NATIONAL QUALITY FORUM

Patient Experience and Function

Standing Committee Meeting
January 31, 2018

Kyle Nicholls Cobb, MS, Senior Director
Suzanne Theberge, MPH, Senior Project Manager
Tara Rose Murphy, MPAP, Project Manager
Mauricio Menendez, MS, Project Analyst

NQF Project Team

- Elisa Munthali, MPH, Senior Vice President
- Kyle Nicholls Cobb, MS, Senior Director
- Suzanne Theberge, MPH, Senior Project Manager
- Tara Rose Murphy, MPAP, Project Manager
- Mauricio Menendez, MS, Project Analyst

Welcome

- Restrooms
  - *Exit main conference area, past elevators, on right.*
- Breaks
  - *10:30am – 15 minutes*
  - *12:15pm – Lunch provided by NQF*
- Laptops and cell phones
  - *Wi-Fi network*
    - » User name: **guest**
    - » Password: **NQFguest**
  - *Please mute your cell phone during the meeting*

Today's Agenda

- Standing Committee Introductions and Disclosures
- Project Introduction and Overview of Evaluation Process
- Consideration of Candidate Measures
- Developer Presentation
- NQF Introduction to Competing Measures Issue
- Developer and Stakeholder Presentations
- Committee Discussion
- Review of project activities and timelines
- Adjourn

Introductions and Disclosures of Interest

Patient Experience and Function Committee Roster – Fall 2017 Cycle

- **Gerri Lamb**, PhD, RN, FAAN - Co-Chair
- **Lee Partridge** - Co-Chair
- **Chris Stille**, MD, MPH - Co-Chair
- **Samuel Biernier**, MD
- **Rebecca Bradley**, LCSW
- **Donald Casey,** MD, MPH, MBA, FACP, FAHA
- **Ryan Coller,** MD, MPH
- **Nicole Friedman**
- **Barbara Gage,** PhD, MPA
- **Dawn Hohl,** RN, BSB, MS, PhD
- **Stephen Hoy**
- **Sherrie Kaplan,** PhD, MPH
- **Brian Lindberg,** BSW, MMHS
- **Brenda Leath,** MHSA, PMP
- **Linda Melillio,** MA, MS, CPHRM, CPXP
- **Lisa Morrise,** MA
- **Patricia Ohtake,** PT, PhD
- **Charissa Pacella,** MD
- **Lenard Parisi,** RN, MA, CPHQ, FNAHQ
- **Debra Saliba,** MD, MPH
- **Ellen Schultz,** MS
- **Lisa Gale Suter,** MD
- **Peter Thomas,** JD

Patient Experience and Function - Fall 2017 Cycle Expert Reviewers & Inactive Members

- **Richard Antonelli,** MD, MS
- **Beth Averback,** MD
- **Adrienne Boissy,** MD, MA
- **Jennifer Bright,** MPA
- **Christopher Dezii,** RN, MBA, CPHQ
- **Shari Erickson,** MPH
- **Russell Leftwich,** MD
- **Jean Malouin,** MD, MPH
- **Ann Monroe**
- **Sharon Cross,** LISW

Project Introduction and Overview

Patient Experience and Function Portfolio – Fall 2017 Cycle Measures Under Review

**Measure for maintenance evaluation*

- **1741**: Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey*
- **3319**: LTSS Comprehensive Assessment and Update
- **3324**: LTSS Comprehensive Care Plan and Update
- **3325**: LTSS Shared Care Plan with Primary Care Practitioner
- **3326**: LTSS Re-Assessment and Care Plan Update After Inpatient Discharge

Patient Experience and Function Portfolio

Functional Status Change and/or Assessment: 30 Measures	
0422	Functional status change for patients with Knee impairments
0423	Functional status change for patients with Hip impairments
0424	Functional status change for patients with Foot and Ankle impairments
0425	Functional status change for patients with lumbar impairments
0426	Functional status change for patients with Shoulder impairments
0427	Functional status change for patients with elbow, wrist and hand impairments
0428	Functional status change for patients with General orthopedic impairments
0429	Change in Basic Mobility as Measured by the AM-PAC:
0430	Change in Daily Activity Function as Measured by the AM-PAC:
2286	Functional Change: Change in Self Care Score
2287	Functional Change: Change in Motor Score
2321	Functional Change: Change in Mobility Score

Patient Experience and Function Portfolio

Functional Status Change and/or Assessment: 30 Measures	
2624	Functional Outcome Assessment
2631	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
2643	Average change in functional status following lumbar spine fusion surgery
2653	Average change in functional status following total knee replacement surgery

Patient Experience and Function Portfolio

Functional Status Change and/or Assessment: 30 Measures	
2769	Functional Change: Change in Self Care Score for Skilled Nursing Facilities
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities
2776	Functional Change: Change in Motor Score in Long Term Acute Care Facilities
2777	Functional Change: Change in Self Care Score for Long Term Acute Care Facilities
2778	Functional Change: Change in Mobility Score for Long Term Acute Care Facilities
0701	Functional Capacity in COPD patients before and after Pulmonary Rehabilitation
2612	CARE: Improvement in Mobility
2613	CARE: Improvement in Self Care

Patient Experience and Function Portfolio

Communication: 7 Measures	
0291	Emergency Transfer Communication Measure
1894	Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
1896	Language services measure derived from language services domain of the C-CAT
1898	Health literacy measure derived from the health literacy domain of the C-CAT
1901	Performance evaluation measure derived from performance evaluation domain of the C-CAT
1905	Leadership commitment measure derived from the leadership commitment domain of the C-CAT
1888	Workforce development measure derived from workforce development domain of the C-CAT

Patient Experience and Function Portfolio

Long Term Services and Support: 4 Measures	
0688	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (long stay)
2614	CoreQ: Short Stay Discharge Measure
2615	CoreQ: Long-Stay Resident Measure
2616	CoreQ: Long-Stay Family Measure

Shared Decision Making: 2 Measures	
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
2962	Shared Decision Making Process

Patient Experience and Function Portfolio

Patient Experience: 12 Measures	
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
0228	3-Item Care Transition Measure (CTM-3)
0258	CAHPS In-Center Hemodialysis Survey
0517	CAHPS® Home Health Care Survey (experience with care)
0700	Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey
1892	Individual engagement measure derived from the individual engagement domain of the C-CAT
2548	Child Hospital CAHPS (HCAHPS)
2967	CAHPS® Home- and Community-Based Services Measures

Overview of Evaluation Process

Roles of the Standing Committee
During the Evaluation Meeting

- Act as a proxy for the NQF multi-stakeholder membership
- Work with NQF staff to achieve the goals of the project
- Evaluate each measure against each criterion
  - *Indicate the extent to which each criterion is met and rationale for the rating*
- Make recommendations regarding endorsement to the NQF membership
- Oversee portfolio of Patient Experience and Function measures

Major Endorsement Criteria *(page 28)*

- ***Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (**must-pass**)*

- ***Reliability and Validity-scientific acceptability of measure properties** : Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (**must-pass**)*

- ***Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches*

- ***Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible **(must pass for maintenance measures)***

- ***Comparison to related or competing measures***

Ground Rules for Today's Meeting

During the discussions, things to keep in mind:

- Base evaluation and recommendations on the measure evaluation criteria and guidance
- Remain engaged in the discussion without distractions
- Attend the meeting at all times (except at breaks)
- Keep comments focused on the discussion topic on discussion topic

Questions?

Review of Measure 1741

- **Title:** Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey
- **Developer:** American College of Surgeons, Division of Advocacy and Health Policy
- **Measure Type:** Outcome
- **Data Source:** Instrument-Based Data
- **Level of Analysis:** Clinician
- **Care Setting:** Inpatient/Hospital, Outpatient, Other
- **Review history:**
  - ***Original Endorsement Date:*** *May, 2012*
  - ***Most Recent Update:*** *November, 2017*
- **Status:** Endorsed

Assessment and Care Planning Measures: Managed Long-Term Services and Supports (MLTSS)

January 31, 2018

Roxanne Dupert-Frank, *Center for Medicaid and CHIP Services*
Jessica Ross, *Mathematica Policy Research*
Erin Giovannetti, *National Committee for Quality Assurance*

Medicaid Long-Term Services and Supports

Broad range of medical and personal care services for people with some self-care needs due to aging, chronic illness or disability

Services include:

- Nursing Home
- Adult day care
- Home health aide
- Personal care aide
- Transportation
- Supportive employment
- Other home- and community-based services

Medicaid is the largest payer for LTSS

Almost half of states deliver (or are planning to deliver) LTSS through managed LTSS plans (MLTSS)

Managed LTSS Plans are accountable

- **In 2015, 18 state Medicaid agencies contracted with plans to provide MLTSS**
- **States typically contract with 3-10 MLTSS plans; 1 in RI and VT, 36 in NY (total of ~120 plans nationally)**
- **State contracts with MLTSS plans obligate plans to conduct in-person assessments and care plans with new LTSS members shortly after they are enrolled, and update them annually, and arrange for needed services and supports**
- **In many states, MLTSS plans cover medical services, so they also contract with primary care providers; if medical services are not covered, most states require MLTSS plans to coordinate care with medical care providers**

CMS Contracts to Develop MLTSS Measures

Project Team:

- **CMS: CCSQ, MMCO, CMCS DQ & CMCS DMCP**
- **Contractors: Mathematica Policy Research and NCQA**

Goals: Identify key MLTSS measure domains and concepts, develop and test measures

Result:

- **4 Assessment and Care Planning measures**
- **3 Rebalancing/Utilization measures**
- **1 Falls Risk Reduction measure**

MLTSS Person-Centered Planning and Coordination Quality Measures

Few existing nationally standardized measures to help make fair comparisons across MLTSS plans and state Medicaid MLTSS programs

Proposed measures address priority measurement gaps in person-centered planning and coordination identified by NQF's HCBS Quality Committee:

- NQF 3319: Comprehensive LTSS Assessment and Update
- NQF 3324: Comprehensive LTSS Care Plan and Update
- NQF 3325: Shared Care Plan with Primary Care Physician
- NQF 3326: Re-Assessment/Care Plan Update After Inpatient Discharge

Conceptual Model

NQF 3319: LTSS Comprehensive Assessment and Update

The percentage of MLTSS enrollees who have documentation of an in-home, comprehensive assessment covering core elements, within 90 days of enrollment or annually

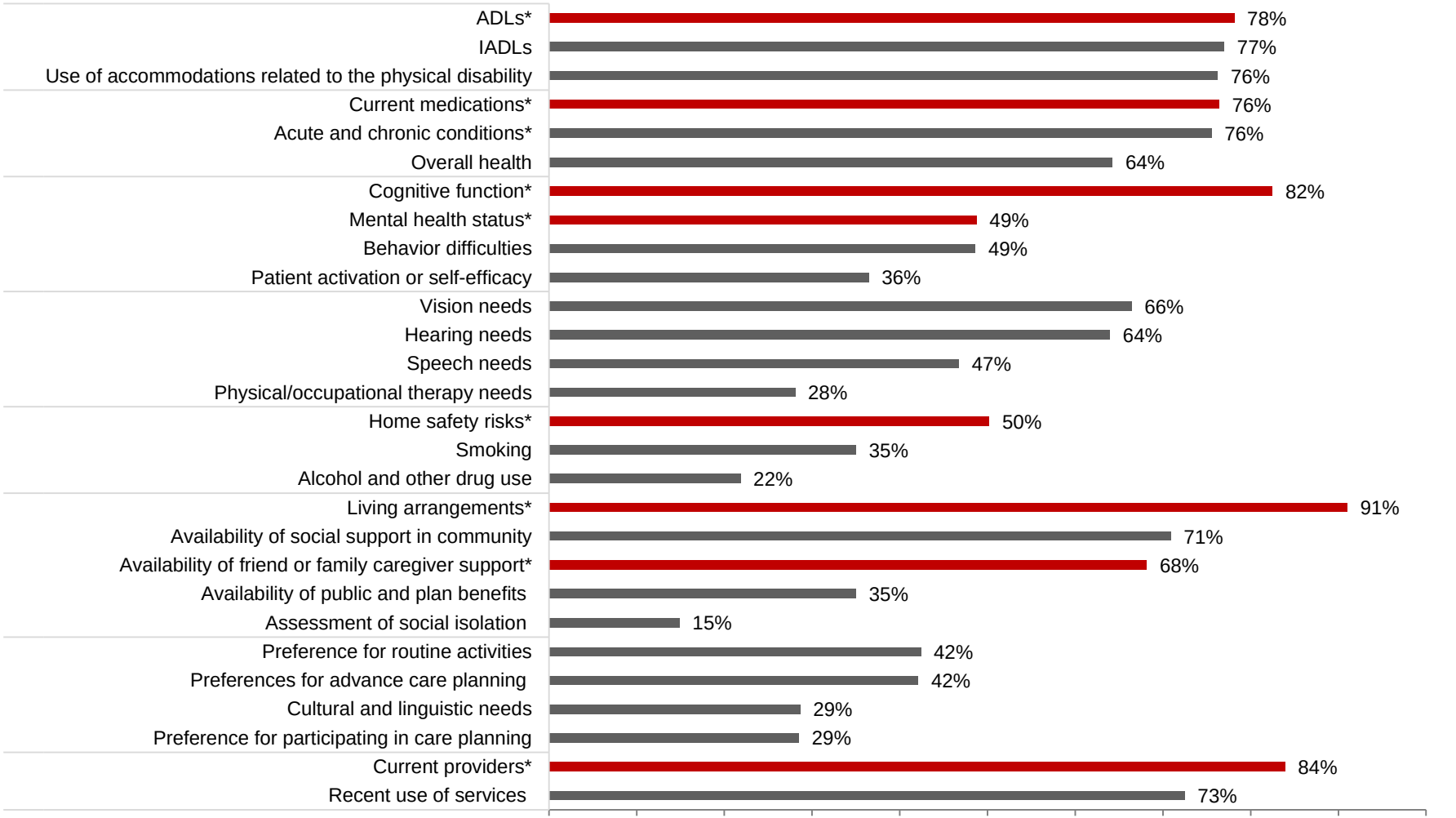
97% had an assessment completed

73% had an assessment completed in the specified timeframe

66% had an assessment in the home

Assessment Elements

Evaluated whether 28 different elements were documented



** Core element*

NQF 3319: LTSS Comprehensive Assessment and Update

Core Elements

1) ADLs
2) Current Medications
3) Acute and chronic conditions
4) Cognitive Function
5) Mental Health Status
6) Home Safety Risk
7) Living Arrangement
8) Availability of friend/family caregiver support
9) Current Providers

	Across 5 MLTSS Plans		
Comprehensive LTSS Assessment	**Mean**	**Min**	**Max**
Rate 1: 9 Core elements	7.9%	0.0%	25.5%
Rate 2: 9 Core elements + at least 12 supplemental elements	6.4%	0.0%	21.6%

NQF 3324: LTSS Comprehensive Care Plan and Update

The percentage of MLTSS enrollees who have documentation of a comprehensive care plan, covering core elements, within 120 days of enrollment or annually with documentation of:

- **Caregiver involvement**
- **Beneficiary consent**

68% had a care plan completed

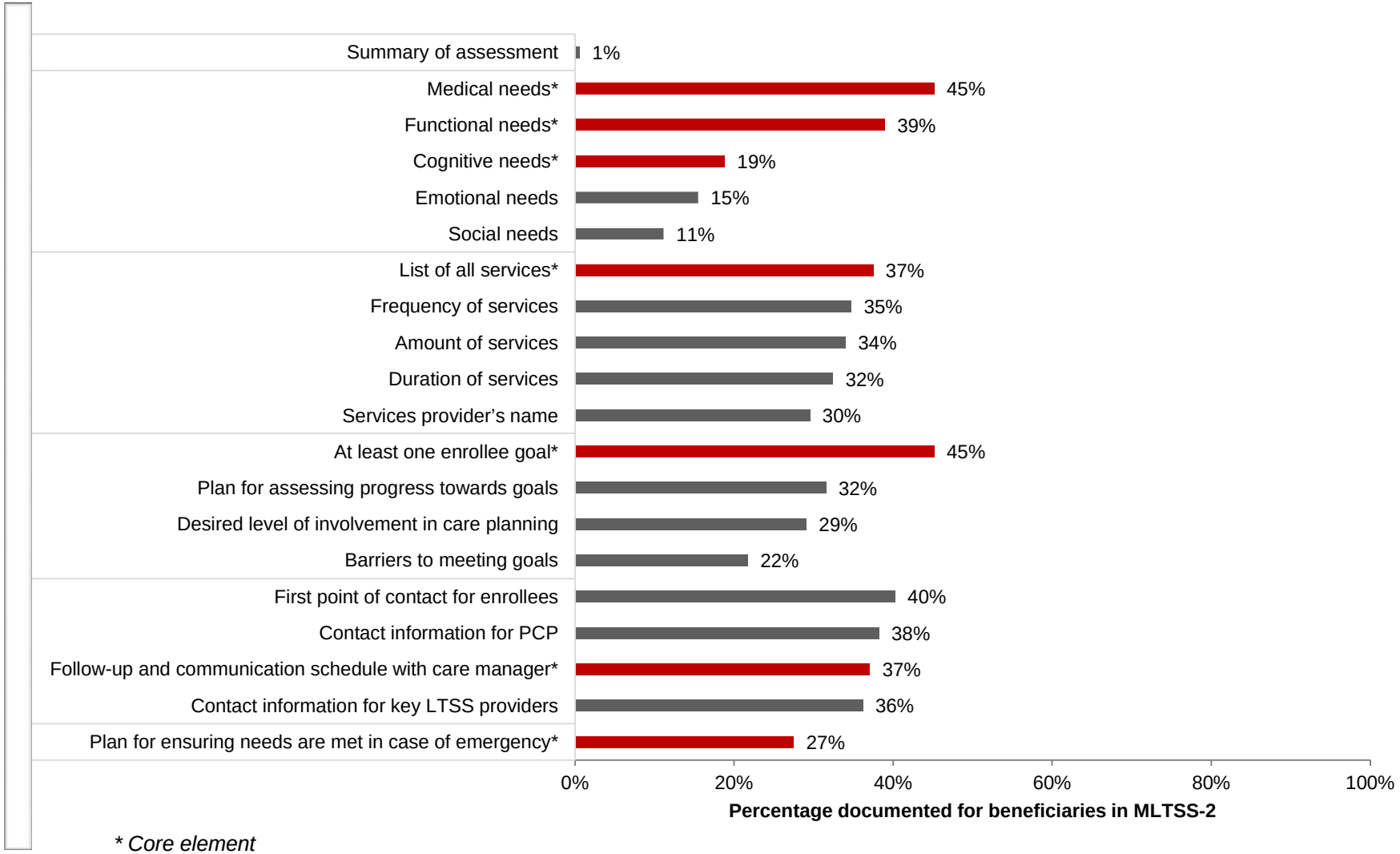
48% had a care plan completed in specified timeframe

21% had documentation of caregiver involvement

17% had documentation of beneficiary (or proxy) consent

Care Plan Elements

Evaluated whether 20 different elements were documented



** Core element*

NQF 3324: LTSS Comprehensive Care Plan and Update

Core Elements

1) Medical needs
2) Functional needs
3) Cognitive needs,
4) List of all services received/expected to receive
5) Beneficiary goal
6) Follow-up and communication schedule with care manager
7) Plan for ensuring beneficiary needs are met in case of emergency

	Across 5 MLTSS Plans		
Comprehensive LTSS Care Plan	**Mean**	**Min**	**Max**
Rate 1: 7 Core elements	0.6%	0.0%	2.5%
Rate 2: 7 Core elements + at least 4 supplemental elements	0.6%	0.0%	2.5%

NQF 3325: LTSS Shared Care Plan with Primary Care Physician

The percentage of MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to the PCP within 30 days of development or update

30% of care plans are shared

19% shared within 30 days

18% of care plans are shared within 30 days with a PCP

NQF 3325: LTSS Shared Care Plan with Primary Care Physician

Focus on Coordination with PCP

- Preliminary measure specification required care plan sharing with both PCP and at least one key LTSS provider
  - **3%** of care plans met this criteria
- Definition of "key LTSS provider" found to be subjective and confusing
- Focused on coordination with PCP based on expert workgroup feedback

	Across 5 MLTSS Plans		
Shared LTSS Care Plan with PCP	**Mean**	**Min**	**Max**
	6.5%	0.0%	23.4%

NQF 3326: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge

The percentage of inpatient discharges of MLTSS enrollees resulting in updates to the assessment and care plan within 30 days of discharge

33% of enrollees had at least one unplanned hospital admission (319 discharges total)

Among the 319 discharges:

- **31% were followed by a re-assessment within 30 days**
- **5.2% also followed by a care plan update within 30 days**

NQF 3326: LTSS Re-Assessment/Care Plan Update After Inpatient Discharge

Need for Ongoing Monitoring

- Preliminary specification required both a re-assessment and care plan update within 30 days
  - **5.2%** of discharges met this criteria
- Use of two rates reflects current practices (Rate 1) and best practices recommended during development by TEP members and experts (Rate 2)

	Across 5 MLTSS Plans		
Re-Assessment/Care Plan Update after Inpatient Discharge	**Mean**	**Min**	**Max**
Rate 1: Re-Assessment	22.4%	7.4%	40.0%
Rate 2: Re-Assessment and care plan update	5.2%	0.0%	14.3%

Review of Measure 3319

- **Title:** Long Term Services and Supports (LTSS) Comprehensive Assessment and Update
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Management Data, Paper Records, Other
- **Level of Analysis**: Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

Break

Review of Measure 3324

- **Title:** Long Term Services and Supports (LTSS) Comprehensive Care Plan Update
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Management Data, Paper Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

Review of Measure 3325

- **Title:** Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Management Data, Paper Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

Review of Measure 3326

- **Title:** Long Term Services and Supports (LTSS) Re-Assessment/Care plan Update after Inpatient Discharge
- **Developer:** Mathematica Policy Research
- **Measure Type:** Process
- **Data Source:** Claims, Management Data, Paper Medical Records, Other
- **Level of Analysis:** Health Plan
- **Care Setting:** Home Care, Other
- **Status:** New Measure

Public Comment

Lunch

Developer Presentation: Patient Engagement and Shared Decision Making

Glyn Elwyn, MD, MSc, FRCGP, PhD,
The Dartmouth Institute for Health Policy and Clinical Practice

collaboRATE™

National Quality Forum
January 31, 2018

Glyn Elwyn, MD PhD

THE Dartmouth INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE

Background

- Patient-reported experience measure
- ‘Screening tool’ to detect shared decision making (SDM)
- Designed to be ‘fast and frugal’ in its administration and interpretation, detecting variation at practice and clinician levels without routinely collecting patient demographic data
- Subject of six validation studies

Study #1

Aims:

- Develop brief, targeted SDM measurement scale
- Obtain iterative feedback from target population on item content, wording, and response scales
- Establish face validity and content validity

Methods:

- Literature review of existing related measures and SDM theoretical models developed by subject-matter experts
- Cognitive interviews
  - Sample: hospital-based general population (n=27)
- Qualitative, iterative analysis

CollaboRATE items

Thinking about the appointment you have just had…

1. How much effort was made to help you understand your health issues?

0	1	2	3	4	5	6	7	8	9
No effort was made									Every effort was made

2. How much effort was made to listen to the things that matter most to you about your health issues?

0	1	2	3	4	5	6	7	8	9
No effort was made									Every effort was made

3. How much effort was made to include what matters most to you in choosing what to do next?

0	1	2	3	4	5	6	7	8	9
No effort was made									Every effort was made

Study #2

Aims:

- Assess psychometric properties of CollaboRATE, including:
  - Intrarater reliability
  - Sensitivity/Discriminative validity
  - Concurrent validity

Methods:

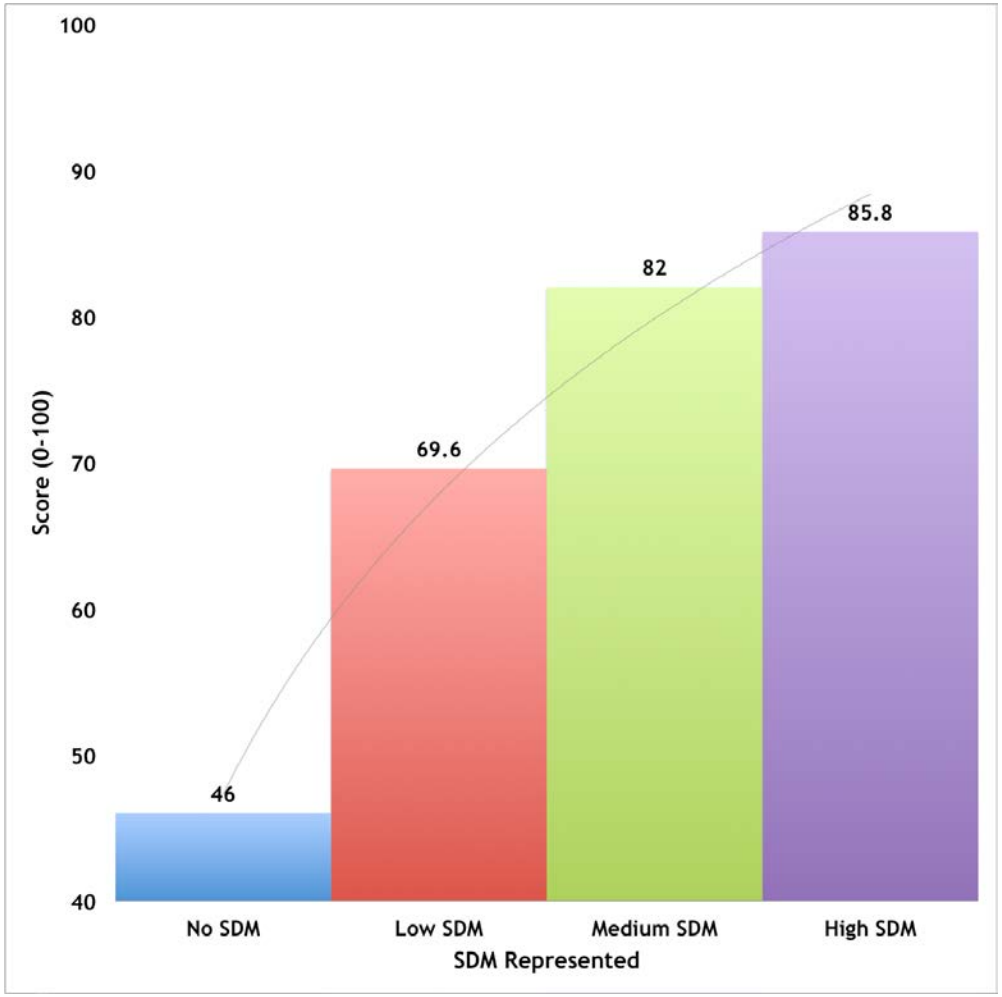
- Online survey featuring six clinical vignettes portraying varied levels of SDM
  - Sample: internet panel representing general public (n=251)
- Statistical testing: descriptive statistics, Cohen's kappa, point-biserial correlation, t-tests/chi-square tests

Study #2 Results

Comparison	Summary statistic	Relationship
Concurrent validity (with SDM-Q-9)	r=0.49	Moderate, positive
Concurrent validity (with PICS-DFS)	r=0.36	Moderate, positive
Intra-rater reliability (Time 1 to Time 2)	Agreement=84.7% Kappa=0.56	Moderate agreement

Barr PJ, Thompson R, Walsh T, Grande S, Ozanne E, Elwyn G. The psychometric properties of CollaboRATE. A fast and frugal patient-reported measure of the shared decision-making process. J Med Internet Res. 2014 Jan 3;16(1):e2.

Study #2 Results: Sensitivity



Barr PJ, Thompson R, Walsh T, Grande S, Ozanne E, Elwyn G. The psychometric properties of CollaboRATE. A fast and frugal patient-reported measure of the shared decision-making process. J Med Internet Res. 2014 Jan 3;16(1):e2.

Study #3

Aims:

- Assess impact of administration mode and patient characteristics on clinician-level CollaboRATE scores
- Determine the extent to which CollaboRATE scores vary by clinician when controlling for potential confounders

Methods:

- Real-time patient survey administered through varied delivery modes
- Sample: consecutive patients of a single primary care clinic
- Mixed effects logistic regression analysis

Study #3: Results

Impact of survey administration mode:

- Significantly lower scores in the online patient portal (OR 0.60, 95% CI 0.45-0.80), IVR (OR 0.45, 95% CI 0.34-0.59), and SMS (OR 0.51, 95% CI 0.38-0.67) modes as compared to the paper mode administered in-clinic

Impact of patient characteristics:

- Scores increased slightly with patient age (OR 1.01 per year of age, 95% CI 1.01-1.02)
- No other patient characteristics predicted scores

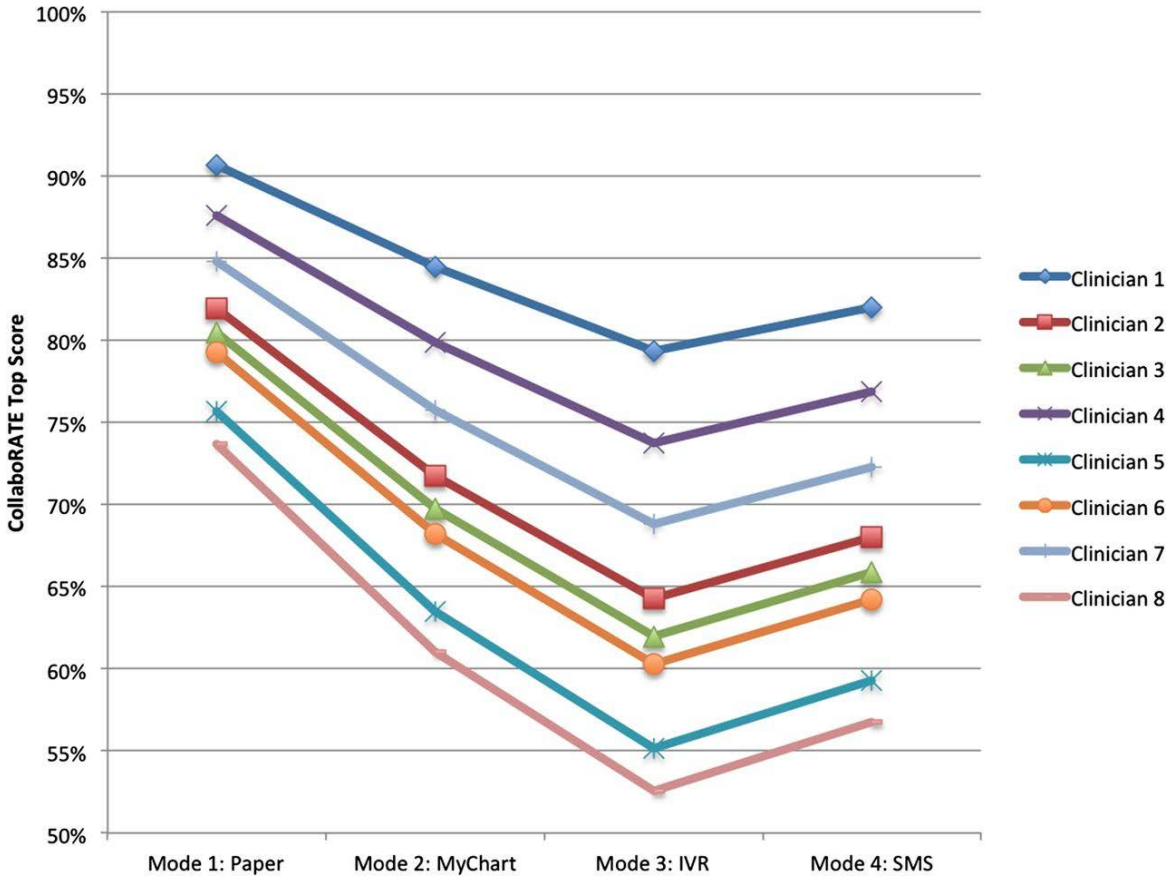
Variation in CollaboRATE scores by clinician:

- Random effect standard deviation of 0.34 implies substantial variation in clinician scores even when controlling for observed patient case mix

Barr PJ, Forcino RC, Thompson R, Ozanne EM, Arend R, Castaldo MG, O'Malley AJ, Elwyn G.Evaluating CollaboRATE in a clinical setting: analysis of mode effects on scores, response rates and costs of data collection. *BMJ Open* 2017;**7:**e014681. doi: 10.1136/bmjopen-2016-014681

Study #3: Results

Controlling for case mix, clinician rank order remains consistent across survey administration modes:



Barr PJ, Forcino RC, Thompson R, Ozanne EM, Arend R, Castaldo MG, O'Malley AJ, Elwyn G.Evaluating CollaboRATE in a clinical setting: analysis of mode effects on scores, response rates and costs of data collection. *BMJ Open* 2017;**7:**e014681. doi: 10.1136/bmjopen-2016-014681

Study #4

Aims:

- Assess impact of patient characteristics on CollaboRATE scores
- Evaluate degree to which CollaboRATE scores vary by site when controlling for potential confounders

Methods:

- Real-time patient survey
- Sample: consecutive patients of three US-based primary care clinics
- Mixed effects logistic regression analysis, z-tests

Study #4: Results

Impact of patient characteristics:

- Scores increased only slightly with increasing patient age (OR 1.018, 95% CI 1.014-1.021)
- Female patients gave significantly higher scores than did male patients (OR 1.224, 95% CI 1.073-1.397)

Variation in scores by clinician:

- Random effect standard deviation of 0.38 shows heterogeneous clinician-level scores

Variation in scores by site:

- Site 3 had higher scores than Site 1 (OR 1.759, 95% CI 1.216-2.545) and Site 2 (z=2.71, 95% CI -1.114 to -0.178, p=0.007)

Forcino RC, Barr PJ, O'Malley AJ, Arend R, Castaldo MG, Ozanne EM, Percac-Lima S, Stults C, Tai-Seale M, Thompson R, Elwyn G..Using CollaboRATE, a brief patient-reported measure of shared decision making: results from three clinical settings in the United States. *Health Expect* 2018;21:82–89. doi: 10.1111/hex.12588.

Study #5

Aims:

- Assess suitability of CollaboRATE as a routine measure of shared decision-making in both inpatient and outpatient settings, including evaluation of:
  - Internal consistency
  - Concurrent validity

Methods:

- Routine survey of Veterans' Administration patients
- Sample: inpatients (n=767) and outpatients (n=1019) having received health care in VA facilities
- Statistical analysis: Cronbach's alpha, correlation analysis

Study #5: Results

Reliability:

- Strong internal consistency among both outpatient respondents (Cronbach's alpha=0.97) and inpatient respondents (Cronbach's alpha=0.96)

Concurrent validity:

- Strongly correlated with Communication Assessment Tool (Makoul 2007) among outpatients ($r=0.85$, $p<0.001$) and inpatients (0.84, $p<0.001$)

Meterko M, Radwin LE, Bokhour BG. Measuring patient-centered care: A brief measure for use in point-of-care assessments. Internal VA White Paper.

Study #6

Aims:

- Evaluate the extent to which CollaboRATE scores vary across medical groups in a large, diverse sample
- Assess concurrent validity with related patient experience measures

Methods:

- Routine, twice yearly California Patient Assessment Survey
- Sample: More than 31,000 patients across primary care and specialty outpatient services
- Statistical analysis: Regression analysis, chi-square tests

Study #6: Results

Variation by medical group:

- In a model controlling for patient characteristics, R^2 value of 0.43 suggests that substantial variation remains between medical groups that is unexplained by case mix

Concurrent validity with related measures

- CollaboRATE scores are highly associated with CAHPS communication items ($p<0.0001$) across primary care and specialty care settings; CAHPS communication items include:
  - Doctor explanations easy to understand
  - Doctor listens carefully
  - Doctor shows respect
  - Doctor spends enough time

Conclusions

- Rigorous development process ensured face and content validity
- Concurrent validity with related measures has been demonstrated in multiple contexts (primary vs. specialty care, inpatient vs. outpatient)
- Sensitivity to variation in SDM level was demonstrated through clinical vignettes
- Variation in scores has been demonstrated across clinical sites and by individual clinician irrespective of case mix

NQF History and Overview: Competing Measures

Suzanne Theberge, NQF Senior Project Manager

Agenda

- NQF Overview
- Presentation from UDSMR
- Presentation from Encompass Health (formerly HealthSouth)
- Committee Discussion and Q&A
  - *UDSMR*
  - *CMS*
  - *Encompass Health*

Today's Committee Charge

The NQF Board of Directors (BOD), in October 2015, endorsed four measures (two sets of competing measures) with special update requirements.

Today's presentations and discussion on these functional status measures is purely informational as a follow-up to the BOD's required updates:

- this not an endorsement discussion;
- there will be no votes or decisions made.

Objectives

- Committee to determine if there is additional information needed to make a decision on *Best in Class*
- Developers to submit additional testing data by August 2018
- Committee will review and consider *Best in Class* during the Fall 2018 Measure Evaluation Cycle

Patient and Family Centered Care Project, Phase 2 (2015)

Self-Care	Mobility
2633: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (CMS)	*2634: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients* (CMS)
2286: Functional Change: Change in Self Care Score (UDSMR)	*2321: Functional Change: Change in Mobility Score* (UDSMR)

History

- Two sets of instrument-based competing measures
  - *Presently in the Inpatient Rehabilitation Facility setting -- there will be more in the future in other care settings*
- Committee and CSAC could not come to consensus on *Best in Class*
- NQF Board of Directors ultimately endorsed both measures with conditions
- HealthSouth (now Encompass) submitted an appeal, but later withdrew it and approached NQF with a opportunity to share feedback data on the measures.

Board of Directors Conditions

CMS (2633, 2634)	UDSMR (2286, 2321)
• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new and will be implemented in 2016. • Provide data on comparison of the competing measure results to gain an understanding of which scale is more reliable, valid and feasible. • Provide a summary of qualitative data gathered during rule-making process including perceived benefits from the field for instruments that cut across settings.	• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new. There is particular interest in measure performance/scientific acceptability across care settings beyond IRF. • Provide information about costs associated with use of the FIM Instrument, respective software and tools; and costs of ongoing training in order to accurately use the FIM Instrument.

Competing Measures Sub-Criteria

- 5b. Competing Measures
  - *The measure is superior to competing measures (e.g. is a more valid or efficient way to measure);* ***OR*** *Multiple measures are justified.*

Questions

- How are legislative and/or regulatory requirements considered in *Best in Class*?
- Is one of the measures clearly superior?
- If not,
  - *Is there a need for multiple measures?*
  - *What would be the burden of having multiple measures?*
  - *Are there ways to harmonize?*

Developer Presentation: Update on Competing Measures: Uniform Data System for Medical Rehabilitation (UDSMR)

Paulette Niewczyk, Director of Research, UDSMR

2286: Functional Change: Change in Self Care Score

2321: Functional Change: Change in Mobility Score

2016-2017 Updates for UDSMR Functional Measures: Measure #2286 Functional Change: Change in Self-Care & Measure #2321Functional Change: Change in Mobility

Paulette Niewczyk, MPH, PhD
Director of Research
UDSMR, University at Buffalo, Amherst, NY

UDSMR: Who We Are

- Not-for-profit organization, established in 1987, affiliated with the University at Buffalo, SUNY
- Developed several instruments for use in the rehabilitation industry to measure patient functional outcomes
- Maintains the world's largest database for medical rehabilitation outcomes; roughly 75% of all US inpatient rehabilitation facilities submit patient level data to include in benchmarking reports including the Veterans Administration in addition to several TBI, SCI and burns model systems.

Measure #2286
Functional Change: Change in Self-Care

Measure #2286 Functional Change: Change in Self-Care

- Measures physical and cognitive aspects of a patient's ability to manage daily self care
- ***8 items- 6 motor and 2 cognitive***: feeding, grooming, upper-body dressing, lower-body dressing, toileting, bowel control, expression and memory
- 7-level rating scale; clinicians rate patient's lowest actual observed score over a 24-hour period
- ***Endorsed by NQF on 11/4/2015;*** PFCC Committee: 71% voted to endorse, CSAC Committee: 100% voted to endorse

Reliability

- ***Cronbach's alpha= .83 indicating a reliable measure***
- N=488,942, missing=0
- Number of items=8
- Inter-item correlation ranged from .79 (expression and memory) to .21 (memory and dressing lower), ***all items were significantly correlated (p<.001)***

Facility Level Reliability Analysis

- An intra-class correlation coefficient (ICC) using the split-half method was used to assess the score level reliability across facilities.
- A random sample of 30 facilities were included from a total of 920 facilities from the most recent complete data file (patients discharged from 10/1/2016 to 9/30/2017, n= 488,942).
- ***ICC= .92, p <.001, demonstrating very high consistency among facilities for the measure***
- Rasch-converted average range in scores for the measure by facility was 9.2 to 21.2

Construct Validity

- Factor analysis using principal component analysis resulted in 2 components identified in the measure, cumulatively accounting for 63.8% of the total explained variance
- Component 1 included: eating (.68), grooming (.72), dressing upper (.77), dressing lower (.68), toileting (.71), and bowel (.59), eigenvalue=3.78, contributing ***47.3% of the explained variance***
- Component 2 included: expression (.61) and memory (.63), eigenvalue=1.32**,** contributing ***16.5% of the explained variance***

Predictive Validity

Regression models were used to determine the predictive ability of the self-care measure items on patient outcomes.

The self-care measure was a significant predictor of:

- ***Patient discharge to the community***, chi-square=50178.4, (df=8), p<.001. R_2 =.15, ***all items were retained in the model and were statistically significant*** (p<.001)
- ***Patient length of stay (LOS)***, adjusted R_2 =.15, p<.001
- ***Patient discharge functional status*** (total functional gain from admission to discharge), adjusted R_2=.44, p<.001

Impact of Cognitive Items

Stepwise regression models were performed to determine the contribution of each item within the measure on the outcomes.

- ***Predicting likelihood of patient discharge to the community***: ***expression and memory*** were retained and statistically significant (p<.001) in the model
- ***Predicting LOS: expression was retained*** and statistically significant (p<.001), memory was not retained in the model
- ***Predicting patient discharge functional status: expression and memory were retained*** and statistically significant (p<.001) in the model. It is noteworthy that ***expression was the first item retained in the model, with a contributing adjusted R_2 = .23.***

Measure #2321
Functional Change: Change in Mobility

Measure #2321 Functional Change: Change in Mobility

- Measures patient's mobility, ability to ambulate and need for assistance with transfers
- ***4 items***: bed/chair transfer, toilet transfer, locomotion, stairs
- 7-level rating scale; clinicians rate patient's lowest actual observed score over a 24-hour period
- ***Endorsed by NQF on 11/4/2015;*** PFCC Committee: 94% voted to endorse, CSAC Committee: 100% voted to endorse

Reliability

- ***Cronbach's alpha= .78 indicating a reliable measure***
- N=488,942, missing=0
- Number of items=4
- Inter-item correlation ranged from .76 (transfer bed/chair and transfer toilet) to .37 (transfer toilet and walking***), all items were significantly correlated (p <.001)***

Facility Level Reliability Analysis

- ICC using the split-half method was used to assess the score level reliability across facilities
- A random sample of 30 facilities were included from a total of 920 facilities from the most recent complete data file (patients discharged from 10/1/2016 to 9/30/2017, n= 488,942)
- ***ICC was 0.951, p <.001, demonstrating very high consistency among facilities for the measure***
- Rasch-converted average range in scores for the measure by facility was 17.1 to 35.6

Construct Validity

- Factor analysis using principal component analysis resulted in 1 component identified in the measure, cumulatively ***accounting for 61.1% of the total explained variance***
- Component 1 included items: transfer bed/chair (.86), transfer toilet (.84), walking (.69), and stairs (.73), eigenvalue=2.44

Predictive Validity

- Regression models were used to determine the predictive ability of the mobility measure items on patient outcomes.

The mobility measure was a significant predictor of:

- ***Patient discharge to the community,*** chi-square=46078.9, (df=4), p<.001. R_2 =.14, all items were retained and statistically significant (p<.001) in the model
- ***Patient LOS,*** adjusted R_2 =.15, p<.001
- ***Patient discharge functional status,*** adjusted R_2=.27, p<.001

Utility in Multiple PAC Settings

Use in Skilled Nursing Facilities and Long-Term Acute Care Facilities

- **The measures have been endorsed by NQF for use in SNF and LTAC settings** (Functional Change: Change in Self-Care for SNF measure #2769 and Change in Mobility for SNF measure #2774 endorsed 10/25/2016; Functional Change: Change in Self-Care for LTAC measure #2777 and Change in Mobility for LTAC measure #2778 endorsed 10/25/2016)
- **A cross-walk for the Self-Care Measure:**

  NQF #2286 (IRF) = NQF #2769 (SNF) = NQF #2777 (LTAC)
- **A cross-walk for the Mobility Measure:**

  NQF #2321 (IRF) = NQF #2774 (SNF) = NQF #2778 (LTAC)

Facility Level Reliability Analysis: SNF Venue

- ICC using the split-half method was used to assess the score level reliability across SNFs, a random sample of 25 facilities were included
- ***Self-care measure: ICC = 0.87, p <.001, demonstrating high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 11.1 to 27.1
- ***Mobility measure: ICC = 0.75, p <.001, demonstrating consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 14.0 to 28.9

Facility Level Reliability Analysis: LTAC Venue

- ICC using the split-half method was used to assess the score level reliability across LTAC facilities, a random sample of 39 facilities were included
- ***Self-care measure: ICC = 0.95, p <.001, demonstrating very high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 11.1 to 20.9
- ***Mobility measure: ICC = 0.94, p <.001, demonstrating very high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 8.8 to 25.6

Conclusions: Summary & Application

The UDSMR Self-Care and Mobility Functional Measures

- ***High reliability and construct, content and predictive validity***
- ***Meet the defined requirements of the IMPACT Act with the inclusion of cognitive functional items***
- ***Ability to assess disparities***; differences in outcomes, based on sociodemographic variability controlling for other factors
- ***May be used in multiple PAC venues for a true 'apples to apples' quality comparison***; ability to track patient outcomes over time for those treated in multiple PAC venues for the same treatment episode (ex. admitted to LTAC from acute hospital, to SNF after LTAC stay, from SNF to IRF, from IRF to home)

Utility

- ***Intended for use among all adult (ages 18+) patients*** (all impairments/conditions, low and high functioning, independent of reimbursement/payment source)
- Items, rating scales and assessment rules are the same for all PAC settings, ***the measures are standardized and interoperable***
- ***All items within both measures are assessed by provider*** (not self-reported) ***based on observed performance*** (actual ability not estimated/assumed capability)
- ***All items are applicable for all patients; N/A-type rating options are not included,*** reducing the extent of missing data and increasing the accuracy of patient outcomes assessment

Accessibility

- Both measures are embedded in the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), mandated for use among IRFs by CMS since 2002 for payment reimbursement; the measures are ***publicly available and free of charge*** (there would be no charge for national reporting of measures if CMS elects to make available)
- Facilities that subscribe to UDSMR ***do not pay for the use of instruments or measures;*** subscription is for specialized services including: clinical training, national benchmarks and facility-level outcomes reporting, report interpretation, coding assistance, performance improvement guidance
- Subscription costs vary based on facility type (ex. single facility or multiple facilities within a corporation) and facility-level service needs

Questions?

Thank you!

Implementer Presentation:
Feedback on Competing Measures - Encompass Health Corporation

Cheryl Miller, VP, Therapy Operations,
Andrew Baird, Director of Government Relations,
Mary Ellen DeBardelben, Director, Quality,

Encompass Health

Implementer Presentation: Feedback on Competing Measures

Andrew Baird, JD

Director, Government Relations

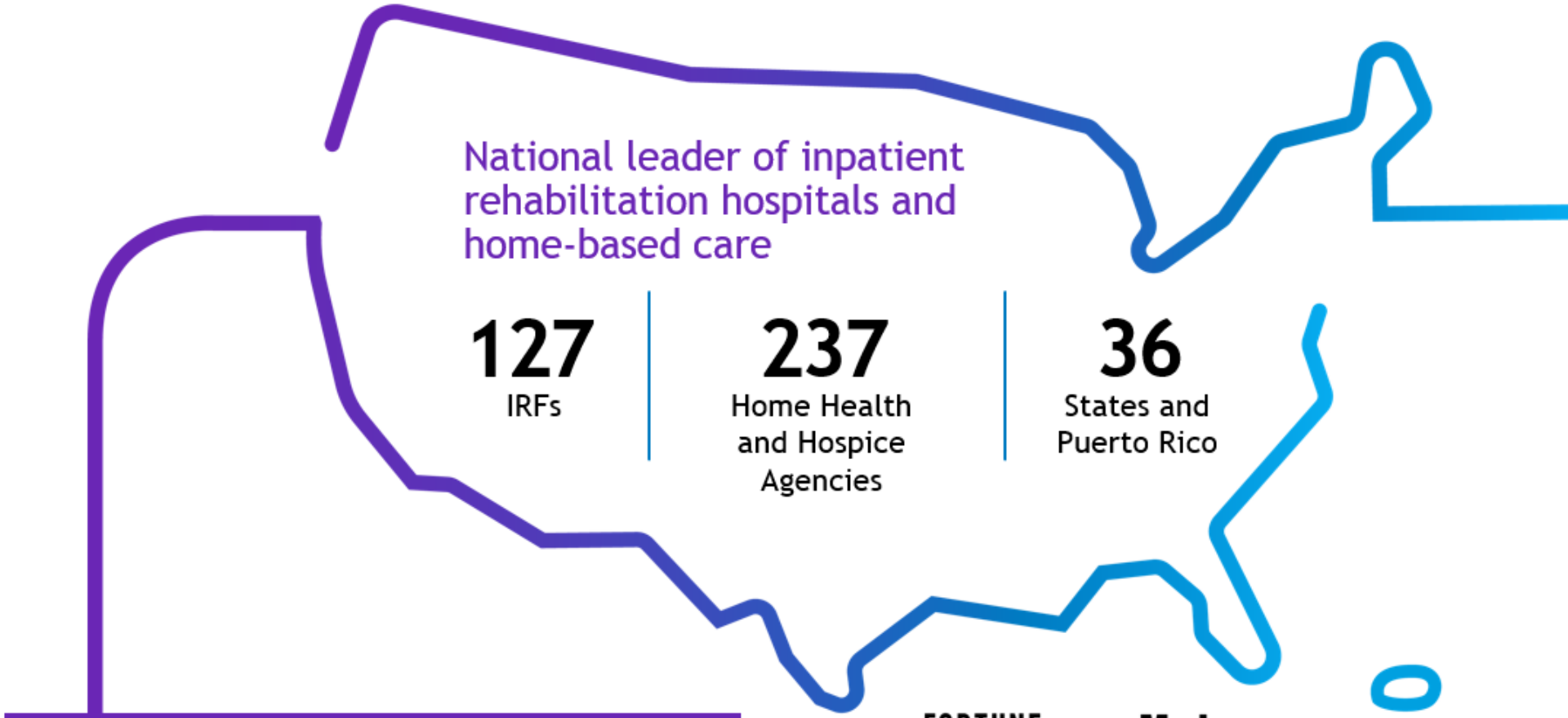
Mary Ellen DeBardeleben, MBA, MPH

Director, Quality

Cheryl Miller OTR/L, DrOT

Vice President, Therapy Operations

Encompass Health



National leader of inpatient rehabilitation hospitals and home-based care

127
IRFs

237
Home Health and Hospice Agencies

36
States and Puerto Rico

Committed to delivering high-quality, cost-effective care across the post-acute continuum

FORTUNE 100 BEST COMPANIES TO WORK FOR 2017

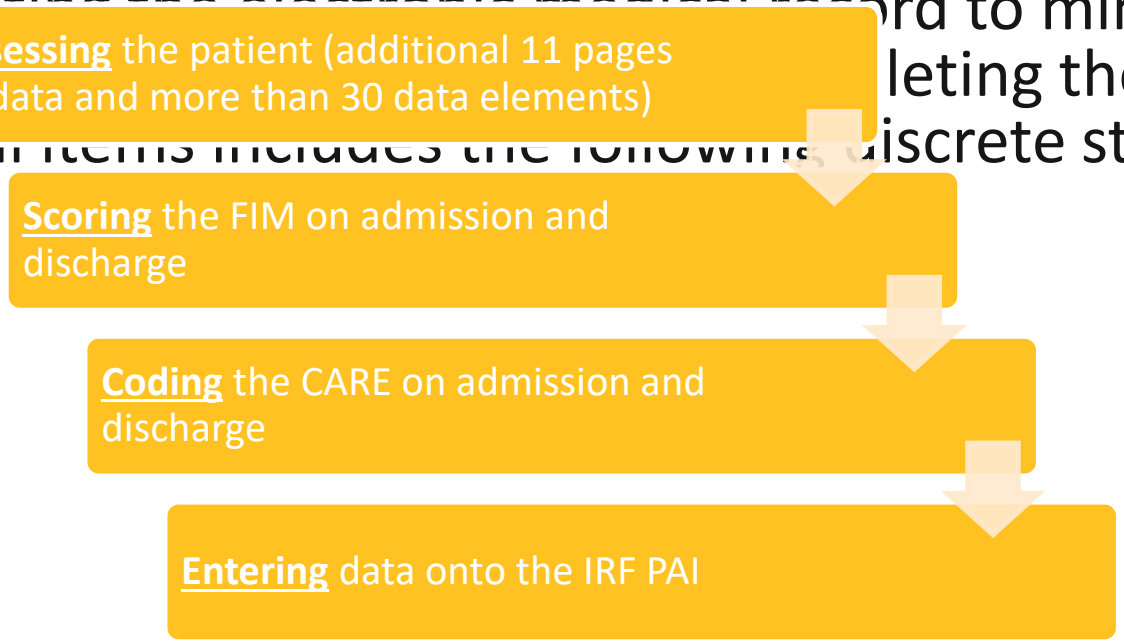
Modern Healthcare BEST PLACES TO WORK 2017

Rebranding and Name Change Initiative

- **Both business segments — inpatient rehabilitation and home health and hospice — will transition to the Encompass Health branding by the end of 2019.**
  - Rebranding and name change reinforce the Company's existing strategy and position as an integrated provider of inpatient and home-based care.
  - Effective as of January 1, 2018, HealthSouth Corporation will change its name to Encompass Health Corporation, with a corresponding ticker symbol change from "HLS" to "EHC."
  - Rollout will be deliberately sequenced across the Company's hospitals and agencies; overlap markets will be prioritized.

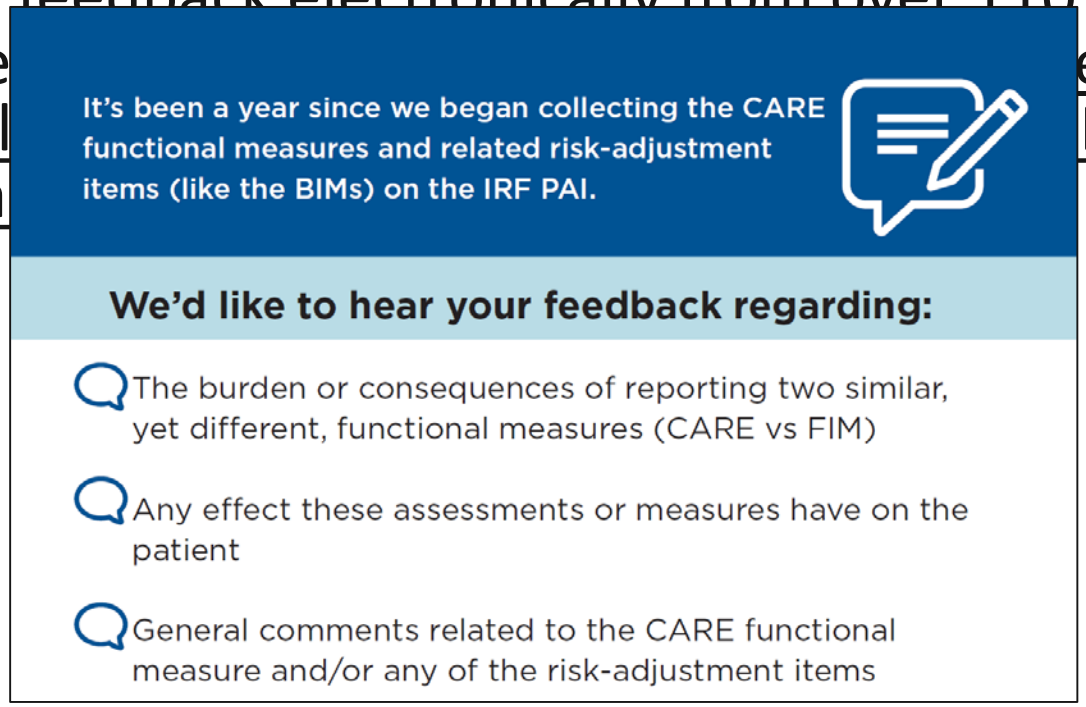
WORKFLOW

- A 40-person Encompass Health workgroup spent approximately one year redefining the process workflow and up[illegible]ord to minimize the impact[illegible]leting the functional items includes the following discrete steps:



FEEDBACK

- Collected feedback from 35 hospital Directors of Therapy Operations (DTO) on feedback cards on-site at national DTO meeting. These individuals oversee clinicians who ASSESS the functional items.
- Collected feedback electronically from over 110 Patient Assessme ese are the individual E the functiona



BURDEN

- Impact on Patient
- ***Delayed initiation of treatment*** *as more time spent on assessment.*
- ***Patients feel they are being ignored****; perceive care providers' attention focused on collecting measures and documenting data instead of treatment.*
- ***Patients can be intolerant or become too fatigued*** *to complete all of the tasks in the required time period.*

- Impact on Staff
- ***Increased time****;*
  - *to assess duplicative measures*
  - *assign scoring/coding and documenting in medical record and IRF PAI*
  - *audit record for completeness and accuracy*
  - *re-work any items that were missed or inaccurate*
- ***Frustration*** *caused by assessing redundant measures creates re-work, additional audits, and decreases job satisfaction*
- *Paralysis by analysis – In effort to collect required data clinicians may sacrifice clinical judgement. Staff also unsure why data is being collected, how they score, or how to improve.*

- Impact on Organization
- ***Increased time/costs*** *associated with increased onboarding education and training on an ongoing basis*
- ***Complete overhaul*** *to electronic medical record to account for additional functional measure*
- ***Increased costs*** *resulting from added staff requirements*
- ***Increased turnover*** *as a result of staff frustration*

ACCURACY

- Confusion for staff between the two measures reduces accuracy
  - » Different Functional Elements Assessed
    - *examples: footwear vs. lower body dressing; oral hygiene vs. hygiene*
  - » Different Scale of measurement (6 point vs. 7 point scale)
  - » Different Rules
    - *Reasons for not scoring an element*
    - *Devices used by patients*

- Most usual performance vs. highest burden of care
  - Paints a different picture of a patient, despite the redundancy in measurement

- Lack of interrater scoring confidence
  - » No competency program for scoring both elements simultaneously

- The biggest issue with collecting two measures, in addition to the *increased burden* and *reduced accuracy*, is that the additional work has not contributed to improved quality of care or outcomes

Committee Discussion and Q&A

Public Comment

Next Steps

Activities and Timeline – Fall 2017 Cycle

Activity	Date
Post-Meeting Conference Call	**Monday, February 5, 1:00-3:00pm**
Draft Report Posted for Public Comment and NQF member comment	March 8 - April 6
Post Draft Report Comment Call	**Friday, April 20, 2:00-4:00pm**
CSAC Review Recommendations	May 21 - June 11
Appeals Period	June 13 - July 12
Final Report Posted	August 2018

Activities and Timeline – Spring 2018 Cycle

Activity	Date
Intent to Submit Deadline	January 4, 2018
Measure submission deadline	April 9, 2018
Commenting & member support period on submitted measures opens	May 1, 2018
Measure Evaluation Web Meeting (1/3)	**Friday, June 22, 2018 1:00-3:00pm ET**
Measure Evaluation Web Meeting (2/3)	**Monday, June 25, 2018 1:00-3:00pm ET**
Measure Evaluation Web Meeting (2/3)	**Friday, June 29, 2018 1:00-3:00pm ET**
Post Measure Evaluation Web Meeting	**Monday, July 9, 2018 10:00am-12:00pm ET**
Report Posted for Public Comment	July 31-August 29, 2018
Post Draft Report Comment Call	**Monday September 17, 2018 11:00am-1:00pm ET**
CSAC Review Recommendations	October 15-November 2
Appeals Period	November 6-December 5
Final Report Posted	January 2019

Project Contact Info

- Email: PatientExperience@qualityforum.org
- NQF Phone: 202-783-1300
- Project page:
- http://www.qualityforum.org/Patient_Experience_and_Function.aspx
- SharePoint site:

http://share.qualityforum.org/Projects/Patient_Experience_and_fucntion/SitePages/Home.aspx

Adjourn