NATIONAL QUALITY FORUM

Memo

March 8, 2018

To: NQF Members and Public

From: NQF Staff

Re: Commenting Draft Report: *Patient Experience and Function Fall 2017*

Background

This report reflects the review of measures in the Patient Experience and Function (PEF) project. Measures included in this portfolio assess patient function and experience of care as they relate to health-related quality of life and the many factors that affect these principles, including communication, care coordination, transitions of care, and use of health information technology. The 25-person PEF Standing Committee reviewed five measures; one was recommended for endorsement, and four were not recommended for endorsement.

Recommended:

- 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons)

Not Recommended:

- 3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS)
- 3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS)
- 3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS)
- 3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS)

The Committee requests comments on all measures.

NQF Member and Public Commenting

NQF Members and the public are encouraged to provide comments via the online commenting tool on the draft report as a whole, or on the specific measures evaluated by the PEF Standing Committee.

Please note that commenting concludes on April 6, 2018 at 6:00 pm ET—no exceptions.

Patient Experience and Function Fall 2017

DRAFT REPORT FOR COMMENT

March 8, 2018

NATIONAL QUALITY FORUM

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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 empower individuals to participate actively in their care. Our 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 aligns 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 the many factors that impact these principles, including communication, care coordination, transitions of care, and use of health information technology.

NQF has long recognized the importance of care coordination. It launched its first care coordination project in 2006 and has guided efforts to advance care coordination through performance measurement over a decade of subsequent work.

NQF's definition of care coordination draws from earlier definitions put forth by Agency for Healthcare Research and Quality (AHRQ) and NQF:

> *Care coordination is the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time.*

The NQF definition of person- and family-centered care is:

> *An approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care.*

It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values.

For the Fall 2017 cycle of work, the Patient Experience and Function (PEF) Standing Committee (see Appendix C), which oversees NQF's portfolio of PEF measures, evaluated four newly submitted measures and one measure undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended the measure submitted for maintenance review for endorsement and did not recommend the four newly submitted measures for endorsement. The measure recommended for endorsement is:

- 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0

The measures not recommended for endorsement are:

- 3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update
- 3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update
- 3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner
- 3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge

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

Introduction

High quality person- and family-centered care defines success by not just the resolution of clinical symptoms, but also by whether patients achieve their desired outcomes. Effective care must adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds. [1]

Poorly coordinated care may lead to negative, unintended consequences, including medication errors and preventable hospital admissions.[2] 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.[3] One in five Medicare beneficiaries discharged from the hospital is readmitted within 30 days, with half of the patients having not yet seen an outpatient doctor for follow-up, and most of these readmissions occur through the emergency department (ED).[4] The coordination of care is essential to reduce preventable hospitalizations, improve patient outcomes, and lower costs in today's healthcare system.

A variety of tools and approaches, when leveraged, can improve patient engagement and care coordination. For instance, 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. Additionally, electronic health records (EHRs) and interoperable health information can reduce 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.[5] Innovative care models such 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.[6]

Building the Evidence Base

A goal of NQF is to promote the development of novel measures that apply to areas in need of measurement. Often, these innovative new measures experience challenges in meeting the NQF evaluation criteria. In the past this has been especially true for measures derived from surveys, instruments, and other tools. The new and expanded NQF PEF portfolio introduces additional complexities in assessing measures that relate to care planning. From an information technology perspective, care plans are structured arrangements of standardized data elements. However, use of standardized data elements is not yet widespread, and this has been a serious barrier to systematic measurement of care coordination activities. In a 2014 report, the NQF Care Coordination Standing Committee identified building the evidence base of effective care coordination practices and more rapid standardization of care plan data as priorities to support the development of performance measurement. During the Fall 2017 review cycle, the PEF Standing Committee was especially interested in further exploring how to support new measurement of patient-reported outcomes (PRO), care assessment, and planning.

NQF Portfolio of Performance Measures for Patient Experience and Function Conditions

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 3 process measures and 53 outcome measures, of which 18 are PRO performance measures (see table below).

Table 1. NQF Patient Experience Portfolio of Measures

	Process	Outcome/Patient Reported Outcome
Functional Status Change and Assessment	2	28
Communication	1	6
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 January 31, 2018, the PEF Standing Committee evaluated four new measures and one measure undergoing maintenance review against NQF's standard evaluation criteria. Table 2 summarizes the Committee's recommendations.

Table 2. Patient Experience and Function Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	1	4	5
Measures recommended for endorsement	1	0	1
Measures not recommended for endorsement	0	4	4

	Maintenance	New	Total
Reasons for not recommending		Scientific Acceptability – 3[a] Overall – X Competing Measure – X	4

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through its 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, 2017 and will close on April 6, 2018. As of January 18, 2018, three comments were submitted and shared with the Committee prior to the measure evaluation meeting (Appendix E).

Overarching Project Themes and Discussion

The PEF Standing Committee discussed the limits of NQF endorsement criteria when addressing measures in emerging fields of quality measurement. Often these emerging fields have too little evidence to meet NQF's criteria. The Committee discussed this topic during deliberations for a set of long-term services and supports (LTSS) measures, a high-priority yet nascent field of quality measurement. The Committee agreed that there is a strong need for quality measures that address poor care coordination performance in LTSS, however, the four LTSS measures under review rely on standardized data elements that have been adopted by only a handful of state Medicaid agencies. NQF endorsement of these measures could support performance improvement and standardized data element adoption efforts; however, without such adoption, the measures' reliability struggles to meet the NQF criteria for endorsement. The Committee acknowledged the "chicken and egg" nature of NQF endorsement in nascent areas of healthcare measurement such as LTSS, and discussed the need for a mechanism through which Standing Committees can make recommendations for promising measures that address important quality gaps, but that do not yet meet the rigor of NQF's endorsement criteria. NQF is committed to cultivating measures that address a high need area but do not yet meet the rigor of criteria for full endorsement.

Feedback Loop

NQF standing committee members often provide feedback to measure developers to refine new and maintenance measure submissions during measure evaluation discussions; in addition, committees are sometimes invited to provide feedback on prospective or upcoming measure submissions that are not ready for formal evaluation. Similarly, NQF often looks for opportunities during measure evaluation meetings to provide committees with additional information to support the committees during current or future measure evaluation discussions. NQF invited Dr. Glyn Elwyn, Professor, Dartmouth Institute for Health Policy and Clinical Practice, to present an overview of his work on patient-report shared decision

[a] The Committee voted to stop the evaluation of measure 3326 citing similarities to failed measures 3324 and 3325.

making and a newly developed tool named CollaboRATE to the PEF Standing Committee. A performance measure based on CollaboRATE scores is being submitted for NQF evaluation in the Spring 2018 cycle. Dr. Elwyn's research and innovative tool development in the area of patient-report and shared decision making was unfamiliar to many Committee members. The Committee was enthusiastic about the tool and its potential use in measurement, and recommended the incorporation of patient identified benchmarks to be included in the performance measure. Pending review by the NQF Scientific Methods Panel, the Committee will review the measure during the Spring 2018 measure review cycle.

The NQF endorsement process relies on feedback from measure users to support the continued improvement of measures. In addition, NQF has taken steps to collect and incorporate feedback from users of NQF measures into the evaluation process. NQF's ongoing feedback initiative currently invites users of measures to submit feedback through the QPS system for committees to consider in their maintenance evaluations. NQF hopes that by engaging measure users through additional channels such as standing committee meetings, incorporating user feedback will become a more robust and consistent part of measure evaluation. As a part of this initiative, NQF invited Encompass Health, a user of two sets of competing NQF endorsed measures within the PEF portfolio, to present to the PEF Standing Committee during its measure evaluation meeting. Encompass presented on their experience implementing and reporting on both measures simultaneously to inform the PEF Standing Committee's future evaluation. The presentation was the first time NQF has invited users to present feedback on the implementation of measures.

Competing Functional Status Measures

During the 2015 Person and Family Centered Care (PFCC) measure evaluation cycle, two sets of competing instrument-based functional status measures were evaluated, prompting a best-in-class deliberation. At that time, the PFCC Standing Committee was unable to determine which of the measures was best-in-class and ultimately the NQF Board of Directors ("Board") provided guidance to recommend both measures for conditional endorsement. The NQF Board's conditions for endorsement included a set of required information to be delivered to the Standing Committee in support of making best-in-class determinations during the Fall 2018 measure evaluation cycle. As a follow up, NQF solicited updates from the measure stewards, CMS and Uniform Data Set for Medical Rehabilitation (UDSMR), on the status of the Board's information request to be presented during the Fall 2017 measure evaluation meeting. Prior to the Committee meeting, NQF provided a memo detailing the history and context of the competing measures, which are based on the Section GG item set (formerly the CARE item set) (CMS) and items from the FIM instrument (UDSMR). The Section GG: Functional Abilities and Goals is a cross care setting item set introduced by CMS in response to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, legislation requiring standardized, interoperable patient assessment data across all post-acute care (PAC) settings including long term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and home health (HH). The FIM instrument and its associated performance measures had been used primarily in IRF settings, as well as other PAC settings, for many years prior to the IMPACT Act. UDSMR presented an overview of the FIM instrument and associated performance measures, the updated measure testing for reliability and validity, and an update on the current use of the FIM instrument, including its accessibility and utility. UDSMR did not provide information about costs associated with the use of the FIM instrument,

respective software/tools, and costs of ongoing training, as requested by the NQF Board. CMS provided a memo that addressed some of the requested information, including a summary of qualitative rule-making data on perceived benefits from the field the Section GG item set and associated performance measures. CMS will provide NQF with updated measure testing for reliability and validity prior to the Fall 2018 Cycle submission. The presentations provided a preview of the missing information that the Committee felt was necessary to render a best-in-class decision.

The Committee questioned if it is possible to choose a best-in-class measure, suggesting the decision may be beyond NQF's endorsement of performance measures, considering the nature of IMPACT Act's mandate to ensure standardized and interoperable patient data elements across all PAC settings. The Committee suggested that rather than picking one set of instrument-based measures, there may be a way to solve the best-in-class question by harmonizing the measures or combining the Section GG and FIM instrument items into a single measure. The Committee questioned the costs associated with collecting both item sets and requested data from the developers on the cost and burden of implementing each measure, as well as some additional performance data. The Committee will make final determinations about the measures when they are submitted for maintenance of endorsement evaluation in the Fall 2018 cycle.

Summary of Measure Evaluation

The following brief summaries of measure evaluations highlight major issues that were considered by the PEF Standing Committee. Details of the Committee's discussion and ratings of the criteria for each measure are in included in Appendix A.

Surgical Experience of Care

1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons): Recommended

Description: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey. **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Clinician : Group/Practice; **Setting of Care**: Inpatient/Hospital, Other, Outpatient Services; **Data Source**: Instrument-Based Data

This outcome maintenance measure evaluates the consumer assessment of surgical healthcare providers and systems (CAHPS) based on a survey. This measure is comprised of six composite components and one single-item measure. The Committee questioned whether the measure focuses on the event of an interaction between a patient and surgeon or on the quality of such an event. The Committee stated that the quality of the provider and patient interaction from the perspective of the patient is highly important, and that patient experience should be combined with patient reported outcomes. The developer noted that there is a parallel effort within the American College of Surgeons to expand patient-reported outcome measures, and elaborated that the S-CAHPS assesses one aspect of the surgical episode of care and that the developer plans to develop additional patient-reported

outcome performance measures. The Committee highlighted two areas of consideration for this measure, including the use of topbox scoring and risk adjustment or sensitivity to disparities. The Committee's concern about using topbox scoring to calculate the measure score, noted that focusing only on high scores fails to identify possible low performing outliers. The developer responded that users of the measure have the option to calculate a variety of other statistics, including the mean, median, and low-box scores, using the measure data. Additionally, the developer noted that topbox scores have proven responsiveness to low performance and are effective at driving change through quality improvement initiatives on each individual measure. The Committee also noted that the measure uses the standard CAHPS case mix adjustment, but does not include any additional risk adjustment models. Several Committee members suggested enhancing the measure further to address social determinants of health. The Committee also questioned the use of the Hospital CAHPS in the hospital setting rather than the S-CAHPS when both are applicable. The developer noted that while there is some overlap, they are different assessments, and in cases where there has been both a hospital stay and surgery, both should be encouraged. In conclusion, the Committee agreed this measure met the NQF evaluation criteria and unanimously recommended this maintenance measure for continued endorsement.

Long Term Services and Supports Measures

3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (Center for Medicare and Medicaid Services [CMS]): Not Recommended

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core and supplemental elements. This measure has two rates: Rate 1: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements within 90 days of enrollment or at least annually. Rate 2: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements AND at least twelve (12) supplemental elements within 90 days of enrollment or at least annually. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Home Care, Other; **Data Source**: Management Data, Other, Paper Medical Records

This new process measure assesses the percent of managed long term services and supports (MLTSS) enrollees who have documentation of a comprehensive assessment using a set of core and supplemental data elements, within a specified timeframe. Committee members expressed surprise at the low number of assessments completed, agreeing that comprehensive assessments are a vitally important tool and a foundation of developing a care plan and providing care. The Committee agreed this measure covers an important gap area of quality measurement and could help to move the field forward by standardizing the elements included in comprehensive assessments. However, the Committee expressed concern in regards to low reliability results for both data element and score level testing. The Committee suggested that low reliability of data elements coupled with low performance rates overall may indicate that the measure may not adequately distinguish between good and poor performance in accountability programs. The developer responded that several state Medicaid agencies have adopted LTSS standardized data elements to support reporting and to improve data element reliability, but that there remains great variation in performance and lack of standard data elements

across the nation. The developer also attributed low reliability scores to the lack of standardization in documentation, lack of documentation of negative responses or non-responses during an assessment, and a large performance gap. The developer also noted that the measure was revised after testing to remove or modify data elements that were among the lowest scores. Due to resource limitations, the measure was not retested following these modifications. The measure is currently under consideration for inclusion in Healthcare Effectiveness Data and Information Set (HEDIS) and, if included, the developer will monitor reliability through HEDIS auditing. Overall, the Committee agreed the measure did not pass reliability, a must-pass criterion for NQF endorsement. However, the Committee strongly supported further analysis and development of the measure and encouraged the developer to resubmit a simpler version of the measure with additional testing information.

3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS): Not Recommended

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive care plan in a specified timeframe that includes documentation of core domains. The measure has two rates: Rate 1: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements documented within 120 days of enrollment or at least annually. Rate 2: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements and at least four (4) supplemental elements documented within 120 days of enrollment or at least annually. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Home Care, Other; **Data Source**: Management Data, Other, Paper Medical Records

This new process measure assesses the percent of LTSS enrollees who have documentation of a comprehensive care plan in a specified timeframe that includes documentation of core domains and supplemental domains. The Committee noted that the formal evidence base for care coordination is still immature, thus making it difficult, if not impossible, for the developer to provide a robust evidence base. However, the literature demonstrates enough of a connection between process and downstream outcomes (particularly the link between documenting preferences and outcomes), that the measure passed the evidence criterion. In addition, the Committee agreed there is a large opportunity for improvement in care based on the performance data analysis. The Committee noted that the reliability was variable, with some rates highly reliable and others less reliable; reliability issues were specific to key data elements, but overall the reliability for the performance score was moderate. The measure relies on face validity, rather than empirical validity testing. The Committee noted that the majority of the measure developer's TEP supported the measure but not an overwhelming number (54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care). Committee members suggested that validity could be improved with more precisely defined and/or standardized data elements. The developer explained that it thought the validity was low because so many entities were reporting performance rates of zero (no enrollees with documented care plans including the core domains). The measure did not pass validity, a must-pass criterion, and was therefore not recommended for endorsement. Committee members, however, strongly encouraged the developer to conduct some additional testing and bring the measure back in

the future for re-review, and/or resubmit the measure with a smaller number of elements that had higher reliability and validity.

3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS): Not Recommended

Description: This measure assesses the percentage of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees with a care plan for whom all or part of the care plan was transmitted to the primary care practitioner (PCP) within 30 days of the care plan's development or update. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Home Care, Other; **Data Source**: Management Data, Other, Paper Medical Records

This new process measure assesses the percent of LTSS enrollees who had a care plan or care plan update transmitted to their primary care provider within 30 days. The Committee noted concerns on the evidence base for this measure similar to concerns on measures 3319 and 3324, but agreed that despite the lack of systematic review or graded evidence, there is existing evidence linking improved communication to better outcomes. In addition, based on the low performance rates, the Committee agreed there is significant opportunity for improvement in care. The Committee expressed concerns with the variability of the reliability score, noting low agreement on the data element scores. The Committee suggested that the reliability issues might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan as well as the timing of transmission. Additionally, because these measures are considered in early development in terms of data standardization and data collection, the Committee expressed concerns about excess burden for the provider. Overall, the Standing Committee agreed the measure did not pass the reliability criterion, a must-pass criterion, and did not recommend the measure for endorsement.

3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS): Not Recommended

Description: The measure has two rates: Rate 1: (LTSS Re-Assessment after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees resulting in a LTSS re-assessment within 30 days of discharge. Rate 2: (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Home Care, Other; **Data Source**: Claims, Management Data, Other, Paper Medical Records

This measure is related to the other LTSS measures, 3319, 3324, and 3325. Based on similar reliability and validity concerns, the Committee elected not to continue the evaluation of this measure after a short discussion and vote to continue the evaluation of this measure; seven committee members voted to continue evaluation and ten voted not to continue evaluation. Additionally, Committee members noted that the evidence is still in a nascent stage for this work, but also believed that there is a large enough performance gap to necessitate continued work on these type of care coordination measures. Committee members reiterated the need for measures in this topic area, but agreed the four submitted

measures in the LTSS set are not ready for NQF endorsement. Since the Committee did not evaluate this measure against NQF's criteria, they did not vote on the recommendation for endorsement.

References

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Measures Recommended

1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons, Division of Advocacy and Health Policy): Recommended

Submission | Specifications

Description: The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey. Each measure is used to assess a particular domain of surgical care quality from the patient's perspective.

Measure 1: Information to help you prepare for surgery (2 items)

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Measure 4: Information to help you recover from surgery (4 items)

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Measure 7: Rating of surgeon (1 item)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.

The S-CAHPS expands on the CAHPS Clinician & Group Survey (CG-CAHPS), which focuses on primary and specialty medical care, by incorporating domains that are relevant to surgical care, such as sufficient communication to obtain informed consent, anesthesia care, and post-operative follow-up and care coordination. Other questions ask patients to report on their experiences with office staff during visits and to rate the surgeon.

The S-CAHPS survey is sponsored by the American College of Surgeons (ACS). The survey was approved as a CAHPS product in early 2010 and the Agency for Healthcare Research and Quality (AHRQ) released version 1.0 of the survey in the spring of 2010. The S-CAHPS survey Version 2.0 was subsequently endorsed by NQF in June 2012 (NQF #1741). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html. Surgeons may customize the S-CAHPS survey by adding survey items that are specific to their patients and practice. However, the core survey must be used in its entirety in order to be comparable with other S-CAHPS data. The S-CAHPS survey is available in English and Spanish.

The 6 composite measures are made up of the following items:

The 1 single item measure (Measure 7) is (Q35): Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate all your care from this surgeon?

Measure 1: Information to help you prepare for surgery (2 items)

Q3. Before your surgery, did anyone in this surgeon's office give you all the information you needed about your surgery?

Q4. Before your surgery, did anyone in this surgeon's office give you easy to understand instructions about getting ready for your surgery?

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Q9. During your office visits before your surgery, did this surgeon listen carefully to you?

Q10. During your office visits before your surgery, did this surgeon spend enough time with you?

Q11. During your office visits before your surgery, did this surgeon encourage you to ask questions?

Q12. During your office visits before your surgery, did this surgeon show respect for what you had to say?

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Q15. After you arrived at the hospital or surgical facility, did this surgeon visit you before your surgery?

Q17. Before you left the hospital or surgical facility, did this surgeon discuss the outcome of your surgery with you?

Measure 4: Information to help you recover from surgery (4 items)

Q26. Did anyone in this surgeon's office explain what to expect during your recovery period?

Q27. Did anyone in this surgeon's office warn you about any signs or symptoms that would need immediate medical attention during your recovery period?

Q28. Did anyone in this surgeon's office give you easy to understand instructions about what to do during your recovery period?

Q29. Did this surgeon make sure you were physically comfortable or had enough pain relief after you left the hospital or surgical facility where you had your surgery?

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Q31. After your surgery, did this surgeon listen carefully to you?

Q32. After your surgery, did this surgeon spend enough time with you?

Q33. After your surgery, did this surgeon encourage you to ask questions?

Q34. After your surgery, did this surgeon show respect for what you had to say?

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Q36. During these visits, were clerks and receptionists at this surgeon's office as helpful as you thought they should be?

Q37. During these visits, did clerks and receptionists at this surgeon's office treat you with courtesy and respect?

Numerator Statement: We recommend that S-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

The top box numerator for the Overall Rating of Surgeon is the number of respondents who answered 9 or 10 for the item, with 10 indicating "Best provider possible".

For more information on the calculation of reporting measures, see What´s Available for the CAHPS Surgical Care Survey: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/surgical/about/whats-available-surgical-care-survey.pdf

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html

Also, for more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf.

Denominator Statement: The measure's denominator is the number of survey respondents. The target population for the survey is adult patients (age 18 and over) who had a major surgery as defined by Common Procedural Terminology (CPT) codes (90 day globals) within 3 to 6 months prior to the start of the survey.

Results will typically be compiled over a 12-month period.

For more information on the calculation of reporting measures, see Patient Experience Measures from the CAHPS Surgical Care Survey, available at https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html.

Exclusions: The following are excluded when constructing the sampling frame:

- Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey.

- Surgical patients younger than 18 years old.

- Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased.

Adjustment/Stratification: If survey users want to combine data for reporting from different sampling strata, they will need to create a text file that identifies the strata and indicates which ones are being combined and the identifier of the entity obtained by combining them.

See pages 18-19 of the Instructions for Analyzing Data available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf.

Level of Analysis: Clinician : Group/Practice

Setting of Care: Inpatient/Hospital, Other, Outpatient Services

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: American College of Surgeons, Division of Advocacy and Health Policy

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STANDING COMMITTEE MEETING [01/31/2018]

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

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

1a. Evidence: **Y-17**; **N-1**; 1b. Performance Gap: **H-3**; **M-13**; **L-2**; **I-0;**

Rationale:

- The Committee supported the measure's inclusion of both pre-operative and post-operative responses in the survey instrument, noting that capturing the full episode is critical.
- The Committee inquired about feedback and criticisms that the developer has received from clinicians regarding use of the measure. The developer noted that clinicians have been key

supporters of the measure. The developer also discussed use of the broader H-CAHPS survey, which is often used instead of S-CAHPS; however, many surgeons prefer the use of the surgery-specific survey. The developer noted that providers were generally supportive of the measure and appreciated the feedback it provides. Committee members echoed the preference for S-CAHPS from a patient perspective, noting experiences when they wished to provide feedback to a specific surgeon, but were instead administered the more general H-CAHPS survey.

- The Committee noted the measure's lack of risk adjustment and disparities data and agreed that the measure presents an opportunity to further examine racial and other types of disparities in experience of care. The developer explained that collecting and using disparities data is a priority and noted that they have recently received a grant from the Agency for Healthcare Research and Quality (AHRQ) to explore further integration of disparities data collection and analysis.
- The developer also discussed a recent move to aggregated patient-reported outcome data in an effort to further examine disparities more meaningfully.
- The Committee noted that the S-CAHPS assesses a process of communication rather than the quality of communication. The developer agreed that quality of the communication is important and explained they are developing a series of measures that focus on an entire episode of care including key elements specific to surgical phases. NCQA is developing sets of measures that link key process of surgical care to surgical outcomes and patient experience. These new measure sets will capture whether the surgical goals were acknowledge and understood by the patient before surgery and whether they were attained. The developer emphasized the importance of capturing the full episode of care and all of those associated with that care (physicians, nurses, patients, pre- and post-op teams, etc.) in order to capture the patient's full experience. The Committee supported this initiative and suggested that any future measures should consider whether the patient had accurate expectations of possible temporary side effects following surgery.

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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-4**; **M-14**; **L-0**; **I-0** 2b. Validity: **H-3**; **M-15**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee discussed the measure's use of top-box scoring and questioned the method's ability to reflect the presence of poor performance. For instance, the measure could report that 90% of surgeons receive a 9 or 10, but would fail to reflect that the other 10% received an average score of one. The developer stated that users of the measure can calculate means or other statistics for quality improvement initiatives.
- The Committee noted the lack of both social and clinical risk adjustment and/or stratification. The measure does include the standard CAHPS case mix adjustment, but the Committee agreed that there is an opportunity to push the measure further in accounting for social determinants of health.
- The Committee asked for clarification around exclusions of patients who are not able to communicate, such as those arriving for emergency surgery. The denominator excludes emergency surgery patients, as they will not have undergone the processes of care leading up to surgery, which are an important part of this measure.

3. Feasibility: H-6; M-10; 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:

- Committee members raised potential feasibility problems; one member noted that the low response rate of the S-CAHPS and H-CAHPS could raise issues regarding the measure's representativeness of the population of patients seen at sites or by providers; another member noted that the data for the measure are derived from patient responses to a 47-question survey and recommended using an electronic option to reduce survey burden for patients with access to a computer and increase data accuracy and response rates.
- A Committee member stated general concern over the feasibility of all Patient-Report Outcome Measures (PROMs), but noted that the use of multiple modalities for data collection and lower burden electronic options for collection will continue to minimize the issue. Ultimately, the Committee agreed the measure met the feasibility criteria.

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**: Pass-17; No Pass-0** 4b. Usability: **H-12; M-5; L-1; I-0**

Rationale:

- The Committee asked whether the developer had considered any real-time data collection in order to allow providers to immediately intervene if a patient reports confusion or sub-par communication. The developer responded that hospitals are working to implement real-time feedback loops for their own quality improvement efforts, but that the process is not currently involved in quality measurement.

5. Related and Competing Measures

Related:

- 0005 : CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child
- 0006: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)
- 0166: HCAHPS
- 0258: CAHPS In-Center Hemodialysis Survey
- 0517: CAHPS Home Health Care Survey (experience with care)
- 2651: CAHPS Hospice Survey (experience with care)
- 2548: Child Hospital CAHPS (HCAHPS)
- 2967: CAHPS Home- and Community-Based Services Measures

Standing Committee Recommendation for Endorsement: **Y-18**; **N-0**

6. Public and Member Comment

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

8. Appeals

Measures Not Recommended

3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core and supplemental elements. This measure has two rates:

Rate 1: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements within 90 days of enrollment or at least annually.

Rate 2: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements AND at least twelve (12) supplemental elements within 90 days of enrollment or at least annually.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1: MLTSS plan enrollees who had either of the following:

• A comprehensive LTSS assessment completed within 90 days of enrollment for new enrollees, with nine (9) core elements documented, or

• A comprehensive LTSS assessment completed at least once during the measurement year for all other enrollees (established enrollees), with nine (9) core elements documented.

Rate 2: MLTSS plan enrollees who had either of the following:

• A comprehensive LTSS assessment completed within 90 days of enrollment for new enrollees, with nine (9) core and at least twelve (12) supplemental elements documented, or

• A comprehensive LTSS assessment completed at least once during the measurement year for all other enrollees (established enrollees) with nine (9) core and at least twelve (12) supplemental elements documented.

Note: Initial assessment should be completed within 90 days of enrollment, and updated annually thereafter.

Denominator Statement: Medicaid MLTSS plan enrollees age 18 years and older.

Note: For individuals who have multiple distinct continuous enrollment periods during the measurement year, plans should look at the assessment completed in the last continuous enrollment period of 120 days or greater during the measurement year. This denominator is aligned with the denominator of a paired measure, LTSS Comprehensive Care Plan and Update, to allow MLTSS plans to use a single sample for assessing both measures.

Exclusions: Exclude enrollees in the denominator who were enrolled in the plan prior to September 1 of the year prior to the measurement year (i.e., established enrollees) who left the plan for more than 45 days between January 1 and December 31 of the measurement year.

Exclude enrollees who could not be reached for a comprehensive assessment or who refused a comprehensive assessment.

Adjustment/Stratification: Not Applicable, no stratification.

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

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

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

1a. Evidence: **H-1**; **M-13**; **L-5**; **I-0**; 1b. Performance Gap: **H-15**; **M-4**; **L-0**; **I-0**

Rationale:

- The Committee agreed this measure covers a critical topic for managed care and has the potential to move the field forward. Committee members expressed shock at the low number of assessments completed, agreeing that comprehensive assessments are a vitally important tool and a foundation of developing a care plan and providing care. A Committee member noted that care plans should be influenced by a patient's goals and resources, and that patients need to see how these assessments influence their care plan.
- Committee members discussed the very low rates of performance (0.0%-25.5% for rate one, nine core elements documented, and 0.0-21.% for rate two, nine core elements and twelve supplemental elements documented), and questioned whether that demonstrates a true gap in care, or whether it is a sign the measure is not looking at the right components of an assessment. The Committee also raised concerns about the process of measuring the documentation of an assessment rather than measuring whether something was done. The developer responded that measuring the process of documentation is a vital part of incentivizing the sharing of information across the care team.
- The developer explained that measurement requires documentation, and that documentation is also key to good care coordination and ensuring that a care plan will include all needs. There are documentation problems with these assessments, leading to a lack of knowledge on whether something was assessed and nothing was found, or whether it was not assessed.
- While the developer collected race and ethnicity information, results were not analyzed or reported due to the lack of data; Committee members flagged cognitive impairment as another area to assess for disparities. In response to a question from the Committee, the developer explained that current reporting rates are too low to assess disparities, but they would like to do so in the future when more data are available.

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2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

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

2a. Reliability: **H-0**; **M-6**; **L-13**; **I-0** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- Committee members asked why the measure does not ask who does the assessment, or require that assessments be done by certain types of providers, and the developer explained that there is too much variation across facilities in the types of providers who performed these assessments. Also in response to questions, the developer explained the list of standardized assessments is suggested, not mandated, because they do not want to stifle the use of new,

innovative assessments; however, Committee members did note the lack of standardization may be influencing the low reliability.

- The Committee expressed concern in regards to low reliability results for both data element and score level testing. The Committee suggested that low reliability of data elements coupled with low performance rates overall may be an indication that the measure may not adequately distinguish between good and poor performance in accountability programs. The developer responded that several state Medicaid agencies have adopted LTSS standardized data elements to support reporting and to improve data element reliability, but that there remains great variation in performance and lack of standard data elements across the nation.
- The developer also attributed low reliability scores to the lack of standardization in documentation, lack of documentation of negative responses during an assessment, and a large performance gap.
- The developer also noted that following the low data element testing results, the measure was revised to remove or modify data elements that were among the lowest scores. Due to resource limitations, the measure was not retested following these modifications. The measure is currently under consideration for inclusion in HEDIS and, if included, the developer will monitor reliability through HEDIS auditing.
- While the measure did not pass the reliability criterion, the Committee strongly supported further analysis and development and encouraged the developer to resubmit the measure with additional testing information.

Standing Committee Recommendation for Endorsement: **Did Not Pass Reliability**

6. Public and Member Comment

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

8. Appeals

3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive care plan in a specified timeframe that includes documentation of core domains. The measure has two rates:

Rate 1: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements documented within 120 days of enrollment or at least annually.

Rate 2: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements and at least four (4) supplemental elements documented within 120 days of enrollment or at least annually.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1: MLTSS plan enrollees who had either of the following:

- A comprehensive LTSS care plan completed within 120 days of enrollment for new enrollees, with seven (7) core elements documented, or

- A comprehensive LTSS care plan completed at least once during the measurement year for all other enrollees (established enrollees) with all seven (7) core elements documented.

Rate 2: MLTSS plan enrollees who had either of the following:

- A comprehensive LTSS care plan completed within 120 days of enrollment for new enrollees, with seven (7) core elements and at least four (4) supplemental elements documented, or

- A comprehensive LTSS care plan completed at least once during the measurement year for all other enrollees (established enrollees) with seven (7) core elements and at least four (4) supplemental elements documented.

Note: Initial care plan should be developed within 120 days of enrollment (allows for 90 days to complete assessment and 30 days to complete care plan), and updated annually thereafter.

Denominator Statement: Medicaid MLTSS enrollees age 18 years and older.

Note: For individuals who have multiple distinct continuous enrollment periods during the measurement year, plans should look at the care plan completed in the last continuous enrollment period of 120 days or greater during the measurement year. This denominator is aligned with the denominator of a paired measure, LTSS Comprehensive Assessment and Update, to allow MLTSS plans to use a single sample for assessing both measures.

Exclusions: Exclude enrollees in the denominator who were enrolled in the plan prior to September 1 of the year prior to the measurement year (i.e. established enrollees) and who left the plan for more than 45 days between January 1 and December 31 of the measurement year. These are enrollees who may have left the plan before their annual care plan update was conducted.

Exclude enrollees who could not be reached for development of a comprehensive care plan or who refused to participate in development of a comprehensive care plan. Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

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

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

1a. Evidence: **H-0**; **M-13**; **L-2**; **I-4**; 1b. Performance Gap: **H-6**; **M-13**; **L-0**; **I-0;**

Rationale:

- The Committee noted that the formal evidence base for care coordination is still immature, thus making it difficult, if not impossible, for the developer to provide a robust evidence base. There is also no agreement on what elements are most important to include in a care plan, but the developer explained this measure is intended to help with that standardization.

- The Committee did note some concerns about burden on providers for a measure with limited evidence.
- Despite these concerns, the literature demonstrates enough of a connection between the process and downstream outcomes, particularly the link between documenting preferences and outcomes, that the measure passed the evidence criterion.
- In addition, the Committee agreed there is a large opportunity for improvement in care based on the performance data analysis (0.0-2.4% have documentation of the seven core elements, or the core elements and four supplemental elements), although they did raise some concerns that the gap may be at least partly attributable to the wide variation in care planning.
- Noting that measure 3319 *LTSS Comprehensive Assessment and Update* was supposed to be the foundation of the set of measures and was not recommended, the Committee was concerned and questioned whether the first measure not passing affected the ability of the Committee to recommend the other measures. Committee members noted this was a "chicken and egg" situation, with more data needed in order to standardize care, but these measures are intended to help collect the data needed to standardize care.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-0**; **M-11**; **L-7**; **I-1 (consensus not reached)** 2b. Validity: **H-0**; **M-6**; **L-12**; **I-1**

<u>Rationale</u>:

- The Committee noted that the reliability was variable, with some rates highly reliable and others less reliable; reliability issues were specific to key data elements, which raised concerns from the Committee, but overall the reliability for the performance score was moderate.
- The measure relies on face validity, rather than empirical validity testing. The Committee raised concerns with these results and noted that the majority of the measure developer's TEP supported the measure but not an overwhelming number (54% agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care).
- Committee members suggested that validity could be improved with more precisely defined and/or standardized data elements. The developer explained that it thought the validity was low because so many entities were reporting zero.
- The measure did not pass Validity, a must-pass criterion, therefore Committee members did not recommend the measure for endorsement. The Committee, however, strongly encouraged the developer to conduct some additional testing and resubmit the measure in the future for re-review, and/or resubmit the measure with a smaller number of elements that had higher reliability and validity.

Standing Committee Recommendation for Endorsement: **Did Not Pass Validity**

<u>Rationale:</u>

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6. Public and Member Comment

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

8. Appeals

3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees with a care plan for whom all or part of the care plan was transmitted to the primary care practitioner (PCP) within 30 days of the care plan's development or update.

Numerator Statement: Medicaid MLTSS enrollees who have a care plan (or part of a care plan) that was transmitted to their PCP within 30 days of the care plan's development or update date.

Denominator Statement: Medicaid MLTSS enrollees age 18 years and older who had a care plan developed or updated in the measurement year.

Exclusions: Exclude enrollees in the denominator who were not enrolled in an MLTSS plan for at least 30 days after a care plan´s development or update date. These are enrollees who may have left the plan before it was shared with the PCP.

Exclude enrollees for whom there is documentation of enrollee refusal to allow care plan sharing.

Adjustment/Stratification: Not Applicable, no stratification.

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

STANDING COMMITTEE MEETING [01/31/2018]

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

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

1a. Evidence: **H-0**; **M-13**; **L-2**; **I-2**; 1b. Performance Gap: **H-4**; **M-13**; **L-0**; **I-0;**

Rationale:

- The Committee noted concerns on the evidence base for this measure similar to concerns on measures 3319 and 3324, but agreed that despite the lack of systematic review or graded evidence, there is existing evidence linking improved communication to better outcomes.
- In addition, the Committee agreed there is significant opportunity for improvement in care: performance ranged from 0.0-23.4% for having a care plan shared within 30 days, and 69.6% of enrollees had no documentation of a care plan shared with an eligible provider.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

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

2a. Reliability: **H-0**; **M-4**; **L-11**; **I-2** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- The Committee expressed concerns with the variability of the reliability score, noting low agreement on the data element scores. The Committee suggested that the reliability might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan as well as the timing of transmission.
- Additionally, because this measure is considered in early development in terms of data standardization and data collection, the Committee expressed concerns about excess burden for the provider. The Standing Committee agreed the measure did not pass the Reliability criterion—a must-pass criterion.

Standing Committee Recommendation for Endorsement: **Did Not Pass Reliability**

Rationale:

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6. Public and Member Comment

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

8. Appeals

3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS): Not Recommended

Submission

Description: The measure has two rates:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Denominator Statement: Acute and non-acute inpatient facility discharges for Medicaid MLTSS enrollees age 18 years and older. The denominator is based on discharges, not enrollees. Enrollees may appear more than once in a sample.

Exclusions: For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Adjustment/Stratification: Not Applicable

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Claims, Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

1. Importance to Measure and Report: The measure does not meet the Importance criteria

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

1a. Evidence: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X; ;**

Rationale:

- This measure is related to the other LTSS measures, 3319, 3324, and 3325. Based on similar reliability and validity concerns, the Committee elected not to continue the evaluation of this measure after a short discussion and vote to continue the evaluation of this measure; seven committee members voted to continue evaluation and ten voted not to continue evaluation.
- Additionally, Committee members noted that the evidence is still in a nascent stage for this work but also felt that there is a large enough performance gap to necessitate continued work on these kinds of measures. Committee members reiterated the need for measures in this topic area, but agreed the four submitted measures in the LTSS set are not ready for NQF endorsement. Since the Committee did not evaluate this measure against NQF's criteria, they did not vote on the recommendation for endorsement.

Standing Committee Recommendation for Endorsement: **The Committee did not formally evaluate this measure due to reliability and validity concerns.**

Rationale:

6. Public and Member Comment

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

8. Appeals

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

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

NQF #	Title	Federal Programs: Finalized as of November, 2017
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
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

NQF #	Title	Federal Programs: Finalized as of November, 2017
2967	CAHPS® Home- and Community-Based Services Measures	N/A

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

STANDING COMMITTEE

Gerri Lamb, PhD, RN, FAAN (Co-Chair)
Associate Professor, Arizona State University
Tucson, Arizona

Lee Partridge (Co-Chair)
Advisor, United Hospital Fund
New York, NY

Christopher Stille, MD, MPH, FAAP (Co-Chair)
Professor of Pediatrics, University of Colorado School of Medicine; Section Head, Section of General Academic Pediatrics University of Colorado School of Medicine & Children's Hospital
Aurora, Colorado

Samuel Bierner, MD
Professor and Chair, Department of Physical Medicine and Rehabilitation, University of Nebraska Medical Center, Medical Director, Madonna Rehabilitation Hospital
Omaha, Nebraska

Rebecca Bradley, LCSW
National Director of Case Management and Quality Standards, Encompass Health
Birmingham, Alabama

Donald Casey, MD, MPH, MBA, FACP, FAHA, DFACMQ
President-Elect, American College of Medical Quality (ACMQ)
Bethesda, Maryland

Ryan Coller, MD, MPH
Division Chief, Pediatric Hospital Medicine, University of Wisconsin-Madison
Madison, Wisconsin

Nicole Friedman
Regional Manager of Patient Navigation, Kaiser Permanente
Portland, Oregon

Barbara Gage, PhD, MPA
Associate Research Professor, George Washington School of Medicine and Health Sciences
Washington, District of Columbia

Dawn Hohl, RN, BSN, MS, PhD
Director of Customer Service, Johns Hopkins Home Care Group
Baltimore, Maryland

Stephen Hoy
Director of Strategy and Programs, Patient Family Centered Care Partners
Long Beach, California

Sherrie Kaplan, PhD, MPH
Professor of Medicine, Assistant Vice Chancellor, Healthcare Measurement and Evaluation, University of California Irvine School of Medicine
Irvine, California

Brenda Leath, MHSA, PMP
Senior Director, Westat
Washington, District of Columbia

Brian Lindberg, BSW, MMHS
Executive Director, Consumer Coalition for Quality Health Care
Washington, District of Columbia

Linda Melillo, MA, MS, CPHRM, CPXP
System Director, Patient Experience, Penn Highlands Healthcare
Dubois, Pennsylvania

Lisa Morrise, MA
Patient Co-Chair, Patient & Family Engagement Affinity Group National Partnership for Patients
Salt Lake City, Utah

Patricia J. Ohtake, PT, PhD
Associate Professor, University of Buffalo
Buffalo, New York

Terrance O'Malley, MD
Medical Director, Non-Acute Care Services, Partners Healthcare System
Boston, Massachusetts

Charissa Pacella, MD
Chief of Emergency Services and Medical Staff, University of Pittsburgh Medical Center (UPMC)
Pittsburg, Pennsylvania

Lenard Parisi, RN, MA, CPHQ, FNAHQ
Vice President of Quality Management and Performance Improvement, Metropolitan Jewish Health System
Brooklyn, New York

Debra Saliba, MD, MPH
Professor of Medicine, UCLA/JH Borun Center, VA GRECC, RAND Health
Los Angeles, California

Ellen Schultz, MS
Senior Researcher, American Institutes for Research (AIR)
Chicago, Illinois

Lisa Gale Suter, MD
Assistant Professor and Associate Director, Yale School of Medicine, and Yale/CORE
New Haven, Connecticut

Peter Thomas, JD
Principal, Powers, Pyles, Sutter & Verville, P.C.
Washington, District of Columbia

NQF STAFF

Elisa Munthali, MPH
Senior Vice President, Quality Measurement

Kyle Nicolls Cobb, MS
Senior Director

Suzanne Theberge, MPH
Senior Project Manager

Tara Rose Murphy, MPAP
Project Manager

Mauricio Menendez, MS
Project Analyst

Appendix D: Measure Specifications

1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0: Specifications

STEWARD

American College of Surgeons, Division of Advocacy and Health Policy

DESCRIPTION

The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey. Each measure is used to assess a particular domain of surgical care quality from the patient's perspective.

Measure 1: Information to help you prepare for surgery (2 items)

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Measure 4: Information to help you recover from surgery (4 items)

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Measure 7: Rating of surgeon (1 item)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.

The S-CAHPS expands on the CAHPS Clinician & Group Survey (CG-CAHPS), which focuses on primary and specialty medical care, by incorporating domains that are relevant to surgical care, such as sufficient communication to obtain informed consent, anesthesia care, and post-operative follow-up and care coordination. Other questions ask patients to report on their experiences with office staff during visits and to rate the surgeon.

The S-CAHPS survey is sponsored by the American College of Surgeons (ACS). The survey was approved as a CAHPS product in early 2010 and the Agency for Healthcare Research and Quality (AHRQ) released version 1.0 of the survey in the spring of 2010. The S-CAHPS survey Version 2.0 was subsequently endorsed by NQF in June 2012 (NQF #1741). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html. Surgeons may customize the S-CAHPS survey by adding survey items that are specific to their patients and practice. However, the core survey must be used in its entirety in order to be comparable with other S-CAHPS data. The S-CAHPS survey is available in English and Spanish.

The 6 composite measures are made up of the following items:

The 1 single item measure (Measure 7) is (Q35): Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate all your care from this surgeon?

Measure 1: Information to help you prepare for surgery (2 items)

Q3. Before your surgery, did anyone in this surgeon's office give you all the information you needed about your surgery?

Q4. Before your surgery, did anyone in this surgeon's office give you easy to understand instructions about getting ready for your surgery?

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Q9. During your office visits before your surgery, did this surgeon listen carefully to you?

Q10. During your office visits before your surgery, did this surgeon spend enough time with you?

Q11. During your office visits before your surgery, did this surgeon encourage you to ask questions?

Q12. During your office visits before your surgery, did this surgeon show respect for what you had to say?

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Q15. After you arrived at the hospital or surgical facility, did this surgeon visit you before your surgery?

Q17. Before you left the hospital or surgical facility, did this surgeon discuss the outcome of your surgery with you?

Measure 4: Information to help you recover from surgery (4 items)

Q26. Did anyone in this surgeon's office explain what to expect during your recovery period?

Q27. Did anyone in this surgeon's office warn you about any signs or symptoms that would need immediate medical attention during your recovery period?

Q28. Did anyone in this surgeon's office give you easy to understand instructions about what to do during your recovery period?

Q29. Did this surgeon make sure you were physically comfortable or had enough pain relief after you left the hospital or surgical facility where you had your surgery?

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Q31. After your surgery, did this surgeon listen carefully to you?

Q32. After your surgery, did this surgeon spend enough time with you?

Q33. After your surgery, did this surgeon encourage you to ask questions?

Q34. After your surgery, did this surgeon show respect for what you had to say?

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Q36. During these visits, were clerks and receptionists at this surgeon's office as helpful as you thought they should be?

Q37. During these visits, did clerks and receptionists at this surgeon's office treat you with courtesy and respect?

TYPE

Outcome: PRO-PM

DATA SOURCE

Instrument-Based Data

LEVEL

Clinician : Group/Practice

SETTING

Inpatient/Hospital, Other, Outpatient Services

NUMERATOR STATEMENT

We recommend that S-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

The top box numerator for the Overall Rating of Surgeon is the number of respondents who answered 9 or 10 for the item, with 10 indicating “Best provider possible”.

For more information on the calculation of reporting measures, see What´s Available for the CAHPS Surgical Care Survey: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/surgical/about/whats-available-surgical-care-survey.pdf

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html

NUMERATOR DETAILS

This section is used to describe the composite top box score. The composite top box score is the average proportion of respondents who answered the most positive response category across the questions in the composite.

The top box numerators for items within Composite measures 1, 2, 4, 5, and 6 is the number of respondents who answered “Yes, definitely" across the items in each composite. The top box composite score is the average proportion of respondents who answered “Yes, definitely" across the items in the composite.

The top box numerator for items within Composite measure 3 is the number of respondents who answered "Yes" across the items in this composite. The top box composite score is the average proportion of respondents who answered "Yes" across the items in this composite.

The top box numerator for the Measure 7, the Global Rating Item, is the number of respondents who answered 9 or 10 to the Global Rating Item.

EXAMPLE:

Given a composite with four items, where each item has three response options, a practice’s score for that composite is the proportion of responses (excluding missing data) in each response category.

The following steps show how those proportions are calculated:

Step 1 – Calculate the proportion of cases in each response category for the first question:

P11 = Proportion of respondents who answered “yes, definitely”

P12 = Proportion of respondents who answered “yes, somewhat”

P13 = Proportion of respondents who answered “no”

Follow the same steps for the second question:

P21 = Proportion of respondents who answered “yes, definitely”

P22 = Proportion of respondents who answered "yes, somewhat"

P23 = Proportion of respondents who answered "no"

Repeat the same procedure for each of the questions in the composite.

Step 2 – Combine responses from the questions to form the composite.

Calculate the average proportion responding to each category across the questions in the composite. For example, in the "How Well Surgeon Communicates With Patients Before Surgery" composite (four items), the calculations would be as follows:

Measure top box score = proportion who said "yes, definitely" = (P11 + P21 + P31 + P41) / 4

Example results: If P11 = 81% and P21=92% and P31 = 84% and P41 = 95% then the top box score = (81% + 92% + 84% = 95%) / 4 = 88%.

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html

DENOMINATOR STATEMENT

The measure's denominator is the number of survey respondents. The target population for the survey is adult patients (age 18 and over) who had a major surgery as defined by Common Procedural Terminology (CPT) codes (90 day globals) within 3 to 6 months prior to the start of the survey.

Results will typically be compiled over a 12-month period.

For more information on the calculation of reporting measures, see Patient Experience Measures from the CAHPS Surgical Care Survey, available at https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html.

DENOMINATOR DETAILS

For each item in a composite and the provider rating item, the top box denominator is the number of respondents who answered the item per aggregate-level entity (e.g., a surgeon or practice site). For each composite score, the denominator is the number of respondents who answer at least one item within the composite. Composite scores are the average proportion of respondents who gave the highest rating across the items in the composite (as discussed in S.5).

The survey is sampled at the ambulatory care level. However, there are questions that ask about care received at the hospital or surgical care facility.

The major criterion for selecting patients is having surgery, as defined by Medicare 90-day global surgery codes within 3 to 6 months prior to the start of the survey. Since post-surgical care was an important component of the survey, surveys could not be appropriately administered until an adequate time for experiencing post-surgical care (3 months) had passed. The time frame for the surgery was selected to (1) minimize recall bias and (2) ensure ample time was allowed for follow-up care after surgery. The survey is not administered more than 6 months post-surgery because of concerns about recall bias.

Patients have to be adults and non-institutionalized. Included surgeries should be scheduled and not an emergency procedure. This is because an important component of the survey deals with pre-surgical office visits – a topic which would not be relevant for most emergency surgeries.

The Survey's denominator code table lists 90-day global CPT codes for major surgery, representing over 10,000 possible codes across multiple surgical specialties. The Surgical Quality

Alliance felt that specifying only Medicare's 90-day global procedure codes would include appropriate procedures while excluding minor procedures that were not intended to be included.

The attached excel file named "Attachment A Main S7 CY2015-90-day-global codes.xlsx" includes the CPT codes that are currently used to identify the S-CAHPS survey's target population of patient with major surgery (i.e., measure denominator).

EXCLUSIONS

The following are excluded when constructing the sampling frame:

- Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey.

- Surgical patients younger than 18 years old.

- Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased.

EXCLUSION DETAILS

The following patients would be excluded from the measure's denominator:

- Survey users and vendors should exclude surveys where the respondent reports he or she has not had surgery performed on the date listed by the surgeon named. (First question of survey.)

- Surgical patients that had an emergency surgical procedure since emergency procedures are unlikely to have visits with the surgeon before the surgery.

- Individuals from a household that has already been sampled.

- Respondents who did NOT answer at least one item of the measure are NOT included in the denominator.

Instructions on how to transform raw data from a CAHPS survey into data that the CAHPS Analysis Program can use can be found in Preparing and Analyzing Data from the CAHPS Clinician & Group Surveys available at https://www.cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1035_Preparing_analyzing_data_from_cg.pdf

Survey code specifications --- including how to code an appropriately skipped item, multiple marks or blank items --- can be found in the Instructions for Analyzing Data available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf.

RISK ADJUSTMENT

Case-mix adjustment

STRATIFICATION

If survey users want to combine data for reporting from different sampling strata, they will need to create a text file that identifies the strata and indicates which ones are being combined and the identifier of the entity obtained by combining them.

See pages 18-19 of the Instructions for Analyzing Data available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf.

TYPE SCORE

Top-box Score; case-mix adjusted score

ALGORITHM

Top Box Score Calculation:

1) Target Population: Patients that had a non-emergency surgery within 3 to 6 months prior to the start of the survey.

2) Exclusions = Patients who did not answer at least one item of the composite measures or rating item.

3) Screener items. Example: Patients who answered “No” to the first item indicating that the patient had surgery performed on the date listed by the surgeon named.

4) Top-box scores (percent with highest rating) are computed for each item

5) Top-box scores are averaged across the items within each composite, weighting each item equally.

Note that for users who want to case-mix adjust their scores, case-mix adjustment can be done using the CAHPS macro and the adjustment is made prior to the calculation of the total score.

Case-mix Adjusted Scores

Case-mix adjustment is done via linear regression. The CAHPS Consortium recommends self-reported overall health, age, and education as adjusters. These items are printed in the "About You" section of the survey, questions 38-45.

The steps for user-defined calculations of risk-adjusted scores can be found in Instructions for Analyzing Data from CAHPS® Surveys: Using the CAHPS Analysis Program Version 4.1 available at

https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf.

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Appendix E: Pre-Evaluation Comments

Comments received as of January 18, 2018.

Topic	Commenter	Comment
3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update	Morgan Buchko, Meridian Health Plan	It was acknowledged that the measure is not currently standardized and may come from free text (3b.2.). This would be difficult for health plans to report on this measure until the standardization occurs. We believe it would be helpful to standardize what is required in the plan of care across all ICOs.
3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner	Morgan Buchko, Meridian Health Plan	This requires the plan to track providing an updated or new care plan to the PCP within 30 days. If we are going to be required to report on this, we will need a spec around what constitutes a significant change that requires the PCP notification.
3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge	Morgan Buchko, Meridian Health Plan	From the LTSS reassessment care elements, it seems like this means an LTSS reassessment is performing a new CA. If it is a new CA/HRA entirely, that would be a large lift to complete a new one after every discharge, even considering the exclusions. There are two rates for this measure: LTSS reassessment after discharge and LTSS reassessment and care plan update after discharge. We are seeking clarification on when a member would fall only into the first rate. If we are completing a new assessment with them, we would update the care plan. The second rate requires the plan of care to have 7 core elements which would be a manual investigation to ensure they are completed in the POC for us or new logic built. Additionally, with the lack of EDT feeds directly from facilities, we anticipate that would be a barrier to completing the 30 day timeframe

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

ISBN