

# Patient Experience and Function, Fall 2017 Cycle: CDP Report

TECHNICAL REPORT

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# Patient Experience and Function, Fall 2017 Cycle

## TECHNICAL REPORT

### Executive Summary

Ensuring that every patient and family member is engaged as a partner in coordinated care is core to advancing the quality of our healthcare system. Often, healthcare is received in an asynchronous manner that does not support effective communication between participants in the process of care, or account for the preferences and goals of individuals and their families. Over the past decade, there have been efforts to change the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers individuals to participate actively in their care. Our 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.<sup>a</sup> Care coordination is also a fundamental part for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes. Well-coordinated care encompasses effective communication between patients, caregivers, and providers, and facilitates linkages between communities and healthcare systems. It also ensures that accountable structures and processes are in place for communication and integration of comprehensive plans of care across providers and settings that align with patient and family preferences and goals.

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

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<sup>a</sup> Centers for Medicare and Medicaid Services. Meaningful measures hub. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>. Last Accessed July 31, 2018.

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. One measure that was submitted for maintenance review was endorsed. Four new measures submitted for evaluation were not endorsed. The endorsed measure is:

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

The measures that were not endorsed 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 that were reviewed 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.<sup>1</sup>

Poorly coordinated care may lead to negative, unintended consequences, including medication errors and preventable hospital admissions.<sup>2</sup> For patients living with multiple chronic conditions, including more than two-thirds of Medicare beneficiaries, poor care transitions between different providers can contribute to poor outcomes and hospitalizations.<sup>3</sup> 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).<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

## Building an 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

The Patient Experience and Function Standing Committee ([Appendix C](#)) oversees NQF's portfolio of patient experience and function measures ([Appendix B](#)) which includes measures of functional status, communication, shared decision making, care coordination, patient experience, and long-term services and supports. This portfolio contains 56 measures: three process measures and 53 outcome measures—of which 18 are PRO performance measures.

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

	Process	Outcome/Patient Reported Outcome
<b>Functional Status Change and Assessment</b>	2	28
<b>Communication</b>	1	6
<b>Shared Decision Making</b>	—	2
<b>Care Coordination</b>	—	1
<b>Patient Experience</b>	—	12
<b>Long Term Services and Supports</b>	—	4
<b>Total</b>	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
Measure endorsed	1	0	1
Measures not endorsed	0	4	4
Reasons for not endorsing		Scientific Acceptability – 3 <sup>b</sup>	4

<sup>b</sup> The Committee voted to stop the evaluation of measure 3326 citing similarities to failed measures 3324 and 3325.

## Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 5, 2017 and closed on April 6, 2018. Three comments were received as of January 18, 2018, and were shared with the Committee prior to the measure evaluation meeting ([Appendix E](#)).

All submitted comments were provided to the Committee prior to its initial deliberations during the in-person meeting.

## Comments Received After Committee Evaluation

Following the Committee's evaluation of the measures under consideration, NQF received 28 comments from seven organizations (including four member organizations) and individuals pertaining to the draft report and to the measures under consideration. [Appendix A](#) summarizes all comments for each measure under consideration.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expression of support/not support. One member supported measure #1741, while two members expressed that they did not support measures #3319, #3324, #3325, #3326.

## 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 area 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 supported by the Office of the National Coordinator for Health Information Technology's (ONC) electronic Long-Term Services and Supports (eLTSS) initiative 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 Loops*

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 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 were 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 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. Ultimately, the NQF Board of Directors 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, such as related software/tools, and costs of ongoing training, as requested by the NQF Board. In addition, CMS provided a memo in response to the NQF Board's request for information. This memo summarized responses gathered during the rulemaking process on perceived benefits from the field for performance measures that cut across care settings. 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.

### *Attribution*

During the post-comment call, the Committee discussed attribution of the CAHPS surgical measure as well as instrument-based measures more broadly. The Committee explored the concept of team-based care and how that impacts patients' experience and outcomes. The Committee will continue to think about attribution of instrument-based measures.

## 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 included in [Appendix A](#).

### *Surgical Experience of Care*

#### **1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)<sup>®</sup> Surgical Care Survey Version 2.0 (American College of Surgeons): Endorsed**

**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 comprises 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 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. On this aspect, 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 top-box scoring and risk adjustment or sensitivity to disparities. The Committee' noted its concern that using top-box scoring to calculate the measure score fails to identify possible low performing outliers because it focuses only on high scores. 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 top-box 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, these are different assessments, and in cases where there has been both a hospital stay and surgery, use of both should be encouraged. In conclusion, the Committee agreed that this measure met the NQF evaluation criteria and unanimously recommended this maintenance measure for continued endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Committee's recommendation to maintain 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 Endorsed**

**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 with all core elements, agreeing that comprehensive assessments are a vitally important tool and a foundation of developing a care plan and providing care. The Committee agreed that 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 the amount of flexibility around how the comprehensive assessment is captured, as well as the low reliability of some of the data elements, and suggested that the overall reliability is high because the performance is so low. 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 nonresponses during an assessment, and a large performance gap. The developer also noted that the number and mix of data elements were revised after reviewing testing results. Updated data elements reflected those that had higher frequency in testing, corresponded to elements used in plan assessment forms, and were recommended by the developers Technical Expert Panel (TEP) members. 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 that 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 version of the measure with fewer data elements that have strong reliability. The CSAC upheld the Committee's recommendation not to endorse.

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

**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: 62 percent agreed that performance scores on the measure in the future will distinguish between good and poor performance; and 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 have higher reliability and validity. The CSAC upheld the Committee's recommendation not to endorse.

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

**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, or an update to a care plan, as well as the timing of transmission. The developer noted that since the care plans may be lengthy, the numerator counts sharing important parts of the care plan when it is updated. 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 Committee agreed that the measure did not pass the reliability criterion, a must-pass criterion, and the Committee did not recommend the measure for endorsement. The CSAC upheld the Committee's recommendation not to endorse.

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

**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. 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 types of care coordination measures. Committee members reiterated the need for measures in this topic area, but agreed that 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, it did not vote on the recommendation for endorsement. The CSAC upheld the Committee's recommendation not to endorse.

## References

- <sup>1</sup> Agency for Healthcare Research and Quality (AHRQ). Priorities of the national quality strategy website. <https://www.ahrq.gov/research/findings/nhqrdr/nhqrdr15/priorities.html>. Last accessed February 2018.
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- <sup>6</sup> Rosenthal MB, Alidina S, Friedberg MW, et al. A difference-in-difference analysis of changes in quality, utilization and cost following the Colorado multi-payer patient-centered medical home pilot. *J of Gen Intern Med*. 2016;31(3):289-296.

## Appendix A: Details of Measure Evaluation

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

### Endorsed Measure

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#### 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)<sup>®</sup> Surgical Care Survey Version 2.0 (American College of Surgeons, Division of Advocacy and Health Policy): Endorsed

[Submission](#) | [Specifications](#)

**Description:** The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) 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 acknowledged 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: The measure meets the Scientific Acceptability criteria**

(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**

### Rationale:

- 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.

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### 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.

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### 4. Usability and Use:

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

4a. Use: **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.

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### 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

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Standing Committee Recommendation for Endorsement: **Yes-18; No-0**

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## **6. Public and Member Comment**

NQF received two comments on this measure during the post-meeting commenting period. One comment expressed general support for the measure's endorsement and did not require a response. The other comment also expressed support for the measure's endorsement, but noted concern over the ability of survey tools for patient satisfaction to measure performance, particularly for surgeons. The commenter also questioned the validity of survey tools for patient satisfaction given that "collection of data is frequently so far removed from the actual patient interaction."

Developer Response: We greatly appreciate the sentiments expressed by AANS. Indeed, these sentiments were among the reasons why the CAHPS Surgical Care Survey was developed. We believe this measure represents a step in the right direction to move towards meaningful, patient-centered surgical care. Future iterations of this measure are in development, and we look forward to continued AANS support.

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**7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-17; No-0** (June 6, 2018: Approved for continued endorsement)

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## **8. Appeals**

No appeals were received.

## Measures Not Endorsed

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

#### [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 concern at the low number of comprehensive assessments completed with all nine required core elements, 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 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 health plans use a variety of qualified professionals, including nurses, social workers, and other members of a care management team to perform these assessments. Also in response to questions, the developer reminded the Committee that the measure focuses on the documentation of data elements, and further explained the list of standardized

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

- The Committee expressed concern in regards to the amount of flexibility around how the comprehensive assessment is captured, as well as the low reliability of some of the data elements, and suggested that the overall reliability was high because the performance is so low. 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 pared down to include data elements that had higher frequency in testing, corresponded to elements used in plan assessment forms, and were recommended by the developers Technical Expert Panel (TEP) members. 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.

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

## 6. Public and Member Comment

Fifteen comments were received on this measure during the post-meeting comment period. Five comments raised concerns with the measure that related to evidence, face-to-face encounters, data availability and stratification; these comments supported the Committee's decision not to recommend. NQF staff forwarded these five comments to the developer for responses (below). Thirteen of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff responded to these comments.

**Developer Responses: (1)** We appreciate the comments regarding the measure's specification that an assessment must include a face-to-face discussion with the member in the home (unless there is documentation of a member refusing in-home assessment) and will consider potential changes to the measure in the future.

We also appreciate the suggestion to include social support as a required core element. We will consider these potential changes to the measure in the future.

Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized

measure to assess the degree to which assessments among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.

Thank you for your suggestions regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

**(2)** We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.

Thank you as well for your comment regarding variation in new state MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new state MLTSS implementations that are not staggered.

**(3)** Thank you for your comments. Although there was a mix in the inter-rater reliability of both core and supplemental elements included in the two rates, the overall score-level reliability was high. Our submission documents that the inter-class correlation coefficient (ICC) (the ratio of the subject variance to the total variance) for both Rate 1 and 2 exceeded 0.9, indicating almost perfect agreement between the samples, and showing a significant association at  $p < 0.05$ .

The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (62 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even greater proportion (69%) of the TEP agreed that performance scores on this measure will distinguish between good and poor performance in the future.

**(4)** We appreciate the comments regarding the measure's specification of face-to-face care plan development and will consider potential changes to the measure in the future.

Thank you for your comment regarding variation in new State MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new State MLTSS implementations that are not staggered.

We appreciate your comment regarding the balance between medical and non-medical/quality of life core elements specified in this measure. Over time, we anticipate that elements from the "supplemental" requirements will move to the "core" requirements as performance improves. In the meantime, the currently proposed "core" rates can fill a long-standing measurement gap while generating results that are both meaningful and usable to stakeholders.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

**(5)** We appreciate your comments about the measure's specification regarding the face-to-face LTSS Assessment in the member's home unless there is documentation of a member refusing in-home assessment.



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**7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-16; No-1** (June 6, 2018: Not approved for endorsement)

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

#### [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.
- The developer addressed the Committee's concerns on provider burden with a clarification that the level of analysis for this measure is health plans, specifically those that participate in Medicaid managed long-term services and supports programs. These plans are under contract with, and paid by, states to manage care for Medicaid beneficiaries receiving LTSS. The burden for data collection would not fall to individual physicians and home health workers; these functions are performed by the health plan and health plan-paid staff.
- 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: 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-11; L-7; I-1 (consensus not reached)** 2b. Validity: **H-0; M-6; L-12; I-1**

### **Rationale:**

- 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.

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

## **6. Public and Member Comment**

Seven comments were received on this measure during the post-meeting comment period. Four comments raised concerns with the measure regarding face-to-face encounters, nonstandardized data, stratification, and the low agreement rates found during reliability testing. The comments also included support of the Committee's decision not to recommend. These four measures were forwarded to the developer for responses (below). Three of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff responded to these comments.

**Developer Responses: (1)** We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider these potential changes to the measure in the future.

Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.

The clarification of ""substantial update"" is included in the description of the measure. The current measure includes MLTSS plan members who had a comprehensive LTSS care plan with seven core elements (and at least four supplemental elements for rate number 2) documented within 120 days of enrollment.

Thank you for your comments regarding stratification on demographic characteristics. We will consider potential changes to the measure in the future. "

**(2)** We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.

**(3)** We appreciate your comments. The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even greater proportion (62%) of the TEP agreed that performance scores on this measure will distinguish between good and poor performance in the future.

Thank you for your comments regarding the measure's scientific acceptability.

**(4)** We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider potential changes to the measure in the future.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

---

**7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-16; No-1** (June 6, 2018: Not approved for endorsement)

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

#### [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

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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-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 issues might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan, or an update to a care plan, as well as the timing of a transmission. The developer noted that since the care plans may be lengthy, the numerator counts sharing important parts of the care plan when it is updated. 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**

NQF received six comment on this measure during the post-meeting comment period. Four of these comments raise concerns with the measure, specifically the denominator exclusions and transmission of information; and also support the Committee's decision not to recommend. These four comments were forwarded to the developer for responses. Two of the comments were from the developer in response

to the draft report and are specific to details outlining the discussion on the measure. These comments have been responded to by NQF staff.

**Developer Responses: (1)** Thank you for your comments. Regarding the measure's denominator exclusion, the current technical specifications exclude members that have documentation of refusal to allow care plan sharing. Additionally, the specified denominator for the measure includes only MLTSS plan members with a care plan.

We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are shared within a timely fashion with the PCP has precluded the collection of comparable data across plans.

Thank you for your comments regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

**(2)** We appreciate your comment regarding additional denominator exclusions; the specified measure's denominator only includes MLTSS plan members with a care plan. Regarding members who declined to choose a PCP, we will consider changing the measure's specification to include these potential exclusions in the future.

**(3)** Thank you for your comments. We would like to clarify that the Interclass Correlation Coefficient (ICC) (the ratio of the subject variance to the total variance) for the measure rate exceeded 0.9, indicating almost perfect agreement between the samples for the single data element indicating that the care plan was shared, and showing a significant association at  $p < 0.01$ . However, the other elements in the LTSS Shared Care Plan with Primary Care Practitioner measure were assessed too infrequently among the 144 paired assessments (<30) to allow for inter-rater reliability analysis. We have updated the measure specifications to help improve reliability of certain elements.

**(4)** Thank you for your comments regarding additional denominator exclusions for enrollees who could not be reached, who refused to participate in the development of a comprehensive care plan, or who declined to choose a PCP. We will consider changing the measure's specification to reflect these potential exclusions in the future. We appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

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**7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-16; No-1** (June 6, 2018: Not approved for endorsement)

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

### [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.

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

#### Rationale:

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## 6. Public and Member Comment

Four comments were received on this measure during the post-meeting comment period. Three of these comments raise concerns with the measure, agree with the Committee's decision not to recommend, and were forwarded to the developer for responses (below). In addition, one comment was directed to NQF staff and raised concerns about the evaluation process, noting that the Committee did not formally vote on the measure but had concerns about the measure passing the importance and scientific acceptability criteria. The commenter was concerned that the measure was not fully assessed against the criteria as per NQF's standard process.

**Developer Responses: (1)** Thank you for your comments. We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which re-assessments/care plan updates among the MLTSS enrollee population are completed in a timely fashion has precluded the collection of comparable data across plans.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

This measure is currently specified such that any discharges from unplanned stays at inpatient facilities should result in a re-assessment or both a re-assessment and care plan update within 30 days of discharge. A face-to-face discussion with the member must be conducted using a structured or semi-structured tool that addresses the member's health status and needs and



includes at a minimum nine core elements, as specified in 3319: Long Term Services and Supports (LTSS) Comprehensive Assessment and Update. The assessment may additionally include supplemental elements. Furthermore a care plan updated to identify member needs, preferences, risks, and contains a list of the services and supports planned to meet those needs while reducing risks.

Thank you for your input regarding denominator exclusions. The stakeholders who advised us during measure development did not consider that a member could not be reached as a valid denominator exclusion; while the member was in the hospital, the plan would know where to reach them. In the future, we will revisit the possibility of adding member refusal of care planning as a denominator exclusion.

Thank you for your comments regarding caregiver involvement, and stratification on demographic characteristics. We will consider these as potential changes to the measure in the future.

**(2)** Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future. Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future.

**(3)** Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider potential changes to the measure in the future.

Thank you for your input regarding additional denominator exclusions for enrollees who could not be reached or who refuse care planning; we will take this into consideration.

Regarding caregiver involvement, we appreciate your suggestion to document the availability of informal caregivers separately from documentation of such caregivers' involvement. We will consider this potential change to the measure specification.

We also appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

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**7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-16; No-1** (June 6, 2018: Not approved for endorsement)

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

NQF #	Title	Federal Programs: Finalized or Implemented 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; Hospital Compare, Hospital Value-Based Purchasing
0228	3-Item Care Transition Measure (CTM-3)	IQR- EHR Incentive Program, Hospital Compare, Hospital Value-Based Purchasing
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

NQF #	Title	Federal Programs: Finalized or Implemented as of November 2017
0701	Functional Capacity in COPD patients before and after Pulmonary Rehabilitation	N/A
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) <sup>®</sup> 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

NQF #	Title	Federal Programs: Finalized or Implemented as of November 2017
2616	CoreQ: Long-Stay Family Measure	N/A
2624	Functional Outcome Assessment	Merit-based Incentive Payment System
2631	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Skilled Nursing Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program, Home Health Quality Reporting Program
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Long-Term Care Hospital Quality Reporting Program
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

NQF #	Title	Federal Programs: Finalized or Implemented as of November 2017
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery	N/A
2962	Shared Decision Making Process	N/A
2967	CAHPS® Home- and Community-Based Services Measures	N/A

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

### STANDING COMMITTEE

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## Appendix D: Measure Specifications

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### 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)<sup>®</sup> 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<sup>®</sup>) 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](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



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