NATIONAL QUALITY FORUM

Measure Applications Partnership
Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care

SUMMARY

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

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

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

The Measure Applications Partnership (MAP) has been charged with developing a coordination strategy for PAC and LTC performance measurement. Post-acute care refers to healthcare provided following an acute hospitalization and typically delivered in skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, home health care, and outpatient rehabilitation.[1] Long-term care includes both medical and non-medical care rendered to people with chronic illnesses or disabilities and can be provided in the home, nursing home, or in assisted living facilities.[2] This performance measurement coordination strategy focuses on a subset of PAC and LTC settings: short- and long-stay nursing facilities, home health care, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Performance measures for hospice care, which may be provided to patients in various PAC or LTC settings, will be addressed in a subsequent MAP report.

Some PAC and LTC providers have been participating in federal performance measurement through submitting Minimum Data Set (MDS) data for public reporting on Nursing Home Compare and Outcome and Assessment Information Set (OASIS) data for public reporting on Home Health Compare. Other providers will be required to participate in new performance measurement programs mandated by the Affordable Care Act (ACA) within the next few years. The ACA provisions that will have a direct impact on PAC and LTC providers include: Section 3004 mandating quality reporting for LTCHs, IRFs, and hospice programs; Section 3021 establishing the Center for Medicare and Medicaid Innovation to implement new care delivery programs; and Section 3023, implementing a national pilot program for acute care and PAC bundled payment.[3] In recognition of the expansion of performance measurement programs and the need to participate in new delivery models, such as accountable care organizations (ACOs), it is imperative to align performance measurement to facilitate coordination across PAC and LTC settings and reduce data collection burden.

Approach

The MAP PAC/LTC Workgroup advised the Coordinating Committee on developing the PAC and LTC performance measurement coordination strategy. The MAP PAC/LTC Workgroup is a 22-member, multi-stakeholder group (see Appendix A for the workgroup roster, Appendix B for the Coordinating Committee roster). The workgroup held two in-person meetings and one web meeting to develop the coordination strategy. The agendas and materials for the PAC/LTC Workgroup meetings can be found on the NQF website.

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

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

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

Alignment

Several factors contribute to the misalignment of performance measurement among PAC and LTC settings. Different providers of PAC and LTC offer different types and levels of care; thus, each provider addresses

differing, though often overlapping, patient goals across the care continuum. For example, IRF and nursing home short-stay patients need rehabilitative services to meet improvement goals, while nursing home long-stay patients are more likely to have maintenance goals. In addition, PAC and LTC providers receive payment from various sources. Medicare primarily funds post-acute care, while Medicaid is often the primary payer for long-term care. As a result, care may be driven by Medicare and Medicaid payment policies and regulations, rather than patient goals. To comply with federal and state reporting requirements, each setting has distinct performance measurement obligations that use varying reporting mechanisms. Each setting complies with these obligations by using a unique assessment tool (e.g., MDS, OASIS, IRF-PAI). These tools capture similar information yet do not enable information sharing, resulting in a lack of care coordination and duplication of information for patients who move among these settings.

The heterogeneity of patient needs across PAC and LTC settings is a barrier to coordinating setting-specific performance measurement. A patient-centered performance measurement approach that assesses care delivered across episodes of care could transcend the current site-specific approach, integrating measurement for PAC and LTC care with measurement for hospital and clinician care. Patients who access PAC and LTC settings, particularly older adults with complex chronic conditions, often transition among care settings, moving among their homes, hospitals, PAC, and LTC facilities when their health and functional status changes. Approximately one-third of Medicare beneficiaries discharged from hospitals enter into a PAC setting immediately after the hospital discharge.[4] Additionally, few individuals who leave nursing homes are considered permanent discharges, as most return to the nursing home after a hospital admission. Thus, transitions between long-term care and acute care typically are part of the same episode of care.[5] Achieving patient-centered measurement across the episodes of care will require health IT that enables information sharing across settings and incorporating patient-reported data into measurement.

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

Priority Areas for Measurement

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

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

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

Goal Attainment is a high priority for performance measurement because patient goals establish a benchmark for patient-centered measurement. Care goals may be different across settings (e.g., improvement, maintenance, palliation) and should be based on the patient's preferences. The patient and family should be actively engaged in setting goals. MAP has determined that assessing outcomes relative to goals is a key measurement approach for assessing the care provided to dual-eligible beneficiaries.[6]

Patient and Family Engagement is a vital part of delivering quality care generally. Beyond assessing patient and family experience, measures should focus on shared decision making and family and caregiver burden to assist in identifying and obtaining needed support. Consideration should be given to defining caregivers, as this role may extend beyond traditional family support. Finally, health literacy is a critical component of meaningful engagement because it enables patients and caregivers to participate fully in the direction and management of care (i.e., shared decision making).

Care Coordination is essential for patients accessing multiple settings of care. Measurement should promote collaborative care among providers and across settings, with a focus on shared accountability, improving care transitions, and bi-directional communication. Care for patients with multiple chronic conditions and dual eligible beneficiaries is often fragmented, and attention should be placed on communication with patients/families/caregivers and between providers to counter this fragmentation.

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

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

Core Set of Measure Concepts

MAP developed a set of 12 core measure concepts that should be used to assess care across all PAC and LTC settings. These concepts address each of the priority areas for measurement described above and are specific yet flexible enough to allow for customization to address the unique care provided within each setting. The table below depicts the core measure concepts, mapped to the PAC and LTC measurement priorities and the NQS priorities.

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

Core Measure Concept	National Quality Strategy (NQS) Priority					
	Making Care Safer	Ensuring Person- and Family-Centered Care	Promoting Effective Communication and Coordination of Care	Effective Prevention and Treatment of the Leading Causes of Mortality	Enable Healthy Living	Making Quality Care More Affordable
Advanced care planning and treatment in accordance with patient preferences.		X	X			X
PATIENT ENGAGEMENT						
Experience of care		X				
Shared decision making in developing care plans.		X	X			
CARE COORDINATION						
Transition planning consists of discharge planning and timely and bi-directional communication during transitions. Successful transitions require educating and preparing patients and patients' families/caregivers, as well as timely communication between the sending and receiving clinicians/institutions.	X	X	X			X
SAFETY						
Falls	X				X	X
Pressure ulcers	X					X
Adverse drug events	X		X			X
COST/ACCESS						
Inappropriate medication use	X					X

Core Measure Concept	National Quality Strategy (NQS) Priority					
	Making Care Safer	Ensuring Person- and Family-Centered Care	Promoting Effective Communication and Coordination of Care	Effective Prevention and Treatment of the Leading Causes of Mortality	Enable Healthy Living	Making Quality Care More Affordable
Infection rates, including healthcare-associated infections (HAIs), such as ventilator-associated pneumonia.	X					X
Avoidable admissions, including ED admissions, hospital admissions, and hospital readmissions.	X		X			X

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

- Unnecessary services and appropriate level of care were not adopted as core measure concepts due to the lack of evidence for appropriateness within the PAC/LTC environments and the difficulty in retrospectively determining if the appropriate level of care was provided. Ultimately, services provided should be driven by patient goals, which is a measure concept already captured within the core measure concepts.
- Staffing ratios and turnover rates were considered but not selected as core measure concepts. Other workforce considerations, such as consistent staff assignment and staff competency, may be better indicators of quality.
- Access to community supports was deemed to be important for all patients; however, ensuring access to community resources is not necessarily within the provider's purview. Providing information about available community supports could be considered as an alternative.
- Mental health assessment is important but not necessarily appropriate for all patients across PAC/LTC settings. For example, the decision to assess depression is dependent upon factors such as length of stay and level of cognition.

Evaluation of the Nursing Home and Home Health Compare Measures

The PAC/LTC Workgroup evaluated the Nursing Home Compare and Home Health Compare measure sets using a draft version of the MAP measure selection criteria, a tool used to evaluate and recommend measure sets for specific public reporting and performance-based payment programs (see Appendix F for the draft criteria used by the PAC/LTC Workgroup). The Nursing Home Compare and Home Health Compare measures sets were selected for evaluation because they are well established and address both PAC and LTC. The

Nursing Home Compare measures are a subset of the measures contained in the Minimum Data Set (MDS). The Home Health Compare measures are a subset of the measures contained in the OASIS data set (see Appendices D and E for the list of the measure sets). The MAP Clinician and Hospital Workgroups participated in similar exercises involving program measure sets relevant to those settings. The exercises of each of the MAP workgroups informed MAP measure selection criteria refinement.

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

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

Nursing Home Compare Measures

Overall, the workgroup felt that the Nursing Home Compare measure set did not adequately address the MAP measure selection criteria. Its concerns with the measure set are described below.

1. While the majority of measures in the Nursing Home Compare set are NQF endorsed, the workgroup noted the set was limited because not all the included measures are endorsed.
2. The Nursing Home Compare measure set adequately addresses two of the National Quality Strategy priorities: safety and the prevention and treatment of leading causes of mortality and morbidity. However, the set does not address the other NQS priorities: effective care coordination, person- and family-centered care, supporting better care in communities, and making care affordable.
3. The measure set addresses some high-impact conditions for post-acute care, including urinary tract infections and pressure ulcers. Measures addressing advanced illness and psychosocial issues are also needed.
4. The measure set adequately addresses program attributes including intended providers and care settings. However, the workgroup felt the measures for short-stay residents and long-stay residents are not aligned. Additionally, key populations not included in the measures are patients with advanced illness and patients in hospice.
5. The measure set does not contain an appropriate mix of measure types, as the measure set is dominated by process measures with a few outcome measures. Experience of care, cost, and structural measures are needed to improve the measure set. Nursing Home CAHPS could be used to measure experience of care.
6. The measure set relies on data collection through the MDS, which collects data at a single point in time. The measure set does not enable measurement across the patient-focused episode of care over time, unless a reassessment is completed.
7. The measure set does not include considerations for healthcare disparities.

8. The measure set demonstrates aspects of parsimony, as all measures in the set are collected through MDS; however, MDS is specific to the nursing home setting, and the measures in the Nursing Home Compare set may not be applicable across multiple programs or applications.

Home Health Compare Measures

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

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

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

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
Functional and cognitive status assessment	• Percent of residents whose need for help with activities of daily living has increased (long-stay) • Percent of residents whose ability to move in and around their room and adjacent corridors got worse (long-stay) • Percent of short-stay residents who have delirium • Percent of residents who have depressive symptoms (long-	• Improvement in ambulation/locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Depression assessment conducted • Pain assessment conducted

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
	stay) • Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period • Percent of residents who self-report moderate to severe pain (short-stay) • Percent of residents who self-report moderate to severe pain (long-stay) • Percent of residents who lose too much weight (long-stay) • Percent of low-risk residents who lose control of their bowel or bladder (long-stay) • Percent of residents who were physically restrained (long-stay)	• Pain interventions implemented during short-term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/caregiver education implemented during short-term episodes of care
Establishment and attainment of patient/family/caregiver goals		
Advanced care planning and treatment		

Experience of care		• HHCAHPS
		  ○ Patient care
		  ○ Communications between providers and patients
		  ○ Issues on medications
		  ○ Issues on home safety
		  ○ Issues on pain

Shared decision making		
Transition planning		• Timely initiation of care
Falls		• Multifactor fall risk assessment conducted for patients 65 and over
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay) • Percent of high-risk residents with pressure ulcers (long-stay) • Percent of low-risk long-stay residents who have pressure sores	• Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention plans implemented
Adverse drug events		• Drug education on all medications provided to

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
		patient/caregiver during short-term episodes of care • Improvement in management of oral medications
Inappropriate medication use		
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)	
Avoidable admissions		• Acute care hospitalization • ED use without hospitalization
Measures not mapped to a core set concept	• Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (short-stay) • Percent of residents assessed and appropriately given the seasonal influenza vaccine (long-stay) • Percent of residents assessed and appropriately given the pneumococcal vaccine (short-stay) • Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long-stay)	• Influenza immunization received for current flu season • Pneumococcal polysaccharide vaccine (PPV) ever received • Heart failure symptoms addressed during short -term episodes of care

Measures for Long-Term Care Hospitals and Inpatient Rehabilitation Facilities

The PAC/LTC Workgroup did not evaluate measure sets for IRFs and LTCHs. Although these settings have process and outcome measures for internal quality improvement and state-mandated reporting, they currently are not required to report performance measurement information to CMS but will be required to do so in fiscal year 2014.[7] Proposed measures for LTCHs and IRFs are mapped to the core measure concepts (see Appendix G) as an initial step to identifying the best available measures and measure gaps. The proposed measures for IRFs address the majority of the core measure concepts, while the proposed measures for LTCHs address only safety.

Data Source and HIT Considerations

MAP has identified a great need for a uniform data collection and reporting infrastructure to support performance measurement across the quality measurement enterprise. PAC and LTC providers, like many others, face significant barriers to efficient data collection. Most PAC and LTC providers have limited HIT and

typically do not have sophisticated data exchange capabilities. The majority of data sharing by PAC and LTC providers is conducted by phone, fax, and paper records. Moreover, the existing health IT infrastructure in PAC and LTC settings primarily supports administrative and billing processes. There is little financial incentive for PAC and LTC providers to adopt health IT due to factors such as training costs for high-turnover staff and ongoing IT maintenance costs.[8] PAC and LTC funding streams, mostly Medicare and Medicaid, do not provide incentives for investment in new technology. PAC and LTC settings are not included in the Meaningful Use program, and it is unclear how these settings will be integrated into new payment models, such as ACO shared savings. Nonetheless, the Affordable Care Act provisions targeting PAC and LTC providers will increase the need for interoperable health IT to support collecting data for performance measurement.

With the intention of promoting standardized data sources and health IT adoption, MAP developed data platform principles (outlined in the Clinician Performance Measurement Coordination Strategy),[9] recommending processes to reduce quality measurement burden and facilitate HIT adoption and use. The following data considerations provide additional context for operationalizing the data platform principles in PAC and LTC settings.

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

A library of all data elements needed for all measures should be defined and maintained. Data elements should contain all information needed to calculate measures, including data elements that could support risk adjustment and stratification, which are imperative considerations for understanding and addressing disparities in health care. The CARE tool could potentially be used across all PAC and LTC settings, replacing current setting-specific tools. CARE could enable harmonized measurement by utilizing using a common set of uniform and standardized data elements aligned with NQF's Quality Data Model. Incorporating EHR-compatible standards would allow for rapid information exchange among settings. Additional field testing and evaluation are needed to demonstrate CARE's broad applicability across all settings. Ideally, CARE should provide the ability to generate care plans and link with clinical decision support tools.

Data collection should occur during the course of care, when possible, to minimize burden, reduce errors, and maximize the use of data in clinical decision making. Health IT also should be used for capturing patient goals and preferences and monitoring progress on the care plan.

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

Timely feedback of measurement results is imperative to support improvement, inform purchaser and consumer decision making, and monitor cost shifting. Policymakers and purchasers also can use timely

information from measurement results to decide whether to continue investing in a program or to make modifications and improvements.

Path Forward

Priority Measure Gaps

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

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

Aligning Performance Measurement

MAP identified additional issues that must be addressed to harmonize performance measures across settings and ensure the availability of data sources to support performance measurement. Uniform care planning tools, including uniform discharge plans, would enhance information sharing across settings and promote standardization of data elements needed for measurement. The MAP safety coordination strategy also calls for standardized discharge plan elements to support care transitions.[10] As measures are implemented for public reporting and performance-based payment, monitoring must be established for potential undesirable, unintended consequences of measurement and associated incentives. For example, an increased focus on preventing falls could inadvertently lead to declines in function if patient activity is restricted. To promote care coordination and safety across multiple settings, payment incentives need to be aligned so that each setting shares the responsibility for improving transitions. The impending financial penalty for hospital readmissions adds urgency to the need for hospitals and PAC/LTC providers to share accountability for safe transitions. Finally, using performance measures for public reporting and performance-based payment raises measurement methodological issues, such as adequate sample size for validity and reliability and risk adjustment for comparability.

Achieving alignment of performance measurement across PAC/LTC settings will require effort from federal and state governments, as well as the private sector. The guidance MAP offers through this report serves as a starting point for moving toward harmonized measures and data sources.

APPENDICES

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

[1] Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center. Uniform Patient Assessment for Post-Acute Care. Final Report. January, 2006. https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityPACFullReport.pdf
[2] Medicare.gov. Long-Term Care. http://www.medicare.gov/longtermcare/static/home.asp. Last accessed October 2011.
[3]. Park. S. , Partner. Post-Acute/Long-Term Care Planning for Accountable Care Organizations. Dixon Hughes Healthcare Consulting. 2011 Available at http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/Dixon_Hughes_Whitepaer.pdf
[4] Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center. Uniform Patient Assessment for Post-Acute Care. Final Report. January, 2006. https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityPACFullReport.pdf
[5] National Institute of Nursing Research. Chapter 12 Transitions in Long-Term Care. October 2006. Available at http://ninr.nih.gov/ninr/research/vo13/Transition.html
[6] National Quality Forum (NQF). Strategic Approach to Quality Measurement for Dual Eligible Beneficiaries. Interim report to HHS. Oct 2011.
[7] Centers for Medicare and Medicaid Services. New Quality Reporting programs for LTCHs, IRFs, and Hospices. https://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/ Accessed at October 2011.
[8] U.S. Department of Health and Human Services Assistant Secretary of Planning and Evaluation office of Disability, Aging and Long-Term Care policy. Health Information Exchange in Post-Acute and Long-Term Care Case Study Findings. September 2007
[9] National Quality Forum. Coordination Strategy for Clinician Performance Measurement. Final Report to HHS. Oct 2011.
[10] National Quality Forum. Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers. Final Report to HHS. Oct 2011.

NATIONAL QUALITY FORUM

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

Chair (voting)
Carol Raphael, MPA

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

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

Federal Government Members (non-voting, ex officio)	**Representatives**
Agency for Healthcare Research and Quality (AHRQ)	Judy Sangl, ScD
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Appendix B: Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		CAHPS Nursing Home Surveys are composed of three separate instruments: 1) an in-person structured interview for long-term residents, 2) a mail questionnaire for recently discharged short-stay residents, and 3) a mail questionnaire for residents' family members.[ff]	Forum (NQF) as a measure of nursing home quality in March 2011. The instrument for residents recently discharged from nursing homes after short stays, which should not exceed 100 days, is designed to be administered by mail. NQF endorsed this instrument in March 2011 on a provisional basis, pending final analyses of reporting composites. The above two resident questionnaires are similar in concept, except the discharged resident instrument also covers therapy services. Both instruments include			on performance, and improve quality of care.[jj]

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

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

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

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

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

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
				performance on 10 of the 19 QMs. These measures have been developed from MDS-based indicators and are currently posted on the Nursing Home Compare website. The QMs include seven long-stay and three short-stay measures.[nn] Star ratings are assigned for each of the three domains and are also combined to calculate an overall rating.[oo]		
Outcome and Assessment Information Set (OASIS) Applies to: Home Health Agencies (HHA)	• According to the 1999 Conditions of Participation (CoPs), Medicare-certified HHAs should collect and submit OASIS data related to all adult (18 years or older) non-maternity patients receiving skilled services with Medicare or Medicaid as a payer. • Based on the Deficit Reduction Act of 2005 (DRA), the annual payment update for	The OASIS is a group of data elements that: • Represent core items of a comprehensive assessment for an adult home care patient • Form the basis for measuring patient outcomes for purposes of outcome-based quality improvement	HHAs must use HAVEN, free software provided from CMS for OASIS data submission.[ss]	The OASIS includes six major domains: 1) sociodemographic, 2) environmental, 3) support system, 4) health status, and 5) functional status, and 6) selected attributes of health service utilization.[tt]	The annual payment update for HHAs that do not submit OASIS is lowered by two percentage points.[uu]	Since Fall 2003, CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website Home Health Compare.[vv]

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

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

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

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

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

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

Quality Initiative/setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism	Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		reporting the survey results on Home Health Compare in early 2012. The survey aims to meet the following three goals:[aaa] • Produce comparable data on the patient's perspective • Create incentives for agencies to improve their quality of care through public reporting • Enhance public accountability by publicly reporting the results				
Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)	Section 4421 of the Balanced Budget Act of 1997, as amended by section 125 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, and by	The IRF PPS will use information from IRF- PAI to categorize patients into distinct groups based on clinical characteristics and expected resource needs, which are used to calculate	To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to	IRF-PAI data items address patients' physical, cognitive, functional, and psychosocial status.[lll] Functional status includes self-care (eating, grooming, bathing, dressing, toileting, bladder, and bowel);	Each IRF must report the date that it transmitted the IRF-PAI instrument to the database on the claim that it submits to the fiscal	

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

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

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

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

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

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

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

Appendix D: Nursing Home Compare Measures

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

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

Appendix D: Nursing Home Compare Measures

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

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

Appendix D: Nursing Home Compare Measures

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

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

Appendix E: Home Health Compare Measures

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

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

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

Appendix F: MAP "Working" Measure Selection Criteria

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

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

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

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

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

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

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

4. Measure set promotes alignment with specific program attributes

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

Response option:

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

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

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

Response option:

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

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

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

Response option:

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

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

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

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

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

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

Response option:

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

8. Measure set promotes parsimony

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

Response option:

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

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions

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

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes

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

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

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

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

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
	• Communication	
Falls	• Falls with major injury • Falls with major injury per 1000 days	• Patient fall rate • Falls with injury • Falls and trauma
Pressure ulcers	• Stage III and IV pressure ulcers • Pressure ulcers that are new or have worsened*	• Pressure ulcer prevalence • Stage III and IV pressure ulcers • Pressure ulcers that are new or have worsened*
Adverse drug events	• Poly-pharmacy related injury • Medication errors	• Medication errors • Injuries secondary to Poly-pharmacy
Infection rates	• Surgical site infections • Multidrug resistant organism infection • Urinary catheter-associated urinary tract infections (CAUTI)*	• Central line bundle compliance • Surgical site infection rate • Ventilator bundle • Multidrug resistant organism infection • Ventilator-associated pneumonia • Urinary catheter-associated urinary tract infections (CAUTI)* • Central line catheter-associated bloodstream infection (CLABSI)*
Avoidable admissions	• Unplanned acute care hospitalizations • All-cause risk-standardized readmission	• Unplanned acute care hospitalizations
Inappropriate medication use		
Measures not mapped to a core set concept	• Incidence of venous thromboembolism (VTE), potentially preventable • VTE prophylaxis • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization	• Restraint prevalence (vest and limb only) • Practice environment scale-nursing work index • Voluntary turnover for RN, APN, LPN, UAP • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization • Mortality

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

Appendix H: Priority Measure Concept Alignment- PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions. Concepts are mapped to one NQS priority; however, concepts may address multiple NQS priorities.

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

Appendix H: Priority Measure Concept Alignment- PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions. Concepts are mapped to one NQS priority; however, concepts may address multiple NQS priorities.

National Priority: Make care safer.								
NQS Measure Concepts	• Hospital admissions for ambulatory-sensitive conditions • All-cause hospital readmission index • All-cause healthcare-associated conditions • Individual healthcare-associated conditions • Inappropriate medication use and polypharmacy • Inappropriate maternity care • Unnecessary imaging	MCC Measure Concepts	• Avoiding inappropriate, non-beneficial end-of-life care • Reduce harm from unnecessary services • Preventable admissions and readmissions • Inappropriate medications, proper medication protocol and adherence	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Falls • Pressure ulcers • Adverse drug events • Inappropriate medication use	MAP Dual Eligible Beneficiaries High-Leverage Opportunities		LTQA-Recommended Measures	• Percentage of patients age 65 years and older with a history of falls who had a plan of care for falls documented within 12 months • Percentage of Medicare members 65 years of age and older who received at least two different high-risk medications. • Percent of discharges from Jan 1 to Dec 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge
National Priority: Promote effective communication and care coordination.								
NQS Measure Concepts	• Experience of care transitions • Complete transition records • Chronic disease control • Care consistent with end-of-life wishes • Experience of bereaved family members • Care for vulnerable populations • Community health outcomes • Shared information and accountability for effective care coordination	MCC Measure Concepts	• Seamless transitions between multiple providers and sites of care • Access to usual source of care • Shared accountability that includes patients, families, and providers • Care plans in use • Advance care planning • Clear instructions/simplification of regimen • Integration between community and healthcare system • Health literacy	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Transition planning	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Care coordination	LTQA-Recommended Measures	• 3-Item Care Transition Measure (CTM-3) • Percentage of patients, regardless of age, discharged from an inpatient facility to home/any other site of care from whom a transition record was transmitted to the facility/primary physical/other health care professional for follow-up care within 24hours of discharge

Appendix H: Priority Measure Concept Alignment- PAC/LTC, Dual Eligible Beneficiaries, and Multiple Chronic Conditions. Concepts are mapped to one NQS priority; however, concepts may address multiple NQS priorities.

National Priority: Make quality care affordable for people, families, employers, and governments.							
NQS Measure Concepts	• Consumer affordability index • Consistent insurance coverage • Inability to obtain needed care • National/state/local per capita healthcare expenditures • Average annual percentage growth in healthcare expenditures • Menu of measures of unwanted variation of overuse, including: - Unwarranted diagnostic/medical/surgical procedures - Inappropriate/unwanted nonpalliative services at end of life - Cesarean section among low-risk women - Preventable emergency department visits and hospitalizations	MCC Measure Concepts	• Transparency of cost (total cost) • Reasonable patient out of pocket medical costs and premiums • Healthcare system costs as a result of inefficiently delivered services, e.g. ER visits, polypharmacy, hospital admissions • Efficiency of care	MAP Post-Acute Care/Long-Term Care Measure Concepts	• Infection rates • Avoidable admissions	MAP Dual Eligible Beneficiaries High-Leverage Opportunities	• Infection rates • Avoidable admissions	LTQA-Recommended Measures	• Percent of patients who need urgent, unplanned medical care • All-cause readmission