MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

For

IN-PERSON MEETING OF THE POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

September 8-9, 2011

NATIONAL QUALITY FORUM

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Post-Acute Care/Long-Term Care Workgroup
In-Person Meeting #2:
September 8-9, 2011

Renaissance Washington DC Downtown Hotel
999 Ninth Street, NW
Washington DC, 20001

Web Streaming: http://www.MyEventPartner.com/NQForum67
Member Dial-In: 877.879.6174 Passcode: 2749311
Public Dial-In: 877.723.9518 Passcode: 2749311

Meeting Objectives:

- *Determine measurement priorities within each PAC/LTC setting and across all settings;*
- *Consider opportunities for standardized data collection across settings;*
- *Develop the pathway for improving measure applications.*

Day 1: September 8

8:30 am **Breakfast**

9:00 am **Welcome and Review of Meeting Objectives**
Carol Raphael, Workgroup Chair
- Guiding frameworks and workgroup charge
- Review coordination strategy elements

9:30 am **Opportunities for Alignment**
Heather Young and Ellen Kurtzman, Long Term Quality Alliance
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF
Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF
- LTQA Measurement Workgroup
- MAP Dual Eligible Beneficiaries Workgroup
- NQF Multiple Chronic Conditions Measurement Framework
- Discussion

11:00 am **Break**

11:15 am **Key Measurement Considerations for PAC/LTC Settings**
Carol Raphael
Aisha Pittman
- Feedback from the MAP Coordinating Committee
- Review of exercise results
- Discussion

12:00 pm **Lunch**

12:30 am **Orientation to the PAC/LTC Performance Measures Table**
Mitra Ghazinour, Project Manager, Strategic Partnerships, NQF

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12:45 pm **Measure Selection Criteria Development**
Connie Hwang, Vice President, Strategic Partnerships, NQF
- Process of measure selection criteria development
- Review measure selection criteria
- Discussion
- Opportunity for public comment

1:30 pm **Small Group Session: Evaluating Performance Measures in Use**

2:30 pm **Break**

2:45 pm **Evaluating Performance Measures in Use**
Carol Raphael
- Report outs from each small group
- Discussion
- Opportunity for public comment

3:30 pm **Finalize Measurement Priorities within Each PAC/LTC Setting and across All Settings**
Carol Raphael
- Presentation of key measure concepts across and within each setting based on workgroup input
- Discussion
- Opportunity for public comment

4:45 pm **Summary of Day 1 and Look-Forward to Day 2**
Carol Raphael
- Summation of day 1
- Expectations for day 2 activities

5:00 pm **Adjourn**

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Day 2: September 9

8:30 am **Breakfast**

9:00 am **Welcome and Recap of Day 1**
Carol Raphael

9:30 am **Data Sources and HIT Implications: Data Collection Approaches**
Long-Term Care Panelists
- MDS and Nursing Home CAHPS Overview- *Thomas Dudley, CMS*
- Reactor- *Debra Saliba, RAND*
- AARP Report Card- *Ari Houser, AARP*
- Discussion

10:30 am **Data Sources and HIT Implications: Data Collection Approaches**
Home Health Care Panelists
- OASIS and Home Health CAHPS Overview- *Robin Dowell, CMS*
- Reactor- *Carol Raphael*
- Discussion

11:00 am **Break**

11:15 am **Data Sources and HIT Implications: Data Collection Approaches**
Other Settings Panelists
- CARE tool, IRF-PAI, LTCH CARE tool- *Judith Tobin, CMS*
- Reactors- *Suzanne Snyder, American Rehabilitation Providers Association*
- Discussion

12:00 pm **Lunch**

12:30 pm **Emerging Data Collection Recommendations**
Carol Raphael
Thomas von Sternberg, Health Partners
- Discussion
- Opportunity for public comment

1:00 pm **Pathway for Improving Measure Applications**
- Priorities for advancing performance measurement in PAC/LTC settings
- Discussion

1:30 pm **Summation and the Path Forward**
- Input to MAP Coordinating Committee
- Summation
- Workgroup next steps

2:00 pm **Adjourn**

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Measure Applications Partnership
Post-Acute Care Workgroup

In-Person Meeting #2

September 8-9, 2011

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Welcome and Review of Meeting Objectives

Meeting Objectives

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- Determine measurement priorities within each PAC/LTC setting and across all settings;
- Consider opportunities for standardized data collection across settings;
- Develop the pathway for improving measure applications.

Meeting Agenda: Day 1

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- Opportunities for alignment
- Key measurement considerations in PAC/LTC settings
- Orientation to the PAC/LTC Performance Measures Table
- Measure selection criteria development
- Evaluating performance measures in use (includes small group activity)
- Finalize measurement priorities within each PAC/LTC setting and across all settings
- Summary of day 1 and look-forward to day 2
- Adjourn

MAP Post-Acute Care/Long Term Care Workgroup Charge

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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

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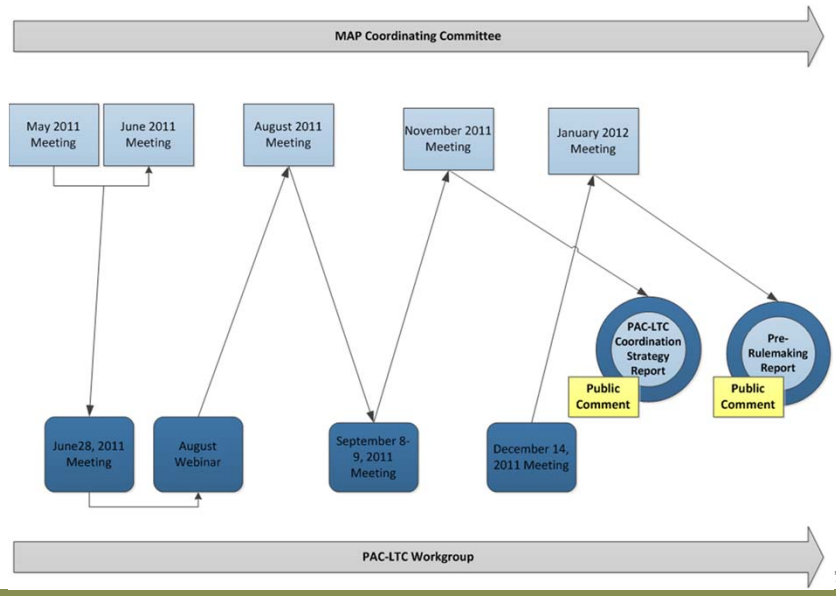
Coordination Strategy and Performance Measurement in PAC/LTC programs

Task Description	Deliverable	Timeline
Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012

PAC/LTC Workgroup will advise the Coordinating Committee

Workgroup Interaction with Coordinating Committee



MAP Guiding Frameworks

- National Quality Strategy
- HHS Partnerships for Patients Safety Initiative
- HHS Prevention and Health Promotion Strategy
- HHS Disparities Strategy
- HHS Multiple Chronic Conditions Framework
- NQF-endorsed Patient-Focused Episodes of Care
- High-Impact Conditions (NQF Measure Prioritization Advisory Committee)

HHS Aims for the National Quality Strategy

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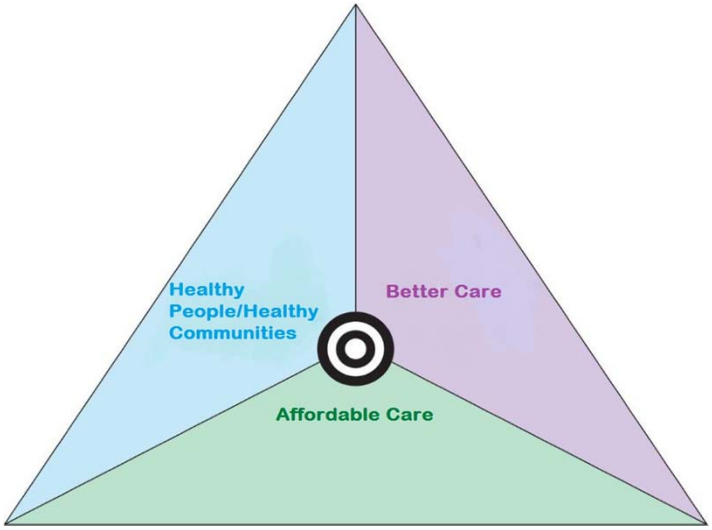

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HHS National Quality Strategy

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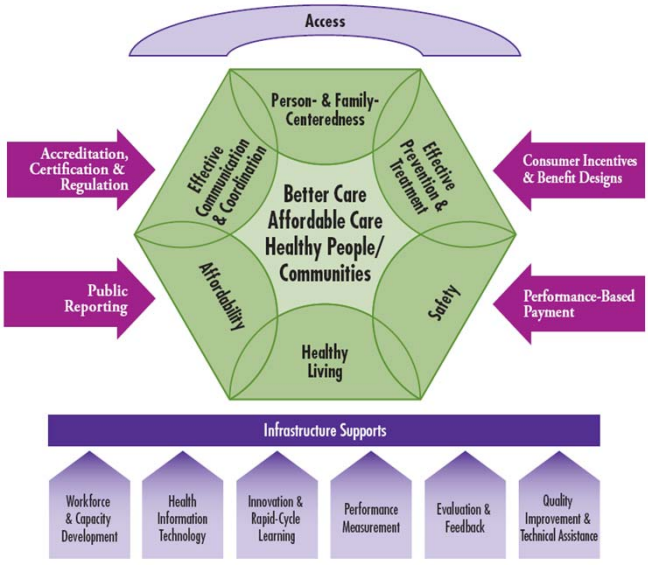

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Principles for the National Quality Strategy

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1. Person-centeredness and family engagement

2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage.

3. Eliminating disparities in care

4. Aligning the efforts of public and private sectors

5. Quality improvement

6. Consistent national standards

7. Primary care will become a bigger focus

8. Coordination will be enhanced

9. Integration of care delivery

10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them will be encouraged.

Patient-Focused Episodes of Care Model

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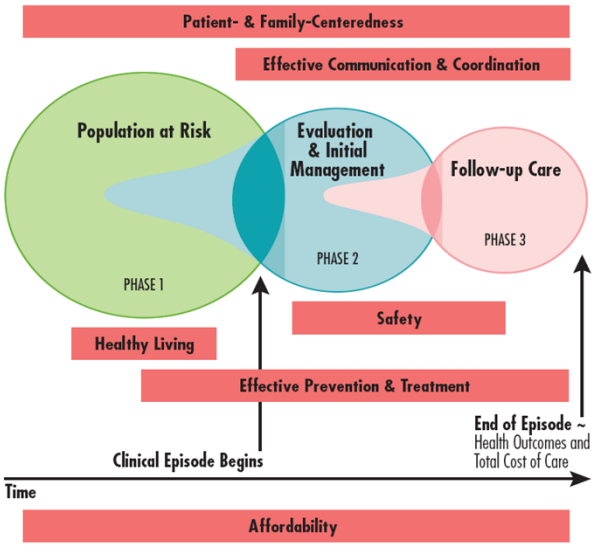

Elements of a Coordination Strategy

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- Measures and measurement issues
  - Measure selection principles
  - Priority areas for measurement
  - Special considerations for dual eligible beneficiaries
  - Identification of measure gaps
- Data sources and HIT implications
- Alignment
- Pathway for improving measure applications

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Opportunities for Alignment

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Long Term Quality Alliance Measurement Workgroup

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Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup

Dual Eligible Beneficiaries Workgroup Charge

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To advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- Identify a core set of current measures that address the identified quality issues and apply to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

Flow of Information to Inform Reports

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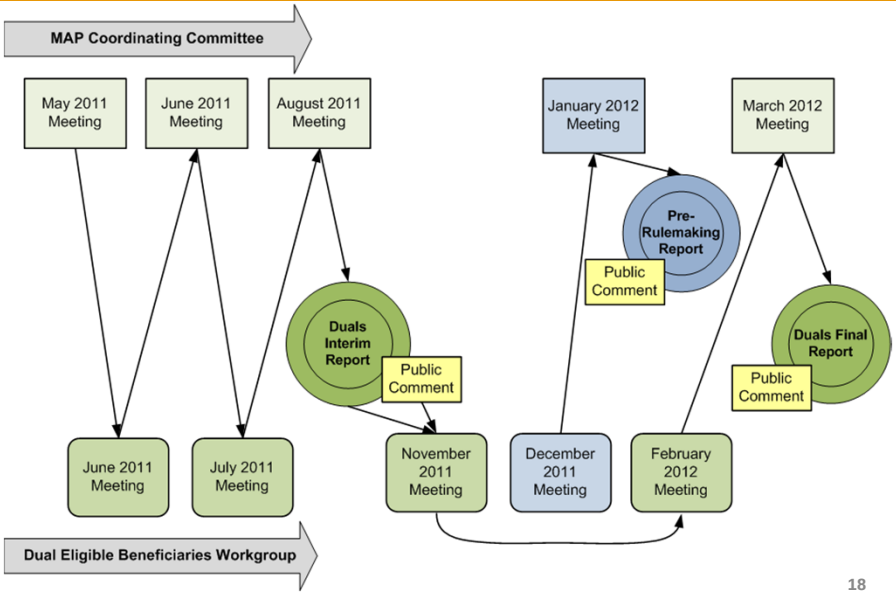

Strategic Approach to Quality Measurement

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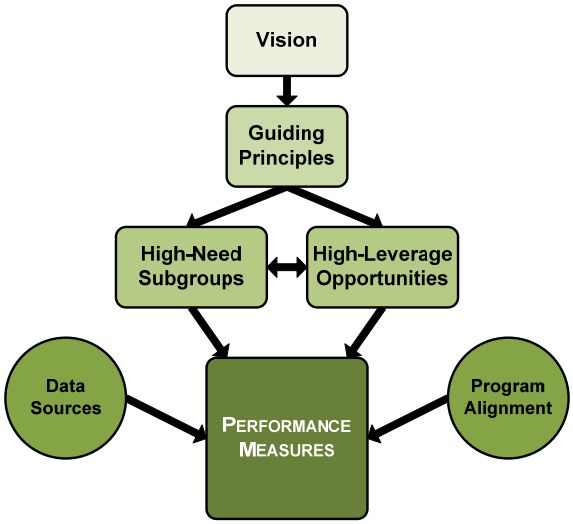

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Vision for High-Quality Care

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In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.

The MAP espouses a definition of health that broadly accounts for health outcomes, determinants of health, and personal wellness. For example, one of the NQS aims is to "improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care."

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Guiding Principles

- A **person- and family-centered plan of care** forms the foundation for the delivery of high-quality care and supports.
- The dually eligible population is a byproduct of payment policy, characterized more by its **heterogeneity** and diversity rather than any inherent similarity.
- Many shortfalls in the quality of care delivered to this population can be traced back to **fragmentation of care delivery** and payment between the Medicare and Medicaid programs. Fragmentation also damages ongoing efforts to promote efficient, affordable care.
- Measurement should drive clinical practice and provision of community supports toward desired models of **integrated, coordinated care**.
- The measurement strategy should encourage **data exchange**.
- It is necessary to clarify the level of analysis and specific use of a measurement strategy or measure set related to the care experience of dual eligible beneficiaries, as the **appropriateness** of specific measures are contingent upon their purpose.

High-Need Subgroups

Additive/Synergistic Effect

Limitations in one or more ADLs resulting from sensory and/or physical impairments

Mental health/substance use disorder

Cognitive impairment

Intellectual disability/developmental disability

Heavy disease burden from one condition (e.g., ESRD) or multiple chronic conditions

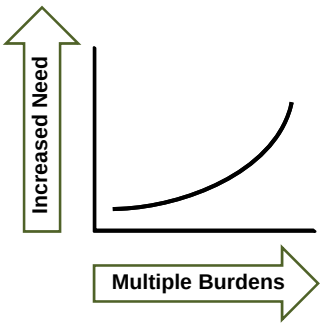
Pain

Residential care setting

Frail elderly

Recipient of Home and Community-Based Services (HCBS)

Social factors (e.g., low SES, homeless, racial/ethnic minority status, education level, cultural beliefs)



Service needs tend to increase along with the number of risk factors or categories that apply to an individual. The exact mathematical relationship is not known, and would vary by combination of factors, but evidence demonstrates it is not linear.

High-Leverage Opportunities

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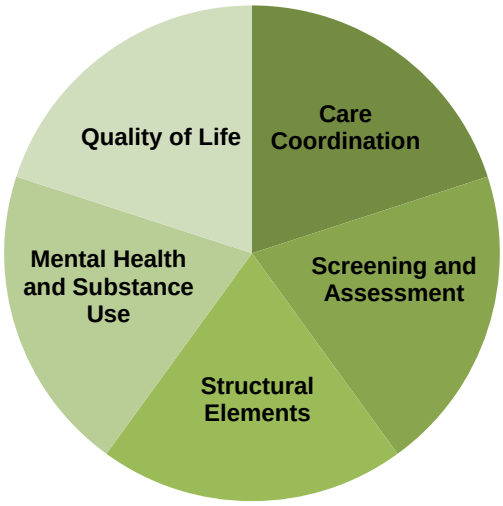

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High-Leverage Opportunities: Quality of Life

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- Focus on outcomes and capture individual's health-related goals, ability to have choice and autonomy, community participation, functional status, pain and symptom control
- Structural measures related to elements that enhance quality of life (e.g., community-based services)

Illustrative Measure	Measure Type	Strengths	Weaknesses
Change in Daily Activity Function as Measured by the AM-PAC The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	Outcome	Broadly applicable across clinical conditions Functional status is a fundamental aspect of quality of life Oriented to outcomes Data for measure comes from EHR Promotes longitudinal measurement	Narrowly limited to post-acute care patients Many others in dual eligible population would benefit from regular assessment of daily activity function, such as individuals receiving HCBS

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High-Leverage Opportunities: Care Coordination

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- Promote coordination across multiple dimensions: settings of care, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid programs
- Address medication management, access to an inter-professional care team, advance care planning, and palliative care

Illustrative Measure	Measure Type	Strengths	Weaknesses
3-Item Care Transition Measure (CTM-3) Uni-dimensional self-reported survey that measures the quality of preparation for a transition in care.	Patient Experience of Care	Captures the beneficiary's perspective Broadly applicable (not condition-specific or restricted by age) Proposed ACO measure	Survey may not be in use as part of current process of care Many individuals may be unable to complete the survey themselves (due to limited English proficiency, cognitive impairment, et cetera)

High-Leverage Opportunities: Screening and Assessment

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- Approach should be thorough and tailored to address the complex care needs of the population: food insecurity, drug and alcohol use, falls, underlying mental and cognitive conditions, HIV/AIDS, etc.
- Assess the home environment, availability of family and community supports, caregiver stress, and consideration of whether the care is in least restrictive setting

Illustrative Measure	Measure Type	Strengths	Weaknesses
Screening for fall risk Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	Process	Not specific to a clinical condition Important risk factor in the dual eligible population, particularly among older adults Proposed ACO measure	Limited by age; others with limitations in mobility may be at risk for a fall Measure does not push provider to change plan of care based on results of the assessment, only to document that one was performed

High-Leverage Opportunities: Mental Health and Substance Use

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- Evaluate all stages of care, including screening, treatment, outcomes, and patient experience
- Base measurement approach in recovery model

Illustrative Measure	Measure Type	Strengths	Weaknesses
Depression Remission at Six Months Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5.	Outcome	PHQ-9 is a standardized tool completed by the patient Promotes longitudinal view of care and ongoing contact between patient and provider Applies to both patients with newly diagnosed and existing depression Highly prevalent condition Can be gathered from multiple data sources	Risk adjustment may be necessary

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High-Leverage Opportunities: Structural Measures

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- Measure level of alignment between Medicare and Medicaid programs in order to promote better integration of care
- Evaluate broad environment in order to identify targets for systematic change

Illustrative Measure	Measure Type	Strengths	Weaknesses
SNP Structure and Process Measure #6: Coordination of Medicare and Medicaid Coverage The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Administrative coordination for dual-eligible benefit packages, Element B: Relationship with state Medicaid agency for dual-eligible benefit packages, Element C: Administrative coordination for chronic condition and institutional benefit packages, Element D: Service coordination	Structure/ Process	Promotes coordination between private Medicare Advantage Special Needs Plans and state Medicaid agencies Affects all dual eligible beneficiaries enrolled in a particular SNP	Applies only to Special Needs Plans, which enroll a minority of dual-eligible beneficiaries Not currently endorsed by NQF

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Data Source and Alignment Issues

- **Data Sources**
  - Identification of appropriate measures should be accompanied by a data collection strategy that identifies specific data sources for each measure
  - Strategy should promote HIT/HIE adoption in order to reduce data collection burden and make information available for multiple purposes across the system, however HIT/HIE should not be viewed as a 'magic bullet'
  - Current CMS data could be harmonized to form the foundation of the data platform
  - Data integrity could be improved through systematic review and feedback loops
- **Alignment**
  - Most dual eligible beneficiaries receive inefficient, fragmented care that is confusing to them as well as to their providers
  - Uniform performance measurement can help to drive alignment across benefit structures, settings of care, and between the healthcare delivery system and providers of community-based services
  - Balance immediate, short-term, and long-term steps to advancing a comprehensive measurement strategy

Next Steps

- Interim Report to HHS due October 1
- Interim Report will be posted for public comment from October 3 – October 21
- Future work will refine the proposed strategic approach as well as closely examine measure gaps, potential modifications to existing measures, and new measure concepts which might be developed

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NQF-endorsed Multiple Chronic Conditions Measurement Framework

Purpose

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This project seeks to achieve consensus through NQF's Consensus Development Process (CDP) on a measurement framework for assessing the efficiency of care—defined as quality and costs—provided to individuals with multiple chronic conditions (MCCs).

Scope

- Establish definitions, domains and guiding principles that are instrumental for measuring and reporting the efficiency of care for patients with MCCs;
- Adapt the NQF-endorsed Patient-focused Episodes of Care Measurement Framework for patients with MCCs;
- Build upon the National Quality Strategy, HHS's Multiple Chronic Conditions Framework, and the work of other private sector initiatives; and
- Support the development and application of measures.

Timelines and Deliverables

Proposed Activity/Deliverable	Timeline
Committee In-person Meeting #1	July 8, 2011
Draft Commission Paper	July 22, 2011
Committee Web Meeting #2	July 29, 2011
Committee In-person Meeting #2	August 8, 2011
Final Commission Paper	September 30, 2011
Committee Web Meeting #3	December 2, 2011
Draft Framework Report	December 5, 2011
Public Comment	Late December 2011 – January 2012
Final Framework Report	Early February 2012
Member Voting	March 2012
CSAC Consideration and Board Endorsement	April 2012

HHS' Multiple Chronic Conditions Framework

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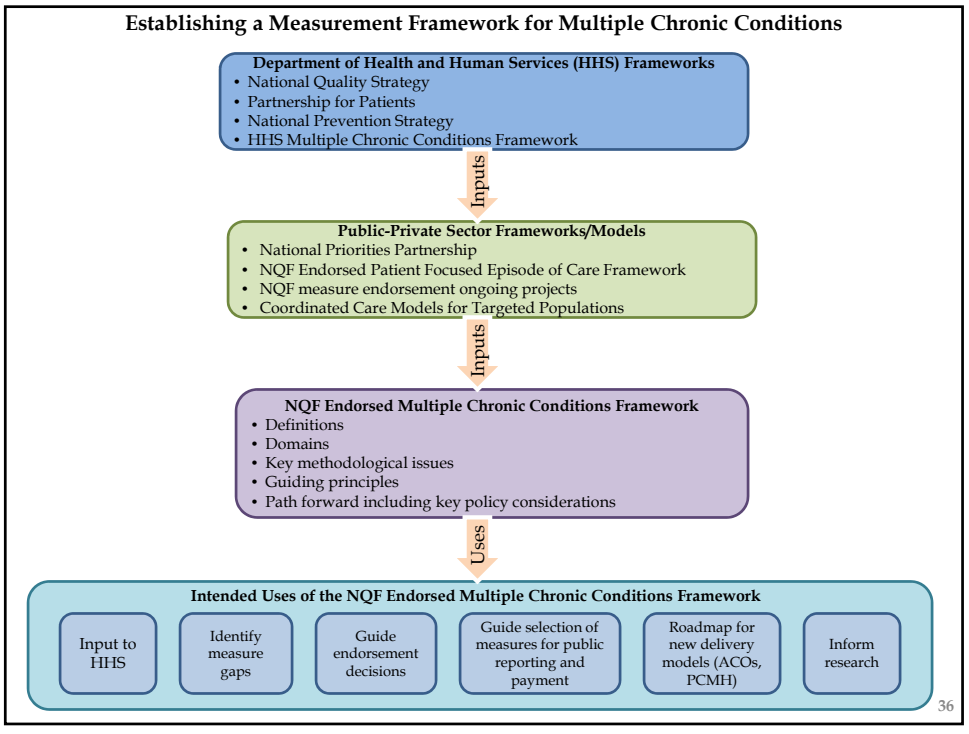
1. Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions
2. Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions
3. Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions
4. Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions



MCC Definition

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- Persons with multiple chronic conditions are defined as having two or more concurrent chronic conditions that collectively have an adverse effect on health status, function or quality of life and that require complex health care management, decision-making or coordination.[1,2]

1. In the context of this definition, chronic conditions encompass a spectrum of disease and other clinical (e.g. obesity), behavioral (e.g. problem drinking), and developmental (e.g. learning disabilities) conditions. Additionally, the social context in which a person lives (e.g., homelessness) is also considered an important influencing factor.
2. A complication associated with a primary diagnosis would also meet the requirement of two or more concurrent conditions (e.g., cystic fibrosis in children with an associated complications such as pancreatic insufficiency)

MCC Draft Detailed Definition

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- Assessment of the quality of care provided to the MCC population should consider persons with two or more concurrent chronic conditions that require ongoing clinical, behavioral or developmental care from members of the health care team and act together to significantly increase the complexity of management and coordination of care— including but not limited to potential interactions between conditions and treatments.

- Importantly, from an individual's perspective the presence of MCCs would:
  - Affect functional roles and health outcomes across the lifespan;
  - Compromise life expectancy; or
  - Hinder a patient's ability to self manage or a family or caregiver's capacity to assist in that individual's care.

MCC Key Measure Concept Areas

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HHS's National Quality Strategy: 6 Priorities	Key Measurement Areas
Effective communication and coordination of care	• **Seamless transitions between multiple providers and sites of care (#2)** • **Access to usual source of care (#5)** • **Shared accountability that includes patients, families, and providers (#7)** • Care plans in use • Advance care planning • Clear instructions/simplification of regimen • Integration between community & healthcare system • Health literacy
Person and family centered care	• **Shared decision-making (#7)** • Patient, experience of care • Family, caregiver experience of care • Self-management of chronic conditions, especially multiple conditions
Making quality care more affordable	• **Transparency of cost (total cost) (#6)** • 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

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MCC Key Measure Concept Areas

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HHS's National Quality Strategy: 6 Priorities	Key Measurement Areas
Enable healthy living	• **Optimize function, maintaining function, prevention of decline in function (#1)** • 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
Make care safer	• **Avoiding inappropriate, non- beneficial end of life care (#4)** • Reduce harm from unnecessary services • Preventable admissions and readmissions • Inappropriate medications, proper medication protocol and adherence
Prevention and treatment for leading causes of mortality	• **Patient clinical outcomes (e.g. mortality, morbidity) (#3)** • Patient reported outcomes (e.g. quality of life, functional status) • Missed prevention opportunities – secondary & tertiary

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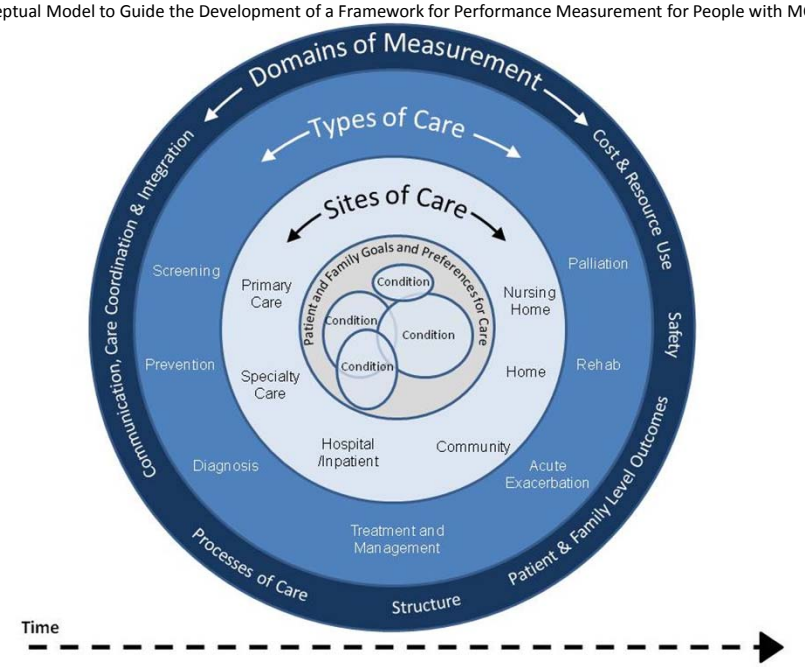
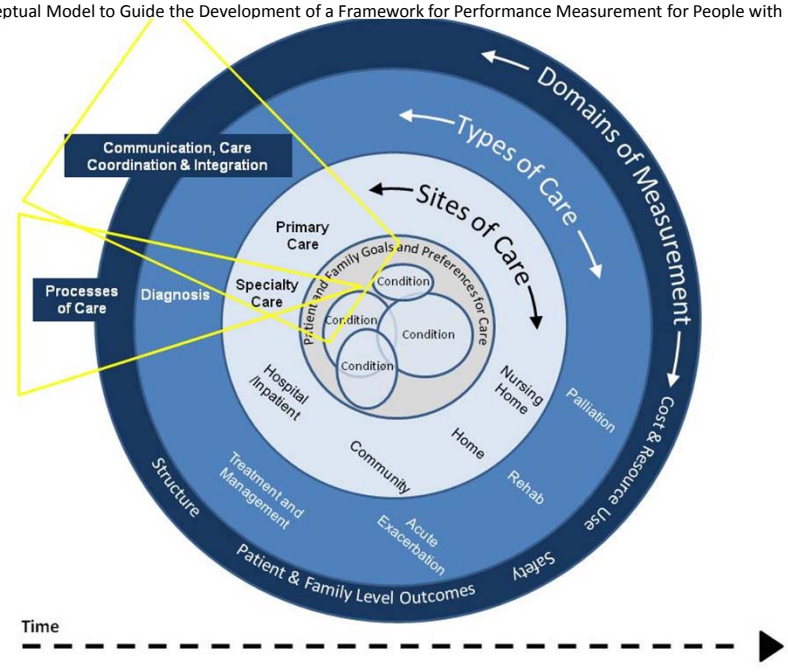
Conceptual Model for Performance Measurement for People with MCCs

Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCCs



Conceptual Model to Guide the Development of a Framework for Performance Measurement for People with MCCs



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DRAFT Guiding Principles for MCC Measurement Approaches

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MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Promote collaborative care among providers and across settings at all levels of the system[1] while aligning across various public and private sector applications (e.g., public reporting, payment).

1. The system includes, but is not limited to; individual patients; individual health care professionals; group practices; hospitals, health systems, and other provider organizations; and health plans.

MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Assess the quality of care[1] and incorporate measures that are crosscutting[2], condition-specific, structural[3], behavioral[4], and address appropriateness of care[5].

1. Quality of care is defined by the Institute of Medicine six aims: safe, timely, effective, efficient, equitable and patient-centered.
2. Crosscutting measures apply to a variety of conditions at the same time or a single disease with multi-organ system ramifications (e.g. cystic fibrosis). Example measure concepts include: care coordination and integration, shared decision making, medication reconciliation, functional status, health related quality of life, and screening and assessment.
3. Structural measures assess if essential infrastructure (e.g., team-based care, registries, EHRs) is in place to support integrated approaches to care management.
4. Behavioral measures targeting major behavioral health risk factors such as obesity, smoking, alcohol and substance abuse, poor diet/nutrition, and physical inactivity.
5. Appropriateness of care includes measures of overuse, underuse, and misuse. For example, measures that assess overuse of services such as imaging. Evidence-based guidelines for people with MCCs are not well developed in this area.

MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Capture inputs in a standardized fashion from multiple data sources[1], particularly patient reported data, to ensure key outcomes of care (e.g., functional status) are assessed and monitored over time.

1. Data sources including, but not limited to: claims, EHRs, PHRs, HIEs, registries, and patient reported data.

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MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Be prioritized based on the best available evidence of linkage to optimum outcomes and take into consideration patient preferences jointly established through care planning.
  - Assess if a shared decision-making process was undertaken as part of care planning and ultimately that the care provided was in concordance with patient preferences or, as appropriate, family or caregiver preferences on behalf of the patient.

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MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Assess care longitudinally (i.e., provided over extended periods of time) and changes in care over time (i.e., delta measures of improvement rather than attainment).
  - Be as inclusive as possible, as opposed to excluding people with MCCs from measure denominators. Where exclusions are appropriate, either existing measures should be modified or new measures should be developed.

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MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Include methodological approaches such as stratification to illuminate and track disparities in care for people with MCCs. In addition to stratifying the MCC population in measurement (which is particularly important to understand application of disease-specific measures to the MCC population), additional bases for stratification include disability, cognitive impairments, life expectancy, illness burden, shadow conditions or dominant conditions, socioeconomic status, and race/ethnicity.

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MCC Measurement Guiding Principles

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- Performance measurement for people with MCCs should:
  - Employ risk adjustment for comparability with caution, as risk adjustment may result in the unintended consequence of obscuring serious gaps in care for the MCC population. Risk adjustment should only be applied to outcomes measures and not process measures.

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Discussion

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Key Measurement Considerations for PAC/LTC Settings

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PAC/LTC Workgroup Interim Findings Presented to Coordinating Committee

Priority Areas for Measurement

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- **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 and family should be engaged in determining the goals
- **Care Coordination**
  - Across settings of care and providers
  - Assessing how the system coordinates care
- **Cost/Access**
  - Total cost and attention to cost-shifting
  - Patients access to additional social supports (e.g., home and community based services)
- *These areas are also critical to the dual-eligible beneficiaries population. Additional considerations for the duals include disparities, risk adjustment, and stratification.*

Identification of Measure Gaps

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- Measures for cognitive impairment and mental health
- Measures addressing psychosocial and spiritual aspects of care
- Measures that assess clinician performance within site-delivered care

Alignment Considerations

- **Balancing Standardization and Customization**
  - Distinct types of care (e.g., long stay vs. short stay) across post-acute care and long-term care settings
  - Multiple provider types and have varying payment structures (particularly differing requirements between Medicare and Medicaid)
  - Similar measure concepts should be standardized across settings; however, additional measures should address the unique qualities of each setting
- **Multi-Level Measurement**
  - Current measurement in post-acute care and long-term care settings is site-specific
  - Measurement should also be attributed to clinicians
  - Some areas of measurement should be assessed across both levels, while some areas may be attributed to only one level (e.g., assessing structural aspects at the setting level)

Elements of a Coordination Strategy

- Data sources and HIT implications
  - Interoperable data platforms are need across settings to reduce data burden and redundancy
  - Need to build upon the existing efforts; new tools or data collection systems would introduce additional burden
- Pathway for improving measure application
  - Recognition of the limitations of current data systems and potential for measures to promote data integration
  - Consider how to move from current to ideal state for each element of coordination strategy

Coordinating Committee Feedback

- Priorities for Measurement
  - Patient preferences; patient/caregiver preparedness
  - End of life care (overuse of treatment)
- Measurement Considerations
  - Accountability
    - Need an emphasis on team-based care although attribution will be difficult
    - Consider how alignment with medical home and ACO approaches can support accountability across the care continuum (i.e. across sites and providers)
  - Defining caregiver
    - Caregivers may not be family; how can this be addressed in measurement

Review of Exercise Results

Priority Areas for Measurement

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95% (N= 19) of respondents agree with the priority areas for measurement across all PAC-LTC settings.

- **Function**
  - Less applicable to LTACH's and certain population subsets (frail, end of life)
  - Needs standardized assessment across disease states and settings
- **Goal Attainment**
  - Difficult to quantify for measurement
- **Care Coordination**
  - Attribution poses measurement challenge
  - Key measures: readmissions, ED visits without admission, effective communication between settings and with patients/family
- **Cost/Access**
  - Assessment of cost-shifting across the care continuum; cannot be isolated to one facility/setting
- **Additional Priorities Raised**
  - Access to community resources
  - Patient and family engagement
    - Satisfaction/ experience with care
    - Self management, education, instructions provided

Key Measurement Considerations

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General agreement with the key measurement consideration

- **Balancing Standardization and Customization** *(95%)*
  - Not a balance; first standardize to reduce administrative burden then customize to address unique attributes of each setting
  - Across all settings need to establish highest leverage opportunities
- **Multi-level measurement** *(95%)*
  - Attribution to individual clinicians is difficult; however, need to target interventions at appropriate level (actionable)
  - Accountability is needed at all levels
    - Need to address team-based care
    - Need to evaluate quality across sites of care to encourage shared accountability
    - Need creative ways to engage clinicians in measurement and quality improvement
- **Reducing Data Burden** *(89%)*
  - Standardization needed (measures, data elements, terminology)
  - Real-time data exchange and interoperability to avoid miscommunication, redundancy, and encourage continuous quality improvement
  - Any change introduces some additional burden; need provider buy-in

Additional Measurement Considerations

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- Measures targeting subpopulations (e.g., frail, end of life/hospice, cognitively impaired)
  - Self-reported measures
  - Management of chronic conditions
- Appropriate representation of measure types
  - Structure, process, outcomes, experience, cost
  - Disease specific vs. cross-cutting measures
  - Composites vs. individual measures
- Staffing measures
  - Staffing hours assumes more is better
  - Consider patient access to clinicians

Other Opportunities for Quality Assessment

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- Tools for Data Collection
  - CARE Tool
    - Potential for standardization using the CARE data elements and terminology
    - Challenges in operationalizing the tool (e.g., infrastructure, training, monitoring)
    - Needs patient centric and hospice measures
  - Utilize CAHPS across all settings
- Accreditation/Certification
  - Provide limited quality information; focus on policies and procedures
  - Can provide information on structural elements and processes

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Discussion

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Orientation to the PAC/LTC Performance Measures Table

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Measure Selection Criteria Development

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Process of measure selection criteria development

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Measures to Be Implemented Through the Federal Rulemaking Process

Task Description	Deliverable	Timeline
Provide input to HHS on measures to be implemented through the federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the metrics for encouraging such improvement.	Final report containing Coordinating Committee framework for decision-making and proposed measures	Draft Report: January 2012 Final Report: February 1, 2012

Coordinating Committee with input from all workgroups

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

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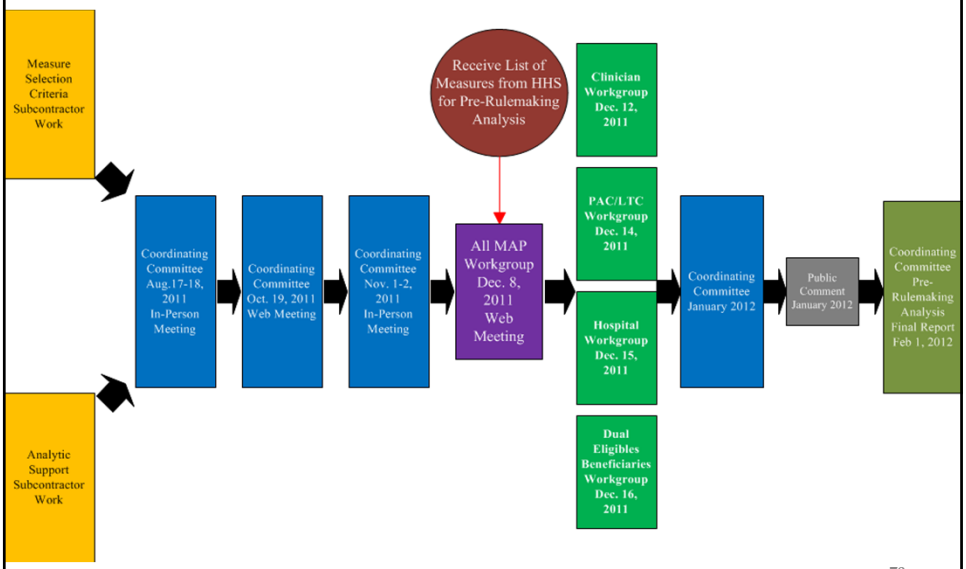

Measure Selection Criteria Development

- Inputs include:
  - Build upon existing NQF measure endorsement process
  - Stanford project team
  - MAP Coordinating Committee and Workgroups
- Measure selection principles first iterated in the May 3-4 Coordinating Committee in-person meeting, further enhanced at the following meetings:
  - June workgroup in-person meetings
  - June 21-22 Coordinating Committee in-person meeting
  - July workgroup in-person meetings
  - August 1 Clinician Workgroup web meeting focused on measure selection exercise
  - August 5 Coordinating Committee web meeting
  - August 17-18 Coordinating Committee in-person meeting

Measure Selection Principles

On June 28th, PAC/LTC Workgroup reviewed the Coordinating Committee Selection Principles and Selection Criteria "Strawperson" and recommended that measures contributing to a comprehensive set should:

- Address stages of illness, not just a single disease or care received in a single setting
- Assess care across providers, settings, and time to promote care coordination
- Be actionable by/attributable to clinicians, not just setting-specific
- Place strong emphasis on unintended consequences
- Incorporate patient outcomes and goal attainment
- Incorporate structural and process measures, which are necessary to target opportunities for improvement
- Considers cost and cost-shifting

Key Concepts Mapped to Criteria

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- National Quality Strategy provides solid foundation for measurement goals described by the MAP committees (e.g., patient-centered, care coordination, and resource use/cost)
- Emphasis on patient-focused episodes of care across settings and time, as one way to address "systemness"
- Representation of measure types relevant to the program (e.g., process, outcomes, patient experience, structure and cost)
- Assessment of measure set suitability for specific programs, including the extent to which a set covers the accountable entities
- Parsimony -- minimum number of measures and the least burdensome
- Avoidance of adverse unintended consequences
- Consideration of disparities

Experience Applying the Set-Level Criteria

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- Clinician Workgroup members evaluated, via a survey monkey tool, the physician value-based modifier proposed measure set – 62 quality measures
- Majority of respondents agree the MAP set-level measure selection criteria are a good starting place for assessing the adequacy of a measure set for a specific purpose
  - Strongly Agree – 30%
  - Agree – 50%
  - Disagree – 20%
  - Strongly Disagree – 0%

  N= 20, 71% response rate

Hospital and PAC/LTC Workgroups will participate in similar exercises

Experience Applying the Set-Level Criteria

- Addresses NQS Priorities, but concern with exact extent
- Criteria should have an appropriate mix of measure types not necessarily equal representation
- Addresses high-leverage opportunities, but should be defined beyond high-impact conditions
- Appropriate for all intended accountable entities, need better ways to assess or encourage “systemness” or shared accountability
- Parsimony, undesirable consequences, health care disparities criteria generally difficult to assess

August Coordinating Committee Meetings

Discussion included the following points:

- Consider alternative criteria rating systems (e.g., binary rating options and range of responses) to avoid regression to the mean
- Include definitions and interpretative guidance to each criterion
  - For example, clarify the meaning of parsimony to include concept of collection of burden not just the number of measures
- Include undesirable consequences in the individual measure criterion
- Use same criteria for public reporting and payment, but measures for different purposes may be different

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Review measure selection criteria

Measure Selection Criteria

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Criterion #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)

*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.

Measure Selection Criteria

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Criterion #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

Measure Selection Criteria

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Criterion #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)

Measure Selection Criteria

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Criterion #4

Measure set promotes the goals of the specific program

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)

Measure Selection Criteria

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Criterion #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

Measure Selection Criteria

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Criterion #6

Measure set enables measurement across the patient-focused episode of care*

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

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

Measure Selection Criteria

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Criterion #7

Measure set includes considerations for healthcare disparities*

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 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)

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

Measure Selection Criteria

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Criterion #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])

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Measure Selection Criteria

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Next Steps:

- Criteria is out for comment via the MAP Clinician Performance Measure Coordination Strategy Report
- Criteria to be finalized at the October 19 Coordinating Committee web meeting
- Criteria to be utilized in the December/January pre-rulemaking activities

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Discussion

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Opportunity for Public Comment

Small Group Session: Evaluating Performance Measures in Use

Small Group Exercise: Evaluating Measure Sets

Individually Evaluate the Measure Set

1. Review the Measure Set
   - Each subgroup assigned to Home Health Compare or Nursing Home Compare
   - For additional details, you may refer to the 'Home Health Compare' or 'Nursing Home Compare' tab in the PAC-LTC Measures Chart
2. Rate the measure set using the measure selection criteria
3. Share your experience using the criteria by providing any suggestions for improvement
   - You have been provided a MAP Measure Selection Criteria Worksheet to record your responses.

Small Group Discussion of Measure Set Evaluation

4. Assign a reporter
5. Topics for Small Group Discussion
   - Overall evaluation of measure set (strengths, gaps)
   - Impressions of using the measure selection criteria

Nursing Home Compare

- Developed to assist consumers, their families, and caregivers in informing their decisions regarding choosing a nursing home
- Provides information on health inspections, staffing, and quality measures
- Uses a Five-Star Quality Rating System
  - 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.
- Data is collected through:
  - Annual inspection surveys and complaint investigations findings
  - CMS Online Survey and Certification Reporting (OSCAR) system
  - Minimum Data Set Quality Measures
    - In June, 2011 NQF endorsed 17 Nursing Home Quality Measures included in MDS 3.0
    - These measures will become the enhanced set of publicly reported quality measures on Nursing Home Compare in the spring of 2012.

Home Health Compare

- Provides information about the quality of care provided by “Medicare-certified” home health agencies
- Contains a subset of OASIS-based quality measures
  - Data from OASIS-C will be displayed in October 2011
- Domains of quality measurement include:
  - managing pain and treating symptoms
  - treating wounds and preventing pressure sores,
  - preventing harm
  - preventing unplanned hospital care

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Evaluating Performance Measures in Use

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Measurement Priorities within Each and across All PAC-LTC Settings

Measurement Priorities across All PAC-LTC Settings (core)

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas
Effective communication and coordination of care	• Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable	
Enable healthy living (Optimize Function)	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions • Preventable adverse outcomes
Prevention and treatment for leading causes of mortality	• Management of chronic conditions

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Measurement Priorities for SNFs (beyond core)

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas Long-Stay	Key Measure Concept Areas Short-Stay
Effective communication and coordination of care	• Experience of care coordination within and across settings • Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life	• Clinician Involvement • Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable		
Enable healthy living (Optimize Function)	• Mental health functioning	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions • Preventable adverse outcomes	• Healthcare Acquired Conditions • Preventable adverse outcomes

Measurement Priorities for Home Health Care (beyond core)

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas
Effective communication and coordination of care	• Experience of care coordination within and across settings • Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable	• Utilization
Enable healthy living (Optimize Function)	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions • Preventable adverse outcomes
Prevention and treatment for leading causes of mortality	• Management of chronic conditions

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Measurement Priorities for IRFs (beyond core)

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas
Effective communication and coordination of care	• PT/OT measures • Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable	• Inappropriate use
Enable healthy living (Optimize Function)	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions • Preventable adverse outcomes
Prevention and treatment for leading causes of mortality	• Management of chronic conditions

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Measurement Priorities for LTCHs (beyond core)

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas
Effective communication and coordination of care	• Experience of care coordination within and across settings • Transition of care and communication across settings • Transition of care and communication with patient • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable	• Cost effectiveness measures • Access to consultations
Enable healthy living (Optimize Function)	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions • Preventable adverse outcomes
Prevention and treatment for leading causes of mortality	• Management of chronic conditions

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Measurement Priorities for Hospice

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HHS's National Quality Strategy Priorities	Key Measure Concept Areas
Effective communication and coordination of care	• Transition of care and communication across settings • Cognitive assessment • Functional status and quality of life
Person and family centered care	• Patient, family, caregiver experience of care • Patient goals and goal attainment
Making quality care more affordable	• Inappropriate Use
Enable healthy living (Optimize Function)	• Mental health functioning
Make care safer	• Healthcare Acquired Conditions
Prevention and treatment for leading causes of mortality	

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Opportunity for Public Comment

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Summary of Day 1
and
Look-Forward to Day 2

Meeting Agenda: Day 2

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- Welcome and recap of day 1
- Data source and HIT implications: data collection approaches
  - Long-term care
  - Home health care
  - Other settings
- Emerging data collection recommendations
- Pathway for improving measure applications
- Summation and the path forward
- Adjourn

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Welcome and Recap of Day 1

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Data Source and HIT Implications: Data Collection Approaches

Data Source and HIT Implications: Data Collection Approaches

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Long-Term Care
- MDS and Nursing Home CAHPS- *Thomas Dudley*
- Reactor- *Debra Saliba*
- AARP Report Card- *Ari Houser*

Home Health Care
- OASIS and Home Health CAHPS- *Robin Dowell*
- Reactor- *Carol Raphael*

Other Settings
- CARE tool, IRF-PAI, LTCH Care tool- *Judith Tobin*
- Reactor- *Suzanne Snyder*

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Emerging Data Collection Recommendations

MAP Data Considerations

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Promote standardized electronic data sources and health IT adoption to reduce data collection burden and make information available for multiple purposes

MAP Data Considerations

- Standardized measurement data collection and transmission process
  - Across all federal programs, and ultimately all payers (e.g., HIEs)
  - Current CMS data and other databases maintained by federal agencies (e.g., AHRQ's HCUP, CDC's NHSN, CMS's Hospital Compare, FDA's Sentinel Initiative) could be harmonized as a starting place for building the data platform
- Library of all data elements needed for all measures
  - Specific data sources needed for each measure
  - Providers and payers should report the necessary data elements to calculate measures
- The data platform should support patient-centered measurement
  - Enabling the collection of patient-reported data (both quantitative and qualitative)
  - Patient-level data can be used for analysis at any level
  - Tracking care across settings and over time
- Data collection should occur during the course of care, when possible, to minimize burden and maximize use 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

Additional Data Considerations

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Pathway for Improving Measure Applications

Pathway for Improving Measure Applications

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Pathway for Improving Measure Applications

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- Aligned Measures
  - Cascading measures across multiple levels of analysis
  - Core sets and subsets for specific purposes
- Identification of Priority Gaps
  - Pathway for gap filling
- Moving from Current to Ideal State
  - Levers for implementing all aspects of coordination strategy
  - Barriers (e.g., funding)
  - Potential interim “ramping up” measurement approaches

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Discussion

Summation and the Path Forward

Next Steps

- Sept. 16: Survey Monkey exercise to solicit feedback on final recommendations
- Week of Sept. 26: Follow-up web meeting
- Week of Oct. 17: Draft PAC-LTC coordination strategy report to PAC-LTC Workgroup and Coordinating Committee
- Nov. 1-2: Coordinating Committee discussion of PAC-LTC coordination strategy report

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

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

The measure concepts were derived from a scan of measures currently used in PAC-LTC quality measurement programs, measures that are NQF-endorsed for use in PAC-LTC settings, and proposed or finalized measures for future use in PAC-LTC settings as indicated in recent federal rules. Major concepts are identified as well as a illustrative examples of measures related to that concept. For example, the OASIS functional status measures are mapped under the concept of functional status and quality of life in the example of ability to perform ADLs.

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
Making Care Safer	Healthcare Acquired Conditions • Pressure ulcers • Injury from falls and immobility • Adverse drug events • CAUTI • Rates of infections Preventable adverse outcomes • Hospital transfer rates for nursing home sensitive conditions • ER visits without hospital admission • Use of restraints • Unnecessary interventions • Medication overuse (sleeping, antipsychotics)	Healthcare Acquired Conditions • Pressure ulcers • Injury from falls and immobility • Adverse drug events Preventable adverse outcomes • Preventable hospital readmissions • Unplanned acute care hospitalization • Use of restraints	Healthcare acquired conditions • Surgical site infections • Multidrug resistant organism infection • Venous Thromboembolism • Pressure ulcers • Injury from falls and immobility • Adverse drug events Preventable adverse outcomes • Balance problems • Radiation exposure or exposure time • Unplanned acute care hospitalization • ER visits without hospital admission • Preventable hospital readmissions • Unnecessary interventions • Medication overuse (sleeping,	Healthcare Acquired Conditions • Rates of infections • Ventilator-associated pneumonia • Injury from falls and immobility • Adverse drug events • Pressure ulcers • Poor glycemic control • Blood incompatibility • Foreign object retained after surgery • Multidrug resistant organism infection • CLABSI prevention • Ventilator associate pneumonia prevention • Venous Thromboembolism • Air embolism • CAUTI	Healthcare Acquired Conditions • Pressure ulcers(OASIS data shows very low frequency) • Injury from falls and immobility (staff is present for a very limited time) • Adverse drug events • Surgical site infection • CAUTI Preventable adverse outcomes • Emergent care for adverse outcomes (improper medication, wound infections, fall) • Emergent care for hypo/ hyperglycemia • Preventable hospital	Healthcare Acquired Conditions • Injury from falls and immobility • Adverse drug events • Rates of infections

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
			antipsychotics)	Preventable adverse outcomes • Unplanned acute care hospitalization • Mortality • Preventable readmissions • ER visits without hospital admission • Observation stays • Use of restraints • Unnecessary hospitalization and ER use • Unnecessary interventions • Medication overuse(sleeping, antipsychotics) • Use of restraints *general comment: many measures for NHs can be applied here*	readmissions • Observation stays • Emergent care for other conditions that results in hospital transfers that could be safely managed in the home • Unnecessary Interventions • Medication overuse(sleeping, antipsychotics)	

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
Ensuring Person- and Family-Centered Care	Patient, family, caregiver experience of care • Long-Stay Resident NH CAHPS • Family member CAHPS • Assessment of the bereaved family perception of quality of care prior to patient death • Burden carried by family members Patient goals and goal attainment • Patient and family involvement in care	Patient, family, caregiver experience of care • Assessment of discharge • ~~Assessment of the bereaved family perception of quality of care prior to patient death~~ (only for hospice patients in short stay) Patient goals and goal attainment • Involvement in plan of care, • Perceptions of care	Patient, family, caregiver experience of care • Inpatient Consumer Survey • Patient Survey (e.g., HCAPS) Patient goals and goal attainment • Patient preferences for care, treatment, and management of symptoms by healthcare providers • Measures to assess whether the care delivered was consistent with patient stated care preferences	Patient, family, caregiver experience of care • HCAHPS Patient goals and goal attainment • Patient preference for care	Patient, family, caregiver experience of care • CAHPS® Home Health Care Survey • ~~Assessment of the bereaved family perception of quality of care prior to patient death~~ (only for hospice patients in home care) • Burden carried by family members Patient goals and goal attainment • Self-care management • Patient and Family care preferences • Education on medications • Education in plan of care • Consistency and validity of education across providers	Patient, family, caregiver experience of care • Assessment of the bereaved family perception of the quality of care prior to the patient death- should be expanded beyond post death evaluation • Family Evaluation of Hospice Care (FEHC) • Counseling or other services for family members during the grief process Patient goals and goal attainment • Death in the setting of choice • Patient/family goals attainable in providers perspective/scope of work • Patient and care giver education in managing conditions with education in plan of care

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
Promoting Effective Communication and Coordination of Care	Transition of care and communication across settings • Timely transition of medical records Transition of care and communication with patient • Reconciled med list was provided to patient • Referral information provided to patient/family • Staff communication and responsiveness to patient needs • Communication about palliative care and end of life care, advance directives, location of death (facility or hospital) Cognitive assessment • Dementia	Transition of care and communication across settings • Timely transition of medical records Transition of care and communication with patient • Reconciled med list was provided to patient • Communication about advanced directives • Explanation of care plan to patient/family Cognitive assessment • Dementia assessment Functional status and quality of life • Ability to perform ADLs • Communication • Return to stability	Transition of care and communication across settings • Transition record received by discharged patients • Timely transition of medical records • Post discharge appointment • Care transitions measure-3 (CTM-3) • Discharge Outcome/ discharge disposition (home, assisted living, nursing home, LTCH, hospital, hospice) Transition of care and communication with patient • Reconciled med list was provided to patient Functional status and quality of life	Transition of care and communication across settings Transition of care and communication with patient • Communication about palliative care Experience of care coordination within and across settings Functional status and quality of life • Ability to perform ADLs • Weight loss	Transition of care and communication across settings • Discharge to community with unresolved conditions Cognitive assessment • Delirium assessment • Dementia assessment • Assessment of the patient's cognitive status (not just delirium) Functional status and quality of life • Communication • Ability to perform ADLs • Improvement in dyspnea • Behavior assessment • Self-reported pain • Improvement in pain • Weight loss	Transition of care and communication across settings • Plan of care of family members to community services based on bereavement assessment and needs) Cognitive assessment Functional status and quality of life • Self-reported pain • Ability to perform ADLs • Locomotion • Behavior assessment • Spiritual Considerations

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
	assessment Functional status and quality of life • Continence (bladder, bowel) • Ability to perform ADLs • Weight loss • Communication • Self-reported pain Experience of care coordination within and across settings	• goal directed measure of function • Self-reported pain Clinician Involvement • Time to when patient seen after admission • Frequency of onsite visits	• Ability to perform ADLs • Continence (bladder, bowel) • Locomotion • (walk/wheelchair) • Communication • Social cognition (social interaction, problem solving, memory) • Level of pain • Respiratory status • Patient self-reported data PT/OT measures Cognitive assessment • Dementia assessment		Experience of care coordination within and across settings • Timely initiation of care • Physician notification guidelines • Timely physician contact • Communication with other disciplines settings • Access to resources necessary to stay at home	

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
Effective Prevention and Treatment of the Leading Causes of Mortality	Management of chronic conditions ~~Chronic disease under control (diabetes, heart disease, kidney disease~~) Primary prevention • Vaccination (influenza, pneumococcal)	Management of chronic conditions Primary prevention • Vaccination (influenza, pneumococcal)	Primary prevention • Vaccination (influenza, pneumococcal)	~~Primary prevention~~ • ~~Vaccination (influenza, pneumococcal)~~	Management of chronic conditions ~~Chronic disease under control (diabetes, heart disease, kidney disease)~~ Primary prevention • Vaccination (influenza immunization, pneumococcal)	
Enable Healthy Living	Mental health functioning • Depression assessment	Mental health functioning • Depression assessment	Mental health functioning • Depression assessment		Mental health functioning • Depression assessment	Mental health functioning • Depression assessment
Making Quality Care More Affordable			Inappropriate use	Cost effectiveness measures Access to consultations	Utilization • Emergency department use with and without hospitalization • Acute Care hospitalization • Discharged to community	Inappropriate Use • Chemotherapy in the last 14 days of life • ICU and emergency room in the last 30 days of life

MAP PAC/LTC Measure Concepts Chart- Workgroup Feedback

*The results of the Workgroup exercise are reflected with suggested additions (highlights) and deletions (strikethroughs).

National Quality Strategy Priority	Nursing Homes/Skilled Nursing Facility (Long-Stay)	Nursing Homes/Skilled Nursing Facility (Short-Stay)	Inpatient Rehabilitation	Long-Term Care Hospitals	Home Care	Hospice
Not Mapped to an NQS Priority	Structural measurement • Staff immunization • Productive hours worked by facility staff • Access to and availability of physician, medical team, and nurses	Structural measurement • Productive hours worked by facility staff • Staff immunization	Structural measurement • Productive hours worked by facility staff • Staff immunization • Total staffing hours per resident day	Structural measurement • Nursing care hours per patient day • Voluntary turnover for RN, APN, LPN, UAP • Staff immunization • RN hours per resident day	Structure measurement • Visits per day by discipline; • Time spent is non-clinical or administrative functions; • Staff immunization (should be for all disciplines in home care)	Structure measurement • Productive hours worked by all disciplines • Availability of 24 hour services (maybe an access issue) • Productive hours worked by facility staff • Length of stay in hospice in-patient facilities/nursing homes

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.
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.

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
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.