MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

COORDINATING COMMITTEE IN-PERSON MEETING

NOVEMBER 1-2, 2011

Table of Contents

Agenda

Tab 1

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #4

NQF Conference Center 9th Floor
1030 15th Street, NW
Washington, DC 20005

Dial: 877-856-1968
Passcode: 6249749

Web Access (Audio Streaming):
http://www.MyEventPartner.com/NQForum53

DAY 1 AGENDA: NOVEMBER 1, 2011

Meeting Objectives:

- *Finalize MAP measure selection criteria;*
- *Set pre-rulemaking analysis approach;*
- *Identify core measures and prioritize measure gap concepts;*
- *Review findings from the Post-Acute Care/Long-Term Care Workgroup and finalize input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care settings.*

8:30 am **Breakfast**

9:00 am **Welcome, Introductions, and Review of Meeting Objectives**
George Isham and Beth McGlynn, Committee Co-Chairs

9:15 am **Measure Selection Criteria**
George Isham
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF

11:15 am **Proposed Approach to Pre-rulemaking Analysis**
Beth McGlynn
Connie Hwang, Vice President, Measure Applications Partnership, NQF

- *Proposed approach for consideration*
- *Discussion*
- *Opportunity for public comment*

11:40am **Partnership Alignment – NPP and MAP**
George Isham
Bernard Rosof, Co-Chair, National Priorities Partnership

- *Discussion*
- *Opportunity for public comment*

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

12:00 pm **MAP Hospital Workgroup Experience with Core Measures**
Beth McGlynn
Frank Opelka, Chair, MAP Hospital Workgroup

12:30 pm **Lunch**

1:00 pm **Report Out on Coordinating Committee Core Measures Survey Exercise**
George Isham
Connie Hwang
- *Discussion*
- *Opportunity for public comment*

1:30 pm **Core Measures: Small Group Breakout Session**
Beth McGlynn

2:45 pm **Break**

3:00 pm **Core Measures: Hospital Report Out and Discussion**
George Isham
- *Discussion*
- *Opportunity for public comment*

4:30 pm **Summary of Day 1 and Look-Forward to Day 2**
George Isham and Beth McGlynn

4:45 pm **Adjourn for the Day**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #4

DAY 2 AGENDA: NOVEMBER 2, 2011

8:30 am **Breakfast**

9:00 am **Welcome and Recap of Day 1**
George Isham and Beth McGlynn

9:15 am **Finalize Post-Acute/Long-Term Care Quality Measurement Strategy**
Beth McGlynn
Carol Raphael, Chair, MAP Post-Acute/Long Term Care Workgroup
- *Review Post-Acute Care/Long Term Care Workgroup findings*
- *Discussion*
- *Opportunity for public comment*

10:45 am **Break**

11:00 am **Core Measures: PAC/LTC Report Out and Discussion**
George Isham
- *Discussion*
- *Opportunity for public comment*

12:30 pm **Working Lunch**

1:00 pm **Core Measures: Clinician Report Out and Discussion**
Beth McGlynn
- *Discussion*
- *Opportunity for public comment*

2:30 pm **Break**

2:45 pm **Review Hospital, Clinician and PAC/LTC Core Sets**
George Isham
- *Measure parsimony and harmonization issues across settings*
- *Discussion*
- *Opportunity for public comment*

3:15 pm **Summation and Path Forward**
Beth McGlynn

3:30 **Adjourn**

Powerpoint Slides

Tab 2

NQF
National Quality Forum

Measure Applications Partnership Coordinating Committee

In-Person Meeting #3

November 1-2, 2011

NQF
National Quality Forum

Welcome, Introductions, and Review of Meeting Objectives

Meeting Objectives

NQF National Quality Forum

- Finalize Measure Selection Criteria;
- Set pre-rulemaking analysis approach;
- Identify core measures and prioritize measure gap concepts;
- Review findings from the Post-Acute Care/Long-Term Care Workgroup and finalize input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care settings.

In-Person Meeting Agenda – Day 1

NQF National Quality Forum

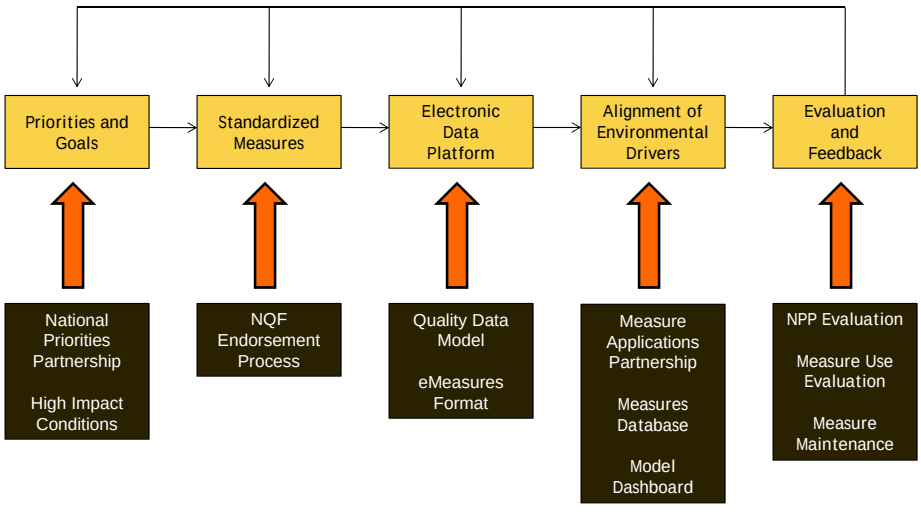
- Measure Selection Criteria
- Proposed Approach to Pre-rulemaking Analysis
- Partnership Alignment – NPP and MAP
- MAP Hospital Workgroup Experience with Core Measures
- Report Out on Coordinating Committee Core Measures Survey Exercise
- Core Measures: Small Group Breakout Session
- Core Measures: Hospital Report Out and Discussion
- Summary of Day 1 and Look-Forward to Day 2

NQF
National Quality Forum

Measure Selection Criteria

Quality Measurement Enterprise

NQF
National Quality Forum

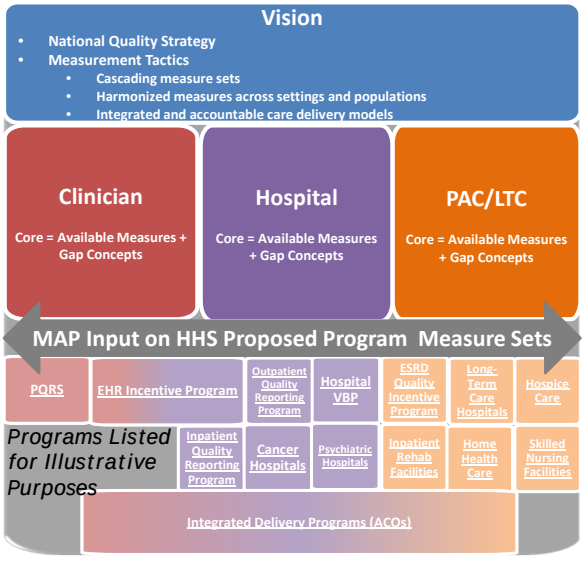


NQF
National Quality Forum

Proposed Approach to Pre-rulemaking Analysis

MAP Pre-Rulemaking Proposed Approach

NQF
National Quality Forum



Illustrative Cardiovascular Measure Cascade: Control of High Cholesterol

National Priority: Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.

GOALS	Measure Concepts
Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.	• Access to healthy foods • Access to recreational facilities • Use of tobacco products by adults and adolescents • Consumption of calories from fats and sugars • Control of high blood pressure • Control of high cholesterol
Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.	
Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.	

National	National Rates of Cholesterol Control (NHANES)
Regional/ State/Community	Regional/State/Community Rates of Cholesterol Control (NHANES)
Health Plan/Health System/ACO	Percentage of patients discharged for AMI, CABG, PCI or with IVD with stable Lipid Control (LDL-C <100mg/dL) (NQF# 0075)
Group Practice/Medical Home	Percentage of patients with CAD with Stable Lipid Control (LDL-C <100mg/dL) (NQF# 0074)
Patient/Individual Provider	Percentage of patients with CAD with Stable Lipid Control (LDL-C <100mg/dL) (NQF# 0074)

9

Pre-Rulemaking Analysis Proposed Process

NQF National Quality Forum

BEFORE NOVEMBER 1	NOVEMBER 1-2	DECEMBER	JANUARY 5-6
MAP WORKGROUPS • Develop core measures • Identify priority measure gap concepts	**COORDINATING COMMITTEE** • Review MAP workgroup evaluations of core measures • Confirm and prioritize measure gap concepts	**MAP WORKGROUPS** • Assess HHS proposed program measure sets • Evaluate measures relative to core measures, gaps, and measure selection criteria	**COORDINATING COMMITTEE** • Review setting-specific recommendations from MAP workgroups • Finalize input to HHS for February 1 Report

10

www.qualityforum.org

Before November 1

MAP WORKGROUPS

- Develop core measures
- Identify priority measure gap concepts

Key Deliverable	• Preliminary core measures for each setting (i.e., clinician, hospital, PAC/LTC) that reflect the ideal characteristics of a core and identified priority measure gaps concepts
Activity	• Complete evaluation of initial starting point for core measures, including identification of priority measure gap concepts
Background Materials	• List of measures used in federal programs • Federal program descriptions • Measure selection criteria

November 1-2

COORDINATING COMMITTEE

- Review MAP workgroup evaluations of core measures
- Confirm and prioritize measure gap concepts

Key Deliverable	• Finalize core measures and prioritized measure gap concepts
Activity	• Review MAP workgroup evaluations of preliminary core measures and identified measure gap concepts
Background Materials	• List of measures used in federal programs • Workgroup evaluations of existing program measure sets and associated measure concept gaps • Measure selection criteria

December

MAP WORKGROUPS

- Assess HHS proposed program measure sets
- Evaluate measures relative to core measures, gaps, and measure selection criteria

Key Deliverable	• Input to MAP Coordinating Committee on HHS proposed program measure sets
Activity	• Assess HHS proposed program measure sets against MAP core measures and prioritized gaps concepts
Background Materials	• HHS proposed program measure sets list • Finalized MAP core measures and prioritized measure gap concepts • Measure selection criteria

January 5-6

COORDINATING COMMITTEE

- Review the setting-specific recommendations from MAP workgroups
- Finalize input to HHS for February 1 Report

Key Deliverable	• Finalized input to HHS on proposed program measure sets
Activity	• Review MAP workgroup input regarding HHS proposed program measure sets
Background Materials	• MAP workgroup input to Coordinating Committee on HHS proposed program measure sets

NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Partnership Alignment – NPP and MAP

INPUT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES ON

PRIORITIES FOR THE NATIONAL QUALITY STRATEGY

ALIGNING MEASUREMENT WITH THE NQS

BERNIE ROSOF, NPP CO-CHAIR

NATIONAL PRIORITIES PARTNERSHIP
Convened by the National Quality Forum

The Affordable Care Act: A Framework and Resources for Measurement-Based Improvement

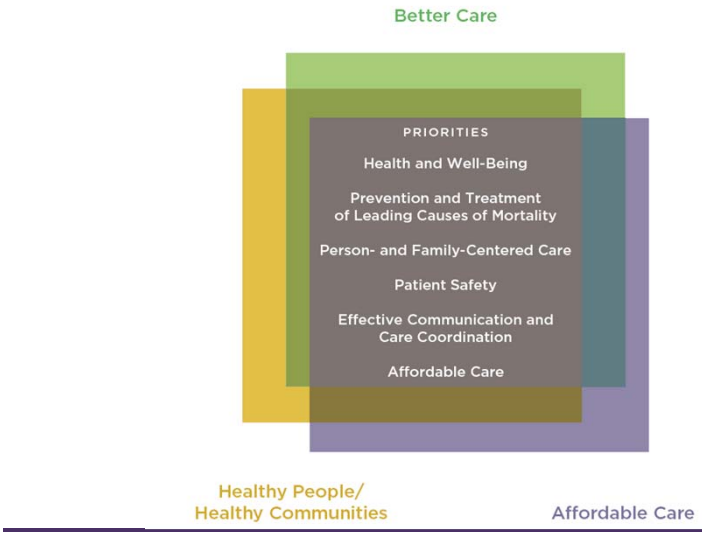
- HHS must develop a National Quality Strategy (NQS) to make care safe, effective and affordable
- NQS to be shaped – and specified – with input from diverse healthcare leaders representing the public and private sectors
- Coordination and alignment within the Federal government and across the public and private sectors is key to the ultimate success of the NQS in transforming the US healthcare system

Enter the NPP

HHS Requests National Priorities Partners (NPP) Counsel:

- *October 2010*: NPP provides input to HHS to inform the development of the NQS
- *March 2011*: HHS issues NQS based on the triple aim
- *September 2011*: NPP input to HHS helps to make NQS more actionable:
  - Identification of goals and measures
  - Recommendation of strategic opportunities
  - Consensus across key leaders about where they should drive their organizations

HHS's National Quality Strategy Aims and Priorities



NATIONAL PRIORITIES

- Work with communities to promote wise use of best practices to enable healthy living and well-being.
- Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.

- Ensure person- and family-centered care.

NATIONAL PRIORITIES

- Make care safer.

- Promote effective communication and care coordination.

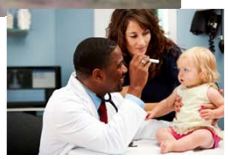
- Make quality care affordable for people, families, employers, and governments.

NPP Report: Three Sets of Strategies

- **One: A national strategy for data collection, measurement and reporting that supports measurement-based improvement so we know "how we are doing" against the NQS**
- **Two:** Community infrastructure (public-private) responsible for improvement efforts, resources for benchmarking and comparing performance, & mechanisms to identify, share and evaluate progress
- **Three:** Payment and delivery system reform—emphasizing primary care—that rewards value over volume and promotes patient-centered outcomes, efficiency, and appropriate care while reducing waste

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Health and Well-Being



Goals:

Promote health and well-being through:

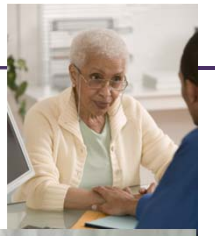
- community interventions (e.g., adequate social supports)
- adoption of healthy lifestyle behaviors (e.g., no smoking, healthy diet, adequate exercise
- delivery of clinical preventive services (e.g., immunizations)

Measure Concepts:

- Adequate social support
- ED visits for injuries
- Healthy behavior index
- Binge drinking
- Obesity
- Mental health
- Dental caries and untreated dental decay
- Use of the oral health system
- Immunizations

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Person- and Family-Centered Care



Goals:

- Improve patient, family, and caregiver experience of care related to quality, safety, and access
- Using a shared decisionmaking process, develop culturally sensitive and understandable care plans
- Enable patients and their families and caregivers to effectively navigate and coordinate their care

Measure Concepts:

- Patient and family experience of quality, safety and access
- Patient and family involvement in decisions about their care
- Joint development of treatment goals and plans of care
- Confidence in managing chronic conditions
- Easy-to-understand instructions to manage conditions

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Patient Safety

Goals:

- Reduce preventable hospital admissions and readmissions*
- Reduce the occurrence of adverse healthcare associated conditions*
- Reduce harm from inappropriate or unnecessary care

Measure Concepts:

- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index*
- All-cause healthcare-associated conditions*
- Inappropriate medication use and polypharmacy
- Inappropriate maternity care
- Unnecessary imaging

*Aligned with HHS's Partnership for Patients initiative. Healthcare-associated conditions include adverse drug events, catheter-associated urinary tract infections, central line blood stream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Effective Communication and Care Coordination

Goals:

- Improve the quality of care transitions and communications across settings
- Improve the quality of life for patients with chronic illness and disability
- Establish shared accountability and integration between communities and healthcare systems

Measure Concepts:

- Experience of care transitions
- Complete transition records
- Chronic disease control
- Community health outcomes
- Shared accountability for health
- Care consistent with end-of-life wishes
- Experience of bereaved family members
- Care for vulnerable populations

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Affordable Care

Goals:

- Ensure affordable and accessible high-quality healthcare for people, families, employers, and governments
- Reduce national per capita healthcare costs
- Support and enable communities to ensure accessible high-quality care while reducing unnecessary costs

Measure Concepts:

- Consumer affordability index
- Consistent insurance coverage
- Inability to obtain needed care
- Unwarranted variation/overuse*
- Average annual percentage growth in healthcare expenditures
- National and state per capita healthcare costs

** NPP proposes a menu of options, including unwarranted diagnostic, medical, or surgical procedures; inappropriate/unwanted nonpalliative services at end of life; inappropriate maternity care; and; preventable ED visits and hospitalizations.*

NPP INPUT ON HHS'S NATIONAL PRIORITIES:

Prevention and Treatment of Cardiovascular Disease

Goals:

Promote cardiovascular health through:

- community interventions (e.g, access to healthy food and recreational facilities
- adoption of healthy lifestyle behaviors (e.g., tobacco cessation)
- delivery of clinical preventive services (e.g., to achieve blood pressure and cholesterol control)

Measure Concepts:

- Access to healthy foods
- Access to recreational facilities
- Tobacco use by adults and adolescents
- Consumption of calories from fats and sugars
- Control of high blood pressure
- Control of high cholesterol

Illustrative National Measurement Needs

Health and Well-Being:
- Healthy lifestyle behavior composite
- Community environmental assessment
- Productivity measures

Prevention and Treatment of Cardiovascular Disease:
- **Blood pressure and cholesterol control composite**
- **ABCS composite**
- **Access to healthy foods**

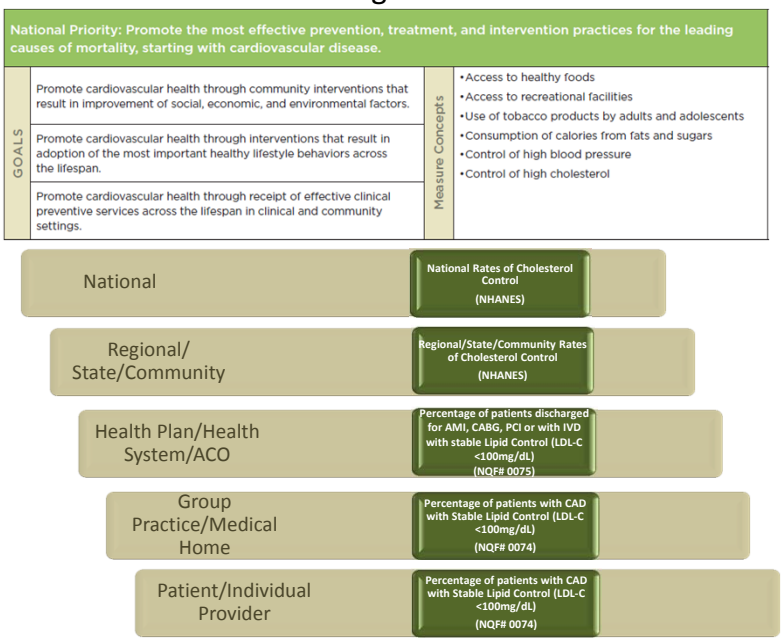
Person- and Family-Centered Care:
- Person and family experience of care composites
- National indicator of the use of experience surveys in various settings
- Joint care planning developed through shared decision-making

Patient Safety:
- Healthcare-associated condition composite
- Harmonized readmission measures
- Inappropriate medication use and polypharmacy
- Unnecessary imaging

Effective Communication and Care Coordination:
- Care transition composite across settings
- Care concordant with end-of-life preferences
- Exchange of patient information & records composite
- Care of vulnerable populations requiring healthcare and social supports

Affordable Care:
- Consumer affordability indices
- Measures of unwarranted variation and overuse

Illustrative Cardiovascular Measure Cascade: Control of High Cholesterol



NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

MAP Hospital Workgroup Experience with Core Measures

Hospital Workgroup Experience

- As a pre-meeting exercise, the Workgroup evaluated CMS Hospital Inpatient Quality Reporting measures using the draft measure selection criteria
- Workgroup then evaluated CMS Hospital Outpatient Quality Reporting and Hospital Value-based Purchasing measures
- Focusing on high-impact conditions, the NQS and NQF-endorsed measures, the Workgroup identified measures for inclusion in a hospital core measures list as well as measure gap areas
  - Included 2 ranking exercises to determine more concise final list
  - Workgroup did not consider cancer-related measures initially due to their separate cancer care measures task
- Core measures list includes measures receiving two-thirds majority vote for inclusion by the Workgroup

NQF
National Quality Forum

Report Out on Coordinating Committee Core Measures Survey Exercise

Core Measures Homework Survey Exercise

NQF
National Quality Forum

- MAP Coordinating Committee divided into Hospital, PAC/LTC, Clinician subgroups
- Evaluated MAP workgroup proposed core measures as a starting place for pre-rulemaking activities
- Confirmed and prioritized gap areas

Hospital Core Measures Exercise – Survey Results

- Survey response rate = 4/12
- Strengths
  - All measures are NQF endorsed
  - Addresses aspects of the National Quality Strategy:
    - Safer care
    - Preventing and treating leading causes of mortality and morbidity
  - Addresses many high-impact conditions
  - "Appropriate" mix of measure types
- Weaknesses
  - Weakness in addressing NQS priorities includes:
    - Person and family centered care
    - Making care more affordable
    - Effective care coordination
  - Few patient reported outcome measures and cost/resource use/appropriateness measures in the set
  - Does not consider small volume issues

Hospital Core Measures Exercise – Survey Results

- Missing concepts
  - Specific safety measures (CLABSI and CAUTI measures)
  - Cost of care/resource use measures
    - Specifically imaging resource use measures
  - Hospital outpatient measures
- Priority gap areas
  - Patient safety
  - Imaging
  - Cost measures
- Suggested removal
  - 468 Endorsed – Pneumonia 30-day mortality rate
  - 529 Endorsed – SCIP-INF-3 – Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)
  - 218 Endorsed – SCIP-VTE-2 – Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery

PAC/LTC Core Measures Exercise – Survey Results

NQF National Quality Forum

- Survey response rate = 4/11
- Strengths
  - Addresses aspects of the National Quality Strategy :
    - Safer care
    - Coordination of care
  - Promotes alignment with specific program attributes
  - Represents outcome, process and experience of care measures
- Weaknesses
  - Weakness in addressing NQS priorities includes:
    - Person and family centered care
    - Making care more affordable
  - "Check box" assessments with no link to actions are included
  - Unclear how set includes considerations for healthcare disparities

PAC/LTC Core Measures Exercise – Survey Results

NQF National Quality Forum

- Missing concepts
  - Although included, additional experience of care measures would be beneficial
  - Mental health measures
  - Age-appropriate preventive and chronic care management measures
  - Cost/resource use/appropriateness measure types
- Priorities
  - Measuring unnecessary, inappropriate and excessive care
- Suggested removal
  - No specifics listed

Clinician Core Measures Exercise – Survey Results

- Survey response rate = 4/11
- Strengths
  - Majority of measures are endorsed
  - Addresses aspects of the National Quality Strategy
    - Preventing and treating leading causes of mortality and morbidity
  - Address high impact conditions of CHF, ischemic heart disease and diabetes
  - Include several measure that are relevant for disparities
- Weaknesses
  - Includes NQF measures which may be retired
  - Weakness in addressing NQS priorities includes:
    - Safer care, effective care coordination, person- and family- centered care, making care more affordable
  - Weak mix of measure type
    - Emphasis on process
    - Lack of outcome measures, cost/overuse measures, experience of care measures, and composite measures
  - Focused on primary care – not specialty or team based care

Clinician Core Measures Exercise – Survey Results

- Missing concepts
  - Depression
  - Person and family centered care
  - Patient reported outcome measures
  - Care coordination
  - Disparities
- Priority gap areas
  - Patient reported outcome measure to address gaps in NQS
  - Person and family centered care measures
- Suggested removal
  - Duplicative measures
  - “Check the box” type measures
  - Measures proposed for NQF retirement

Clinician Core Measures Exercise – Survey Results

- Suggested removal (cont.)
  - Specific measures to be removed:
    - 0055 Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
    - 0056 Diabetes Mellitus: Foot Exam
    - 0073 Ischemic Vascular Disease (IVD): Blood Pressure Management Control
    - 0079 Heart Failure: Left Ventricular Function (LVF) Assessment
    - 0082 Heart Failure: Patient Education
    - NA89 Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years

Small Group Breakout

- Break into Clinician, Hospital, PAC/LTC subgroups
- Apply findings from Coordinating Committee homework exercise, measure selection criteria and Workgroups proposed core measures
- Deliver to Committee:
  - Core measures
  - Prioritized gaps
  - If applicable, measures to be removed

NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

Core Measures: Small Group Breakout Session

Committee Member Assignment

Clinician	Hospital	PAC/LTC
David Baker	Rhonda Anderson	Carol Raphael
Frank Opelka	Chip Kahn	Michael Mussallem
Carl A. Sirio	Mark Chassin	Steven Findlay
Sam Lin	Peggy O'Kane	Cheryl Phillips
Joyce Dubow	Aparna Higgins	Elizabeth Mitchell
Foster Gesten	Marla Weston	Bobbie Berkowitz
Richard Antonelli	Gerald Shea	Harold Pincus
Christine Cassel	Suzanne Delbanco	Nancy Wilson
Joseph Betancourt	Christine Bechtel	Chesley Richards
Joshua Seidman	Ira Moscovice	Judith A. Cahill
William Kramer	Victor Freeman	John O'Brien
	Patrick Conway	

NQF
National Quality Forum

Core Measures: Hospital Report Out and Discussion

NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Summary of Day 1 and Look-Forward to Day 2

NQF
National Quality Forum

Welcome and Recap of Day 1

NQF
National Quality Forum

Measure Applications Partnership Coordinating Committee

In-Person Meeting #4

Recap of Day 1

November 1-2, 2011

Recap of Day 1 – Measure Selection Criteria

Suggestions	Accepted
Item 1 – Program measure sets should promote alignment within specific program attributes, as well as *alignment across programs*	Yes
Item 2 – Clarification of term "measure set" (e.g., program, core, condition), top down and bottom up review of sets	Yes
Item 3 – Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Yes
Item 4 – Additional criteria proposed for outcome and process measures	No

Recap of Day 1 – Presentations

- Reviewed proposed approach to pre-rulemaking analysis
- Identified opportunities for further connection with National Priorities Partnership and the National Quality Strategy
- Discussed MAP Hospital Workgroup experience in selecting core measures

Recap of Day 1 – Report Out on Coordinating Committee Core Measures Survey Exercise

NQF National Quality Forum

- Hospital subgroup report out
  - Focused on expectations for MAP Hospital Workgroup in upcoming pre-rulemaking analysis
    - Coordinating Committee should build upon workgroup's recommendations not do a de novo exercise
    - Workgroup should be supplied with adequate specifications for measures for their evaluation
    - Include contextual overlay (e.g., pros/cons)
    - Recommend removal of measures
    - Considerations for critical access hospitals (CAH)

Recap of Day 1 – Report Out on Coordinating Committee Core Measures Survey Exercise

NQF National Quality Forum

- Clinician subgroup report out
  - When assessing core measures against measure selection criteria, recognition of significant gap areas
  - Two types of measurement gaps
    - Measures exist but not included (short term)
    - Measures do not exist (long term)
  - Prioritization of 4 gaps out of 13
    - Child health
    - Missing conditions for specialty providers
    - Patient and family experience
    - Resource use
  - Removal of measures
    - Agreement to remove NQF retired measures (0082, 0084, 0085, 0013)
    - Considered some diabetic measures to be weak

In-Person Meeting Agenda – Day 2

- Welcome and Recap of Day 1
- Finalize Post-Acute/Long-Term Care Quality Measurement Strategy
- Core Measures: PAC/LTC Report Out and Discussion
- Core Measures: Clinician Report Out and Discussion
- Review Hospital, Clinician and PAC/LTC Core Measures
- Summation and Path Forward

Finalize Post-Acute Care/Long-Term Care Performance Measurement Coordination Strategy

MAP Post-Acute Care/Long Term Care Workgroup Charge

NQF National Quality Forum

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings.

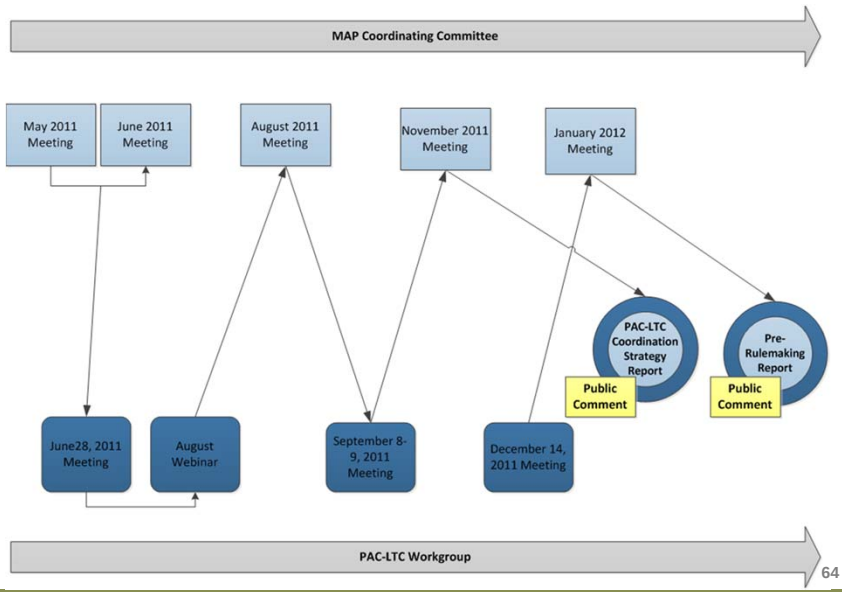
The Workgroup will:

- **Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:**
  - **Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures**
  - **Identifying critical measure development and endorsement gaps**
- Identify measures for quality reporting for hospice programs and facilities
- Provide input on measures to be implemented through the federal rulemaking process that are applicable to post-acute settings

63

PAC/LTC Workgroup Interaction with MAP Coordinating Committee

NQF National Quality Forum



64

Elements of a Coordination Strategy

NQF National Quality Forum

- Alignment
- Measures and measurement issues
  - Measure selection criteria
  - Priority areas for measurement
  - Core measure concepts across PAC/LTC settings
  - Identification of priority measure gap concepts
- Data sources and HIT implications
- Pathway for improving measure application

PAC/LTC Priority Areas for Measurement

NQF National Quality Forum

- **Function**
  - Patient factors such as ADLs and stage of illness
  - Helps define population subsets for measurement
- **Goal Attainment**
  - Goals of care may be different across settings (e.g., improvement, maintenance, palliation)
- **Patient/Family Engagement**
- **Care Coordination**
  - Across settings of care and providers
  - Assessing how the system coordinates care
- **Safety**
  - Health risks
- **Cost/Access**
  - Total cost and attention to cost-shifting
  - Patients access to additional social supports (e.g., home and community based services)

PAC/LTC Core Set of Measure Concepts

NQF National Quality Forum

- 12 core concepts that should be used across all PAC and LTC settings
- Are specific, yet flexible for customization to meet the needs of each setting
- Nursing Home Compare and Home Health Compare program measure sets evaluated against the core concepts
- *Coordinating Committee members provided feedback on core concepts through the recent survey exercise*

67

PAC/LTC Core Set of Measure Concepts

NQF National Quality Forum

- Functional and cognitive status assessment
- Establishment and attainment of patient/family/caregiver goals
- Advanced care planning
- Experience of care
- Shared decision making
- Transition planning

68

PAC/LTC Core Set of Measure Concepts

NQF National Quality Forum

- Falls
- Pressure ulcers
- Adverse drug events
- Inappropriate medication use
- Infection rates
- Avoidable admissions

69

PAC/LTC Priority Measure Gap Areas

NQF National Quality Forum

- Patient-reported measures
  - Patient experience
  - Shared-decision making
  - Establishment of patient/family/caregiver goals
- Care coordination
  - Communication across settings
  - Transition planning
- Cost, overuse

70

www.qualityforum.org

MAP Data Platform Principles

- A **standardized measurement data collection and transmission infrastructure** is needed across all payers and settings to support data flow and reduce data collection burden.
- A **library of all data elements needed for all PAC/LTC measures** should be created and maintained.
- **Data collection should occur during the course of care**, when possible, to minimize burden and maximize the use of data in clinical decision making.
- **Systematic review of data and feedback loops** should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications.
- **Timely feedback of measurement results** is imperative to support improvement, inform purchaser and consumer decision making, and monitor cost shifting.

PAC/LTC Data Considerations

- Standardization of measurement data collection and transmission
  - Currently have data collection tools tailored for each setting
  - New tools or data collection systems must build on or replace current processes to avoid additional burden
- Library of all data elements
  - CARE tool could potentially be used across all PAC and LTC settings, replacing current tools
  - CARE tool should align with the Quality Data Model and requires additional field testing

Questions for the Coordinating Committee

- Additional considerations for the PAC/LTC coordination strategy
  - Priority areas of measurement and core measure concepts?
  - PAC/LTC considerations for the data platform principles?
  - Measure gap areas?
- Moving beyond identification of gaps
  - Priorities for gap filling?
  - Who are the key stakeholders that can facilitate closing the gaps?
  - Future work for the MAP?
- Additional levers for improving performance measurement in PAC and LTC settings
  - How to include PAC and LTC in new delivery models (e.g., ACOs) and HIEs?

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Core Measures: PAC/LTC Report Out and Discussion

NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Core Measures: Clinician Report Out and Discussion

NQF
National Quality Forum

Discussion

NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Review Hospital, Clinician and PAC/LTC Core Measures

Review of Hospital, Clinician, and PAC Core Measures

NQF National Quality Forum

- What are the important areas of measurement to consider across clinician office, hospital and PAC/LTC settings?
- What specific inputs do you have for the workgroups (Duals, Hospital, Clinician, PAC/LTC) for their upcoming pre-rulemaking meetings?
- What information would be helpful for the workgroups to bring back to the Coordinating Committee for Jan 5-6 meeting?

NQF National Quality Forum

Discussion

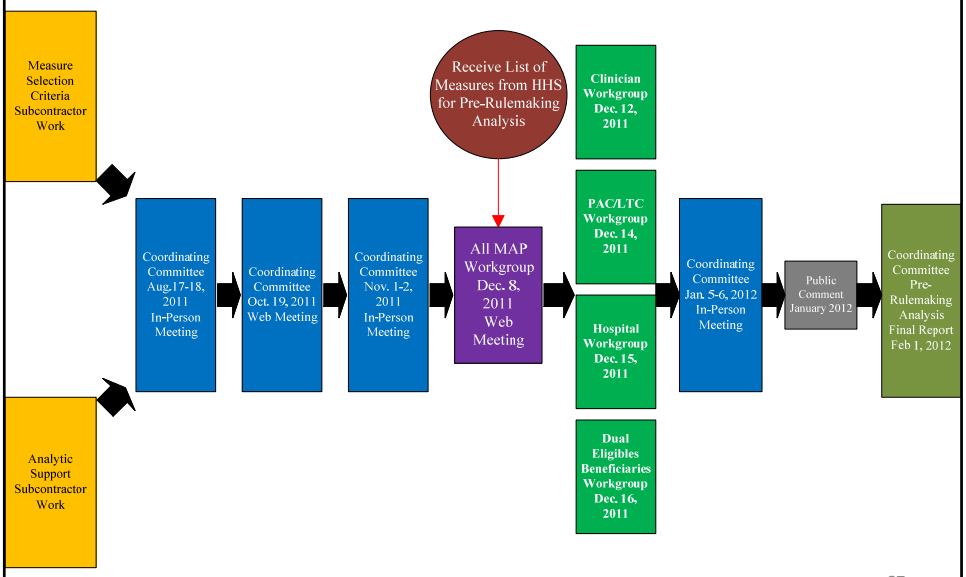
NQF
National Quality Forum

Opportunity for Public Comment

NQF
National Quality Forum

Summation and Path Forward

MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report



87

www.qualityforum.org

Committee Scope of Work and Timeline

December 8, 2011
- Convene an ALL MAP web meeting to begin pre-rulemaking tasks.

January 5-6, 2012
- Conduct an in-person meeting to finalize recommendation for the pre-rulemaking task.

February 1, 2012
- MAP pre-rulemaking recommendations due to HHS.

88

www.qualityforum.org

MAP Meeting Schedule

NQF
National Quality Forum

ALL MAP Web Meeting #2

December 8, 2011 1:00-3:00 pm EST

Coordinating Committee In-Person Meeting #5

January 5-6, 2012 (Washington, DC)

MAP "Working" Measure Selection Criteria

Tab 3

MAP "Working" Measure Selection Criteria

1. **Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review**

   Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

   Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

   Measures within the program measure set are NQF endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

   Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. **Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities**

   Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	*Safer care*
Subcriterion 2.2	*Effective care coordination*
Subcriterion 2.3	*Preventing and treating leading causes of mortality and morbidity*
Subcriterion 2.4	*Person- and family-centered care*
Subcriterion 2.5	*Supporting better health in communities*
Subcriterion 2.6	*Making care more affordable*

   Response option for each subcriterion:
   Strongly Agree / Agree / Disagree / Strongly Disagree:

   NQS priority is adequately addressed in the program measure set

3. **Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)**

   Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option:
Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	*Program* measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	*Program* measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	*Program* measure set is applicable to the program's population(s)

5. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care [1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion:
Strongly Agree / Agree / Disagree / Strongly Disagree

[1] National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC: NQF; 2010.

Subcriterion 6.1 Measures within the program measure set are applicable across relevant providers

Subcriterion 6.2 Measures within the program measure set are applicable across relevant settings

Subcriterion 6.3 *Program* measure set adequately measures patient care across time

7. Program measure set includes considerations for healthcare disparities[2]

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Response option for each subcriterion:

Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion:

Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 *Program* measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 *Program* measure set can be used across multiple programs (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

Table 1: National Quality Strategy Priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention *and* treatment practices for the leading causes of mortality, starting with cardiovascular disease.

[2] NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)

12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP "Working" Measure Selection Criteria Interpretive Guide

Tab 4

MAP "Working" Measure Selection Criteria Interpretive Guide

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of Strongly Agree, Agree, Disagree, Strongly Disagree is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best that reflects 'quality' health and healthcare. The term "measure set" can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

<u>For criterion 1 – NQF endorsement:</u>

The optimal option is for all measures in the program measure set to be NQF endorsed. The endorsement process evaluates individual measures against four main criteria:

1) 'Importance to measure and report" - how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;

2) 'Scientific acceptability of the measurement properties' - evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.

3) 'Usability'- the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.

4) 'Feasibility' - the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

<u>To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:</u>

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use

- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)

Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

<u>For criterion 2 – Program measure set addresses the National Quality Strategy priorities:</u>

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

<u>For criterion 3 – Program measure set addresses high-impact conditions:</u>

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and child health conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

<u>For criterion 4 – Program measure set promotes alignment with specific program attributes, as well as alignment across programs</u>

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- Care settings include: Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute

Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.

- Level of analysis includes: Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.

- Populations include: Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

<u>For criterion 5 – Program measure set includes an appropriate mix of measure types:</u>

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1) Outcome measures – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]

2) Process measures – Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures– Defined as patients' perspective on their care.[5]

3) Cost/resource use/appropriateness measures–
    a. Cost measures – Total cost of care.

[1] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

[2] Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

[3] Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

4 National Quality Forum. (2011). Consensus development process. Retrieved from http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx

[5] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

b. Resource use measures - Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[6]
c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]

4) Structure measures– Reflect the conditions in which providers care for patients. [8]This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organizations, methods of peer review, and methods of reimbursement).[9] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

<u>For criterion 6 – Program measure set enables measurement across the person-centered episode of care</u>:

The optimal option is for the program measure set to approach measurement in such a way as to capture a person's natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or

[6] National Quality Forum. (2011). National voluntary consensus standards for cost and resource use (cycle 1): a consensus report. (draft report for commenting). Retrieved from http://www.qualityforum.org/projects/efficiency_resource_use_2.aspx?section=PublicandMemberComment-Non-ConditionSpecificCVDiabetes2011-08-302011-09-28

[7] National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

[8] National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

[9] Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

For criterion 7 – Program measure set includes considerations for healthcare disparities:

Program measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[10]

> Subcriterion 7.1 seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).
>
> Subcriterion 7.2 seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

For criterion 8 – Program measure set promotes parsimony:

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entitles, while also measuring the patient's health and healthcare comprehensively.

> Subcriterion 8.1 can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entitles.
>
> Subcriterion 8.2 can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.)

[10] Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

MAP Post-Acute/Long-Term Care Workgroup

Coordinating Committee Reaction Draft

Tab 5

Measure Applications Partnership
Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care
Coordinating Committee Reaction Draft

SUMMARY

The post-acute care (PAC) and long-term care (LTC) performance measurement coordination strategy aims to enhance alignment across public and private initiatives with a focus on three key areas:

- Defining priorities and core measure concepts for PAC and LTC performance measurement to harmonize measures and promote common goals across initiatives;
- Highlighting the need for common data sources and health information technology (HIT) so that data can be collected once, in the least burdensome way, and used for multiple purposes; and
- Determining a pathway for improving measure application to meet current and emerging needs of all relevant initiatives.

PERFORMANCE MEASUREMENT COORDINATION STRATEGY FOR POST-ACUTE CARE AND LONG-TERM CARE

MAP has been charged with developing a coordination strategy for PAC and LTC performance measurement. Post-acute care refers to healthcare that is provided following an acute hospitalization and is typically delivered in skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, home health care, and outpatient rehabilitation.[i] Long-term care includes both medical and non-medical care rendered to people with chronic illnesses or disabilities and can be provided in the home, nursing home, or assisted living.[ii] This performance measurement coordination strategy focuses on a subset of PAC and LTC settings: short- and long-stay nursing facilities, home health care, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Performance measures for hospice care, which may be provided to patients in various PAC or LTC settings, will be addressed in a subsequent MAP report.

Some PAC and LTC providers have been participating in federal performance measurement through submitting Minimum Data Set (MDS) data for public reporting on Nursing Home Compare and Outcome and Assessment Information Set (OASIS) data for public reporting on Home Health Compare. Other providers will be required to participate in new performance measurement programs mandated by the Affordable Care Act within the next few years. The ACA provisions that will have a direct impact on PAC and LTC providers include: Section 3004 mandating quality reporting for LTCHs, IRFs, and hospice programs; Section 3021 establishing the Center for Medicare and Medicaid Innovation to implement new care delivery programs; and Section 3023, implementing a national pilot program for acute care and PAC bundled payment. [iii] In recognition of the expansion of performance measurement programs and the need to participate in new delivery models, such as accountable care organizations (ACOs), it is imperative to align performance measurement to facilitate coordination across PAC and LTC settings and reduce data collection burden.

Approach

The MAP PAC/LTC Workgroup advised the Coordinating Committee on developing the PAC and LTC performance measurement coordination strategy. The MAP PAC/LTC Workgroup is a 22-member, multi-stakeholder group (see

Appendix A for the workgroup roster). The workgroup held two, in-person meetings and one web meeting to develop the coordination strategy. The agendas and materials for the PAC/LTC Workgroup meetings can be found on the NQF website.

To inform planning for the PAC/LTC Workgroup meetings, NQF staff developed an overview of current federal performance measurement programs in PAC and LTC settings (Appendix C), summarizing the approach, payment incentives, public reporting requirements, and data sources for each program. Additionally, NQF staff compiled a table of PAC-LTC performance measures that included NQF-endorsed® measures for PAC and LTC settings and measures currently used in federal PAC and LTC performance measurement programs (see NQF website for the table). Measure attributes included in the table are endorsement status, retooled eMeasure specification availability, description, steward, numerator, denominator, data sources, and type, as well as the corresponding settings and programs in which the measure is used. Further, each measure in the table is mapped to the relevant NQS priorities.

The PAC/LTC Workgroup reviewed the characteristics of current federal programs, focusing on current measures in use, and identified opportunities for alignment across the continuum of PAC and LTC settings. This review led to the identification of the six most salient measurement areas for PAC and LTC settings. In establishing these priority areas, which are discussed in the Priority Areas for Measurement section below, the group considered other efforts aimed at addressing the unique performance measurement needs of patients receiving care in these settings, including the Long-Term Quality Alliance, the NQF Multiple Chronic Conditions project, and the MAP Dual Eligible Beneficiaries strategic approach. (See Appendix H for a comparison of the measurement priorities outlined in this report with the measurement priorities identified by these initiatives.) Establishing the priority areas for measurement led to agreement that a core measure set should be defined across all PAC and LTC settings, as individual measures for the same concept can vary from setting to setting. For example, when assessing function, focus on restoration of function is more likely in post-acute settings, while maintenance of function is more likely for long-term care settings. Using the MAP measure selection criteria, the group then evaluated two current measure sets, Nursing Home Compare and Home Health Compare, and determined how the measure sets align with the core measure concepts.

The PAC/LTC Workgroup built on the data platform principles that have emerged from the MAP work to date (see MAP clinician, safety, and dual eligible beneficiaries reports) by adding considerations specific to the PAC and LTC settings. The Workgroup reviewed and discussed data sources and data collection tools currently in use in or in development for PAC and LTC settings (MDS, OASIS, CAHPS, IRF-PAI, CARE), focusing on the replication of information across the tools and noting promising opportunities for alignment. Considering the MAP Data Platform Principles, the Workgroup also discussed the ability of PAC and LTC providers to adopt HIT as a way to reduce data collection burden. This discussion identified PAC and LTC considerations for the MAP Data Platform Principles.

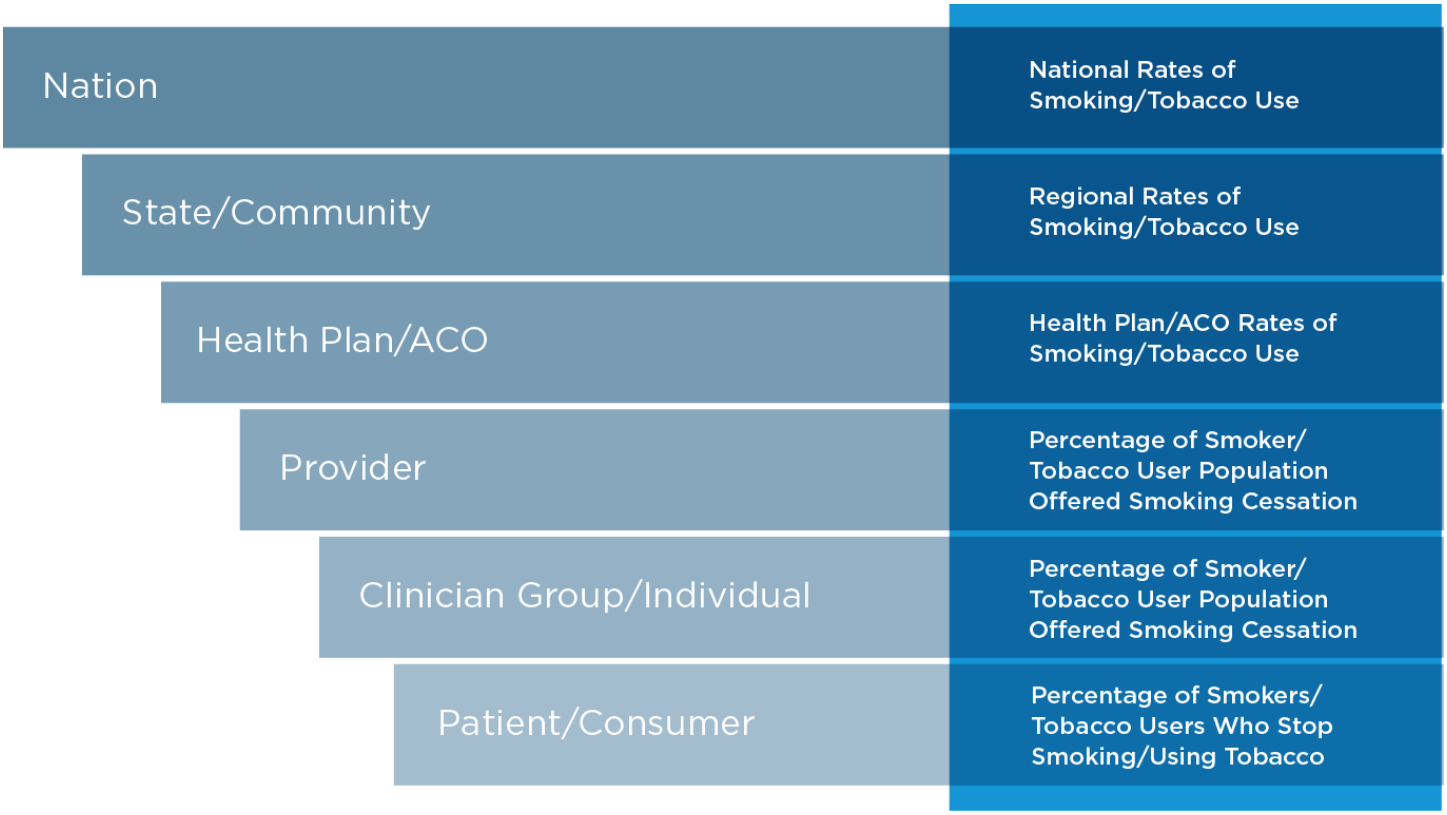
Alignment

Several factors contribute to the misalignment of performance measurement among PAC and LTC settings. Different providers of PAC and LTC offer different types and levels of care; thus each provider addresses differing, though often overlapping, patient goals across the care continuum. For example, IRF and nursing home short-stay patients need rehabilitative services to meet improvement goals, while nursing home long-stay patients are more likely to have maintenance goals. In addition, PAC and LTC providers receive payment from various sources. Medicare primarily funds post-acute care, while Medicaid is often the primary payer for long-term care. To comply with federal and state reporting requirements, each setting has distinct performance measurement obligations, which utilize varying reporting mechanisms. Each setting complies with these obligations by using a unique assessment tool (e.g., MDS, OASIS, IRF-PAI).

These tools capture similar information yet do not enable information sharing, resulting in a lack of care coordination and duplication of information for patients who move between these settings.

The heterogeneity of patient needs across PAC and LTC settings is a barrier to coordinating setting-specific performance measurement. A patient-centered performance measurement approach that assesses care delivered across episodes of care could transcend the current site-specific approach, integrating measurement for PAC and LTC care with measurement for hospital and the clinician care. Patients who access PAC and LTC settings, particularly older adults with complex chronic conditions, often transition between care settings, moving among their homes, hospitals, PAC, and LTC facilities when their health and functional status changes. Approximately one-third of Medicare beneficiaries discharged from hospitals enter into a PAC setting immediately after the hospital discharge.[iv] Additionally, few individuals who leave nursing homes are considered permanent discharges, as most return to the nursing home after a hospital admission. Thus, transitions between long-term care and acute care are typically part of the same episode of care.[v] Achieving patient-centered measurement across the episodes of care will require HIT that enables information sharing across settings and incorporation of patient-reported data into measurement.

The use of "cascading measures," harmonized measures or families of measures applied at each level of the system, could be used to assess care across an entire episode while providing a comprehensive picture of quality. To facilitate an aligned measurement approach, MAP will be identifying core measures for the clinician office, hospital, and PAC and LTC settings that support the National Quality Strategy's (NQS) six priorities. The core measures will reflect the ideal characteristics of a measure set, identified through the use of MAP measure selection criteria. Recognizing that existing measures will not fulfill all of the ideal characteristics of a measure set, MAP will also identify and prioritize measure gaps. MAP will be evaluating measures under consideration by HHS for rulemaking relative to the core measures, to determine if the measures under consideration strengthen desired aspects of the measure set or address an identified gap area. The diagram below illustrates the cascading measures approach for smoking.



Priority Areas for Measurement

In moving toward aligned performance measurement across PAC and LTC settings, MAP employed the NQS priorities as a roadmap to identify the highest leverage areas for measurement for PAC and LTC providers. The six priority areas for measurement are described below.

Measurement Priority	National Quality Strategy (NQS) Priority					
	Making Care Safer	Ensuring Person- and Family-Centered Care	Promoting Effective Communication and Coordination of Care	Effective Prevention and Treatment of the Leading Causes of Mortality	Enable Healthy Living	Making Quality Care More Affordable
Function		X			X	
Goal Attainment		X		X		
Patient and Family Engagement		X	X		X	
Care Coordination	X	X	X			X
Safety	X					X
Cost/Access	X	X	X			X

Function should be assessed to capture patient-centered outcomes. Typically, performance measures focus on the care from a provider for a single disease or condition, ignoring patient factors such as activities of daily living, quality of life, cognitive impairment, and stage of illness. Function is an essential baseline assessment that could be used across PAC and LTC settings to define population subsets with particular care needs. Function is of particular importance to patients with multiple chronic conditions and some dual eligible beneficiaries who have limited function due to heavy disease burden, frailty, cognitive impairments, or behavioral health issues.

Goal Attainment is a high priority for performance measurement because patient goals establish a benchmark for patient-centered measurement. Typical goals of care may be different across settings (e.g., improvement, maintenance, palliation); regardless, the patient and family should be engaged in setting goals. MAP has determined that assessing outcomes relative to goals is a key measurement approach for assessing the care provided to dual-eligible beneficiaries.[vi]

Patient and Family Engagement is a vital part of delivering quality care generally. Beyond assessing patient and family experience, measures should focus on shared decision making and family and caregiver burden and support.

Care Coordination is essential for patients accessing multiple settings of care. Measurement should promote collaborative care among providers and across settings, with a focus on improving care transitions. Patients with multiple chronic conditions and dual eligible beneficiaries often receive fragmented care and need focused attention on communication with patients/families/caregivers and between providers to counter fragmentation.

Safety has long been incorporated into measurement for PAC and LTC settings and remains a priority as each provider should seek to avoid and reduce harm. Areas of focus for PAC and LTC providers include falls, pressure ulcers, adverse drug events, and infections.

Cost/Access measures highlight areas where resources are overused or underused and elucidate total cost and cost-shifting across care settings. Measures assessing patient access to social supports such as home and community based services should be a focus, as well as measures that can highlight significant drivers of cost such as avoidable admissions, readmissions, and ED visits. Special consideration should be given to the limited resources of dual eligible beneficiaries, as these patients may not have access to a usual source of care and my more heavily rely on community supports.

Core Set of Measure Concepts

MAP developed a set of twelve core measure concepts that should be used to assess care across all PAC and LTC settings. These concepts address each of the priority areas for measurement described above and are specific, yet flexible enough to allow for customization to address the unique care provided within each setting. The table below depicts the core measure concepts, mapped to the PAC and LTC measurement priorities and the NQS priorities.

Core Measure Concept	National Quality Strategy (NQS) Priority					
	Making Care Safer	Ensuring Person- and Family-Centered Care	Promoting Effective Communication and Coordination of Care	Effective Prevention and Treatment of the Leading Causes of Mortality	Enable Healthy Living	Making Quality Care More Affordable
FUNCTION						
Functional and cognitive status assessment. Functional status assessment follow-up may include reassessment for maintenance or improvement. Cognitive assessment should be pursued to identify whether it has been appropriately acted on.		X			X	
GOAL ATTAINMENT						
Establishment and attainment of patient/family/caregiver goals, including the evaluation of patient and family/caregiver preparedness and support and burden in achieving the goals. Goal evaluation should account for patient quality of life attributes such as pain and symptom management.		X	X			
Advanced care planning and treatment in accordance with patient preferences.		X	X			X

Core Measure Concept	National Quality Strategy (NQS) Priority					
	Making Care Safer	Ensuring Person- and Family-Centered Care	Promoting Effective Communication and Coordination of Care	Effective Prevention and Treatment of the Leading Causes of Mortality	Enable Healthy Living	Making Quality Care More Affordable
PATIENT ENGAGEMENT						
Experience of care		X				
Shared decision making in developing care plans.		X	X			
CARE COORDINATION						
Transition planning consists of discharge planning and timely and bi-directional communication during transitions. Successful transitions require educating and preparing patients and patients' families/caregivers, as well as timely communication between the sending and receiving institutions.	X	X	X			X
SAFETY						
Falls	X				X	X
Pressure ulcers	X					X
Adverse drug events	X		X			X
COST/ACCESS						
Inappropriate medication use	X					X
Infection rates, including health care associated infections (HAIs), such as ventilator-associated pneumonia.	X					X
Avoidable admissions, including ED admissions, hospital admissions, and hospital readmissions.	X		X			X

MAP considered a broader list of measure concepts in the process of determining core measure concepts. MAP concluded that the following concepts, which were all identified as important but not adopted as core, are difficult to

define for measurement, are better measured by the concepts adopted, are not relevant to all settings, or do not rise to the level of being a core measure concept when the parsimony criterion is applied.

- Unnecessary services
- Staffing turnover
- Appropriate level of care
- Access to community supports
- Mental health assessment
- Timeliness of initiation of care
- Restorative care management

Evaluation of the Nursing Home and Home Health Compare Measures

The PAC/LTC Workgroup evaluated the Nursing Home Compare and Home Health Compare measure sets using a draft version of the MAP measure selection criteria, a tool used to evaluate and recommend measure sets for specific public reporting and performance-based payment programs (see Appendix F for the draft criteria used by the PAC/LTC Workgroup). The Nursing Home Compare and Home Health Compare measures sets were selected for evaluation because they are well-established and address both PAC and LTC. The Nursing Home Compare measures are a subset of the measures contained in the Minimum Data Set (MDS). The Home Health Compare measures are a subset of the measures contained in the OASIS data set (see Appendices D and E for the list of the measure sets).The MAP Clinician and Hospital Workgroups participated in similar exercises involving program measure sets relevant to those settings. The exercises of each of the MAP workgroups informed refinement of the MAP measure selection criteria.

In evaluating the Nursing Home Compare and Home Health Compare measures, the PAC/LTC Workgroup applied the following measure selection criteria:

1. Measures within the set meet NQF endorsement criteria
2. Measure set adequately addresses each of the National Quality Strategy priorities
3. Measure set adequately addresses high-impact conditions relevant to the program's intended population(s)
4. Measure set promotes alignment with specific program attributes
5. Measure set includes an appropriate mix of measure types
6. Measure set enables measurement across the patient-focused episode of care
7. Measure set includes considerations for healthcare disparities
8. Measure set promotes parsimony

Nursing Home Compare Measures

Overall, the Workgroup felt that the Nursing Home Compare measure set did not adequately address the MAP measure selection criteria. The Workgroup's concerns with the measure set are described below.

1. While the majority of measures in the Nursing Home Compare set are NQF-endorsed, the workgroup noted it was a limitation of the set that not all the included measures are endorsed.
2. The Nursing Home Compare measure set adequately addresses two of the National Quality Strategy priorities: safety and the prevention and treatment of leading causes of mortality and morbidity. However, the set does not address the other NQS priorities: effective care coordination, person and family centered care, supporting better care in communities, and making care affordable.

3. The measure set addresses some high impact conditions for post-acute care, including urinary tract infections and pressure ulcers. Measures addressing advanced illness and psychosocial issues are also needed.
4. The measure set adequately addresses program attributes including intended providers and care settings. However, the workgroup felt that the measures for short-stay residents and long-stay residents are not aligned. Additionally, key populations not included in the measures are patients with advanced illness and patients in hospice.
5. The measure set does not contain an appropriate mix of measure types, as the measure set contains only process measures. Outcome, experience of care, cost, and structural measures are needed to improve the measure set.
6. The measure set relies on data collection through the MDS, which collects data at a single point in time; therefore, this measure set does not enable measurement across the patient-focused episode of care over time.
7. The measure set does not include considerations for health care disparities.
8. The measure set demonstrates aspects of parsimony, as all measures in the set are collected through MDS; however, MDS is specific to the nursing home setting and the measures in the Nursing Home Compare set may not be applicable across multiple programs or applications.

Home Health Compare Measures

The PAC/LTC Workgroup expressed similar concerns with the Home Health Compare measure set.

1. Though most measures in the Home Health Compare set are NQF-endorsed, the workgroup noted that all measures included in the set should be NQF-endorsed.
2. The measure set addresses the NQS safety priority and the prevention and treatment of leading causes of mortality and morbidity priority, but does not address the other four priorities: care coordination, person and family centered care, better health in communities, and affordable care.
3. The measure set addresses high impact conditions for post-acute care and has a restorative focus; however, the set could be strengthened by including measures that address cognitive, mental, and behavioral health. The measure set addresses the general home health population, but does not address specific subpopulations who receive home health care, such as cancer patients and patients with dementia.
4. The workgroup determined that the measure set addresses the intended care settings and level of analysis. However, the group did not think that the set assesses care across relevant providers, such as clinicians.
5. The types of measures included in the set are narrowly focused on processes. The set lacks outcomes, experience, structural, and cost measures.
6. The measure set does not enable measurement across the patient-focused episode of care, as measures are generated from data is collected at a single point in time.
7. The measure set is not sensitive to health care disparities and would benefit from direct measures of disparities, such as consideration of cultural issues.
8. The measure set promotes aspects of parsimony, as all measures are collected through OASIS; however, OASIS measures are not used across multiple programs or applications.

The table below illustrates how the Nursing Home Compare and Home Health Compare measure sets align with the core measure concepts. This mapping further demonstrates how the measure sets address some ideal characteristics, yet still have large gap areas.

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
Functional and cognitive status assessment	• Percent of residents whose need for help with activities of daily living has increased (long-stay) • Percent of residents whose ability to move in and around their room and adjacent corridors got worse (long -stay) • Percent of short-stay residents who have delirium • Percent of residents who have depressive symptoms (long-stay) • Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period • Percent of residents who self-report moderate to severe pain (short-stay) • Percent of residents who self-report moderate to severe pain (long-stay) • Percent of residents who lose too much weight (long-stay) • Percent of low risk residents who lose control of their bowel or bladder (long-stay) • Percent of residents who were physically restrained (long-stay)	• Improvement in ambulation/locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Depression assessment conducted • Pain assessment conducted • Pain interventions implemented during short term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/caregiver education implemented during short term episodes of care
Establishment and attainment of patient/family/caregiver goals		
Advanced care planning and treatment		
Experience of care		
Shared decision making		
Transition planning		• Timely initiation of care
Falls		• Multifactor fall risk assessment conducted for patients 65 and over
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay) • Percent of high risk residents with pressure ulcers (long-stay) • Percent of low-risk long-stay residents who have pressure sores	• Increase in number of pressure ulcers • Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented during short term

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
		episodes of care
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications
Inappropriate medication use		
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)	
Avoidable admissions		• Acute care hospitalization
Measures not mapped to a core set concept	• Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (short-stay) • Percent of residents assessed and appropriately given the seasonal influenza vaccine (long-stay) • Percent of residents assessed and appropriately given the pneumococcal vaccine (short-stay) • Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long-stay)	• Influenza immunization received for current flu season • Pneumococcal polysaccharide vaccine (PPV) ever received • Heart failure symptoms addressed during short -term episodes of care

Measures for Long-Term Care Hospitals and Inpatient Rehabilitation Facilities

The PAC/LTC Workgroup did not evaluate measure sets for IRFs and LTCHs. These settings currently are not required to report performance measurement information, but will be required to do so in fiscal year 2014.[vii] Proposed measures for LTCHs and IRFs are mapped to the core measure concepts (see Appendix G) as an initial step to identifying the best available measures and measure gaps. The proposed measures for IRFs address the majority of the core measure concepts, while the proposed measures for LTCHs only address safety.

Data Source and HIT Considerations

MAP has identified a great need for a uniform data collection and reporting infrastructure to support performance measurement across the quality measurement enterprise. PAC and LTC providers, like many others, face significant barriers to efficient data collection. Most PAC and LTC providers have limited HIT and typically do not have sophisticated data exchange capabilities. The majority of data sharing by PAC and LTC providers is conducted by phone, fax, and paper records. Moreover, the existing HIT infrastructure in PAC and LTC settings primarily supports administrative and billing processes. There is little financial incentive for PAC and LTC providers to adopt HIT due to factors such as training costs

for high-turnover staff and ongoing IT maintenance costs[viii]. PAC and LTC funding streams, mostly Medicare and Medicaid, do not provide incentives for investment in new technology. PAC and LTC settings are not included in the Meaningful Use program, and it is unclear how these settings will be integrated into new payment models, such as ACO shared savings. Nonetheless, the Affordable Care Act provisions targeting PAC and LTC providers will increase the need for interoperable IT to support data collection for performance measurement.

With the intention of promoting standardized data sources and HIT adoption, MAP developed data platform principles (outlined in the Clinician Performance Measurement Coordination Strategy),[ix] recommending processes to reduce quality measurement burden and facilitate HIT adoption and use. The following data considerations provide additional context for operationalizing the data platform principles in PAC and LTC settings.

A standardized measurement data collection and transmission infrastructure is needed across all payers and settings to support data flow among providers and reduce data collection burden. Data collection and transmission are varied across PAC and LTC settings. For example, nursing homes submit MDS data to states that then submit data to CMS, while other settings submit data directly to CMS. Standardization of data collection can help further align PAC and LTC performance measurement programs. Currently, performance measurement within these settings is built on data collection tools tailored for each individual setting (i.e., MDS, OASIS), creating challenges to harmonizing measures across settings. However, given that current data collection processes are already geared to these tools, new tools or data collection systems must build on the current process to avoid introducing additional burden.

A library of all data elements needed for all measures should be defined and maintained. Data elements should contain all information needed to calculate measures, including data elements that could support risk adjustment and stratification, which are imperative considerations for the PAC/LTC population. As an initial step, the CARE tool could be used across all PAC and LTC settings, replacing current setting-specific tools, to support the development of a library of standardized data elements. CARE could enable harmonized measurement by developing a common set of uniform and standardized data elements used in PAC and LTC settings and incorporating EHR-compatible standards so that information could be rapidly exchanged among settings. Additional field testing and evaluation will be needed to demonstrate CARE's broad applicability across all settings. Ideally, CARE should provide the ability to generate care plans and link with clinical decision support tools.

Data collection should occur during the course of care, when possible, to minimize burden, reduce errors, and maximize the use of data in clinical decision making.

Systematic review of data and feedback loops should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications.

Timely feedback of measurement results is imperative to support improvement, inform purchaser and consumer decision making, and monitor cost shifting. Policymakers and purchasers can also use timely information from measurement results to decide whether to continue investing in a program, or to make modifications and improvements.

Path Forward

Priority Measure Gaps

The core measure concepts for PAC and LTC settings highlight gaps in the measures available and currently used in applicable programs. The long-standing performance measurement programs for nursing homes and home health agencies address some of the core concepts, such as functional and cognitive status assessment, pressure ulcers, infection rates, and falls. However, these program measure sets lack measures that assess care longitudinally and across settings, such as transition planning, shared decision making, and establishment of patient/family/caregiver goals. The new quality reporting requirements for inpatient rehabilitation facilities and long-term care hospitals introduce a unique opportunity to select measures targeted to each of the core measure concepts.

Across all PAC and LTC settings there is a need for a coordinated approach to filling measure gaps. Both leveraging quality measures that have not yet been tested and endorsed for multiple settings and de novo measure development should be pursued to fill gaps. Efforts should be made to identify good measures that could be tested and endorsed for additional settings. For example, the Care Transitions Measure-3 (CTM-3) would facilitate aligned measurement of transition planning and promote bi-directional communication across settings; however, the CTM-3 is not endorsed for use beyond hospitalization. Other core concepts address measurement gaps which rely on the availability of patient-reported data (e.g., shared decision making) or require additional evidence for measure development.

We welcome additional direction from the MAP Coordinating Committee on the path forward for improving measure application to meet current and emerging needs of PAC and LTC performance measurement initiatives.

Appendices

Appendix A: MAP PAC/LTC Workgroup Roster
Appendix B: MAP Coordinating Committee Roster
Appendix C: Overview of PAC and LTC Performance Measurement Programs
Appendix D: Nursing Home Compare Measure List
Appendix E: Home Health Compare Measure List
Appendix F: Draft MAP “Working” Measure Selection Criteria
Appendix G: Alignment of Proposed Measures for Long-Term Care Hospitals and Inpatient Rehabilitation Hospitals with the Core Measure Concepts
Appendix H: Alignment of Priority Measure Concepts for PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions

[i] Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center. Uniform Patient Assessment for Post-Acute Care. Final Report. January, 2006. https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityPACFullReport.pdf

[ii] Medicare.gov. Long-Term Care. http://www.medicare.gov/longtermcare/static/home.asp. Last accessed October 2011.

[iii]. Park. S. , Partner. Post-Acute/Long-Term Care Planning for Accountable Care Organizations. Dixon Hughes Healthcare Consulting. 2011 Available at http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/Dixon_Hughes_Whitepaer.pdf

[iv] Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center. Uniform Patient Assessment for Post-Acute Care. Final Report. January, 2006. https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityPACFullReport.pdf

[v] National Institute of Nursing Research. Chapter 12 Transitions in Long-Term Care. October 2006. Available at http://ninr.nih.gov/ninr/research/vo13/Transition.html

[vi] National Quality Forum (NQF). Strategic Approach to Quality Measurement for Dual Eligible Beneficiaries. Interim report to HHS. Oct 2011.

[vii] Centers for Medicare and Medicaid Services. New Quality Reporting programs for LTCHs, IRFs, and Hospices. https://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/ Accessed at October 2011.

[viii] U.S. Department of Health and Human Services Assistant Secretary of Planning and Evaluation office of Disability, Aging and Long-Term Care policy. Health Information Exchange in Post-Acute and Long-Term Care Case Study Findings. September 2007

[ix] National Quality forum. Coordination Strategy for Clinician Performance Measurement. Final Report to HHS. Oct 2011.

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

Chair (voting)

Carol Raphael, MPA

Organizational Members (voting)	Representative
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurse Associations of America	Emilie Deady, RN, MSN, MGA

Expertise	Individual Subject Matter Expert Members (voting)
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	MaryAnne Lindeblad, MPH
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)	Judy Sangl, ScD
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

Co-Chairs (voting)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Organizational Members (voting)	Representatives
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Judith Cahill
AdvaMed	Michael Mussallem
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Steven Findlay, MPH
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

Expertise	Individual Subject Matter Expert Members (voting)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD

Accreditation/Certification Liaisons (non-voting)	Representatives
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

A brief description of each Post-Acute Care and Long-Term Care setting and its corresponding performance measurement programs is described below followed by a more detailed description in the accompanying chart.

Nursing Homes refer to both nursing facilities and skilled nursing facilities (SNFs). This report focuses on short- and long-stay SNFs, which provide physical, occupational, and other rehabilitative therapies to their residents in addition to providing care and assistance with ADL.[a] Nursing homes are required to conduct clinical assessments of patients upon admission and then periodically using the *Minimum Data Set (MDS)* assessment. MDS data are used by nursing home staff to identify health issues and create individual patient care plans[b] and are used to generate quality measurement information, which is publicly reported on the consumer-oriented website *Nursing Home Compare.* Patient and family experience of care can be assessed using the *Consumer Assessment of Healthcare Providers and Services (CAHPs) Nursing Home Surveys*; however, the surveys are not required and are currently being piloted by a few states. Currently, CMS has a demonstration program, value-based purchasing (VBP) for nursing homes, which provides incentives to nursing homes that demonstrate high quality care or improvement in care and would utilize quality measures generated from MDS data.[c]

Home Health Agencies coordinate home health care which consists of skilled nursing care and other skilled care services such as, physical therapy, occupational therapy, speech-language pathology services, and medical social services or assistance from a home health aide.[d] HHAs are required to conduct clinical assessments of patients at three points (admission, 60-day follow-up, discharge) using the *Outcome and Assessment Information Set (OASIS)*.[e] A subset of the quality measures generated from OASIS data is reported on the consumer-oriented website, *Home Health Compare*.[f] *Home Health Consumer Assessment of Healthcare Providers and Services (HHCAHPS)* will be incorporated into the quality reporting requirements beginning in 2012.[g] Similar to nursing homes, CMS has a value-based payment demonstration program for home health care.[h]

Inpatient Rehabilitation Facilities (IRFs) are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals which provide rehabilitation services such as physical, occupational, rehab therapy, social services, and prosthetic services.[i] IRFs conduct clinical assessments at admission and upon discharge using the *Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)* which generates data used to compare facilities and determine prospective payment.[j] Starting 2014, IRFs will also be required to report quality measures.

Long-term Care Hospitals (LTCHs) provide post-acute intensive care to medically complex patients with unresolved medical conditions; while these patients are more stable than patients in an ICU they typically require support for respiratory problems, have failure of two or more major organ systems, neuromuscular damage, contagious infections, or complex wounds needing extended care. LTCHs currently do not have any quality reporting requirements.[k] Similar to IRFs, LTCHs will be mandated to report quality measures beginning in 2014.

The **Post-Acute Care Payment Reform Demonstration (PAC-PRD),** authorized by the Deficit Reduction Act of 2005, sought to standardize patient assessment information from PAC settings and use the data for payment purposes. To do so, the **Continuity Assessment Record and Evaluation (CARE)** tool was developed as a standardized tool to measure the health, functional status, changes in severity, and other outcomes for Medicare PAC patients.[l] Additionally, Section 3004 of the Affordable Care Act requires CMS to establish quality reporting programs for LTCHs, IRFs, and hospice programs. The quality reporting programs will be linked to payment beginning in fiscal year 2014 and the results will be publicly available.[m]

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Post-Acute Care Payment Reform Initiative Applies to: Skilled Nursing Facilities, IRFs, LTCHs, Home Health Care, and Outpatient Rehabilitation	As a component of the Deficit Reduction Act of 2005 (S1932.Title V.Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). [n]	This initiative aims to standardize patient assessment information across Acute Care Hospitals and four PAC settings: LTCHs, IRFs, SNFs, and HHAs. [o]Additionally, it aims to employ the data to guide payment policy in the Medicare program. The initiative has been carried out in two parts: 1) develop a standardized patient assessment tool called the Continuity Assessment Record and Evaluation (CARE) tool for measurement and 2) conduct a PAC payment reform demonstration to examine differences in costs and outcomes for PAC patients of similar case mix who use different types of PAC providers. [p]	Data is collected using the CARE tool, which is an Internet-based Uniform Patient Assessment Instrument that will measure the health and functional status of Medicare acute discharges and measure changes in severity and other outcomes for Medicare PAC patients. The CARE tool includes two types of items: 1. Core items which are asked of every patient in that setting, regardless of condition, and 2. Supplemental items which are only asked of patients having a specific condition. The	The CARE tool includes four major domains: medical, functional, cognitive impairments, and social/environmental factors. These domains gauge case mix severity differences within medical conditions or predict outcomes such as discharge to home or community, rehospitalization, and changes in functional or medical status. [s]	The data from the assessment will be used to guide payment policy in the Medicare program. [t]	

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			supplemental items measure severity or degree of need for those who have a condition. [q] Data is submitted through web-based data submission systems.[r]			
Quality Measurement Reporting Program Applies to: Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), and Hospice Programs	Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs, IRFs, and Hospice Programs. [u]	The Act requires The Centers for Medicare and Medicaid Services (CMS) to establish quality reporting programs for LTCHs, IRFs and hospice programs, which in turn, require providers to submit data on selected quality measures to receive annual payment update for fiscal year 2014 and subsequent years.[v]	Measures can be generated from standards-based CARE data set. [w]	CMS aims to implement quality measures for LTCHs, IRFs, and hospices that are both site-specific and cross-setting. The measures should also be valid, meaningful, and feasible to collect, and address symptom management, patient preferences, and avoidable adverse events. [x]	Starting in fiscal year 2014, and each subsequent year, There will be penalties for failure to submit required quality data which will amount to a 2% reduction in the annual payment update.[y]	According to the act, no later than October 1, 2012, the Secretary of HHS is required to publish the quality measures that must be reported by LTCHs, IRFs, and Hospice Programs. All data submitted will be made available to the public; however, the Secretary is required to establish procedures to ensure that the reporting hospital or hospice

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
						has an opportunity to review the data that is to be made public before its release.[z]
Minimum Data Set (MDS) Applies to: Nursing Home, Skilled Nursing Facility	The Omnibus Budget Reconciliation Act of 1987 required the implementation of the National Resident Assessment Instrument (RAI) for all nursing homes participating in the federal health care programs Medicare and Medicaid. The RAI is comprised of two parts, the MDS and Resident Assessment Protocols (RAPs).[aa]	MDS is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. MDS assessment forms are completed for all residents in certified nursing homes on admission and then periodically, regardless of source of payment. [bb]	Nursing homes transmit MDS information electronically to the MDS database in their respective state. Subsequently, the information from the state databases is captured into the national MDS database at CMS.[cc]	The MDS contains items that measure physical, psychological and psychosocial functioning, which provide a multidimensional view of the patient's functional capacities and identify health problems.[dd]		MDS data is publicly reported on Nursing Home Compare which includes quality data (MDS), survey results, staffing and facility characteristics.[ee]
CAHPS® Nursing Home Surveys Applies to: Nursing Home, Skilled Nursing Facility		The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to support the assessment of consumers' experiences	The CAHPS long-stay resident instrument is for residents living in nursing home facilities for more than 100 days. The instrument is designed to be administered in person and has been endorsed	The instruments include the following topics: environment; care; communication and respect; autonomy; and activities. [ii]		Consumers, public and private purchasers, researchers, and healthcare organizations can use CAHPS results to assess the patient-centeredness of care,

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		with health care. The CAHPS Nursing Home Surveys are comprised of three separate instruments: an in-person structured interview for long-term residents, a mail questionnaire for recently discharged short-stay residents, and a mail questionnaire for residents' family members.[ff]	by the National Quality Forum (NQF) as a measure of nursing home quality in March 2011. The instrument for residents recently discharged from nursing homes after short stays which should not exceed 100 days is designed to be administered by mail. NQF endorsed this instrument in March 2011 on a provisional basis, pending final analyses of reporting composites. The above two resident questionnaires are similar in concept, except the discharged resident instrument also covers therapy services. Both			compare and report on performance, and improve quality of care.[jj]

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			instruments include questions about the quality of care residents have received at their nursing home and their quality of life in the facility.[gg] The family member instrument was developed to complement the Long-Stay Resident Instrument, which was also endorsed by NQF as a measure of nursing home quality in March 2011. The instrument assesses family member's experience with the nursing home and their perceptions of the quality of care provided to a family member living in a nursing home. [hh]			

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Nursing Home Compare Applies to: Nursing Home, Skilled Nursing Facility	The Five-Star Quality Rating System used in Nursing Home Compare is based on the Omnibus Reconciliation Act of 1987 (OBRA '87), a nursing home reform law, and other quality improvement campaigns such as the Advancing Excellence in America's Nursing Homes, a coalition of consumers, health care providers, and nursing home professionals. [kk]	CMS has developed the Nursing Home Compare web site to assist consumers, their families, and caregivers in informing their decisions regarding choosing a nursing home. The Nursing Home Compare includes the Five-Star Quality Rating System which assigns each nursing home a rating of 1 to 5 stars, with 5 representing the above average quality and 1 indicating the below average quality. [ll]	The data for the Nursing Home Compare is collected through different mechanisms such as annual inspection surveys and complaint investigations findings, the CMS Online Survey and Certification Reporting (OSCAR) system, and MDS quality measures (QMs).[mm]	The Nursing Home Compare performance domains include the following: Health Inspections — facility ratings for this domain are based on the number, scope, and severity of deficiencies discovered during the three most recent annual surveys in conjunction with major findings from the most recent 36 months of complaint investigations. Other factors considered under this domain are the number of revisits required to ensure that deficiencies have been resolved. Staffing — facility ratings on this domain are based on two measures: RN hours per resident day and total staffing hours including RN, LPN, and nurse aide hours per resident day. QMs — facility ratings for this		Nursing Home Compare web site provides consumers, their families, and caregivers with information on the quality of care each individual nursing home offer.

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
				domain are based on performance on 10 of the 19 QMs. These measures have been developed from MDS-based indicators and are currently posted on the Nursing Home Compare web site. The QMs include seven long-stay and three short-stay measures. [nn] Star ratings are assigned for each of the three domains and are also combined to calculate an overall rating. [oo]		
Outcome and Assessment Information Set (OASIS) Applies to: Home Health Agencies (HHA)	• According to the 1999 Conditions of Participation (CoPs), Medicare-certified HHAs should collect and submit OASIS data related to all adult (18 years or older) non-maternity patients receiving skilled services with Medicare or Medicaid as a payer. • Based on the Deficit Reduction Act of 2005 (DRA),	The OASIS is a group of data elements that: •Represent core items of a comprehensive assessment for an adult home care patient •Form the basis for measuring patient outcomes for purposes of outcome-based quality	HHAs must use HAVEN that is free software provided from CMS for OASIS data submission.[ss]	The OASIS includes six major domains: sociodemographic, environmental, support system, health status, and functional status. It also includes selected attributes of health service utilization.[tt]	The annual payment update for HHAs that do not submit OASIS is lowered by two percentage points. [uu]	Since fall 2003, CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website Home Health Compare.[vv]

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
	the annual payment update for HHAs that do not submit OASIS is reduced by two percentage points. • Additional major revision based on stakeholder and industry expert recommendations were implemented in 2010.[pp]	improvement (OBQI). [qq] OASIS data are used for the following purposes:[rr] • Identify patient needs, plans care, and deliver services • Guidance to surveyors • Payment algorithms – basis of the HH PPS • HHA Pay for Reporting (Annual Payment Update) • HHA performance improvement activities/benchmarking • Publicly reported quality measures (HH Compare)				
Home Health		CMS created the Home Health Compare Web site,		Domains of the quality measurement include:		Home Health Compare includes a

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Compare Applies to: Home Health Care		which provides information about the quality of care provided by "Medicare-certified"[i] home health agencies throughout the country.[ww]		managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.[xx]		subset of OASIS-based quality measures that are publicly reported. [yy]
Home Health Consumer Assessment of Healthcare Providers and Services (HHCAHPS) Applies to: Home Health Care	• According to the 2010 Home Health Prospective Payment System (HHPPS) Final Rule, HHCAHPS will be linked to the quality reporting requirement for the CY 2012 annual payment update (APU). • Based on the 2011 HHPPS Final Rule, quality reporting for the 2013 APU is required of all Medicare –certified home health agencies, provided they meet some criteria.[zz]	AHRQ developed the HHCAHPS instrument in 2008, which was endorsed by NQF in March 2009 and approved by the Office of Management and Budget (OMB) in July 2009. The national implementation of the survey began in October 2009 with agencies participating on a voluntary basis to when quality reporting requirements for the home health APU began in 2010. CMS plans to start publicly reporting	Multiple survey vendors under contract with home health agencies conduct ongoing data collection and submit data files to the Home Health Care CAHPS Survey Data Center, which is operated and maintained by RTI International.[bbb]	The survey covers the following topics: patient care (gentleness, courtesy, problems with care); communication with health care providers and agency staff; specific care issues related to pain and medication; and overall rating of care.[ccc]	HHCAHPS will be linked to the quality reporting requirement for the CY 2012 APU. [ddd]	CMS plans to start publicly reporting the survey results on Home Health Compare in early 2012. [eee]

[i] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		the survey results on Home Health Compare in early 2012. The survey aims to meet the following three goals:[aaa] • Produce comparable data on the patient's perspective, • Create incentives for agencies to improve their quality of care through public reporting, • Enhance public accountability by publicly reporting the results.				
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)	Section 4421 of the Balanced Budget Act of 1997, as amended by section 125 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget	The IRF PPS will use information from IRF- PAI to categorize patients into distinct groups based on clinical characteristics and expected resource needs,	To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument	IRF-PAI data items address the physical, cognitive, functional, and psychosocial status of patients. [lll] Functional status includes self-care (eating, grooming, bathing,	Each IRF must report the date that it transmitted the IRF-PAI instrument to the database on the claim that it submits	

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Applies to: IRFs	Refinement Act of 1999, and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, authorizes the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units - referred to as inpatient rehabilitation facilities (IRFs). [fff]	which is used to calculate separate payments for each group, including the application of case and facility level adjustments.[ggg] Although the Medicare IRF-PAI data elements were developed primarily for IRF PPS, the data collected will also be used for quality of care purposes on all Medicare Part A fee-for-service patients who receive services under Part A from an IRF at admission and upon discharge.[hhh] The Functional Independence Measure (FIM) is a functional assessment measure used in the rehabilitation community which is embedded in the IRF-PAI, with some modifications.	for each IRF stay to CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains.[jjj] Prior to the IRF-PAI data transmission to the CMS national assessment collection database, an IRF must be assigned a login and password for accessing the Medicare data communication network (MDCN) and a login and password for accessing the national assessment collection database.[kkk]	dressing, toileting, bladder & bowel); transfers; locomotion; and communication. Quality indicators include pressure ulcers measures.[mmm]	to the fiscal intermediary. If the instrument were transmitted more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.[nnn]	

Overview of Post-Acute Care and Long-Term Care Performance Measurement Programs

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		The FIM instrument was designed for adult rehabilitation patients and is used with a computerized analysis and reporting system.[iii]				

[a] Nursing Home Compare. Supporting Information. Glossary. Available at http://www.medicare.gov/NHCompare/static/tabSI.asp?activeTab=2
[b] Centers for Medicare and Medicaid Services. Overview. Available at http://www.cms.gov/MDSPubQIandResRep/. Last accessed October 2011.
[c] Centers for Medicare and Medicaid Services. Nursing Home Value-Based Purchasing Demonstration- Fact Sheet August 2009. Available at: https://www.cms.gov/DemoProjectsEvalRpts/downloads/NHP4P_FactSheet.pdf
[d] Medicare.gov. What is Home Health Care?. http://www.medicare.gov/HomeHealthCompare/About/GettingCare/WhatisHomeHealthCare.aspx. Last accessed October 2011.
[e] Centers for Medicare and Medicaid Services. HAVEN. https://www.cms.gov/OASIS/045_HAVEN.asp#TopOfPage. Last accessed October 2011.
[f] Medicare.gov. Introduction. http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.
[g] Home Health Care CAHPS Survey. https://homehealthcahps.org/GeneralInformation/AboutHomeHealthCareCAHPSSurvey.aspx. Last accessed October 2011.
[h] Centers for Medicare and Medicaid Services. Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program. Available at https://www.cms.gov/qualityinitiativesgeninfo/downloads/VBPRoadmap_OEA_1-16_508.pdf
[i] Centers for Medicare and Medicaid Services. https://www.cms.gov/CertificationandComplianc/16_InpatientRehab.asp#TopOfPage. Last accessed October 2011.
[j] Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007. June 2010. Available at http://oig.hhs.gov/oas/reports/region1/10900507.pdf
[k] Medpac. Report to the Congress. New Approaches in Medicare. Chapter 5 Defining Long-Term Care Hospitals. June 2004. Available at http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch5.pdf
[l] RTI International. Overview of the Medicare Post-Acute Care Payment Reform Initiative. Available at http://www.cms.gov/DemoProjectsEvalRpts/downloads/PACPR_RTI_CMS_PAC_PRD_Overview.pdf
[m] Centers for Medicare and Medicaid Services. New Quality Reporting programs for LTCHs, IRFs, and Hospices. https://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/ Accessed at October 2011.
[n] Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration Program. Available at http://www.cms.gov/DemoProjectsEvalRpts/downloads/PACPR_Section5008.pdf
[o] Research Triangle Institute. Overview of the Post-Acute Care Payment Reform Demonstration/Medicare Payment Reform Demonstration. http://www.pacdemo.rti.org/ Last accessed October 2011.
[p] Research Triangle Institute. Overview of the Medicare Post-Acute Care Payment Reform Initiative. Available at https://www.cms.gov/DemoProjectsEvalRpts/downloads/PACPR_RTI_CMS_PAC_PRD_Overview.pdf
[q] Research Triangle Institute. Post-Acute Care Payment Reform Demonstration. http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool. Last accessed October 2011.

[r] Ibid.
[s] Ibid.
[t] Ibid.
[u] Centers for Medicare and Medicaid Services. Overview. Available at http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/. Last accessed October 2011.
[v] Development of a CMS Quality Reporting Program for Long Term Care Hospital, Inpatient Rehabilitation Hospitals and Hospice Programs. Centers for Medicare & Medicaid Services Special Open Door Forum Presentation. 2010.
[w] Ibid.
[x] Centers for Medicare and Medicaid Services. Overview. Available at http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/. Last accessed October 2011.
[y] Ibid.
[z] Ibid.
[aa] Elsevier. Association Between the Nursing Home Minimum Data Set for Vision and Vision-Targeted Health-Related Quality of Life in Nursing Home Residents as Assessed by Certified Nursing Assistants. Available at http://www.elsevier.es/es/node/2455610. Last accessed October 2011.
[bb] Centers for Medicare and Medicaid Services. Overview. Available at http://www.cms.gov/MDSPubQIandResRep/. Last accessed October 2011.
[cc] Ibid.
[dd] Centers for Medicare and Medicaid Services. Long-Term Care Minimum Data Set. Available at http://www.cms.gov/IdentifiableDataFiles/10_LongTermCareMinimumDataSetMDS.asp.
[ee] CMS Presentation. Post-Acute Care/Long-Term Care Workgroup – MDS, OASIS, and CARE
[ff] Agency for Healthcare Research and Quality. Facility Surveys. Available at https://www.cahps.ahrq.gov/content/products/PROD_FacilitiesSurveys.asp?p=102&s=22. Last accessed October 2011.
[gg] CAHPS Nursing Home Surveys: Resident Instruments. Available at https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Resident.asp?p=1022&s=223. Last accessed October 2011.
[hh] CAHPS Nursing Home Surveys: Family Member Instrument. Available at https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Family.asp?p=1022&s=223. Last accessed October 2011.
[ii] CAHPS Nursing Home Surveys: Resident Instruments. Available at https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Resident.asp?p=1022&s=223#Long-Stay. Last accessed October 2011.
[jj] Consumer Assessment Healthcare Providers and Systems Home. Available at https://www.cahps.ahrq.gov/default.asp. Last accessed October 2011.
[kk] Nursing Home Important Information. Five Star Quality Rating. Available at: http://www.medicare.gov/NHCompare/static/tabhelp.asp?language=English&activeTab=6&subTab=0version=default.
[ll] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.
[mm] Centers for Medicare and Medicaid Services. Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide. July 2010. Available at https://www.cms.gov/CertificationandComplianc/Downloads/usersguide.pdf. Last accessed June 2011.
[nn] Ibid.
[oo] Centers for Medicare and Medicaid Services. Background. Available at http://www.medicare.gov/NHCompare/static/tabhelp.asp?language=English&activeTab=6&subTab=0version=default. Last accessed October 2011
[pp] CMS Presentation. Post-Acute Care/Long-Term Care Workgroup – MDS, OASIS, and CARE
[qq] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2011.
[rr] CMS Presentation. Post-Acute Care/Long-Term Care Workgroup – MDS, OASIS, and CARE
[ss] Centers for Medicare and Medicaid Services. Haven. September 2011. Available at https://www.cms.gov/OASIS/045_HAVEN.asp#TopOfPage. Last accessed October 2011.
[tt] Centers for Medicare and Medicaid Services. Available at http://www.cms.gov/OASIS/Downloads/maincomponentsandgeneralapplication.pdf. May 2011.
[uu] CMS Presentation. Post-Acute Care/Long-Term Care Workgroup – MDS, OASIS, and CARE
[vv] Centers for Medicare and Medicaid Services. Overview. Available at http://www.cms.gov/HomeHealthQualityInits/. Last accessed October 2011.
[ww] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.
[xx] The Official U.S. Government Site for Medicare. Information about a Home Health Agency's Quality of Care. Available at http://www.medicare.gov/HomeHealthCompare/About/FindanAgency/QualityofCare.aspx. Last accessed October 2011.
[yy] Centers for Medicare and Medicaid Services. Overview. June 2011. Available at http://www.cms.gov/HomeHealthQualityInits/01_Overview.asp. Last accessed October 2011.
[zz] Home Health Care CAHPS Survey. General Information. Available at https://homehealthcahps.org/GeneralInformation/AboutHomeHealthCareCAHPSSurvey.aspx. Last accessed October 2011.

[aaa] Ibid.
[bbb] Web Site User and Data Submission Manual, Version 1.0 Home Health Care CAHPS survey. 2010 Available at https://homehealthcahps.org/LinkClick.aspx?fileticket=GWXA8eDTjKA%3d&tabid=247. Last accessed October 2011.
[ccc] Agency for Healthcare Research and Quality. CAHPS Home Health Care Survey: Reporting Measures. August 2009. Available at https://www.cahps.ahrq.gov/content/products/HH/PROD_HH_Intro.asp#Reporting. Last accessed October 2011.
[ddd] Home Health Care CAHPS Survey: General Information. Available at https://homehealthcahps.org/GeneralInformation/AboutHomeHealthCareCAHPSSurvey.aspx. Last accessed October 2011.
[eee] Ibid.
[fff] Centers for Medicare and Medicaid Services. Overview. Available at https://www.cms.gov/InpatientRehabFacPPS/01_Overview.asp#TopOfPage. Last accessed October 2011.
[ggg] Ibid.
[hhh] Research Data Assistance Center. IRF-PAI Data Available. August 2011. Available at http://www.resdac.org/IRF-PAI/data_available.asp. Last accessed October 2011.
[iii] Medscape Reference. Quality and Outcome Measures for Rehabilitation Programs. June 2011. Available at http://emedicine.medscape.com/article/317865-overview#aw2aab6b3. Last accessed October 2011.
[jjj] Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007. June 2010. http://oig.hhs.gov/oas/reports/region1/10900507.asp.
[kkk] Centers for Medicare and Medicaid Services. IRF Patient Assessment Instrument. June 2011. Available at https://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage. Last accessed October 2011.
[lll] Research Data Assistance Center. IRF-PAI Data Available. August 2011. Available at http://www.resdac.org/IRF-PAI/data_available.asp. Last accessed October 2011.
[mmm] CMS Presentation. Post-Acute Care/Long-Term Care Workgroup – MDS, OASIS, and CARE
[nnn] Nationwide Review of Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007. June 2010. http://oig.hhs.gov/oas/reports/region1/10900507.asp. Last accessed October 2011.

Nursing Home Compare Measures

***Measures on this list are drawn from MDS 3.0 which will be replacing measures from MDS 2.0 currently reported on Nursing Home Compare**

NQF Measure # and Status	Measure Name	Description
0194 Not Endorsed	Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period	Percentage of residents on most recent assessment. who spent most of their time in bed or in a chair in their room during the 7-day assessment period
0676 Endorsed	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	This measure updates CMS' current QM on pain severity for short-stay residents (people who are discharged within 100 days of admission). This updated measure is based on data from the Minimum Data Set (MDS 3.0) 14-day PPS assessments. This measure reports the percentage of short-stay residents with a 14-day PPS assessment during a selected quarter (3 months) who have reported almost constant or frequent pain and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the 14-day PPS assessment.
0677 Endorsed	Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	The proposed long-stay pain measure reports the percent of long-stay residents of all ages in a nursing facility who reported almost constant or frequent pain and at least one episode of moderate to severe pain or any severe or horrible pain in the 5 days prior to the MDS assessment (which may be an annual, quarterly, significant change or significant correction MDS) during the selected quarter. Long-stay residents are those who have had at least 100 days of nursing facility care. This measure is restricted to the long stay population because a separate measure has been submitted for the short-stay residents (those who are discharged within 100 days of admission).
0678 Endorsed	Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	This measure updates CMS' current QM pressure ulcer measure which currently includes Stage 1 ulcers. The measure is based on data from the MDS 3.0 assessment of short-stay nursing facility residents and reports the percentage of residents who have Stage 2-4 pressure ulcers that are new or have worsened. The measure is calculated by comparing the Stage 2-4 pressure ulcer items on the discharge assessment and the previous MDS assessment (which may be an OBRA admission or 5-day PPS assessment). The quality measure is restricted to the short-stay population defined as those who are discharged within 100 days of admission. The quality measure does not include the long-stay residents who have been in the nursing facility for longer than 100 days. A separate measure has been submitted for them.
0679 Endorsed	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage 1 ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage 1 ulcers from the definition. The measure reports the percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition. Long-stay residents are those who have been in nursing facility care for more than 100 days. This measure is restricted to the population that has long-term needs; a separate pressure ulcer measure is being submitted for short-stay populations. These are defined as having a stay that ends with a discharge within the first 100 days.
0680 Endorsed	Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	The measure is based on data from MDS 3.0 assessments of nursing facility residents. The measure reports the percent of short-stay nursing facility residents who are assessed and appropriately given the seasonal influenza vaccination during the influenza season as reported on the target MDS assessment (which may be an OBRA admission, 5-day PPS, 14-day PPS, 30-day PPS, 60-day PPS, 90-day PPS or discharge assessment) during the selected quarter. Short-stay residents are those residents who are discharged within the first 100 days of the stay. The measure is restricted to the population that has short-term needs and does not include the population of residents with stays longer than 100 days. A separate quality measure has been submitted for the long-stay population. The specifications of the proposed measure mirror those of the harmonized measure endorsed by the National Quality Forum under measure number 0432 Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents. The NQF standard specifications were developed to achieve a uniform approach to measurement across settings and populations addressing who is included in the target denominator population, who is excluded, who is included in the numerator population, and time windows for measurement and vaccinations.
0681 Endorsed	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were assessed and appropriately given the seasonal influenza vaccine during the influenza season. The measure reports on the percentage of residents who were assessed and appropriately given the seasonal influenza vaccine (MDS items O0250A and O250C) on the target MDS assessment (which may be an admission, annual, quarterly, significant change or correction assessment). Long-stay residents are those residents who have been in the nursing facility at least 100 days. The measure is restricted to the population with long-term care needs and does not include the short-stay population who are discharged within 100 days of admission. This specification of the proposed measure mirrors the harmonized measure endorsed by the National Quality Forum (Measure number 0432: Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents.) The NQF standard specifications were developed to provide a uniform approach to measurement across settings and populations. The measure harmonizes who is included in the target denominator population, who is excluded, who is included in the numerator population, and time windows for measurement and vaccinations.

Nursing Home Compare Measures

***Measures on this list are drawn from MDS 3.0 which will be replacing measures from MDS 2.0 currently reported on Nursing Home Compare**

NQF Measure # and Status	Measure Name	Description
0682 Endorsed	Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	This measure is based on data from MDS 3.0 assessments of nursing facility residents. The measure reports the percentage of short-stay nursing facility residents who were assessed and appropriately given the Pneumococcal Vaccine (PPV) as reported on the target MDS 3.0 assessment (which may be an OBRA admission, 5-day PPS, 14-day PPS, 30-day PPS, 60-day PPS, 90-day PPS or discharge assessment) during the 12-month reporting period. The proposed measure is harmonized with the NQF's quality measure on Pneumococcal Immunizations.(1) Short-stay residents are those residents who are discharged within the first 100 days of the stay. The measure is restricted to the population that has short-term needs and does not include the population of residents with stays longer than 100 days. A separate quality measure has been submitted for the long-stay population. The NQF standard specifications were harmonized to achieve a uniform approach to measurement across settings and populations addressing who is included in or excluded from the target denominator population, who is included in the numerator population, and the time windows. The NQF standardized specifications differ from the currently reported measure in a several ways. It is important to note that, for some residents, a single vaccination is sufficient and the vaccination would be considered up to date; for others (those who are immunocompromised or older than 65 but the first vaccine was administered more than 5 years ago when the resident was younger than 65 years of age), a second dose would be needed to qualify as vaccination up to date. Although the guidelines recommend a second dose in these circumstances, the NQF Committee believed that adding that requirement would make measurement too complex for the amount of benefit gained. Also, given the importance of revaccination among older adults, focusing on up-to-date status, rather than ever having received the vaccine, is of critical importance. 1. National Quality Forum. National voluntary consensus standards for influenza and pneumococcal immunizations. December 2008. Available from http://www.qualityforum.org/Publications/2008/12/National_Voluntary_Consensus_Standards_for_Influenza_and_Pneumococcal_Immunizations.aspx.
0683 Endorsed	Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)	This measure is based on data from MDS 3.0 assessments of long-stay nursing facility residents. The measure reports the percentage of all long-stay residents who were assessed and appropriately given the Pneumococcal Vaccination (PPV) as reported on the target MDS assessment (which may be an admission, annual, quarterly, significant change or correction assessment) during the 12-month reporting period. This proposed measure is harmonized with NQF's quality measure on Pneumococcal Immunizations.(1) The MDS 3.0 definitions have been changed to conform to the NQF standard. The NQF used current guidelines from the Advisory Committee on Immunization Practices (ACIP) and others to guide decisions on all parameters for the harmonized measures.(2-10) The recently updated ACIP guidelines remain unchanged relative to their recommendations for pneumonia vaccinations.(12) The NQF standard specifications were harmonized to achieve a uniform approach to measurement across settings and populations, addressing who is included or excluded in the target denominator population, who is included in the numerator population, and time windows for measurement and vaccinations. Long-stay residents are those residents who have been in the nursing home facility for at least 100 days. The measure is restricted to the population with long-term care needs and does not include the short-stay population who are discharged within 100 days of admission. The NQF standardized specifications differ from the currently reported measure in several ways. It is important to note that, for some residents, a single vaccination is sufficient and the vaccination would be considered up to date; for others (those who are immunocompromised or older than 65, but the first vaccine was administered more than 5 years ago when the resident was younger than 65 years of age), a second dose would be needed to qualify a vaccination as up to date. Although the guidelines recommend a second dose in these circumstances, the NQF Committee believed that adding that requirement would make measurement too complex for the amount of benefit gained, especially given the complexity of determining "up-to-date status".(1) 1. National Quality Forum. National voluntary consensus standards for influenza and pneumococcal immunizations. December 2008. Available from http://www.qualityforum.org/Publications/2008/12/National_Voluntary_Consensus_Standards_for_Influenza_and_Pneumococcal_Immunizations.aspx
0684 Endorsed	Percent of Residents with a Urinary Tract Infection (Long-Stay)	This measure updates CMS' current QM on Urinary Tract Infections in the nursing facility populations. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (which may be an annual, quarterly, or significant change or correction assessment). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those whose stay in the facility is over 100 days. The measure is limited to the long-stay population because short-stay residents (those who are discharged within 100 days of admission) may have developed their urinary tract infections in the hospital rather than the nursing facility.
0685 Endorsed	Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder (Long-Stay)	This measure updates CMS' current QM on bowel and bladder control. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing facility residents (those whose stay is longer than 100 days). This measure reports the percent of long-stay residents who are frequently or almost always bladder or bowel incontinent as indicated on the target MDS assessment (which may be an annual, quarterly, significant change or significant correction assessment) during the selected quarter (3-month period). The proposed measure is stratified into high and low risk groups; only the low risk group's (e.g., residents whose mobility and cognition are not impaired) percentage is calculated and included as a publicly-reported quality measure.
0686 Endorsed	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)	This measure updates CMS' current QM on catheter insertions. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home residents (those whose stay is longer than 100 days). This measure captures the percentage of long-stay residents who have had an indwelling catheter in the last 7 days noted on the most recent MDS 3.0 assessment, which may be annual, quarterly, significant change or significant correction during the selected quarter (3-month period). Long-stay residents are those residents who have been in nursing care at least 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short stay population who are discharged within 100 days of admission.

Nursing Home Compare Measures

***Measures on this list are drawn from MDS 3.0 which will be replacing measures from MDS 2.0 currently reported on Nursing Home Compare**

NQF Measure # and Status	Measure Name	Description
0687 Endorsed	Percent of Residents Who Were Physically Restrained (Long Stay)	The measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment).
0688 Endorsed	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay)	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents in a nursing facility whose need for help with late-loss Activities of Daily Living (ADLs), as reported in the target quarter's assessment, increased when compared with a previous assessment. The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. This measure is calculated by comparing the change in each item between the target MDS assessment (which may be an annual, quarterly or significant change or correction assessment) and a previous assessment (which may be an admission, annual, quarterly or significant change or correction assessment).
0689 Endorsed	Percent of Residents Who Lose Too Much Weight (Long-Stay)	This measure updates CMS' current QM on patients who lose too much weight. This measure captures the percentage of long-stay residents who had a weight loss of 5% or more in the last month or 10% or more in the last 6 months who were not on a physician-prescribed weight-loss regimen noted on an MDS assessment (which may be an annual, quarterly, significant change or significant correction MDS assessment) during the selected quarter (3-month period). In order to address seasonal variation, the proposed measure uses a two-quarter average for the facility. Long-stay residents are those who have been in nursing care at least 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short-stay population who are discharged within 100 days of admission.
0690 Endorsed	Percent of Residents Who Have Depressive Symptoms (Long-Stay)	This measure is based on data from MDS 3.0 assessments of nursing home residents. Either a resident interview measure or a staff assessment measure will be reported. The preferred version is the resident interview measure. The resident interview measure will be used unless either there are three or more missing sub-items needed for calculation or the resident is rarely or never understood , in which cases the staff assessment measure will be calculated and used. These measures use those questions in MDS 3.0 that comprise the Patient Health Questionnaire (PHQ-9) depression instrument. The PHQ-9 is based on the diagnostic criteria for a major depressive disorder in the DSM-IV.
NH-023-10 Withdrawn (MDS measure)	Percent of Residents Whose Ability to Move In and Around their Room and Adjacent Corridors Got Worse (Long Stay)	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents in a nursing facility whose mobility, as reported in the target quarter's assessment, declined when compared with a previous assessment. This measure is calculated by comparing the change in the "locomotion on unit" item between the target MDS assessment (which may be an annual, quarterly or significant change or correction assessment) and a previous MDS assessment (which may be an admission, annual, quarterly or significant change or correction assessment).
NA	Percent of short-stay residents who have delirium	
NA	Percent of low-risk long-stay residents who have pressure sores	

Home Health Compare Measures

***Measures on this list are drawn from OASIS-C which will be replacing measures from OASIS-B1 currently reported on Home Health Compare**

NQF Measure # and Status	Measure Name	Description
0167 Endorsed	Improvement in Ambulation/locomotion	Percentage of home health episodes of care during which the patient improved in ability to ambulate.
0171 Endorsed	Acute care hospitalization	Percentage of home health episodes of care that ended with the patient being admitted to the hospital.
0174 Endorsed	Improvement in bathing	Percentage of home health episodes of care during which the patient got better at bathing self.
0175 Endorsed	Improvement in bed transferring	Percentage of home health episodes of care during which the patient improved in ability to get in and out of bed.
0176 Endorsed	Improvement in management of oral medications	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly (by mouth).
0177 Endorsed	Improvement in Pain Interfering with Activity	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.
0178 Endorsed	Improvement in status of surgical wounds	Percentage of home health episodes of care during which the patient demonstrates an improvement in the condition of surgical wounds.
0179 Endorsed	Improvement in dyspnea	Percentage of home health episodes of care during which the patient became less short of breath or dyspneic.
0181 In Maintenance	Increase in number of pressure ulcers	Percentage of home health episodes of care during which the patient had a larger number of pressure ulcers at discharge than at start of care.
0518 Endorsed	Depression Assessment Conducted	Percentage of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care.
0522 Reopened	Influenza Immunization Received for Current Flu Season	Percentage of home health episodes of care during which patients received influenza immunization for the current flu season.
0523 Endorsed	Pain Assessment Conducted	Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care
0524 Endorsed	Pain Interventions Implemented during Short Term Episodes of Care	Percentage of short term home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented.
0525 Endorsed	Pneumococcal Polysaccharide Vaccine (PPV) Ever Received	Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).
0526 Endorsed	Timely Initiation of Care	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
0537 Endorsed	Multifactor Fall Risk Assessment conducted for Patients 65 and Over	Percentage of home health episodes of care in which patients 65 and older had a multi-factor fall risk assessment at start/resumption of care.
0538 Endorsed	Pressure Ulcer Prevention in Plan of Care	Percentage of home health episodes of care in which the physician-ordered plan of care includes interventions to prevent pressure ulcers.
0540 Endorsed	Pressure Ulcer Risk Assessment Conducted	Percentage of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers at start/resumption of care.
NA	Diabetic Foot Care and Patient/Caregiver Education Implemented during Short Term Episodes of Care	Percentage of short term home health episodes of care during which diabetic foot care and education were included in the physician-ordered plan of care and implemented.
NA	Drug Education on All Medications Provided to Patient/Caregiver during Short Term Episodes of Care	Percentage of short term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.

NQF Measure # and Status	Measure Name	Description
NA	Heart Failure Symptoms Addressed during Short Term Episodes of Care	Percentage of short term home health episodes of care during which patients exhibited symptoms of heart failure and appropriate actions were taken.
NA	Pressure Ulcer Prevention Implemented during Short Term Episodes of Care	Percentage of short term home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented.

MAP "Working" Measure Selection Criteria

1. **Measures within the set meet NQF endorsement criteria**
   Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF endorsed but meet requirements for submission, including measures in widespread use and/or tested, may be submitted for expedited consideration).

   Response option:
   Yes/No: Measures within the measure set are NQF endorsed or meet requirements for NQF submission (including measures in widespread use and/or tested)[1]

2. **Measure set adequately addresses each of the National Quality Strategy (NQS) priorities**
   Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	*Safer care*
Subcriterion 2.2	*Effective care coordination*
Subcriterion 2.3	*Preventing and treating leading causes of mortality and morbidity*
Subcriterion 2.4	*Person- and family-centered care*
Subcriterion 2.5	*Supporting better health in communities*
Subcriterion 2.6	*Making care more affordable*

   Response option for each subcriterion:
   Yes/No: NQS priority is adequately addressed in the measure set

3. **Measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)**
   Demonstrated by the measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Reference tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by NQF's Measure Prioritization Advisory Committee.)
   Response option:
   Yes/No: Measure set adequately addresses high-impact conditions relevant to the program's intended population(s)

[1] Individual endorsed measures may require additional discussion and may not be included in the set if there is evidence that implementing the measure results in undesirable unintended consequences.

4. Measure set promotes alignment with specific program attributes

Demonstrated by a measure set that is applicable to the intended provider(s), care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option:

Subcriterion 4.1	Yes/No: Measure set is applicable to the program's intended provider(s)
Subcriterion 4.2	Yes/No: Measure set is applicable to the program's intended care setting(s)
Subcriterion 4.3	Yes/No: Measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.4	Yes/No: Measure set is applicable to the program's population(s)

5. **Measure set includes an appropriate mix of measure types**

Demonstrated by a measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option:

Subcriterion 5.1	Yes/No: Outcome measures are adequately represented in the set
Subcriterion 5.2	Yes/No: Process measures with a strong link to outcomes are adequately represented in the set
Subcriterion 5.3	Yes/No: Experience of care measures are adequately represented in the set (e.g. patient, family, caregiver)
Subcriterion 5.4	Yes/No: Cost/resource use/appropriateness measures are adequately represented in the set
Subcriterion 5.5	Yes/No: Structural measures and measures of access are represented in the set when appropriate

6. Measure set enables measurement across the patient-focused episode of care[2]

Demonstrated by assessment of the patient's trajectory across providers, settings, and time.

Response option:

Subcriterion 6.1	Yes/No: Measures within the set are applicable across relevant providers
Subcriterion 6.2	Yes/No: Measures within the set are applicable across relevant settings
Subcriterion 6.3	Yes/No: Measure set adequately measures patient care across time

7. Measure set includes considerations for healthcare disparities[3]

Demonstrated by a measure set that promotes equitable access and treatment by addressing race, ethnicity, socioeconomic status, language, gender, or age disparities. Measure set also

[2] National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC: NQF; 2010.

[3] NQF, *Healthcare Disparities Measurement, (commissioned paper under public comment)*, Washington, DC: NQF; 2011.

can address populations at risk for healthcare disparities (e.g., patients with behavioral/mental illness).

Response option:

Subcriterion 7.1	Yes/No: Measure set includes measures that directly address healthcare disparities (e.g., interpreter services)
Subcriterion 7.2	Yes/No: Measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Measure set promotes parsimony

Demonstrated by a measure set that supports efficient (i.e., minimum number of measures and the least burdensome) use of resources for data collection and reporting and supports multiple programs and measurement applications.

Response option:

Subcriterion 8.1	Yes/No: Measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)
Subcriterion 8.2	Yes/No: Measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

Table 1: National Quality Strategy Priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention *and* treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese ($\geq 85^{th}$ percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma

7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

Alignment of Proposed Measures for Long-Term Care Hospitals and Inpatient Rehabilitation Hospitals with the Core Measure Concepts

This table includes measures that could be used in Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs) mapped to the core measure concepts identified by the PAC/LTC Workgroup. Measures listed include the measures finalized for use in 2014 and possible future topics of interest suggested by CMS. Finalized measures are marked with an asterisk.

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
Functional and cognitive status assessment	• Percent of patients with pain assessment conducted and documented prior to therapy • Functional change: change in motor score • Change in cognitive function: change in cognitive score • Percent of patients on a scheduled pain management regime on admission who report a decrease in pain intensity or frequency • Percent of patients who self-report moderate to severe pain • Percent of patients with dyspnea improved within one day of assessment	
Establishment and Attainment of Patient/Family/Caregiver Goals	• Percent of patients whose individually stated goals were met • Percent of patients for whom care delivered was consistent with patient stated care preferences	
Advanced Care Planning		
Experience of care	• Patient survey, for example, Hospital Consumer Assessment of Healthcare Providers & Systems	
Shared decision making in developing care plan	• Patient preferences for care, treatment and management of symptoms by healthcare providers	
Transition planning	• Care Transitions Measure-3 (CTM-3) • Discharge outcome/discharge disposition: home, assisted living, nursing home, LTCH, hospital, hospice • Communication	
Falls	• Falls with major injury • Falls with major injury per 1000 days	• Patient fall rate • Falls with injury • Falls and trauma

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
Pressure ulcers	• Stage III and IV pressure ulcers • Pressure ulcers that are new or have worsened*	• Pressure ulcer prevalence • Stage III and IV pressure ulcers • Pressure ulcers that are new or have worsened*
Adverse drug events	• Poly-pharmacy related injury • Medication errors	• Medication errors • Injuries secondary to Poly-pharmacy
Infection rates	• Surgical site infections • Multidrug resistant organism infection • Urinary catheter-associated urinary tract infections (CAUTI)*	• Central line bundle compliance • Surgical site infection rate • Ventilator bundle • Multidrug resistant organism infection • Ventilator-associated pneumonia • Urinary catheter-associated urinary tract infections (CAUTI)* • Central line catheter-associated bloodstream infection (CLABSI)*
Avoidable admissions	• Unplanned acute care hospitalizations • All-cause risk-standardized readmission	• Unplanned acute care hospitalizations
Inappropriate medication use		
Measures not mapped to a core set concept	• Incidence of venous thromboembolism (VTE), potentially preventable • VTE prophylaxis • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization	• Restraint prevalence (vest and limb only) • Practice environment scale-nursing work index • Voluntary turnover for RN, APN, LPN, UAP • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization • Mortality • Blood incompatibility • Foreign object retained after surgery • Manifestation of poor glycemic control • Air embolism

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
		• Venous thromboembolism • Injuries related restraint use • Skill Mix (Registered Nurses [RN], Licensed Vocational/Practical Nurse [LPN/LVN], unlicensed assistive personal {UAP], and contract)

Priority Measure Concept Alignment- PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions.

Concepts are mapped to one NQS priority, however concepts may address multiple NQS priorities

NQS Measure Concepts	MCC Measure Concepts	MAP Post-Acute Care/Long-Term Care Measure Concepts	MAP Dual Eligible Beneficiaries High-Leverage Opportunities
National Priority: Work with communities to promote wide use of best practices to enable healthy living and well-being.			
• Adequate social support • Emergency department visits for injuries • Healthy behavior index • Binge drinking • Obesity • Mental health • Dental caries and untreated dental decay • Use of the oral health system • Immunizations	• Optimize function, maintaining function, prevention of decline in function • Patient family perceived challenge in managing illness or pain • Social support/connectedness • Productivity, absenteeism/presenteeism • Community/social factors • Healthy lifestyle behaviors • Depression/substance abuse/mental health • Primary prevention	• Functional and cognitive status assessment.	• Quality of life • Mental health and substance use
National Priority: Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.			
• Access to healthy foods • Access to recreational facilities • Use of tobacco products by adults and adolescents • Consumption of calories from fats and sugars • Control of high blood pressure • Control of high cholesterol	• Patient clinical outcomes (e.g. mortality, morbidity) • Patient reported outcomes (e.g. quality of life, functional status) • Missed prevention opportunities – secondary & tertiary		• Quality of life • Mental health and substance use
National Priority: Ensure person- and family-centered care.			
• Patient and family experience of quality, safety, and access • Patient and family involvement in decisions about healthcare • Joint development of treatment goals and longitudinal plans of care • Confidence in managing chronic conditions • Easy-to-understand instructions to manage conditions	• Shared decision-making • Patient, experience of care • Family, caregiver experience of care • Self-management of chronic conditions, especially multiple conditions	• Establishment and attainment of patient/family/ caregiver goals • Advanced care planning and treatment • Experience of care • Shared decision making	• Structural measures

Priority Measure Concept Alignment- PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions.

Concepts are mapped to one NQS priority, however concepts may address multiple NQS priorities

National Priority: Make care safer.						
NQS Measure Concepts	• Hospital admissions for ambulatory-sensitive conditions • All-cause hospital readmission index • All-cause healthcare-associated conditions • Individual healthcare-associated conditions • Inappropriate medication use and polypharmacy • Inappropriate maternity care • Unnecessary imaging	MCC Measure Concepts	• Avoiding inappropriate, non-beneficial end of life care • Reduce harm from unnecessary services • Preventable admissions and readmissions • Inappropriate medications, proper medication protocol and adherence	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Falls • Pressure ulcers • Adverse drug events • Inappropriate medication use	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	
National Priority: Promote effective communication and care coordination.						
NQS Measure Concepts	• Experience of care transitions • Complete transition records • Chronic disease control • Care consistent with end-of-life wishes • Experience of bereaved family members • Care for vulnerable populations • Community health outcomes • Shared information and accountability for effective care coordination	MCC Measure Concepts	• Seamless transitions between multiple providers and sites of care • Access to usual source of care • Shared accountability that includes patients, families, and providers • Care plans in use • Advance care planning • Clear instructions/simplification of regimen • Integration between community & healthcare system • Health literacy	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Transition planning	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Care coordination
National Priority: Make quality care affordable for people, families, employers, and governments.						
NQS Measure Concepts	• Consumer affordability index • Consistent insurance coverage • Inability to obtain needed care • National/state/local per capita healthcare expenditures • Average annual percentage growth in healthcare expenditures • Menu of measures of unwanted variation of overuse, including: - Unwarranted diagnostic/medical/surgical procedures - Inappropriate/unwanted nonpalliative services at end of life - Cesarean section among low-risk women - Preventable emergency department visits and hospitalizations	MCC Measure Concepts	• Transparency of cost (total cost) • Reasonable patient out of pocket medical costs and premiums • Healthcare system costs as a result of inefficiently delivered services, e.g. ER visits, poly-pharmacy, hospital admissions • Efficiency of care	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Infection rates • Avoidable admissions	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Infection rates Avoidable admissions

MAP Coordinating Committee October 19 Web Meeting Summary

Tab 6

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE

Convened by the National Quality Forum

Summary of Web Meeting #3

A web meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Wednesday, October 19, 2011. For those interested in viewing an online archive of the web meeting, please use the link below:

http://www.MyEventPartner.com/nqfmeetings11

The next meeting of the Coordinating Committee will be in-person and will take place on November 1-2, 2011, in Washington, DC.

Committee Members in Attendance at the October 19, 2011 Web Meeting:

George Isham (Co-Chair)	Chip Kahn, Federation of American Hospitals
Elizabeth McGlynn (Co-Chair)	William Kramer, Pacific Business Group on Health
Rhonda Anderson, American Hospital Association	Sam Lin, American Medical Group Association
David Baker, American College of Physicians	Ted Rooney, Maine Health Management Coalition (substitute for Elizabeth Mitchell)
Bobbie Berkowitz, [subject matter expert: population health]	Steven Brotman, AdvaMed (substitute for Michael Mussallem)
Eric Holmboe, American Board of Medical Specialties (substitute for Christine Cassel)	Frank Opelka, American College of Surgeons
Mark Chassin, The Joint Commission	Harold Pincus [subject matter expert: mental health]
Marla Weston, American Nurses Association	Carol Raphael [subject matter expert: health IT]
Suzanne Delbanco, Catalyst for Payment Reform	Gerald Shea, AFL-CIO
Joyce Dubow, AARP	Carl Sirio, American Medical Association
Steven Findlay, Consumers Union	Marla Weston, American Nurses Association
Aparna Higgins, America's Health Insurance Plans	

The primary objectives of the web meeting were to:

- Finalize measure selection criteria for pre-rulemaking input;
- Discuss proposed pre-rulemaking approach;
- Prepare for November 1-2 in-person Coordinating Committee meeting.

Welcome and Review of Meeting Objectives
Coordinating Committee Co-Chairs, George Isham and Beth McGlynn, began the meeting with a welcome and review of the meeting objectives.

Timeline Review and Update on Workgroup Activities
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the timelines for the MAP workgroups and Coordinating Committee and gave an update on the progress of the MAP workgroups' activities to date. Highlights included the submission of final clinician and safety performance measurement coordination strategy reports to the Department of Health and Human Services, as well as an interim report on performance measurement for dual eligible beneficiaries.

Measure Selection Criteria
Beth McGlynn began the section on the measure selection criteria. Connie Hwang, Vice President, Measure Applications Partnership, NQF, provided an update on the developmental timeline of the measure selection criteria and the latest version of the criteria. Connie discussed how the development of the measure selection criteria is a critical component of the pre-rulemaking task and how the latest version of the criteria incorporated the feedback from MAP workgroups, as well as public comment. Connie highlighted the creation of an interpretive guide to provide clarity and assistance on applying the selection criteria.

Following Connie's presentation, Committee members raised the following points regarding the measure selection criteria:

- Chip Khan asked for clarification of the meaning of "measure set";
- Steve Brotman recommended strengthening Criterion 1 (Measures within the set meet NQF-endorsement criteria);
- Mark Chassin recommended adding criteria to the characteristics of outcome and process measure types in the interpretive guide for Criterion 5 (Measure set includes an appropriate mix of measure types).
- Marla Weston commented that Criterion 4 (Measure set promotes alignment with specific program attributes) could work against harmonization across programs.

Mark Chassin made a motion to add specific criteria to the characteristics of outcome and process measure types in the interpretive guide for Criterion 5. The motion was as follows:

> Outcome Measures: Measures must accurately capture the occurrence of the outcome being assessed. When risk adjustment of clinical outcome measures is appropriate, measures are risk adjusted for all clinically important factors, including factors that

assess comorbidity and severity of illness. A strong evidence base shows that specific processes of care influence the outcome that is the subject of the measure.

Process Measures: The process being measured has a strong evidence base showing that the care process leads to improved outcomes. Measures that are more proximal to outcomes are preferred. The measure accurately captures whether the care process has in fact been provided.

Gerry Shea made a motion to table the vote on the main motion until the November 1-2 in-person meeting. A formal vote was taken on the motion to table that yielded the following results (see attachment for recording of the votes):

15 = Supporting the motion to table the vote

6 = Opposing the motion to table the vote

6 = Absent at the time of the vote

It was therefore determined that further consideration and finalization of the measure selection criteria would occur at the November Coordinating Committee In-person meeting.

Proposed Approach to Pre-Rulemaking Analysis
Connie Hwang explained the proposed approach and the roles of the Coordinating Committee and the MAP workgroups for the pre-rulemaking task. The approach includes setting a vision for harmonized measurement, developing core measures for settings, and reviewing measures under consideration by CMS for rulemaking for specific programs.

Allison Ludwig, Project Manager, Measure Applications Partnership, NQF, presented a homework activity that Coordinating Committee members will be asked to complete prior to the November in-person meeting. The objectives of the homework activity are to:

- Determine setting-specific core measures;
- Confirm priority measure gap concepts;
- Suggest potential removal and addition of measures to cores.

Next Steps
The next meeting of the Coordinating Committee is November 1-2, 2011, in Washington D.C.

Attachment: Recording of the Votes on the Motion to Table

Coordinating Committee Voting Member	Yes (Table)	No (Not Table)	Absent
George Isham		X	
Beth McGlyn		X	
AARP	X		
Academy of Managed Care Pharmacy			X
AdvaMed	X		
AFL-CIO	X		
America's Health Insurance Plan	X		
American College of Physicians		X	
American College of Surgeons	X		
American Hospital Association		X	
American Medical Association		X	
American Medical Group Association	X		
American Nurses Association	X		
Catalyst for Payment Reform	X		
Consumers Union	X		
Federation of American Hospitals		X	
LeadingAge			X
Maine Health Management Coalition	X		
National Association of Medicaid Directors			X
National Partnership for Women and Families	X		
Pacific Business Group on Health	X		
Richard Antonelli			X
Bobbie Berkowitz	X		
Joseph Betancourt			X
Ira Moscovice			X
Harold Pincus	X		
Carol Raphael	X		
TOTAL	14	6	7

MAP Coordinating Committee Small Group Breakout Materials

Tab 7

Dear MAP Coordinating Committee Member,

At the October 19th Coordinating Committee web meeting, we introduced an exercise for the Coordinating Committee to evaluate core measures and associated gaps that have been put forward by the MAP Clinician, Hospital, and PAC/LTC Workgroups. This exercise is designed to help us prepare and to use our time most efficiently at the November 1-2 Coordinating Committee in-person meeting.

The core measures will serve as a starting place for decisions about pre-rulemaking input to HHS. The exercise will also give the Coordinating Committee more experience using the DRAFT measure selection criteria and interpretive guide, to inform discussion regarding the criteria at the November 1-2 Coordinating Committee meeting.

As discussed at the web meeting, the Coordinating Committee has been divided into 3 subgroups that will each review core measures for a specific setting. We ask you to participate in identifying core measures and associated gaps for the clinician setting, using the Physician Value-Based Modifier proposed measures as a starting place.

Objectives of the activity include:

1. Evaluate the Physician Value-Based Modifier proposed measures as a starting place for clinician core measures for MAP pre-rulemaking activities
2. Confirm measure gap areas for the Value-Based Modifier measures and then prioritize those measure gap areas
3. Gain experience using the DRAFT measure selection criteria and interpretive guide to inform subsequent Coordinating Committee deliberations

Follow these steps to complete the exercise:

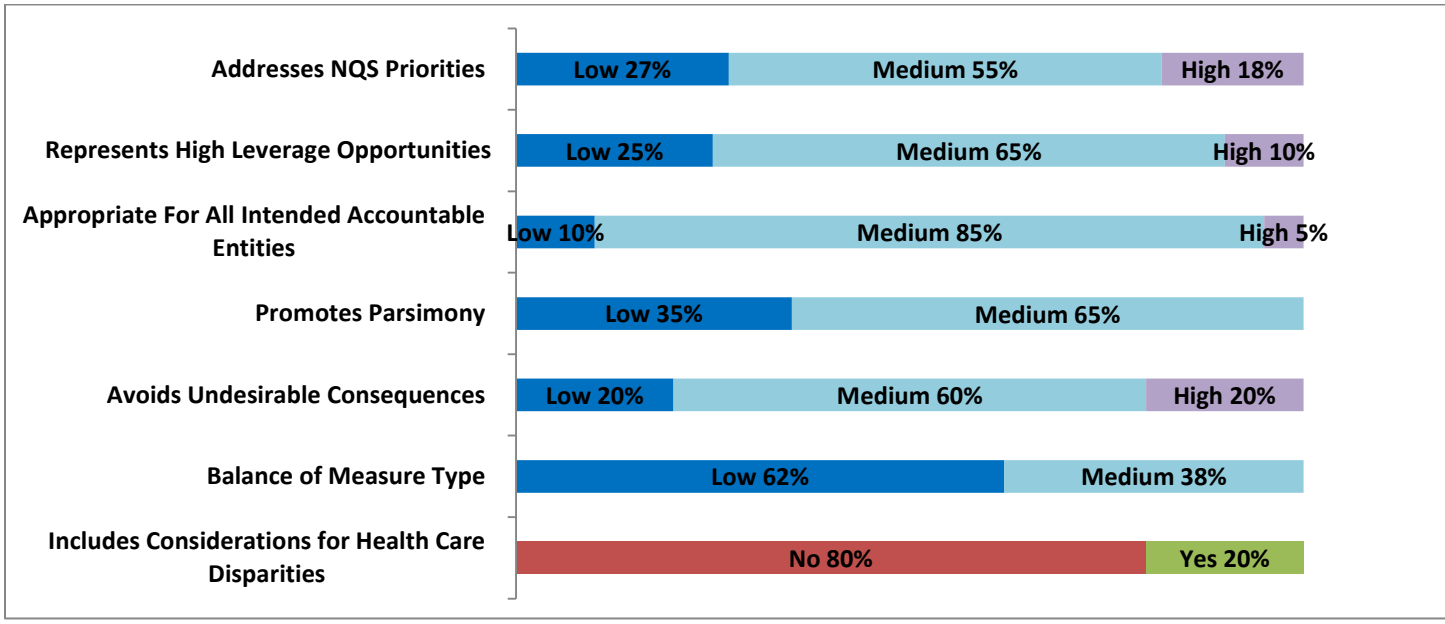
1. Review the following documents:
    a. Attachment 1: Program information (tab 1) and Physician Value-Based Modifier proposed measure tables (tabs 2-6)
    b. Attachment 2: MAP Clinician Workgroup inputs from their review of the Value-Based Modifier proposed measures
    c. Attachment 3: DRAFT MAP measure selection criteria and interpretive guide
2. Review the MAP Clinician Workgroup inputs on the Value-Based Modifier proposed measures as a basis for determining your clinician core measures and the associated gaps. Use the DRAFT measure selection criteria and interpretive guide when reviewing the core measures.
3. Share your conclusions by answering the survey questions. Access the survey here. While the questions are simple in nature, the rationale for your answers is important to capture in the text boxes embedded in the survey.
4. Further discussion and finalization of core measures will occur at the November 1-2 MAP Coordinating Committee in-person meeting.

NQF
NATIONAL QUALITY FORUM

Evaluating the CMS Value-Based Payment Modifier Proposed Quality Measures

In July, the Clinician Workgroup evaluated the Physician Value-Based Payment Modifier[1] (Value-Modifier) quality measure list that was published in the 2012 Medicare Physician Fee Schedule proposed rule, using an early version of the MAP measure selection criteria. The measure selection criteria have since evolved as it has been assessed by other MAP workgroups. The Value-Modifier quality measure list was selected for review because it applies to both individual and group or team levels of analysis and because of its significance as the initial list of measures for the Value-Modifier program, which will be the first performance-based payment program to be applied to all clinicians participating in Medicare. The core list will be augmented by incorporating additional quality and cost measures over time. The initial Value-Modifier proposed list includes measures from the PQRS and EHR-MU programs for 2012.

The graph below reflects the extent to which the Clinician Workgroup found the proposed Value-Modifier measure list met each criterion in the draft measure selection criteria:



The workgroup members provided the following rationale in support of their responses:

Addresses NQS priorities

The Value-Modifier proposed measure list addresses most NQS priorities but does not necessarily cover the true intent of the priority. Whereas treatment and secondary prevention (i.e., clinical effectiveness) measures dominate the list, measures representing patient-

centeredness are notably absent. Other NQS priorities—healthy living, care coordination, affordability, and safety—also are inadequately represented in the measure list.

Represents high-leverage opportunities

The measure list heavily addresses conditions that have been a focus for years, such as cardiovascular conditions and diabetes. Less consideration is given to other high-leverage opportunities for improvement, such as care coordination measures that cut across conditions and measures of patient experience.

Appropriate for all intended accountable entities

The measure list is appropriate for individual clinicians and groups or teams of clinicians, though focused on primary care. Team-based care, pediatrics (by design for this Medicare program), and most specialties are not addressed. The lack of measures related to specialties and team-based care may hinder shared accountability and understanding the performance of the entire system. Moreover, some measures may not have sufficient sample size to calculate rates for individual clinicians.

Promotes parsimony

The lack of measures that cross conditions and specialties works against parsimony for the list. Focus on systems of care beyond specific conditions would help achieve parsimony. The alignment with EHR-MU measures should be stronger to reduce duplication and data collection burden. Removing duplicative hypertension and lipid control measures from the list would further reduce burden.

Avoids undesirable consequences and healthcare disparities

Attention to downstream consequences is important, as all measures have the potential for undesirable consequences (e.g., adverse selection). However, the group found it difficult to assess the measure list for potential undesirable consequences and disparities, given the information in the proposed rule. Program implementation could include processes to monitor and detect undesirable consequences and disparities.

Appropriate mix of measure types

The measure list is dominated by process measures. Outcomes, experience, and cost have minimal or no representation. While not yet fully specified, cost information ultimately will be a part of the Value-Modifier. The addition of clinician-group CAHPS, which assesses patient experience, would greatly enhance the measure list.

Gaps in the Value-Modifier measures

- Patient-centeredness, patient preferences, patient experience, patient-reported outcomes
- Care coordination, communication with patient/family, social supports
- Clinical outcome measures (represented but ideally emphasized more)
- Function, quality of life, pain, fatigue
- Affordability, overuse, appropriateness of care
- Safety
- Surgical care
- Oral health
- Mental and behavioral health
- Team approach to care delivery

Measures to consider removing from the value-modifier proposed measures

While the Clinician Workgroup members were not specifically asked to select measures to be removed from the value-modifier list, workgroup members raised concerns with the following measures:

- Measures that are not NQF-endorsed
- Process measures not tied to outcomes
- Duplicative measures
- "Standard of care" process measures
- Measure for low back pain
- Influenza vaccine in the elderly (NQF measure 0041)

1. CMS, *Physician Fee Schedule.*

MAP Coordinating Committee – Clinician Core Measures Exercise Survey Results

1. **What are the strengths of the Physician Value Based Modifier proposed measures as clinician core measures, evaluated against the MAP DRAFT measure selection criteria?**
    - Addresses certain areas fairly well--AMI, CHI, Diabetes. Virtually all measures are NQF-endorsed As a "set" (term used loosely!) addresses some (Prevention, Secondary treatment, but not all, of the NQS priorities Attempts to address the age continuum (which, broadly speaking, applies to criterion for aligning with program-specific attributes)
    - These materials represent an initial intent to look beyond the traditional clinical parameters of care - that are very structure and process oriented - and begin to include/align with newly defined parameters of patient-centric care and quality of life. This approach is new for many established providers, but is absolutely necessary for aligning with the new hallmarks of quality care and coordinated care.
    - 1. Most of the measures are NQF endorsed 2. The measures address prevention and treatment of NQS priorities well 3. The measures address most high-impact conditions for adults 4. Includes several measures that are relevant for disparities
    - 1) The PVbM measures do not adequately address the National Quality Strategies priorities, with gaps in sub-criterions 2.1, 2.2, 2.4, 2.5, and 2.6 (only three measures directly involve issues of cost as overuse measures) 2) While three high impact conditions have a reasonable "portfolio" of measures (CHF, Ischemic Heart disease and diabetes), there are limited to no measures in all other high impact conditions. A related problem is the imbalance in both the quantity and types of measures (MAP criterion 5). To this end, we strongly recommend that the PVbM measures quickly embrace a transition to composite measures within, but equally if not more importantly, across conditions to provide a more accurate, reliable and comprehensive value of practice performance. 3) The PVbM measures are do not perform well on MAP criteria 6-8, especially criterion 6 with zero patient-reported measures in the set. The results of the original MAP survey using the first draft set of criteria still holds up relatively well, showing the PVbM measures were not rated highly against those draft MAP criteria. We also want to make a point about criterion 1. We strongly endorse the criterion as written because we believe a reasonable degree of flexibility is critical at this juncture. Among the measures in the CMS proposed set (of 64) are 6 that have not yet been submitted for NQF endorsement. Under the a stricter “must be NQF-endorsed first” standard, they would not be included in this proposed “core” measure set. We believe this would be very unfortunate – these are examples of essential measures that CMS needs the room to use even before NQF endorsement. They are: • Heart Failure: LVF Testing • 30-day post-discharge physician visit • CAD: LDL level <100 mg/dl • COPD: smoking counseling received • Proportion of adults 18 y and older who have had their BP measured in preceding 2 years • Preventive Care: Cholesterol LDL test performed These are evidence-based measures (and some admittedly more important than others) and to hold them up for endorsement would further reduce the limited number of measures and weaken measures sets like CHF, AMI and diabetes. For example, the LDL level is an important intermediate outcome measure. Furthermore, given our strong belief of the need for composite

measures, it would be unfortunate if robust, valid and reliable composites were not incorporated into PVbM measures when they are ready. We agree that the window for use without endorsement should be limited, but a strict "must: criterion of NQF endorsement runs the risk of slowing meaningful progress.

2. **What are the weaknesses of the Physician Value Based Modifier proposed measures as clinician core measures, evaluated against the MAP DRAFT measure selection criteria?**
    - Includes some NQF-endorsed measures that are to be retired. No indication that measures that are not endorsed are in the NQF pipeline. Focus confined to some high-impct conditions. Weak on cost/overuse measures Overly reliant on process measures--therefore, doesn't meet criterion for inclusion of appropriate mix of measuer types.
    - Given the comment above regarding an initial intent, the parameters/measures related to outcomes, quality of life and patient satisfaction must be factored into the measures to get beyond traditional structural and procedural metrics.
    - Criteria 2: Few measures for safer care, care coordination, and making care more affordable. Does not adequately address parsimony. Some of the measures have very weak process-outcome links and could be dropped (e.g., "heart failure education", which has not been associated with reduced readmissions). Some of the measures will have a high burden for collecting and reporting data (e.g., plan of care documented for hypertension out of control) Outcome measures weakly represented
    - The primary weaknesses are: a. Too much process, not enough outcome; b. Primary and secondary prevention dominate c. Patient experience/outcomes not represented d. Not clear how cost will be introduced or how future cost measures will be added. e. Applicable primarily to primary care, not specialty care or team-based care
3. **What measure concepts are missing from the proposed clinician core measures?**
    - Missing depression, which applices to multiple population groups of programmatic interest. Cost/resource use patient experience patient-reported outcomes
    - See #2 and delineate/expand on the parameters/categories mentioned.
    - Person and family centered care Supporting health in communities (but I really don't think this is something we should be trying to measures for this) Direct assessments of healthcare delivery that contributes to disparities
    - We see three main gaps: a. Lack of composite measures within and across conditions. If the goal is to really "center" measurement around the patient, then composites within and across conditions will be critical. This is especially true for older patients who do not experience "single conditions" across episodes of care. Most elderly patients suffer from multiple co-morbidities and the PVbM measures ultimately need to reflect that. Evidence is accumulating quickly that composite measures are more statistically robust and valid and may be easier for patients to understand. Given the purpose behind the PVbM measures, this is an important issue. b. Concepts that address NQS priorities related to – effective care coordination (esp for duals); person- and family-centered care; making care more affordable; c. Patient reported outcome measures. This is perhaps the biggest hole in the current set, and it is hard to say the PVbM measures system is truly patient-centered when

no PROMs are part of the set. Evidence is also developing that PROMs are correlated with quality measures.

4. **How would you prioritize the missing concepts (gaps) that you and/or the workgroup identified?**
    - Patient experience Patient-reported outcomes Resource use Measures on depression
    - These are not either/or since are all required so that prioritization is not a factor. If anything, prioritize by alphabetical order....
    - Patient-centered care measures (e.g. CAHPS): communication, access, coordination of care Outcome measures: ambulatory care sensitive hospitalizations, readmissions
    - I think the three listed above in 3 are equally important and should be interconnected. For example, composites can and should include PROMs as part of the model. PROMs can be a good methodology to address gaps in the NQS priorities.

5. **What measures, if any, should be removed from the proposed clinician core measures?**
    - Measures proposed for NQF retirement NA 89 Blood pressure screening within past 2 years NA 90 Cholesterol LDL test performed Hypertension measurement (NQF 13)
    - None - they are all part of the total patient care.
    - 0013- unsure whether the opportunity for improvement is too small to justify this 0017- high measurement burden, weak link to outcomes 0041- because many patients get influenza vaccination at work or local pharmacies, measurement by providers is highly inaccurate. 0055 – not all diabetics need annual eye exam (i.e., if past exam normal and A1c controlled can go every 2 years). This measure promotes overuse 0056 – very difficult to collect data for this. No process-outcome link established 0073 – redundant with 0018 (blood pressure control for all hypertensives) 0079 – our problem right now is excessive use of echocardiography. We do not need a measure of underuse 0082 – this is a “check the box” measure that has been shown to NOT be associated with outcomes (i.e., those who got education (checked) did not have lower readmission rates 0084 – very hard to measure accurately because so many patients have exclusions. 0085 – no process-outcome link 0102 – I do not think opportunity for improvement is large enough to justify use of this measure. Very low bar 0729 – the description of this is a composite measure. Is this correct?
    - Duplicative HTN/BP measures.

Value Based Payment Modifier Measures
(A total of 62)

NQF Measure Number and Status	Measure Name
0028 Endorsed	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
0001 Endorsed	Asthma: Asthma Assessment
0002 Endorsed	Appropriate Testing for Children with Pharyngitis
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
0012 Endorsed	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
0013 Endorsed	Hypertension: Blood Pressure Measurement
0014 Endorsed	Prenatal Care: Anti-D Immune Globulin
0017 Endorsed	Hypertension (HTN): Plan of Care
0018 Endorsed	Controlling High Blood Pressure
0024 Endorsed	Weight Assessment and Counseling for Children and Adolescents
0031 Endorsed	Preventive Care and Screening: Screening Mammography
0032 Endorsed	Cervical Cancer Screening
0033 Endorsed	Chlamydia Screening for Women
0034 Endorsed	Preventive Care and Screening: Colorectal Cancer Screening
0036 Endorsed	Use of Appropriate Medications for Asthma
0038 Endorsed	Childhood Immunization Status
0041 Endorsed	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
0043 Endorsed	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
0045 Endorsed	Osteoporosis:Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
0047 Endorsed	Asthma: Pharmacologic Therapy
0052 Endorsed	Low Back Pain: Use of Imaging Studies
0055 Endorsed	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
0056 Endorsed	Diabetes Mellitus: Foot Exam
0059 Endorsed	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
0064 Endorsed	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
0066 Endorsed	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0082 Endorsed(to be retired)	Heart Failure: Patient Education
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0084 Endorsed (to be retired)	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
0085 Endorsed (to be retired)	Heart Failure: Weight Measurement
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089 Endorsed	Diabetic Retionpathy: Communication with the Physician Managing On-going Diabetes Care
0091 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

Value Based Payment Modifier Measures
(A total of 62)

NQF Measure Number and Status	Measure Name
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
0101 Endorsed	Falls: Screening for Fall Risk
0102 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
0105 Endorsed	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
0385 Endorsed	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
0387 Endorsed	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0555 Endorsed	Monthly INR for Beneficiaries on Warfarin
0575 Endorsed	Diabetes: HbA1c Control < 8%
0729 Endorsed	Diabetes Mellitus: Tobacoo Non-Use
0729 Endorsed	Diabetes: Aspirin Use
NA1	Heart Failure: Left Ventricular Function (LVF) Testing
NA2	30 Day Post Discharge Physician Visit
NA5	Coronary Artery Disease (CAD): LDL level < 100 mg/dl
NA88	Chronic obstructive pulmonary Disease (COPD): smoking cessation counseling received
NA89	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years
NA90	Preventive Care: Cholesterol-LDL test performed

Note: NA denotes measures that have not been submitted to NQF.

Dear MAP Coordinating Committee Member,

At the October 19th Coordinating Committee web meeting, we introduced an exercise for the Coordinating Committee to evaluate core measures and associated gaps that have been put forward by the MAP Clinician, Hospital, and PAC/LTC Workgroups. This exercise is designed to help us prepare and to use our time most efficiently at the November 1-2 Coordinating Committee in-person meeting.

The core measures will serve as a starting place for decisions about pre-rulemaking input to HHS. The exercise will also give the Coordinating Committee more experience using the DRAFT measure selection criteria and interpretive guide, to inform discussion regarding the criteria at the November 1-2 Coordinating Committee meeting.

As discussed at the web meeting, the Coordinating Committee has been divided into 3 subgroups that will each review core measures for a specific setting. We ask you to participate in identifying core measures and associated gaps for the hospital setting, starting with the MAP Hospital Workgroup's proposed core measures. (Please note that the MAP Hospital Workgroup will be participating in a similar, concurrent survey exercise, in follow up to their October 12-13 meeting. Results from both the Hospital Workgroup and Coordinating Committee surveys will be shared at the November 1-2 Coordinating Committee meeting.)

The objectives of the activity include:

1. Evaluate the Hospital Workgroup's proposed core measures as a starting place for hospital core measures for the MAP pre-rulemaking activities
2. Confirm measure gap areas for the Hospital Workgroup's proposed core measures and then prioritize those measure gap areas
3. Gain experience using the DRAFT measure selection criteria and interpretive guide to inform subsequent Coordinating Committee deliberations

Follow these steps to complete the exercise:

1. Review the following documents:
    a. Attachment 1: Hospital Workgroup's proposed core measures
    b. Attachment 2: DRAFT measure selection criteria and interpretive guide
2. Review the MAP Hospital Workgroup's proposed core measures, which were identified at the October 12-13 workgroup meeting, as a basis for determining your core set and the associated gaps. Use the DRAFT measure selection criteria and interpretive guide when determining the core set.
3. Share your conclusions by answering the survey questions. Access the survey here. While the questions are simple in nature, the rationale for your answers is important to capture in the text boxes embedded in the survey.
4. Further discussion of core measures will occur at the November 1-2 MAP Coordinating Committee In-person meeting.

MAP Coordinating Committee – Hospital Core Measures Exercise Survey Results

1. **What are the strengths of the Hospital Workgroup's proposed core measures, evaluated against the MAP DRAFT measure selection criteria?**
    - Measures meet NQF endorsement criteria Measures address many high-impact conditions Measures are appropriate for setting
    - All measures were NQF endorsed - measures have been vetted against the NQF mesure selection criteria Measures seemed to address two of the priorities in the NQS (safety and prevention and treatment of conditions that are high cause of mortality) adequately and included several outcome measures which represents a step in the right direction. Measures also seemed to promote alignment with program goals and had an approrpiate mix of measure types. Comment: In the future it would be helpful to have a list of the program goals to better evaluate this measure against this particular criterion.
    - The proposed core measures meet almost all of the draft measure selection criteria with the exception of the lack of measures addressing the "making care more affordable" goal within the National Quality Strategy. There are a number of measures listed in Table C that should be added to the proposed core set to make up that gap. I've noted them below.
    - Generally reflects broad set of process and outcome measures with available data
2. **What are the weaknesses of the Hospital Workgroup's proposed core measures, evaluated against the MAP DRAFT measure selection criteria?**
    - The measure set does not strongly focus on patient and family centered care or care coordination (#2) There are no patient reported oucomes (only satisfaction) Exprience of care measures are underrepresented (#5.3) Cost/resource use/ appropriateness are under represented (#5.4) Considering the preponderance of nursing intensive care in hospitals it seems stricking that no nursing sensitive measures are included at all All in all this seems very focused on an outdated acute care physican focused model of care
    - Inclusion of measures for Medicare but few measures that are relevant to the commercial population. The domains of costs and affrodability were not adressed adequately and similarly for the priorities of the NQS other than the two mentioned above . Given that these measures were mostly focused on the care provided within the hospital it was hard to evaluate how well these measures performed against the criterion of patient-centered care. There were a few measures that try to address this issue such as readmissions but on the whole the measures were setting specific. Finally, the process measures included in the core measures may require chart abstraction and can add signficiant burden to the data collection and measurement.
    - .Measure 355, Bilateral Cardiac Catheterization Rate (IQI 25): was not included in the core set, and it is a measure of overuse/appropriateness. Measures 139 (Central Line Associated Bloodstream Infection) and 138 (Catheter-Associated Urinary Tract Infection) were not included: They are NQF-endorsed and critically important. It is surprising they were not included in the core set. Also not in the measure set were Imaging measures: 514, MRI lumbar spine for low back pain; and 513, Thorax CT: Use of contrast material. Imaging

measures can be proxies for appropriateness. And these two are also considered measures of cost and patient safety, respectively. They should be in the core set.

- My main concern with the hospital measures is that they do not take into account small volume issues. As a result, they will not be useful/relevant for most rural hospitals(particularly CAHs). We have just finished a paper that discusses this issue in greater detail that I believe was shared with the Hospital Workgroup. Another key issue is care coordination for hospital patients who are transferred. It is not clear to me why NQF endorsed care coordination measures(including ones not on Table B) were not included in the hospital core measure set. I missed the Oct 19 web meeting so these issues may have been discussed there.

3. What measure concepts are missing from the proposed hospital core measures?

- breast cancer
- There were several measures that seemed to be missing from the core measures including the following: cost of care - under HVBP CMS will be measuring hospital efficiency and therefore not having measures of per beneficiary spending seemed to be a significant gap. Other measures of resource use - such as imaging need to be included. Studies have shown signficiant overuse of imaging services and such overuse impacts both quality and costs. patient safety - Need additional measures of safety such as CLABSIs and UTIs etc. There needs to be better alignment between core measures and some of the measures used in various CMS initiatives. Finally, given that a signficiant amount of care is provided in hospital OP departments the core measures need to include measures for HOPDs as well.
- There is a significant lack of measures related to overuse/appropriateness, and cost. While appropriateness isn't a specific "track" within the National Quality Strategy, it is a critical area, and since there are measures that are good proxies for this (e.g. imaging), they should be included in the core set Medicare spending per beneficiary: This measure has not been submitted for NQF endorsement yet, but it was proposed in last Spring's IPPS proposed rule, and its inclusion is important for aligning with the NQS and the "Making Care More Affordable" goal. There are no other HIT/EHR-related measures in the core set, aside from the measure re: receiving lab data electronically (which is not a huge advancement)
- See answer to Q2 (note: matches with bullet 4 of q2)

4. How would you prioritize the missing concepts (gaps) that you and/or the workgroup identified?

- N/a
- Cost of care/over use and patients safety; ensuring that hospital core measures combined with measures for other settings track the quality of care at the patient level across settings. We need an evaluation of how these measures fare against the measure selection criteria but also how they fare in conjunction with other measures for physicians etc in measuring patient-centered care.
- I would prioritize the imaging and patient safety measures, given that they are NQF endorsed and already implemented in some programs. The cost measures are as important, but process-wise, they are not as far along.
- See answer to Q2 (note: matches with bullet 4 of q2)

Response Rate: 4/12

5. **What measures, if any, should be removed from the proposed hospital core measures?**
    - N/a
    - Measure 468 (Pneumonia 30 day mortality), if the mortality composite (NQF measure 530) is included since it comprises pneumonia. • Remove the two SCIP (surgery care) measures, NQF 529 and 218. We need a surgery outcome measure, rather than the current set of SCIP process measures, which do not seem to be having an effect on quality or outcomes.

Response Rate: 4/12

Table A: Measures Proposed for Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival and OP-2: Fibrinolytic therapy received within 30 minutes	164 Endorsed and 288 Endorsed	Process			X			
Cardiac	AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	163 Endorsed	Process			X			
Cardiac	Acute myocardial infarction (AMI) 30-day mortality rate	230 Endorsed	Outcome			X			
Cardiac	Heart failure (HF) 30-day mortality rate	229 Endorsed	Outcome			X			
Cardiac	Acute myocardial infarction 30-day risk standardized readmission measure	505 Endorsed	Outcome	X	X	X			
Cardiac	Heart failure 30-day risk standardized readmission measure	330 Endorsed	Outcome	X	X	X			
Cardiac	OP–3: Median time to transfer to another facility for acute coronary intervention	290 Endorsed	Process		X	X			

Table A: Measures Proposed for Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Complications	Complication/patient safety for selected indicators (composite) Includes potentially preventable adverse events for: • Accidental puncture or laceration • Iatrogenic pneumothorax • Postoperative DVT or PE • Postoperative wound dehiscence • Decubitus ulcer • Selected infections due to medical care • Postoperative hip fracture • Postoperative sepsis	531 Endorsed	Other (composite)	X					
Diabetes	Lower extremity amputations among patients with diabetes (PQI 16)	0285 Endorsed	Outcome					X	
Maternal/ child health	Elective delivery prior to 39 completed weeks gestation	0469 Endorsed	Outcome	X					X
Maternal/ child health	Cesarean Rate for low-risk first birth women (aka NTSV CS rate)	0471 Endorsed	Outcome	X					X
Maternal/ child health	Healthy Term Newborn	0716 Endorsed	Outcome	X					

Table A: Measures Proposed for Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Mental Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	0004 Endorsed	Process					X	
Mortality	Mortality for selected medical conditions (composite) Includes in-hospital deaths for: • CHF • Stroke • Hip fracture • Pneumonia • Acute myocardial infarction • GI hemorrhage	530 Endorsed	Other (composite)			X			X
Patient Experience	HCAHPS survey	166 Endorsed	Patient Experience				X		
Respiratory	PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	148 Endorsed	Process			X			
Respiratory	Pneumonia (PN) 30-day mortality rate	468 Endorsed	Outcome			X		X	
Respiratory	Pneumonia 30-day risk standardized readmission measure	506 Endorsed	Outcome	X	X				X

Table A: Measures Proposed for Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Respiratory	Asthma Emergency Department Visits	1381 Endorsed	Outcome	X					
Safety	SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	529 Endorsed	Process	X		X			X
Safety	SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	218 Endorsed	Process	X					
Safety	Death among surgical inpatients with treatable serious complications (failure to rescue)	200 Withdrawn	Outcome	X					
Safety	Surgical site infection	299 Endorsed	Outcome	X					
Safety	OP-24 surgical site infection	299 Endorsed	Outcome	X					
Safety	Death in Low Mortality DRGs (PSI 2)	0347 Submitted	Outcome	X					
Stroke	STK-4: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke	0434 Endorsed	Process	X		X			
Stroke	STK–2: Ischemic stroke patients discharged on antithrombotic therapy	0435 Endorsed	Process	X		X			

Table A: Measures Proposed for Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Stroke	STK–5: Antithrombotic therapy by the end of hospital day two	0438 Endorsed	Process			X			
Stroke	STK–10: Assessed for rehabilitation services	0441 Endorsed	Process			X	X		

Table B: Measure Gaps Identified for Proposed Hospital Core Measures

Conditions/Areas for which no NQF-endorsed measures are identified
Alzheimer's disease
Atrial fibrillation
Behavioral health; major depression
Cancer care
Chronic obstructive pulmonary disease (COPD)
Composites containing outcome and process measures
Cost of care
Disparities-sensitive
ED visits
Medication errors/adverse drug events
Mortality rate composite – all-payer with condition-specific rate reporting
Nursing-sensitive
Patient-reported outcomes
Serious reportable events – inclusion for reporting; best methodology needs to be explored
Transitions in care/communication

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	AMI–2 Aspirin prescribed at discharge	142 Endorsed	Process			X			
Cardiac	AMI–10 Statin prescribed at discharge	639 Endorsed	Process			X			
Cardiac	HF–1 Discharge instructions		Process	X	X	X	X	X	
Cardiac	HF–2 Evaluation of left ventricular systolic function	135 Endorsed	Process			X			
Cardiac	HF–3 Angiotensin converting enzyme inhibitor (ACE–I) or angiotensin II receptor blocker (ARB) for left ventricular systolic dysfunction	162 Endorsed	Process			X			
Cardiac	SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	300 Endorsed	Process	X		X			
Cardiac	SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta	284 Endorsed	Process			X			

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
	blocker during the perioperative period								
Cardiac	Participation in a systematic database for cardiac surgery	113 Endorsed	Structure		X	X			
Cardiac	OP–4: Aspirin at arrival	286 Endorsed	Process			X			
Cardiac	OP-5 Median time to ECG	289 Endorsed	Process			X			
Cardiac	OP–13: Cardiac imaging for preoperative risk assessment for non-cardiac low risk surgery	669 Endorsed	Cost	X					X
Cardiac	OP–16: Troponin results for emergency department acute myocardial infarction (AMI) patients or chest pain patients (with probable cardiac chest pain) received within 60 minutes of arrival	660 Endorsed	Process			X			
Cardiac	OP–30: Cardiac rehabilitation patient referral from an outpatient setting	643 Endorsed	Process		X	X		X	
Cardiac	Congestive heart failure (PQI 8)	0277 Endorsed	Outcome						

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	Congestive Heart Failure Mortality (IQI 16) (risk adjusted)	0358 Endorsed	Outcome	X		X			
Cardiac	Hypertension (PQI 7)	0276 Not Recommended	Outcome						
Cardiac	Bilateral Cardiac Catheterization Rate (IQI 25)	0355 Endorsed	Outcome	X					
Care Coordination	OP–17: Tracking clinical results between visits	491 Endorsed	Process	X	X				X
Care Coordination	OP–19: Transition record with specified elements received by discharged patients	649 Endorsed	Process	X	X				X
Care Coordination	OP–20: Door to diagnostic evaluation by a qualified medical professional	498 Endorsed	Process	X			X		
Care Coordination	OP–21: ED–median time to pain management for long bone fracture	662 Endorsed	Process				X		
Care Coordination	OP–22: ED–patient left without being seen	499 Endorsed	Patient Experience	X			X		
Cost	Medicare spending per beneficiary		Cost						

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Diabetes	OP–25: Diabetes: hemoglobin A1c management.	59 Endorsed	Outcome			X			
Diabetes	OP–26: Diabetes measure pair: A lipid management: low density lipoprotein cholesterol (LDL–C) <130, B lipid management: LDL–C <100	64 Endorsed	Outcome			X			
Diabetes	OP–27: Diabetes: blood pressure management	61 Endorsed	Process			X			
Diabetes	OP–28: Diabetes: eye exam	55 Endorsed	Process						
Diabetes	OP–29: Diabetes: urine protein screening	62 Endorsed	Process						
Diabetes	Uncontrolled Diabetes Admission Rate (PQI 14)	0638 Endorsed	Outcome	X	X			X	
Diabetes	Diabetes, short-term complications (PQI 1)	0272 Endorsed	Outcome	X					
Diabetes	Diabetes, long-term complications (PQI 3)	0274 Endorsed	Outcome	X					
ED	ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital	495 Endorsed	Process						

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
ED	ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status	497 Endorsed	Process				X		
ED	OP–18: Median time from ED arrival to ED departure for discharged ED patients	496 Endorsed	Process				X		
HIT	OP–12: The ability for providers with HIT to receive laboratory data electronically directly into their qualified/certified EHR system as discrete searchable data	489 Endorsed	Structure	X	X				
Imaging	OP–8: MRI lumbar spine for low back pain	514 Endorsed	Cost	X					X
Imaging	OP–9: Mammography follow-up rates		Process		X				
Imaging	OP–10: Abdomen CT—use of contrast material		Cost	X					
Imaging	OP–11: Thorax CT—use of	513 Endorsed	Cost	X					

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
	contrast material								
Imaging	OP–14: Simultaneous use of brain computed tomography (CT) and sinus computed tomography (CT)		Cost	X					X
Imaging	OP–15: Use of brain computed tomography (CT) in the emergency department for atraumatic headache		Cost	X					X
Maternal/child health	Low birth weight (PQI 9)	0278 Endorsed	Outcome					X	
Nursing Sensitive	Participation in a systematic clinical database for nursing sensitive care	493 Endorsed	Structure		X				
Respiratory	PN–6 Appropriate initial antibiotic selection	147 Endorsed	Process			X			
Respiratory	Chronic obstructive pulmonary disease (PQI 5)	0275 Endorsed	Outcome	X					
Respiratory	Use of relievers for inpatient asthma (Note: pediatric measure)	0143 Endorsed	Process						
Respiratory	Use of systemic corticosteroids for inpatient asthma (Note: pediatric measure)	0144 Endorsed	Process						

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Respiratory	Bacterial pneumonia (PQI 11)	0279 Endorsed	Outcome					X	
Respiratory	Adult asthma (PQI 15)	0283 Endorsed	Outcome						
Safety	SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision	527 Endorsed	Process	X					
Safety	SCIP INF–2: Prophylactic antibiotic selection for surgical patients	528 Endorsed	Process	X					
Safety	SCIP INF–9: Postoperative urinary catheter removal on post-operative day 1 or 2 with day of surgery being day zero	453 Endorsed	Process	X					
Safety	SCIP INF–10: Surgery patients with perioperative temperature management	452 Endorsed	Process	X					
Safety	SCIP INF—VTE-1: Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered	217 Endorsed	Process	X					
Safety	PSI 06: Iatrogenic pneumothorax, adult	346 Endorsed	Outcome	X					
Safety	PSI 11: Post-operative	533 Endorsed	Outcome	X		X			

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
	respiratory failure								
Safety	PSI 14: Post-operative wound dehiscence	368 Endorsed	Outcome	X					
Safety	PSI 15: Accidental puncture or laceration	345 Endorsed	Outcome	X					
Safety	IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)	359 Endorsed	Outcome	X					
Safety	IQI 19: Hip fracture mortality rate	354 Endorsed	Outcome	X					
Safety	PSI 04 Death among surgical in patients with serious treatable complications	351 Endorsed	Outcome	X					
Safety	Central line associated bloodstream infection	139 Endorsed	Outcome	X					
Safety	Catheter-Associated Urinary Tract Infection	138 Endorsed	Outcome	X					
Safety	Foreign object retained after surgery		Outcome	X					
Safety	Air embolism		Outcome	X					
Safety	Blood incompatibility		Outcome	X					
Safety	Pressure ulcer stages III and IV		Outcome	X					
Safety	Falls and trauma		Outcome	X					

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Safety	Vascular-catheter associated infection		Outcome	X					
Safety	Catheter-associated urinary tract infection		Outcome	X					
Safety	Manifestations of poor glycemic control		Outcome	X					
Safety	Immunization for influenza		Process					X	
Safety	Immunization for pneumonia		Process					X	
Safety	OP–6: Timing of antibiotic prophylaxis.	270 Endorsed	Process	X					
Safety	OP-7: Prophylactic Antibiotic Selection for Surgical Patients	268 Endorsed	Process	X					
Safety	OP–31: Safe surgery checklist use		Process	X					
Safety	Perforated appendicitis (PQI 2)	0273 Endorsed	Outcome						
Safety	Decubitus Ulcer (PDI 2)	0337	Outcome	X					
Safety	Pancreatic Resection Mortality Rate (IQI 9) (risk adjusted)	0365 Endorsed	Outcome	X					
Safety	Dehydration (PQI 10)	0280 Endorsed	Outcome					X	
Safety	Urinary infections (PQI 12)	0281 Endorsed	Outcome					X	
Safety	Incidental Appendectomy	0364 Not	Process	X					

Table C: Measures Not Included in Proposed Hospital Core Measures

Subject/ Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
	in the Elderly Rate (IQI 24) (risk adjusted)	recommend							
Safety	Esophageal Resection Volume (IQI 1)	0361 Endorsed	Structure						
Safety	Pancreatic Resection Volume (IQI 2)	0366 Endorsed	Structure						
Stroke	Participation in a systematic clinical database for stroke care	493 Endorsed	Structure		X	X			
Stroke	OP–23: ED–head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	661 Endorsed	Process	X					
Stroke	STK–8: Stroke education	0440 Endorsed	Process			X	X		
Surgery	Participation in a systematic clinical database registry for general surgery	493 Endorsed	Structure		X				
Surgery	OP–32: Hospital outpatient volume data on selected outpatient surgical procedures		Structure						

Dear MAP Coordinating Committee Member,

At the October 19th Coordinating Committee web meeting, we introduced an exercise for the Coordinating Committee to evaluate core measures and associated gaps that have been put forward by the MAP Clinician, Hospital, and PAC/LTC Workgroups. This exercise is designed to help us prepare and to use our time most efficiently at the November 1-2 Coordinating Committee in-person meeting.

The core measures will serve as a starting place for decisions about pre-rulemaking input to HHS. The exercise will also give the Coordinating Committee more experience using the DRAFT measure selection criteria and interpretive guide, to inform discussion regarding the criteria at the November 1-2 Coordinating Committee meeting.

As discussed at the web meeting, the Coordinating Committee has been divided into 3 subgroups that will each review core measures for a specific setting. We ask you to participate in identifying core measure concepts and associated gaps for the PAC/LTC setting. In addition, this feedback will also tie into the PAC/LTC coordination strategy that will be discussed on November 1-2.

The objectives of the activity include:

1. Evaluate the PAC/LTC Workgroup's proposed core measure concepts as a starting place for PAC/LTC core measure concepts for the pre-rulemaking activities
2. Confirm measure gap areas for the PAC/LTC Workgroup's proposed core measure concepts and then prioritize those gap areas
3. Gain experience using the DRAFT measure selection criteria and interpretive guide to inform subsequent Coordinating Committee deliberations

Follow these steps to complete the exercise:

1. Open the following documents:
    a. Attachment 1: PAC/LTC Workgroup's proposed core measure concepts and mapping to important characteristics
    b. Attachment 2: DRAFT measure selection criteria and interpretive guide
2. Review the program information and measure concept mapping documents (inputs from previous MAP PAC/LTC Workgroup activities) as a basis for determining your core measure concepts and the associated gaps. Use the DRAFT measure selection criteria and interpretive guide when reviewing the core measure concepts.
3. Share your conclusions by answering the survey questions via survey monkey. Access the survey here. While the questions are simple in nature, the rationale for your answers is important to capture in the text boxes embedded in the survey.
4. Further discussion of core measures will occur at the November 1-2 MAP Coordinating Committee in-person meeting.

MAP Coordinating Committee – PAC/LTC Core Measure Concepts Exercise Survey Results

1. **What are the strengths of the PAC/LTC Workgroup's proposed core measure concepts, evaluated against the MAP DRAFT measure selection criteria?**
    - Criterion 1: Unknown if there are NQF measures that address these concepts. Criterion 2; Concepts do not seem to address 2.2, 2.5 and 2.6 Criterion 3: Set meets criterion Criterion 4: Set meets 4.1 and 4.3, Not sure on 4.2 Criterion 5: Set meets 5.1, 5.2, and 5.3. It does not address 5.4 or 5.5. Cirterion 6: Unclear whther the set addresses 6.1 and 6.2. Set addresses 6.3. Criterion 7: Set does not seem to address these issues. Criterion 8: Unclear how the set would measure up against these issues.
    - The core PAC/LTC measure concepts and sets mesh well with the MAP draft selection criteria. They advance safer and more coordinated care that is "patient centered." The proposed specific list of meaures that draw on those due to be implemented by CMS in 2012 in Nursing Home Compare etc....also mesh well with the MAP draft criteria.
    - the measure concepts are , for the most part, a broad domain/category of measurement rather than a specific concept-which makes them hard to evaluate as a concept
    - The proposed core measure concepts are responsive to Nursing Home Compare, Home Health Compare, and the Post-Acute Care/Long-Term Performance Measurement recommendations.
2. **What are the weaknesses of the PAC/LTC Workgroup's proposed core measure concepts, evaluated against the MAP DRAFT measure selection criteria?**
    - See response to #1. (note: first bullet above)
    - Some of the specific measures in the 10/10/11 draft PAC/LTC set fall into the "monitoring" or "check the box" caregories. Others are or should be standards of care and may not be worth measuring. For example, pain assessment documentation alone should be standard of care and is not that useful. What we really need to know is self-reported pain levels over time on a scale that shows improvement or lack thereof or records the number of patients over time who report a subjective "unacceptable" level of pain. Also, in this category, there should be a measure that shows whether unacceptable pain was addressed/resolved over say 24 hours....along with the proposed pain measures, all of which are good.
    - assessments not really linked to potential actions to improve clinical outcomes (and thus not meet criterion 5.2) not explicit about application for identifying disparities (criterion7) outcomes / improvement in aspects of "cognitive/functional assessment" do not seem to include risk adjustment (criterion 5.1)
    - Advanced care planning and treatment are two different concepts. I recommend that they be separate. I don't see where chronic care management fits into any of these concepts although it could be a component of avoidable admissions.
3. **What measure concepts are missing from the proposed PAC/LTC core measure concepts?**
    - Affordability of care Cost factors Accessibility to care

- The need for more patient experience of care measures can not be over emphasized. Similarly, mental health status in these care venues needs to be at the forefront.
- Mental Health measures Timeliness (though there is unclear mention of timeliness under "Transition Planning")
- Access to and attainment of age appropriate preventive services including those for managing chronic disease. .

4. **How would you prioritize the missing concepts (gaps) that you and/or the workgroup identified?**
    - All three factors listed above rate high priority.
    - in order as noted in Q3 (q3 bullet 3)
    - Measuring unnecessary, inappropriate and excessive care would be my first "gap" priority.
5. **What measure concepts, if any, should be removed from the proposed PAC/LTC proposed measure concepts?**
    - None
    - expriemce of care could be a component of goal attainment (Establishment and attainment of paitient/family/caregiver goals). If so, it could be removed as a stand alone concept.
    - None

Proposed PAC/LTC Core Measure Concepts and Measure Mapping

This table is a mapping of the MAP PAC/LTC Workgroup's proposed measure concepts to measures that are or will be used in PAC and LTC settings, as defined in federal regulations. Measures included for Nursing Home Compare and Home Health Compare are finalized for implementation for 2012. Measures included for Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs) are finalized for use in 2014 when measure requirements will go into effect for IRFs and LTCHs.

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY 2014
Functional and cognitive status assessment	• Percent of residents whose need for help with activities of daily living has increased (long-stay) • Percent of residents whose ability to move in and around their room and adjacent corridors got worse (long -stay) • Percent of short-stay residents who have delirium • Percent of residents who have depressive symptoms (long-stay) • Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period • Percent of residents who self-report moderate to severe pain (short-stay) • Percent of residents who self-report moderate to severe pain (long-stay) • Percent of residents	• Improvement in ambulation/locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Depression assessment conducted • Pain assessment conducted • Pain interventions implemented during short term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/caregiver education implemented during short term episodes of care		

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY 2014
	who lose too much weight (long-stay) • Percent of low risk residents who lose control of their bowel or bladder (long-stay) • Percent of residents who were physically restrained (long-stay)			
Establishment and attainment of patient/family/ caregiver goals				
Advanced care planning and treatment				
Experience of care				
Shared decision making				
Transition planning		• Timely initiation of care		
Falls		• Multifactor fall risk assessment conducted for patients 65 and over		
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay)	• Increase in number of pressure ulcers • Pressure ulcer	• Pressure ulcers that are new or have worsened	• Pressure ulcers that are new or have worsened

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY 2014
	• Percent of high risk residents with pressure ulcers (long-stay) • Percent of low-risk long-stay residents who have pressure sores	prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented during short term episodes of care		
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications		
Inappropriate medication use				
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)		• Urinary Catheter-Associated Urinary Tract Infections (CAUTI)	• Urinary Catheter-Associated Urinary Tract Infections (CAUTI) • Central Line Catheter-Associated Bloodstream Infection (CLABSI)
Avoidable admissions		• Acute care hospitalization	• 30-day comprehensive all-cause risk standardized readmission	
Measures not mapped to a core measure	• Percent of residents who were assessed and appropriately	• Influenza immunization received for		

Core Measure Concepts	Nursing Home Compare Measures (Based on MDS 3.0)	Home Health Compare Measures (Based on OASIS-C)	IRF Quality Measures for Reporting Program beginning FY 2014	LTCH Quality Measures for Reporting Program beginning FY 2014
concept	given the seasonal influenza vaccine (short-stay) • Percent of residents assessed and appropriately given the seasonal influenza vaccine (long-stay) • Percent of residents assessed and appropriately given the pneumococcal vaccine (short-stay) • Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long-stay)	current flu season • Pneumococcal polysaccharide vaccine (PPV) ever received • Heart failure symptoms addressed during short -term episodes of care		

MAP considered a broader list of measure concepts in the process of determining core measure concepts. MAP concluded that the following concepts, which were all identified as important but not adopted as core, are difficult to define for measurement, are better measured by the concepts adopted, are not relevant to all settings, or do not rise to the level of being a core measure concept when the parsimony criterion is applied.

- Unnecessary services
- Staffing turnover
- Appropriate level of care
- Access to community supports
- Mental health assessment
- Timeliness of initiation of care
- Restorative care management