received one comment from one member organization pertaining to the draft report and to the measures under consideration.

~~NQF received one comment on the spring 2018 Patient Experience and Function draft report.~~ The comment supported the Committee's recommendations to endorse the two new measures under review as well as the Committee's identification of priority gaps in the Patient Experience and Function portfolio. The commenter encouraged further work in the area of patient experience and care coordination. The full text of this comment is available in the Comment Table.

Throughout the 16-week 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. No NQF members provided their expression of support.

Summary of Measure Evaluation

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.

3420: CoreQ AL Resident Satisfaction: Recommended

Description: The measure calculates the percentage of Assisted living (AL) residents, those living in the facility for two weeks or more, who are satisfied. This patient reported outcome measure is based on the CoreQ: AL Resident Satisfaction questionnaire that is a four-item questionnaire. **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Facility; **Setting of Care**: Assisted Living; **Data Source**: Instrument-Based Data

Patient-centered care is an essential element of high-quality care. Measuring patient satisfaction is core to understanding a patient's perception of quality of care, and can aid in understanding patient preferences. Measuring and reporting satisfaction can also help patients and families choose and trust a healthcare facility, as well as provide facilities with information to improve the quality of care they provide. Research has shown a positive effect of the patient-provider relationship on healthcare outcomes.[14]

This patient-reported outcome measure assesses residents' overall satisfaction with assisted living facilities and is based on a three-question survey. The Standing Committee considered differences between measuring experience and satisfaction, and how they relate to patient preferences. They ultimately agreed that the empirical data submitted by the measure developer sufficiently demonstrated a relationship between the process and outcome of care. In addition, the Committee questioned if the elements of satisfaction in the CoreQ survey were meaningful to assisted living residents. The measure developer provided context for the Committee on the development of the survey ~~questions which~~questions, which included feedback from multiple resident and family member focus groups. The Committee discussed the variability of performance in assisted living facilities, and agreed that accountability measures support an opportunity for improvement in this somewhat new area of measurement.

Members of the Committee emphasized that assisted living is not a typical healthcare insurance benefit, but there is potential for improved access to this service through the new Medicaid Elderly Waiver program. The ~~scientific acceptability criterion was evaluated by the NQF Scientific Methods Panel~~NQF Scientific Methods Panel evaluated the scientific acceptability criterion; the Panel ~~who~~ voted moderate on both reliability and validity. After a discussion on facility-level variation, the Committee agreed with the Methods Panel's input and voted moderate as well. The Committee discussed the feasibility of survey administration specific to cost and potential response bias. In response to this concern, the measure developer provided additional background on survey administration and how assisted living facilities typically hire vendors to administer these surveys to eliminate bias. The measure is currently not used in any accountability program~~s~~, but assisted living facilities in the state of Oregon may potentially report on it. The Committee agreed that the measure is extremely helpful for quality improvement, but if used as a national benchmark, it would need more constraints on how data are obtained to reduce gaming. Overall, the Committee agreed that this is an important new measure and voted to recommend it for endorsement.

3422: CoreQ AL Family Satisfaction: Recommended

Description: The measure calculates the percentage of family or designated responsible party for assisted living (AL) residents. This consumer reported outcome measure is based on the CoreQ: AL Family Satisfaction questionnaire that has three items. **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Facility; **Setting of Care**: Assisted Living; **Data Source**: Instrument-Based Data

This measure assesses overall family satisfaction with assisted living facilities and is related to the resident satisfaction measure. The measure is calculated on data from a four-question survey for family members of assisted living facility residents. Research suggests that substantial improvements in residents' satisfaction in long-term care facilities can be made by improving care.[15] The Standing Committee had a brief conversation about differences between family and resident satisfaction and how they are linked. Based on the similarities and the relation of the AL Family Satisfaction and AL Resident Satisfaction measures, the Committee agreed to apply their conversation from AL Resident Satisfaction to this measure and subsequently voted on the measure. The Committee agreed that this is an important new measure and voted to recommend it for endorsement

References

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14 Kelley JM, Kraft-Todd G, Schapira L, et al. The influence of the patient-clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. *PLoS One*. 2014;9(4):e94207.

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Appendix A: Details of Measure Evaluation

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

Measures Recommended

3420 CoreQ AL Resident Satisfaction

Submission | Specifications

The measure calculates the percentage of Assisted living (AL) residents, those living in the facility for two weeks or more, who are satisfied. This patient reported outcome measure is based on the CoreQ: AL Resident Satisfaction questionnaire that is a four-item questionnaire.

Numerator Statement: The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the four questions on the CoreQ: AL Resident Satisfaction questionnaire.

Denominator Statement: The denominator includes all of the residents that have been in the AL facility for two weeks or more regardless of payer status; who received the CoreQ: AL Resident Satisfaction Questionnaire (e.g. people meeting exclusions do not receive the questionnaire), who responded to the questionnaire within the two month time window, who did not have the questionnaire completed by somebody other than the resident, and who did not have more than one item missing

Exclusions: Exclusions made at the time of sample selection are the following: (1) Residents who have poor cognition (described below in S.9); (2) residents receiving hospice; (3) residents with a legal court appointed guardian; and (4) residents who have lived in the AL facility for less than two weeks. Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) b) surveys that have more than one questionnaire item missing c) surveys from residents who indicate that someone else answered the questions for the resident. (Note this does not include cases where the resident solely had help such as reading the questions or writing down their responses.)

Adjustment/Stratification: None

Level of Analysis: Facility

Setting of Care: Assisted Living

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: American Health Care Association/National Center for Assisted Living

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STANDING COMMITTEE MEETING [06/22/2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-15; N-0**; 1b. Performance Gap: **H-0; M-13; L-4; I-0**

Rationale:

- The measure developer provided a logic model outlining the relationship between the outcome of assisted living resident satisfaction and drivers such as staff competency, concern, and

responsiveness management based on eleven sources of evidence specific to patient satisfaction and the impact of patient-clinician relationships on healthcare outcomes.
- Structure and process drivers and their influence on assisted living resident satisfaction were submitted for review by the measure developer.
- Data from 483 assisted living facilities from multiple states indicated performance score variation between facilities demonstrating an opportunity for improvement.
- The Standing Committee discussed demographic limitations in the performance data (e.g. 90% white and 50% with a higher education). The measure developer confirmed that this is reflective of the current assisted living population. The Committee was concerned that these results may not generalize to a more diverse patient/facility population and agreed that they would like to see these performance data be more sensitive to potential disparities in care in future evaluations.
- The Committee agreed that the performance data indicated a gap in care.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-13; L-4; I-0** 2b. Validity: **H-0; M-16; L-2; I-1**

<u>Rationale</u>:

- The measure developer submitted data element, questionnaire-level, facility level reliability testing that showed that the data elements were highly repeatable and indicated measure score reliability at both the questionnaire and facility level.
- Validity testing included assessment of face validity and the relationship of satisfaction summary score with other variables.
- The measure was reviewed by the NQF Scientific Methods Panel and received an overall moderate rating for both reliability and validity, however there was some concern in regards to the correlation analyses.
- The Standing Committee had some concern about the reliability of the measure at the facility level, but agreed that since this is a new measure, future evaluations should focus on facility variation.
- The measure is not risk adjusted similar to CAHPS measures.

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3. Feasibility: H-5; M-14; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- This measure is based on a patient / family reported information in either paper or electronic format.
- The overall measure is calculated on a sample of 20 responses .
- No fees, licensing or other requirements are associated with the measure.
- The Standing Committee considered if a cognitive assessment be included in the administration of the survey, but agreed that additional costs for this type of service to resident or family would be burdensome.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Yes-16; No-3** 4b. Usability: **H-1; M-12; L-5; I-2**

Rationale:

- The measure developer is currently working to get this measure adopted for state level reporting in Oregon.
- This is a new measure and not publicly reported.

5. Related and Competing Measures

- 3422: CoreQ AL Family Satisfaction

Standing Committee Recommendation for Endorsement: **Y-18**; **N-2**

6. Public and Member Comment

No comments were received on this measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

3422 CoreQ AL Family Satisfaction

Submission | Specifications

Description: The measure calculates the percentage of family or designated responsible party for assisted living (AL) residents. This consumer reported outcome measure is based on the CoreQ: AL Family Satisfaction questionnaire that has three items.

Numerator Statement: The numerator assesses the number of family or designated responsible party for AL residents that are satisfied. Specifically, the numerator is the sum of the family or designated responsible party for AL residents that have an average satisfaction score of =>3 for the three questions on the CoreQ: AL Family Satisfaction questionnaire.

Denominator Statement: The target population is family or designated responsible party members of a resident residing in the facility for at least two weeks. The denominator includes all of the individuals in the target population who respond to the CoreQ: AL Family Satisfaction questionnaire within the two month time window who do not meet the exclusion criteria.

Exclusions: Exclusions made at the time of sample selection are the following: (1) Court-appointed guardian; (2) family of residents receiving hospice; (3) Family members who reside in another country and (4) family of residents who have lived in the AL facility for less than two weeks.

Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) and b) surveys that have more than one questionnaire item missing.

Adjustment/Stratification: None

Level of Analysis: Facility

Setting of Care: Assisted Living

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: American Health Care Association/National Center for Assisted Living

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STANDING COMMITTEE MEETING [06/22/2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-15; No-5** 1b. Performance Gap: **H-0; M-17; L-3; I-1**

Rationale:

- The evidence submitted for this measure was the same as the CoreQ: AL Resident Satisfaction measure 3420.
- The Standing Committee considered differences between family and resident satisfaction measures, elected not to discuss, and went straight to a vote.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-15; L-3; I-3** 2b. Validity: **H-0; M-11; L-3; I-3**

Rationale:

- The measure developer submitted data element, questionnaire-level, facility level reliability testing that showed that the data elements were highly repeatable and indicated measure score reliability at both the questionnaire and facility level.
- Validity testing included assessment of face validity and the relationship of satisfaction summary score with other variables.
- The measure was reviewed by the NQF Scientific Methods Panel and received an overall moderate rating for both reliability and validity, however there was some concern in regards to the correlation analyses.
- The Standing Committee considered differences between family and resident satisfaction measures, elected not to discuss, and went straight to a vote.

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3. Feasibility: H-5; M-14; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- This measure is based on a patient / family reported information in either paper or electronic format.
- The overall measure is calculated on a sample of 20 responses.
- No fees, licensing or other requirements are associated with the measure.
- The Standing Committee considered differences between family and resident satisfaction measures, elected not to discuss, and went straight to a vote.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use: Y-16; N-5 4b. Usability: H-3; M-12; L-4; I-2

Rationale:

- The measure developer is currently working to get this measure adopted for state level reporting in Oregon.
- This is a new measure and not publically reported.
- The Standing Committee considered differences between family and resident satisfaction measures, elected not to discuss, and went straight to a vote.

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5. Related and Competing Measures

- 3420: CoreQ AL Resident Satisfaction

Standing Committee Recommendation for Endorsement: **Y-14**; **N-5**

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6. Public and Member Comment

No comments were received on this measure.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

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8. Appeals

Appendix B: Patient Experience and Function Portfolio—Use in Federal Programs

Per CMS Measures Inventory Tool as of June 12, 2018

NQF #	Title	Federal Programs: Finalized as of November, 2017
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Merit-based Incentive Payment System, Medicare Shared Savings Program
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Merit-based Incentive Payment System
0166	HCAHPS	PCHQR, IQR- EHR Incentive Program
0228	3-Item Care Transition Measure (CTM-3)	IQR- EHR Incentive Program
0258	CAHPS In-Center Hemodialysis Survey	ESRD Quality Incentive Program
0291	EMERGENCY TRANSFER COMMUNICATION MEASURE	N/A
0422	Functional status change for patients with Knee impairments	Merit-based Incentive Payment System
0423	Functional status change for patients with Hip impairments	Merit-based Incentive Payment System
0424	Functional status change for patients with Foot and Ankle impairments	Merit-based Incentive Payment System
0425	Functional status change for patients with lumbar impairments	Merit-based Incentive Payment System
0426	Functional status change for patients with Shoulder impairments	Merit-based Incentive Payment System
0427	Functional status change for patients with elbow, wrist and hand impairments	Merit-based Incentive Payment System
0428	Functional status change for patients with General orthopaedic impairments	Merit-based Incentive Payment System
0429	Change in Basic Mobility as Measured by the AM-PAC	N/A
0430	Change in Daily Activity Function as Measured by the AM-PAC	N/A
0517	CAHPS® Home Health Care Survey (experience with care)	Home Health Quality Reporting Program
0688	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (long stay)	N/A
0700	Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation	N/A
0701	Functional Capacity in COPD patients before and after Pulmonary Rehabilitation	N/A

NQF #	Title	Federal Programs: Finalized as of November, 2017
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	N/A
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	N/A
1888	Workforce development measure derived from workforce development domain of the C-CAT	N/A
1892	Individual engagement measure derived from the individual engagement domain of the C-CAT	N/A
1894	Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT	N/A
1896	Language services measure derived from language services domain of the C-CAT	N/A
1898	Health literacy measure derived from the health literacy domain of the C-CAT	N/A
1901	Performance evaluation measure derived from performance evaluation domain of the C-CAT	N/A
1905	Leadership commitment measure derived from the leadership commitment domain of the C-CAT	N/A
2286	Functional Change: Change in Self Care Score	N/A
2287	Functional Change: Change in Motor Score	N/A
2321	Functional Change: Change in Mobility Score	N/A
2483	Gains in Patient Activation (PAM) Scores at 12 Months	N/A
2548	Child Hospital CAHPS (HCAHPS)	N/A
2612	CARE: Improvement in Mobility	N/A
2613	CARE: Improvement in Self Care	N/A
2614	CoreQ: Short Stay Discharge Measure	N/A
2615	CoreQ: Long-Stay Resident Measure	N/A
2616	CoreQ: Long-Stay Family Measure	N/A
2624	Functional Outcome Assessment	Merit-based Incentive Payment System
2631	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Skilled Nursing Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program, Home Health Quality Reporting Program
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Long-Term Care Hospital Quality Reporting Program

NQF #	Title	Federal Programs: Finalized as of November, 2017
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Skilled Nursing Facility Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Skilled Nursing Facility Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Skilled Nursing Facility Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Skilled Nursing Facility Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program
2643	Average change in functional status following lumbar spine fusion surgery	N/A
2653	Average change in functional status following total knee replacement surgery	N/A
2769	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	N/A
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	N/A
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities	N/A
2776	Functional Change: Change in Motor Score in Long Term Acute Care Facilities	N/A
2777	Functional Change: Change in Self Care Score for Long Term Acute Care Facilities	N/A
2778	Functional Change: Change in Mobility Score for Long Term Acute Care Facilities	N/A
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery	N/A
2962	Shared Decision Making Process	N/A
2967	CAHPS® Home- and Community-Based Services Measures	N/A

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Appendix D: Measure Specifications

3420 CoreQ: AL Resident Satisfaction: Specifications

STEWARD

American Health Care Association/National Center for Assisted Living

DESCRIPTION

The measure calculates the percentage of Assisted living (AL) residents, those living in the facility for two weeks or more, who are satisfied. This patient reported outcome measure is based on the CoreQ: AL Resident Satisfaction questionnaire that is a four-item questionnaire

TYPE

Outcome: PRO-PM

DATA SOURCE

Instrument-Based Data

LEVEL

Facility

SETTING

Assisted Living

NUMERATOR STATEMENT

The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the four questions on the CoreQ: AL Resident Satisfaction questionnaire.

NUMERATOR DETAILS

A specific date is chosen. On that date all residents in the facility are identified. The data is then collected from all the residents in the facility meeting eligibility criteria on that date. Residents are given a maximum 2 month time window to complete the survey. While the frequency in which the questionnaires are administered is left up to the provider, they should at least administer the Core Q questionnaire once a year. Only surveys returned within two months of the resident initially receiving the survey are included in the calculation.

The numerator includes all of the AL residents that had an average response =>3 on the CoreQ: AL Resident Satisfaction Questionnaire that do not meet any of the exclusions (see exclusions)

The calculation of an individual patient's average satisfaction score is done in the following manner:

- Respondents within the appropriate time window and who do not meet the exclusions (See: S.8) are identified.
- A numeric score is associated with each response scale option on the CoreQ: AL Resident Satisfaction Questionnaire (that is, Poor=1, Average=2, Good=3, Very Good=4, and Excellent=5).

- The following formula is utilized to calculate the individual's average satisfaction score. [Numeric Score Question 1 + Numeric Score Question 2 + Numeric Score Question 3 + Numeric Score Question 4]/4
- The number of respondents whose average satisfaction score >=3 are summed together and function as the numerator.

For residents with one missing data point (from the 4 items included in the questionnaire) imputation is used (representing the average value from the other three available questions). Residents with more than one missing data point, are not counted in the measure (i.e., no imputation is used for these residents since their responses are excluded).

DENOMINATOR STATEMENT

The denominator includes all of the residents that have been in the AL facility for two weeks or more regardless of payer status; who received the CoreQ: AL Resident Satisfaction Questionnaire (e.g. people meeting exclusions do not receive the questionnaire), who responded to the questionnaire within the two month time window, who did not have the questionnaire completed by somebody other than the resident, and who did not have more than one item missing.

DENOMINATOR DETAILS

The target population includes all current individuals in the facility on a given day who have been in the AL facility for two weeks or more and respond to the CoreQ: AL Resident Satisfaction Questionnaire and completed the survey within the two month time window. Residents have up to 2 months to complete and return the survey. The length-of-stay is identified from AL facility records.

EXCLUSIONS

Exclusions made at the time of sample selection are the following: (1) Residents who have poor cognition (described below in S.9); (2) residents receiving hospice; (3) residents with a legal court appointed guardian; and (4) residents who have lived in the AL facility for less than two weeks. Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) b) surveys that have more than one questionnaire item missing c) surveys from residents who indicate that someone else answered the questions for the resident. (Note this does not include cases where the resident solely had help such as reading the questions or writing down their responses.)

EXCLUSION DETAILS

Individuals are excluded based on information from facility records.

(1) Residents who have poor cognition: The the Brief Interview for Mental Status (BIMS), a well validated dementia assessment tool is used. BIMS ranges are 0-7 (lowest); 8-12; and 13-15 (highest). Residents with BIMS scores of equal or less than 7 are excluded. Or MMSE score of 12 or lower {Note: we understand that some AL communities may not have information on cognitive function. We will suggest administering the survey to all AL residents and assume that those with cognitive impairment will not complete the survey or have someone else complete on their behalf with in either case will exclude them from the analysis. The main impact of including all residents with any level of cognitive impairment is a drop in the response rate,

which for smaller communities can result in their not having a reportable measure (see response rate exclusion discussed later) (Saliba, et al., 2012).

(2) Residents receiving or having received any hospice. This is recorded in facility health information systems. This exclusion is consistent with other CMS CAHPS surveys.

(3) Residents with court appointed legal guardian for all decisions will be identified from facility health information systems.

(4) Residents who have lived in the AL facility for less than two weeks will be identified from facility health information systems.

(5) Residents that respond after the 2 month response period (see S.14 on how this is determined).

(6) Residents whose responses were completed by someone other than the resident will be excluded. Identified from an additional question on the CoreQ: AL Resident Satisfaction questionnaire. We have developed a CoreQ: Family Satisfaction for families to respond to.

(7) Residents without usable data (defined as missing data for 2 or more questions on the survey).

Saliba D, Buchanan J, Edelen MO, Streim J, Ouslander J, Berlowitz D, Chodosh J.

J Am Med Dir Assoc. 2012 Sep;13(7):611-7. doi: 10.1016/j.jamda.2012.06.004. Epub 2012 Jul 15.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

No stratification is used.

TYPE SCORE

Score is a percent and is not weighted.

ALGORITHM

1. Identify the residents that have been residing in the AL facility for two weeks or more.

2. Take the residents that have been residing in the AL facility for >=two weeks and exclude the following:

a. Residents who have poor cognition.

b. Patients receiving or having received any hospice. This is recorded in facility health information systems.

c. Residents with Court appointed legal guardian for all decisions will be identified from facility health information systems.

3. Administer the CoreQ: AL Resident Satisfaction questionnaire to these individuals. The questionnaire should be administered to all residents in the facility after exclusions in step 2 above. Communicate to residents that we will include surveys received up to two months from administration. Providers should use follow-up to increase response rates.

4. Create a tracking sheet with the following columns:

a. Data Administered

b. Data Response Received

c. Time to Receive Response ([Date Response Received – Date Administered])

5. Exclude any surveys received after 2 months from administration.

6. Exclude responses not completed by the intended recipient (e.g. questions were answered by a friend or family members (Note: this does not include cases where the resident solely had help such as reading the questions or writing down their responses).

7. Exclude responses that are missing data for 1 or more of the CoreQ questions.

8. All of the remaining surveys are totaled and become the denominator.

9. Combine the CoreQ: AL Resident Satisfaction questionnaire items to calculate a resident level score. Responses for each item should be given the following scores:

a. Poor = 1,

b. Average = 2,

c. Good = 3,

d. Very Good =4 and

e. Excellent = 5.

10. Impute missing data if only one of the three questions are missing data.

11. Calculate resident score from usable surveys.

a. Patient score= (Score for Item 1 + Score for Item 2 + Score for Item 3 + Score for Item 4) / 4.

i. For example, a resident rates their satisfaction on the four Core Q questions as excellent = 5, very good = 4, very good = 4, and good = 3. The resident's total score will be 5 + 4 + 4 + 3 for a total of 16. The resident total score (16) will then be divided by the number of questions (4), which equals 4.0. Thus the residents average satisfaction rating is 4.0. Since the resident's score is >3.0, this resident will be counted in the numerator.

b. Flag those patients with a score equal to or greater than 3.0. These residents will be included in the numerator.

12. Calculate the CoreQ: AL Resident Satisfaction Measure which represents the percent of residents with average scores of 3.0 or above. CoreQ: AL Resident Satisfaction Measure= ([number of respondents with an average score of =3.0] / [total number of respondents])*100.

13. No risk-adjustment is used.

Saliba, D., Buchanan, J., Edelen, M.O., Streim, J., Ouslander, J., Berlowitz, D, & Chodosh J. (2012). MDS 3.0: brief interview for mental status. Journal of the American Medical Directors Association, 13(7): 611-617.

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3422 CoreQ: AL Family Satisfaction Measure: Specifications

STEWARD

American Health Care Association/National Center for Assisted Living

DESCRIPTION

The measure calculates the percentage of family or designated responsible party for assisted living (AL) residents. This consumer reported outcome measure is based on the CoreQ: AL Family Satisfaction questionnaire that has three items.

TYPE

Outcome: PRO-PM

DATA SOURCE

Instrument-Based Data

LEVEL

Facility

SETTING

Assisted Living

NUMERATOR STATEMENT

The numerator assesses the number of family or designated responsible party for AL residents that are satisfied. Specifically, the numerator is the sum of the family or designated responsible party for AL residents that have an average satisfaction score of =>3 for the three questions on the CoreQ: AL Family Satisfaction questionnaire.

NUMERATOR DETAILS

While the frequency in which the questionnaires are administered is left up to the provider, they should at least be administered once a year. Once the questionnaire is administered to the family member or designated responsible party for AL residents, they have up to 2 months to return the questionnaire. Only surveys returned within two months of the resident initially receiving the survey are included in the calculation.

The numerator includes all the family or designated responsible party members for AL residents that had an average response =>3 on the CoreQ: AL Family Satisfaction questionnaire.

We calculate the average satisfaction score for the individual family or designated responsible party member for AL residents in the following manner:

- Respondents within the appropriate time window and who do not meet the exclusions are identified.

- A numeric score is associated with each response scale option on the CoreQ: AL Family Satisfaction questionnaire (that is, Poor=1, Average=2, Good=3, Very Good=4, and Excellent=5).

- The following formula is utilized to calculate the individual's average satisfaction score: [Numeric Score Question 1 + Numeric Score Question 2 + Numeric Score Question 3]/3

- The number of respondents whose average satisfaction score >=3 are summed together and function as the numerator.

For respondents with one missing data point (from the 3 items included in the questionnaire) imputation will be used (representing the average value from the other two available questions). For respondents with more than one missing data point, they will be excluded from the analyses (i.e., no imputation will be used for these family members). Imputation details are described further below.

No risk-adjustment is used.

DENOMINATOR STATEMENT

The target population is family or designated responsible party members of a resident residing in the facility for at least two weeks. The denominator includes all of the individuals in the target population who respond to the CoreQ: AL Family Satisfaction questionnaire within the two month time window who do not meet the exclusion criteria.

DENOMINATOR DETAILS

The denominator includes all of the family or the designated responsible party members for residents that have been in the facility for at least two weeks or more regardless of payer status; who received the CoreQ: AL Family Satisfaction questionnaire (e.g. people meeting exclusions do not receive the questionnaire), and who responded to the questionnaire within the two month time window.

The length-of-stay (of the resident of the family member or designated responsible party) will be identified from facility records.

EXCLUSIONS

Exclusions made at the time of sample selection are the following: (1) Court-appointed guardian; (2) family of residents receiving hospice; (3) Family members who reside in another country and (4) family of residents who have lived in the AL facility for less than two weeks.

Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) and b) surveys that have more than one questionnaire item missing.

EXCLUSION DETAILS

Please note, the resident representative for each current resident is initially eligible regardless of their being a family member or not. Only one primary contact per resident should be selected.

Exclusions made at the time of sample selection include: (1) family or designated responsible party for residents with hospice; (2) family or designated responsible party for residents with a legal court appointed guardian; (3) representatives of residents who have lived in the facility for less than two weeks; and (4) all representatives reside in another country.

Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (more than two months after the administration date) and b) surveys that have more than one questionnaire item missing.

No stratification is used.

Exclusions will be based on information from the facility health information system. Representatives of residents with the following criteria will be excluded:

(1) Residents on hospice. This is recorded in the facility health information system.

(2) Residents with court appointed legal guardian for all decisions will be identified from the facility health information system.

(3) Residents who have lived in the facility for less than two weeks days will be identified. This is recorded in the facility health information system.

(4) Respondents who reside in another country, to be identified from nursing facility health information system.

(5) Respondents who have two or more missing data point are excluded from the analysis.

(6) Respondents that respond after the two month response period will be excluded.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

No stratification is used.

TYPE SCORE

Score is a percent and is not weighted.

ALGORITHM

1. Identify the representatives of residents that have been residing in the facility for two weeks or more.

2. Take the representatives of residents that have been residing in the facility for >=two weeks and exclude the following:

a. Representatives of residents on hospice. This is recorded in the facility health information system.

b. Residents with Court appointed legal guardian for all decisions as identified from the facility health information system.

3. Exclude representatives of residents who reside in another country.

4. Administer the CoreQ: AL Family Satisfaction questionnaire to the representatives that do not meet these exclusion criteria. Provide the family or designated responsible party member for the resident two months to respond to the survey.

a. Create a tracking sheet with the following columns:

i. Date Administered

ii. Date Response Received

iii. Time to Receive Response: ([Date Response Received – Date Administered])

b. Exclude any surveys where Time to Receive Response >60 days (2 months)

5. Combine the CoreQ: AL Family Satisfaction questionnaire items to calculate a resident' representative satisfaction score. Responses for each item should be given the following scores:

a. Poor = 1,

b. Average = 2,

c. Good = 3,

d. Very good =4 and

e. Excellent = 5.

6. Impute missing data if only one of the three questions are missing data. Drop all survey response if 2 or more survey questions have missing data.

7. Calculate resident's representative score from usable surveys.

a. Representative average score = (Score for Item 1 + Score for Item 2 + Score for Item 3) / 3.

b. Flag those representatives with a score equal to or greater than 3.0

i. For example, a representative of a resident rates their satisfaction on the three CoreQ questions as excellent = 5, very good = 4, and good = 3. The family member's total score will be 5 + 4 + 3 for a total of 12. The representative of the AL resident total score (12) will then be divided by the number of questions (3), which equals 4.0. Thus, the representative's average satisfaction rating is 4.0. Since this person’s average response is >3.0 they would be counted in the numerator. If it was <3.0 they would not be counted.

8. Calculate the facility’s CoreQ: AL Family Satisfaction Measure which represents the percent of respondents with average scores of 3.0 or above.

a. CoreQ: AL Family Satisfaction Measure = ([number of respondents with an average score of =3.0] / [total number of valid responses])*100

9. No risk-adjustment is used.

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