NATIONAL QUALITY FORUM
Driving measurable health improvements together

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

TECHNICAL REPORT
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Contents

Executive Summary

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

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

The care coordination measures within the Committee portfolio represent a fundamental component for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes.[10-12] 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.[13-15]

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

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

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

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

The Committee did not recommend the following measure:

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

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

Track 1: Measures That Remained in Fall 2019 Cycle:

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

Track 2: Measures Deferred to Spring 2020 Cycle:

- **NQF #0291** Emergency Transfer Communication Measure

This report contains details of the evaluation of the measure assigned to *Track 2* and moved to the spring 2020 cycle. Detailed summaries of the Committee's discussion and ratings of the criteria for the measure are in Appendix A. The detailed evaluation summary of the measure assigned to *Track 1* that remained in the Fall 2019 cycle was included in a separate report.

Introduction

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

The coordination of care is an essential component to the improvement of patient experiences and outcomes. Poorly coordinated and fragmented care not only compromises the quality of care patients receive, but may also lead to negative, unintended consequences, including medication errors and preventable hospital admissions.[7] 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.[1] Nearly 15 percent of Medicare beneficiaries discharged from the hospital are readmitted within 30 days, with half of the patients not having yet seen an outpatient doctor for a follow-up, and most of these readmissions occur through an emergency department (ED).[2,9] The existing evidence suggests that care in the United States (U.S.) is largely uncoordinated, even though evidence also suggests that quality improvement strategies within care can improve performance.[11] 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.[1,3,6,12,15]

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

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 for functional status,

communication, shared decision making, care coordination, patient experience, and long-term services and supports. This portfolio contains 50 measures: three process measures, one composite measure, and 46 outcome measures, of which 29 are PRO-PMs (see table below).

Table 1. NQF Patient Experience and Function Portfolio of Measures

	Process	Outcome/Patient-Reported Outcome	Composite
Functional status change and assessment	1	23	0
Shared decision making	0	3	0
Care coordination	2	5	0
Patient experience	0	11	1
Long-term services and supports	0	4	0
Total	3	46	1

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

Patient Experience and Function Measure Evaluation

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

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

	Maintenance	New	Total
Measures under review	1	0	1
Measures not endorsed	1	0	1
Reasons for not recommending	Importance - 0 Scientific Acceptability - 1 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

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

Comments Received After Committee Evaluation

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

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

Track 1: Measures That Remained in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations moved forward to the CSAC for review and discussion during its meeting on July 28-29, 2020.

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

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures that required further action or discussion from a Standing Committee were deferred to the spring 2020 cycle. This includes measures in which consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review retained endorsement during that time.

During the spring 2020 CSAC meeting on November 17-18, 2020, the Consensus Standards Approval Committee (CSAC) reviewed all measures assigned to *Track 2*. A list of measures assigned to *Track 1* can be found in the Executive Summary section of this report for tracking purposes, but these measures were reviewed during the July 28-29, 2020 CSAC meeting.

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

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

Overarching Issues

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

Score Level and Data Element Level Reliability

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

Summary of Measure Evaluation: Fall 2019 Measures Track 2

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

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

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

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

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

The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion. This measure was discussed during the February 26, 2020 post-comment call, which did not achieve quorum. Therefore, voting was completed asynchronously after the call. NQF #0291 is a maintenance measure assessing the percentage of all patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all required information be sent to the receiving facility within 60 minutes of the transfer. The Committee noted that this maintenance measure was granted an exception to evidence on the previous review. The Committed observed this considering that the evidence to support the connection between positive patient outcomes and the transfer of information with the patient within 60 minutes from the emergency room has not been well studied and that it is difficult to design a study that makes a clear and empirical connection between this process and desirable outcomes. Nonetheless, the Committee noted that there is strong expert opinion that suggests this is an industry best practice for better coordination of care. Committee members also expressed that NQF #0291 is a particularly important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers, further expressing that it would be very difficult to assess causation of an important outcome, such as mortality and morbidity, as evidence of the need for this type of measure. The Committee noted it is also uncertain if public reporting and payment could be conducted fairly without substantial bias and lack of adjustment for between-facility variation around technology. As it relates to performance gap, the Committee initially expressed concern that the data and presented analyses originated from the revised measure, but they were otherwise comfortable with the measure gap once the developer clarified that the testing was done according to the new specifications.

The Standing Committee did not pass the measure on reliability due to concerns that the inter-rater reliability at the data-element level produced low results. The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision. The Committee noted that the data-element reliability testing for the measure produced fair to moderate crude agreement for inter-rater reliability between abstractors for the eight items in the measure. However, the results using Cohen's kappa statistics produced mostly low results for the eight items. The Committee also noted that while the score-level reliability results were good, they were produced using the beta-binomial methodology, which assumes that error is random. Since the inter-rater reliability is low, this implies that the error is systematic.

References

[1] Centers for Medicare & Medicaid Services (CMS). *Medicare Beneficiary Characteristics.* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Medicare_Beneficiary_Characteristics. Last accessed February 2020.

[2] United Health Foundation. America's Health Rankings website. https://www.americashealthrankings.org/explore/senior/measure/hospital_readmissions_sr/state/ALL. Last accessed February 2020.

[3] Institute of Medicine Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, eds. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary.* Washington, DC: National Academies Press; 2010.

[4] Agency for Healthcare Research and Quality (AHRQ). Priorities of the national quality strategy website. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/priorities.html. Last accessed February 2020.

[5] CMS. Meaningful Measures Hub website. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page#Measurement_Areas. Last accessed February 2020.

[6] Frandsen BR, Joynt KE, Rebitzer JB, et al. Care fragmentation, quality, and costs among chronically ill patients. *AJMC.* 2015; 21(5):355-362.

[7] Schultz EM, Pineda N, Lonhart J, et al. A systematic review of the care coordination measurement landscape. *BMC Health Serv Res*. 2013;13:119.

[8] 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.

[9] Jencks SF, Williams MV, Coleman EA, et al. Rehospitalizations among patients in the Medicare fee-for-service program. *New Engl J Med*. 2009;360(14):1418-1428.

[10] Tricco AC, Antony J, Ivers NM, et al. Effectiveness of quality improvement strategies for coordination of care to reduce use of health care services: a systematic review and meta-analysis. *CMAJ*. 2014;186(15): E568-578.

[11] Turchi RM, Antonelli RC, Norwood KW Jr, et al. Patient-and family-centered care coordination: a framework for integrating care for children and youth across multiple systems. *Pediatrics*. 2014;133(5): e1451-e1460.

[12] Pronovost P, Weast B, Schwarz M, et al. Medication reconciliation: a practical tool to reduce the risk of medication errors. *J Crit Care.* 2003;18(4):201-205.

[13] Gnanasakthy A, Mordin M, Evans E, et al. A review of patient-reported outcome labeling in the United States (2011-2015). *Value Health.* 2017;20(3):420-429.

[14] Shay LA, Lafata JE. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Med Decis Making*. 2015;35(1):114-131.

[15] Berkowitz SA, Parashuram S, Rowan K, et al. Johns Hopkins Community Health Partnership (J-CHiP) Team. Association of a care coordination model with health care costs and utilization: the Johns Hopkins Community Health Partnership (J-CHiP). *JAMA Netw Open*. 2018;1(7):e184273.

[16] Frampton SB, Guastello S, Hoy L, et al. Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care. Washington, DC: National Academy of Medicine (NAM); 2017.

Appendix A: Details of Measure Evaluation

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

Track 2 – Measures Not Endorsed

#0291 Emergency Transfer Communication Measure

Submission

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

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

For purposes of this measure, a shared EHR is defined as one in which data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a HIE cannot assume immediate access by the receiving facility to the transferred patient's record.

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home medications
- Allergies and reactions
- Medications administered in ED
- ED provider note
- Mental status and orientation assessment
- Reason for transfer and plan of care
- Tests and/or procedures performed
- Tests and/or procedures results

Denominator Statement: Transfers from an ED to another healthcare facility

Included Populations: All transfers from an ED to another healthcare facility

Excluded Populations: Patients observation status

Exclusions: All emergency department patients not discharged to another healthcare facility

Those admitted, sent home, left AMA, those on observations status, etc.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records

Measure Steward: University of Minnesota Rural Health Research Center

STANDING COMMITTEE MEETING February 2, 2020 & February 6, 2020

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

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

1a. Evidence: **M-2**; **L-5**; **I-10**; 1b. Performance Gap: **H-0**; **M-15**; **L-2**; **I-0**; Evidence Exception: **Yes-13; No-4**

Rationale:

- The Committee noted the developer has added additional evidence of the need for better care transitions since the last submission.

#0291 Emergency Transfer Communication Measure

- The Committee noted this maintenance measure was granted an exception to evidence on the previous review.
- Committee members expressed that this is an important process measure for care coordination between small rural or critical access facilities and larger tertiary or quaternary centers and that it would be very difficult to assess causation of an important outcome, such as mortality and morbidity, as evidence of the need for this type of measure.
- The Committee noted it is also uncertain if public reporting and payment could be done fairly without substantial bias and lack of adjustment for between-facility variation around technology.
- The Committee felt there was an adequate performance gap.
    - Results provided suggest a mean emergency department transfer communication (EDTC) performance rate of 0.75 and 0.79 in quarters 1 and 4 of 2017.
    - The interquartile range was approximately 0.65-0.97 for both quarters, indicating good spread and continued opportunity for improvement.

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

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

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

<u>Rationale</u>:

- The Committee noted that the data element-level inter-rater reliability testing produced a low kappa statistic score.
- Score-level reliability using beta binomial was high.
- The Committee felt that the data element reliability was truly a concern considering that the beta binomial methodology used for score-level reliability testing assumes that error is random, but low inter-rater reliability would be considered systematic error.
- The developer noted that several hospitals are currently engaging with Stratis Health to improve their abstraction precision.
- The Committee did not pass the measure on reliability.

3. Feasibility: <u>The Standing Committee did not vote on this criterion since the measure did not pass Scientific Acceptability.</u>

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

4. Usability and Use: <u>The Standing Committee did not vote on these criteria since the measure did not pass Scientific Acceptability.</u>

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

5. Related and Competing Measures

- No related or competing measures were noted.

6. Standing Committee Recommendation for Endorsement: Yes-X; No-X

<u>Rationale</u>

- The Standing Committee did not recommend the measure for continued endorsement because the measure did not pass reliability—a must-pass criterion.

7. Public and Member Comment

Comments received outlined concerns with the data element reliability results, approaches to improving reliability, and expressions of support for the Committee's endorsement decision. The Committee agreed the measure is both valuable and relevant and should be considered in the future. The Committee encouraged the developer to improve the measure's overall reliability testing result in future submissions.

#0291 Emergency Transfer Communication Measure
8. Consensus Standards Approval Committee (CSAC) Vote to Uphold the Standing Committee's Recommendation (November 17-18, 2020): Yes-11; No-0 **CSAC Decision: Not Approved for Continued Endorsement**
9. Appeals: No appeals were received.

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

NQF #	Title	Federal Programs: Finalized or Implemented as of June 22, 2020
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Merit-based Incentive Payment System (MIPS) Program (Implemented) Medicare Shared Savings Program (Shared Savings Program) (Implemented)
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Marketplace Quality Rating System (QRS) (Implemented)
0166	HCAHPS	Hospital Inpatient Quality Reporting (IQR) (Implemented) Hospital Value-Based Purchasing (HVBP) (Implemented) Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) (Implemented)
0258	CAHPS In-Center Hemodialysis Survey	End-Stage Renal Disease Quality Incentive Program (ESRD QIP) (Implemented)
0422	Functional status change for patients with Knee impairments	MIPS Program (Implemented)
0423	Functional status change for patients with Hip impairments	MIPS Program (Implemented)
0424	Functional status change for patients with Foot and Ankle impairments	MIPS Program (Implemented)
0425	Functional status change for patients with lumbar impairments	MIPS Program (Implemented)
0426	Functional status change for patients with Shoulder impairments	MIPS Program (Implemented)
0427	Functional status change for patients with elbow, wrist, and hand impairments	MIPS Program (Implemented)
0428	Functional status change for patients with General orthopedic impairments	None
0517	CAHPS® Home Health Care Survey (experience with care)	Home Health Quality Reporting Program (HH QRP) (Implemented)

[a] Per CMS Measures Inventory Tool as of 02/08/2021

NQF #	Title	Federal Programs: Finalized or Implemented as of June 22, 2020
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	None
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	None
2286	Functional Change: Change in Self Care Score	None
2287	Functional Change: Change in Motor Score	None
2321	Functional Change: Change in Mobility Score	None
2483	Gains in Patient Activation (PAM) Scores at 12 Months	None
2548	Child Hospital CAHPS (HCAHPS)	None
2612	CARE: Improvement in Mobility	None
2613	CARE: Improvement in Self Care	None
2614	CoreQ: Short Stay Discharge Measure	None
2615	CoreQ: Long-Stay Resident Measure	None
2616	CoreQ: Long-Stay Family Measure	None
2631	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Long-Term Care Hospital Quality Reporting Program (LTCHQRP) (Implemented)
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	LTCHQRP (Implemented)
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) (Implemented)
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of June 22, 2020
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	IRF QRP (Implemented)
2643	Average change in functional status following lumbar spine fusion surgery	MIPS Program (Implemented)
2653	Average change in functional status following total knee replacement surgery	MIPS Program (Implemented)
2769	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	None
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	None
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities	None
2776	Functional Change: Change in Motor Score in Long-Term Acute Care Facilities	None
2777	Functional Change: Change in Self Care Score for Long-Term Acute Care Facilities	None
2778	Functional Change: Change in Mobility Score for Long-Term Acute Care Facilities	None
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery	None
2962	Shared Decision Making Process	None
2967	CAHPS® Home and Community-Based Services Measures	Medicaid (Implemented)
3227	CollaboRATE Shared Decision Making Score	None
3420	CoreQ: AL Resident Satisfaction Measure	None
3422	CoreQ: AL Family Satisfaction Measure	None
3455	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	None
3461	Functional Status Change for Patients with Neck Impairments	MIPS Program (Finalized)
3477	Discharge to Community-Post Acute Care Measure for Home Health Agencies	HH QRP (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of June 22, 2020
3479	Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities	IRF QRP (Implemented)
3480	Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals	LTCHQRP (Implemented)
3481	Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities	Skilled Nursing Facility Quality Reporting Program (SNF QRP) (Implemented)

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

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Appendix D: Measure Specifications

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

Appendix E: Related and Competing Measures

No related or competing measures were identified.

Appendix F: Pre-Evaluation Comments

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

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