NATIONAL QUALITY FORUM

Appendix A: Measure Applications Partnership (MAP)
Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

Chair (voting)
Carol Raphael, MPA

Organizational Members (voting)	**Representatives**
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)	**Representatives**
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 J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Appendix B: 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	Marissa Schlaifer
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	Doris Peter, PhD
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)	Ahmed Calvo, MD, MPH
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

Appendix C: 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] as well as 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, the Centers for Medicare & Medicaid (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 use 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 (HHA).[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 that provide rehabilitation services, such as physical, occupational, rehab therapy, social services, and prosthetic services.[i] IRFs conduct clinical assessments at admission and discharge using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI), which generates data used to compare facilities and determine prospective payment.[j] Starting in 2014, IRFs also will 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 and 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]

Appendix C: 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 are 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 that are asked of every patient in that setting, regardless of condition, and 2. Supplemental items that are asked only of patients having a specific condition. The supplemental	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]	

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			items measure severity or degree of need for those who have a condition.[q] Data are 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 & 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 should 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 that 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 has an opportunity to

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						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 healthcare 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 are 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 with healthcare. The	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 by the National Quality	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, compare and report

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		CAHPS Nursing Home Surveys are composed of three separate instruments: 1) an in-person structured interview for long-term residents, 2) a mail questionnaire for recently discharged short-stay residents, and 3) a mail questionnaire for residents' family members.[ff]	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 instruments include			on performance, and improve quality of care.[jj]

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Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			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 members' experience with the nursing home and their perceptions of the quality of care provided to a family member living in a nursing home.[hh]			
Nursing Home	The Five-Star Quality Rating	CMS has developed the	The data for the	The Nursing Home Compare		Nursing Home

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Compare Applies to: Nursing Home, Skilled Nursing Facility	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, healthcare providers, and nursing home professionals.[kk]	Nursing Home Compare website 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 highest standard of quality, and 1 representing the lowest.[ll]	Nursing Home Compare are 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]	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. Another factor considered under this domain is 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 domain are based on		Compare website provides consumers, their families, and caregivers with information on the quality of care each individual nursing home offers.

Appendix C: 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
				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 website. 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 annual payment update for	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 improvement	HHAs must use HAVEN, free software provided from CMS for OASIS data submission.[ss]	The OASIS includes six major domains: 1) sociodemographic, 2) environmental, 3) support system, 4) health status, and 5) functional status, and 6) 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]

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	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]	(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 Compare		CMS created the Home Health Compare website,		Domains of the quality measurement include:		Home Health Compare includes a

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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: 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 NQF endorsed in March 2009 and the Office of Management and Budget (OMB) approved in July 2009. The national implementation of the survey began in October 2009 with agencies participating on a voluntary basis to the point when quality reporting requirements for the home health APU began in 2010. CMS plans to start publicly	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 healthcare 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.

Appendix C: 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
		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 State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, and by	The IRF PPS will use information from IRF- PAI to categorize patients into distinct groups based on clinical characteristics and expected resource needs, which are used to calculate	To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to	IRF-PAI data items address patients' physical, cognitive, functional, and psychosocial status.[lll] Functional status includes self-care (eating, grooming, bathing, dressing, toileting, bladder, and bowel);	Each IRF must report the date that it transmitted the IRF-PAI instrument to the database on the claim that it submits to the fiscal	

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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	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]	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. The FIM instrument was	CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains.[jjj] Before 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]	transfers; locomotion; and communication. Quality indicators include pressure ulcers measures.[mmm]	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]	

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

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[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.
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[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.
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Appendix D: 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.

Appendix D: 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.

Appendix D: 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	

Appendix E: 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.
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 Plans Implemented	
0517	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey • Patient care • Communications between providers and patients • Specific care issues on medications, home safety, and pain	The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, also referred as the "CAHPS Home Health Care Survey" or "Home Health CAHPS" is a standardized survey instrument and data collection methodology for measuring home health patients' perspectives on their home health care in Medicare-certified home health care agencies. AHRQ and CMS supported the development of the Home Health CAHPS to measure the experiences of those receiving home health care with these three goals in mind: (1) to produce comparable data on patients' perspectives on care that allow objective and meaningful comparisons between home health agencies on domains that are important to consumers, (2) to create incentives for agencies to improve their quality of care through public reporting of survey results, and (3) to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment. As home health agencies begin to collect these data and as they are publicly reported, consumers will have information to make more informed decisions about care and publicly reporting the data will drive quality improvement in these areas.
NA	Emergency Department Use without Hospitalization	

Appendix F: 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 (≥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

Appendix G: 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	

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
	• Communication	
Falls	• Falls with major injury • Falls with major injury per 1000 days	• Patient fall rate • Falls with injury • Falls and trauma
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

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
		• Blood incompatibility • Foreign object retained after surgery • Manifestation of poor glycemic control • Air embolism • Venous thromboembolism • Injuries related restraint use • Skill Mix (Registered Nurses [RN], Licensed Vocational/Practical Nurse [LPN/LVN], unlicensed assistive personal [UAP], and contract)

Appendix H: 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: Work with communities to promote wide use of best practices to enable healthy living and well-being.								
NQS Measure Concepts	• 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	MCC Measure Concepts	• 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	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Functional and cognitive status assessment.	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Quality of life • Mental health and substance use	LTQA-Recommended Measures	• Mean change score in basic mobility of patient in a post-acute-care setting assessed • Mean change score in daily activity of patient in a post-acute-care setting assessed
National Priority: Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.								
NQS Measure Concepts	• 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	MCC Measure Concepts	• Patient clinical outcomes (e.g. mortality, morbidity) • Patient reported outcomes (e.g. quality of life, functional status) • Missed prevention opportunities—secondary and tertiary	MAP Post-Acute Care/Long-Term Care Measure Concepts		MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Quality of life • Mental health and substance use	LTQA-Recommended Measures	
National Priority: Ensure person- and family-centered care.								
NQS Measure Concepts	• 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	MCC Measure Concepts	• Shared decision-making • Patient, experience of care • Family, caregiver experience of care • Self-management of chronic conditions, especially multiple conditions	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Establishment and attainment of patient/ family/ caregiver goals • Advanced care planning and treatment • Experience of care • Shared decision-making	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Structural measures	LTQA-Recommended Measures	• Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) • Client Perceptions of Coordination Questionnaire (CPCQ) • Advanced Care Plan

Appendix H: 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		LTQA-Recommended Measures	• Percentage of patients age 65 years and older with a history of falls who had a plan of care for falls documented within 12 months • Percentage of Medicare members 65 years of age and older who received at least two different high-risk medications. • Percent of discharges from Jan 1 to Dec 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge
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 and healthcare system • Health literacy	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Transition planning	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Care coordination	LTQA-Recommended Measures	• 3-Item Care Transition Measure (CTM-3) • Percentage of patients, regardless of age, discharged from an inpatient facility to home/any other site of care from whom a transition record was transmitted to the facility/primary physical/other health care professional for follow-up care within 24hours of discharge

Appendix H: 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 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, polypharmacy, 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	LTQA-Recommended Measures	• Percent of patients who need urgent, unplanned medical care • All-cause readmission