MEASURE APPLICATIONS PARTNERSHIP

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

FINAL REPORT

NATIONAL QUALITY FORUM

CONTENTS

EXECUTIVE SUMMARY

Patients who are cared for by post-acute care (PAC) and long-term care (LTC) providers often transition between multiple sites of care, moving among their homes, hospitals, and PAC and LTC providers when their health and functional status changes. Approximately one-third of Medicare beneficiaries discharged from hospitals enter into a PAC setting immediately after a hospital discharge. Further, the National Clearinghouse for Long-Term Care Information estimates that 21 million people required long-term care services in 2008. These patients are particularly vulnerable and costly to the system, given their clinical complexity and the frequency with which they transition between settings. Currently, performance measurement across PAC and LTC settings is fragmented due to the heterogeneity of patient populations and varying performance measurement obligations and reporting mechanisms across settings. A coordinated performance measurement strategy across PAC and LTC providers will promote safe, efficient, patient-centered care; the capacity to utilize health information technology (health IT) resources is imperative to achieve coordinated performance measurement.

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP is responsible for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting and performance-based payment programs, and for other purposes. The composition of MAP membership is noteworthy. Its diverse, public-private nature ensures future federal strategies, and rulemaking with respect to measure selection for federal programs, are informed upstream by varied, thoughtful organizations that are invested in using performance measurement information to improve health and healthcare. MAP will issue a series of reports as a result of its work.

This report outlines a performance measurement coordination strategy for a subset of PAC and LTC providers including: home health care, short- and

long-stay nursing facilities, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In response to the expansion of federal performance measurement programs for these settings, the timing is right to align measurement across settings, reduce data collection burden, and ultimately, facilitate patient-centered coordinated care.

This strategy aims to synchronize public and private measurement-driven initiatives through a focus on three key areas:

First, MAP defines priorities and core measure concepts for PAC and LTC performance measurement to promote common measurement goals across providers.

The six highest-leverage areas for measurement identified for PAC and LTC providers build on the priorities and goals of the National Quality Strategy (NQS). Within the priority areas for measurement, MAP identified a core set of 13 measure concepts:

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision-making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

Using a draft version of the MAP Measure Selection Criteria and the core measure concepts, the PAC/LTC Workgroup evaluated the current Centers for Medicare & Medicaid Services (CMS) Nursing Home and Home Health Compare program measure sets. The workgroup found that while some criteria were met (for example, most measures are NQF-endorsed®, and multiple NQS priorities are covered), there were also a number of unmet criteria and missing core concepts. These deficiencies speak to the need for new or better measures to generate more meaningful performance information.

Second, MAP highlights the need for uniform data sources and use of health IT so that data can be collected once, in the least burdensome way, and be used for multiple patient-centric purposes.

To improve care coordination for patients across providers, a common data collection and reporting platform is needed. PAC and LTC providers are ripe for deploying a rich health IT-enabled data collection and exchange approach, given their patients' clinical complexity; however, implementation challenges and limited funding streams for PAC and LTC providers to adopt health IT have precluded most providers from adopting sophisticated electronic data collection and exchange capabilities.

MAP has previously delineated data platform principles that would reduce quality measurement burden and facilitate health IT adoption and use.[1] MAP has elaborated on these principles for PAC and LTC providers:

- 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. Currently, performance measurement for PAC and LTC settings is built on data collection tools that are tailored to each setting and do not communicate across settings.
- A library of all data elements needed for all measures should be defined and maintained. The Continuity Assessment Record & Evaluation (CARE) tool[2] could potentially replace current setting-specific tools to enable harmonized data collection.
- Data collection should occur during the course of care, when possible, to minimize burden, reduce errors, and maximize the use of data in clinical decision-making.
- Systematic review of data and feedback loops should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications.
- Timely feedback of measurement results is imperative to support improvement, inform purchaser and consumer decision-making, and monitor cost shifting.

Third, MAP determines a pathway for improving the use of measures through filling priority measure gaps, developing standardized care planning tools, and monitoring for unintended consequences.

MAP has outlined a set of core measure concepts for PAC and LTC providers that identify important gaps in currently available measures. Additional measures that incorporate patient-reported data, assess mental as well as physical health, promote joint care planning and achievement of patient and caregiver goals, encourage smooth care transitions, and capture the cost of care are needed to meet emerging performance measurement needs. A coordinated approach among all stakeholders for filling these gaps will be necessary to ensure that the right measures are available to monitor progress in realizing the goals of the NQS.

MAP, as a public-private sector partnership, hopes to bring unique, multistakeholder perspective and guidance through this report for moving toward greater coordination of measurement and data collection. But achievement of more synchronistic performance measurement for PAC and LTC settings will need to extend well beyond MAP, and into the depths of federal and state government leadership, as well as the private sector.

Tackling this area of healthcare is critical and timely. While PAC and LTC providers care for a wide range of patients, they are a major source of care for the aging. As a generation of (Baby-Boomers) nearly 75 million strong approaches retirement, it is essential that we take a closer look at our current system of care and its capabilities to better prepare for the increased needs to come. Better and smarter measurement will not only help increase efficiency in resource use, but also help build a more coordinated system of care that places the needs of patients and their caregivers first.

MAP BACKGROUND

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[3]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS) three-part aim of creating better, more affordable care and healthier people.[4] Anticipated outcomes from MAP's work include:

- a more cohesive system of care delivery;
- better and more information for consumer decision-making;
- heightened accountability for clinicians and providers;
- higher value for spending by aligning payment with performance;
- reduced data collection and reporting burden through harmonizing measurement activities across public and private sectors; and
- improvement in the consistent provision of evidence-based care.

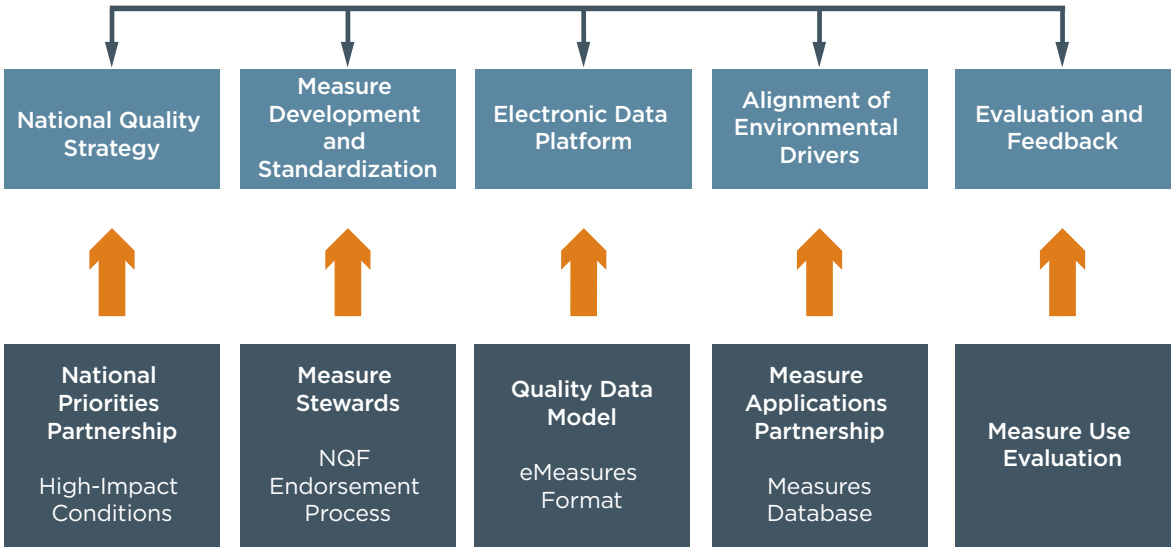
Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency; aligning payment with value; rewarding providers and professionals for using health information technology (health IT) to improve patient care; and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust "quality measurement enterprise" (Figure 1) that includes:

- setting priorities and goals for improvement;
- standardizing performance measures;
- constructing a common data platform that supports measurement and improvement;
- applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- promoting performance improvement in all healthcare settings.

Figure 1. Functions of the Quality Measurement Enterprise



The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress.[5] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[6] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Standardized measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision-support to providers for performance improvement.

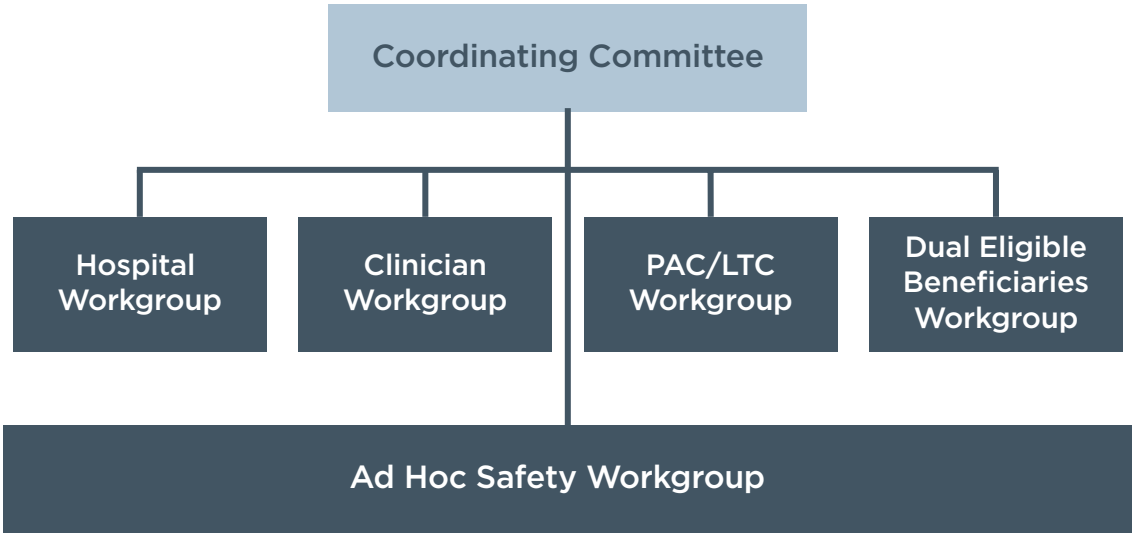
Alignment around environmental drivers, such as public reporting and performance-payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[7] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient

Figure 2. MAP Structure



populations (Figure 2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process included open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision-making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework,[8] the HHS Partnership for Patients safety initiative,[9] the HHS Prevention and Health Promotion Strategy,[10] the HHS Disparities Strategy,[11] and the HHS Multiple Chronic Conditions framework.[12]

One of MAP's early activities has been the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely they align with the NQS's priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and performance-based payment programs (Appendix A: MAP—Schedule of Deliverables). Each of the coordination strategies addresses:

- measures and measurement issues, including measure gaps;
- data sources and health IT implications, including the need for a common data platform;
- alignment across settings and across public- and private-sector programs;
- special considerations for dual eligible beneficiaries; and
- path forward for improving measure applications.

On October 1, 2011, MAP issued three coordination strategy reports. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[13] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[14] An interim report on performance measurement for dual eligible beneficiaries offers a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which will inform the next phase of work to identify specific measures most relevant to improving the quality of care for dual eligible beneficiaries.[15] A final report on performance measurement for dual eligible beneficiaries will be released on June 1, 2012.

This coordination strategy for performance measurement in post-acute and long-term care settings focuses on alignment across settings by delineating a core set of measure concepts for PAC and LTC providers and their patients. Additional coordination strategies for hospice care and cancer care will be released in June 2012.

Through a separate annual task, MAP will provide pre-rulemaking input to HHS on the selection of measures for public reporting and performance-based payment programs in February of each year, beginning with 2012, based on a list of measures under consideration provided by HHS in December of each year, beginning with 2011.

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

MAP has been charged with developing a coordination strategy for PAC and LTC performance measurement. Post-acute care refers to healthcare 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.[16] 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.[17] 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. ACA provisions will directly impact PAC and LTC providers by mandating quality reporting for LTCHs, IRFs, and hospice programs and establishing the Center for Medicare and Medicaid Innovation that will implement new care delivery programs, such as a national pilot program for acute care and PAC bundled payment. 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.[18]

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 B for the workgroup roster, Appendix C 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 D), 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 include 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 workgroup 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 E 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 PAC settings, while maintaining function is more likely for LTC settings. Using the MAP measure selection criteria, the workgroup 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 influenced 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.[19] 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.[20] 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 has begun to identify core measures for the clinician office, hospital, and PAC and LTC settings that support the 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. Each year, MAP will evaluate 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.

PUBLIC COMMENTS

Comments received reiterated the importance and challenges inherent in aligning performance measurement across PAC and LTC providers. Commenters noted two key factors that pose alignment challenges: the heterogeneity of patient needs (i.e., acuity level, goals of care vary across settings) and the lack of a uniform data collection tool (data issues are discussed further below). Many commenters highlighted the need to construe PAC/LTC more broadly, noting the importance of applying performance measurement to community-based services, assisted living facilities, and hospice and palliative care. A broader definition for PAC/LTC is consistent with MAP's overarching goal of measurement across the entire care continuum, but beyond the scope of this report. Of note, MAP will be developing a coordination strategy for hospice measurement in 2012.

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 in Table 1.

Function should be assessed over time to capture patient-centered outcomes. Many performance measures are specific to the healthcare provider setting and focus on a single disease or condition. Few measures capture patient factors such as activities of daily living, quality of life, symptoms, pain, stage of illness, and cognitive status. 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 may have limited function due to heavy disease burden, frailty, cognitive impairments, or behavioral health issues.

Table 1. PAC-LTC Measurement Priorities

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		•			•	
Goal Attainment		•		•		
Patient and Family Engagement		•	•		•	
Care Coordination	•	•	•			•
Safety	•					•
Cost/Access	•	•	•			•

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.[21]

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 emergency department 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.

PUBLIC COMMENTS

Comments received generally agreed with these priority areas for measurement. Several commenters suggested clarifying and expanding the definition of the priorities to reflect specific nuances of measurement; for example, commenters highlighted that some measurement areas may require risk adjustment while other commenters noted how functional assessment might vary across settings. MAP will rely on the NQF endorsement process to address measurement methodology issues. The priority areas for measurement are intended to signal high-leverage opportunities to measure developers and end-users. In MAP's pre-rulemaking input on measure sets and individual measures for use in federal programs, MAP will identify available measures that are ready for application across public and private programs.

Core Set of Measure Concepts

MAP developed a set of 13 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. Table 2 depicts the core measure concepts, mapped to the PAC and LTC measurement priorities and the NQS priorities.

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.

PUBLIC COMMENTS

Generally, commenters supported the MAP PAC/LTC core set of measure concepts; however, commenters raised caution before completely embracing all of the concepts, recommending that the concepts be further defined. MAP identified core measure concepts as a first step in seeking alignment across PAC and LTC providers. Future MAP work will identify specific available measures that address the core concepts, balancing alignment across PAC and LTC settings with customization needed to address unique patient needs for each type of provider. Examples of currently available measures that address the core concepts are provided in Table 3.

Table 2. PAC-LTC Core Measure Concepts

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 include follow-up, which reflects the results of the assessment.		•		•	•	
Mental health assessment		•			•	
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.		•	•			
Advanced care planning and treatment in accordance with patient preferences.		•	•			•
PATIENT ENGAGEMENT						
Experience of care		•				
Shared decision-making in developing care plans.		•	•			

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
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.	•	•	•			•
SAFETY						
Falls, including falls with injury and falls prevention.	•				•	•
Pressure ulcers	•					•
Adverse drug events	•		•			•
COST/ACCESS						
Inappropriate medication use	•					•
Infection rates, including healthcare-associated infections (HAIs), such as ventilator-associated pneumonia.	•					•
Avoidable admissions, including ED admissions, hospital admissions, and hospital readmissions.	•		•			•

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 many, but not all, of the measure concepts that are important to both PAC and LTC settings. The Nursing Home Compare measures are generated from the data collected through the federally required assessment, the MDS. The Home Health Compare measures are generated from the data collected through the federally required assessment, the OASIS data set (see Appendices G and H 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 NQS 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 (e.g., outcome, process, structure, experience of care, cost);
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 evaluation of the measure set is described below.

1. All of the measures in the Nursing Home Compare set are NQF endorsed.
2. The Nursing Home Compare measure set adequately addresses two of the NQS priorities: safety and supporting better health in communities. However, the set does not address the other NQS priorities: care coordination, prevention and treatment of leading causes of mortality and morbidity, person- and family-centered care, 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 contains an appropriate mix of process and outcome measures. Experience of care and cost 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 several specified points in time during the patient's stay in the facility. The measure set enables measurement across the patient-focused episode of care over time when 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, the 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's evaluation of the Home Health Compare measure set is below.

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 all the NQS priorities; though every priority may not be adequately addressed.
3. The measure set addresses high-impact conditions for post-acute care and has a restorative focus; however, including measures that address cognitive, mental, and behavioral health could strengthen the measure set. 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 partially addresses the intended care settings and institutional providers. However, the workgroup 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 several specified points in time, so the measure set enables measurement across the patient-focused episode of care over time when 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.

Table 3 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.

Measures for Long-Term Care Hospitals and Inpatient Rehabilitation Facilities

The PAC/LTC Workgroup did not evaluate measure sets for IRFs and LTCHs. Although many IRFs and LTCHs voluntarily collect data for internal quality improvement, they currently are not required to report performance measurement information to CMS but will be required to do so in fiscal year 2014.[22] Proposed measures for LTCHs and IRFs are mapped to the core measure concepts (see Appendix I) 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 Health IT 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 health IT 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

Table 3. Alignment of Nursing Home Compare Measures and Home Health Compare Measures with the Core Measure Concepts

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
Functional and cognitive status assessment	• The percentage of residents on a scheduled pain medication regimen on admission who self-report a decrease in pain intensity or frequency (short-stay) • 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 low risk residents who lose control of their bowel or bladder (long-stay) • Percent of residents whose need for help with activities of daily living has increased (long-stay) • Percent of residents who lose too much weight (long-stay)	• Improvement in ambulation/ locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Pain assessment conducted • Pain interventions implemented during short term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/ caregiver education implemented during short term episodes of care
Mental health assessment	• Percent of residents who have depressive symptoms (long-stay)	• Depression assessment conducted
Establishment and attainment of patient/ family/caregiver goals		
Advanced care planning and treatment		
Experience of care		• Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Shared decision-making		
Transition planning		• Timely initiation of care
Falls	• Percent of residents experiencing one or more falls with major injury (long stay)	• 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)	• Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications
Inappropriate medication use		
Infection rates	• Percent of residents who have/had a catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)	

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures
Avoidable admissions		• Acute care hospitalization • Emergency department 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) • Nurse staffing hours—4 parts • Percent of residents who were physically restrained (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

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.[23] 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, implemented under the American Recovery and Reinvestment Act (ARRA), and it is unclear how these settings will be integrated into new payment models, such as ACO shared savings. Nonetheless, the ACA 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**),[24] recommending processes to reduce quality measurement burden and facilitate health IT 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 CMS developed (CARE) tool is a

standards-based data set that could potentially be used to standardize data collection and quality measurement across all PAC and LTC settings, replacing current setting-specific tools. CARE could enable harmonized measurement by utilizing a common set of uniform and standardized data elements aligned with NQF's Quality Data Model. Incorporating Electronic Health Record (EHR)-compatible standards would allow for rapid electronic 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.

PUBLIC COMMENTS

Commenters agreed with the considerations above for operationalizing the MAP data platform principles for PAC and LTC providers. Commenters echoed the challenges PAC and LTC providers face in implementing health IT, specifically noting reimbursement structures and exclusion from the Meaningful Use program. Commenters stressed the need to adopt tools that can improve care coordination; however, they cautioned that changes to the existing tools used in PAC and LTC settings may increase staff burden. Accordingly, commenters agreed that CARE could be a common assessment and data collection tool, but more testing and evaluation is needed before it could be widely adopted. CMS has indicated that work is currently under way to improve the CARE tool, by applying interoperability standards, aligning with NQF's Quality Data Model, and demonstrating applicability across multiple settings. Finally, commenters noted the recent efforts by the Office of the National Coordinator (ONC) for Healthcare Information Technology (HIT) to engage PAC and LTC providers with a focus on care transitions and suggested that MAP continue to engage with ONC.

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 IRFs and LTCHs introduce a unique opportunity to select measures targeted to each of the core measure concepts and aligned across provider types.

Across all PAC and LTC providers there is a need for a coordinated approach to filling measure gaps. Application of existing quality measures, adaptation of measures that are in use for one provider but have not yet been tested and endorsed for others, and de novo measure development should all 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 point to measurement gaps that call for additional evidence to support measure development or innovative approaches to measurement, such as measures that incorporate patient-reported information.

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.[25] 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 collection methods.

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APPENDIX A:

Measure Applications Partnership - Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision-making and proposed measures for specific programs	Draft Report: January 2012 Final Report: February 1, 2012
15.2a: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	Draft Report: September 2011 Final Report: October 1, 2011
15.2b: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
15.2c: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.2d: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011

APPENDIX B:

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 Nurses Association of America	Margaret Terry, PhD, RN

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 Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

APPENDIX C:

Roster for the MAP Coordinating Committee

CHAIR (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPPs

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
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 D:

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]

Quality Initiative/Setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism
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 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]
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]

Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
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]	
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 review the data that is to be made public before its release.[z]
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]

Quality Initiative/Setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism
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 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]	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 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 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]

Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
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 on performance, and improve quality of care.[jj]

Quality Initiative/Setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism
Nursing Home Compare Applies to: Nursing Home, Skilled Nursing Facility	The Five-Star Quality Rating System used in Nursing Home Compare is based on the Omnibus Reconciliation Act of 1987 (OBRA '87), a nursing home reform law, and other quality improvement campaigns, such as the Advancing Excellence in America's Nursing Homes, a coalition of consumers, healthcare providers, and nursing home professionals.[kk]	CMS has developed the 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]	The data for the 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]
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 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]	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 (OBQI).[qq] OASIS data are used for the following purposes: • 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)	HHAs must use HAVEN, free software provided from CMS for OASIS data submission.[ss]
Home Health Compare Applies to: Home Health Care		CMS created the Home Health Compare website, which provides information about the quality of care provided by "Medicare-certified" home health agencies throughout the country.[ww]	

Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
The Nursing Home Compare performance domains include the following: Health Inspections—facility ratings for this domain are based on the number, scope, and severity of deficiencies discovered during the three most recent annual surveys in conjunction with major findings from the most recent 36 months of complaint investigations. 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 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]		Nursing Home Compare website provides consumers, their families, and caregivers with information on the quality of care each individual nursing home offers.
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]
Domains of the quality measurement include: managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.[xx]		Home Health Compare includes a subset of OASIS-based quality measures that are publicly reported.[yy]

Quality Initiative/Setting	Statute/Regulation	Description of the Program	Data Reporting/Data Submission Mechanism
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 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	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]
Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Applies to: IRFs	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 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]	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 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 designed for adult rehabilitation patients and is used with a computerized analysis and reporting system.[iii]	To administer the prospective payment system, CMS requires IRFs to electronically transmit a patient assessment instrument for each IRF stay to CMS's National Assessment Collection Database (the Database), which the Iowa Foundation for Medical Care (the Foundation) maintains. 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]

Assessment Domain	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
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]
IRF-PAI data items address patients' physical, cognitive, functional, and psychosocial status.[iii] Functional status includes self-care (eating, grooming, bathing, dressing, toileting, bladder, and bowel); transfers; locomotion; and communication. Quality indicators include pressure ulcers measures.[mmm]	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 intermediary. If the instrument were transmitted more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate for the applicable case-mix group should be reduced by 25 percent.[nnn]	

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APPENDIX E:

Priority Measure Concept Alignment-MAP Post-Acute Care/ Long-Term Care, MAP Dual Eligible Beneficiaries, NQF-endorsed Multiple Chronic Conditions Measurement Framework, and Long-Term Care Quality Alliance

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. • Mental health	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
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
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

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

APPENDIX F:

MAP "Working" Measure Selection Criteria.

The finalized MAP Measure Selection Criteria can be located on the **NQF website.**

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)

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 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])

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.

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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:

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
0190 Endorsed	Nurse Staffing Hours-4 parts	Percentage of daily work in hours by the entire group of nurses or nursing assistants spent tending to residents
0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.
0675 Endorsed	The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-Stay)	This measure is based on data from the MDS 3.0 assessment of short-stay nursing facility residents and reports the percentage of those short-stay residents who can self-report and who are on a scheduled pain medication regimen at admission (5-day PPS MDS assessment) and who report lower levels of pain on their discharge MDS 3.0 assessment or their 14-day PPS MDS assessment (whichever comes first) when compared with the 5-day PPS MDS assessment.
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).

NQF Measure # and Status	Measure Name	Description
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.

NQF Measure # and Status	Measure Name	Description
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.
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.

NQF Measure # and Status	Measure Name	Description
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.

NQF Measure # and Status	Measure Name	Description
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.
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.

NQF Measure # and Status	Measure Name	Description
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.

APPENDIX H:

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.
0517 Endorsed	Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS)	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.
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.

NQF Measure # and Status	Measure Name	Description
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.
0539 Endorsed	Pressure Ulcer Prevention Plans Implemented	Percentage of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).
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.
Not NQF Endorsed	Emergency Department Use without Hospitalization	Percentage of home health episodes of care during which the patient needed urgent, unplanned medical care from a hospital emergency department, without admission to hospital.
0519 Endorsed	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.
0520 Endorsed	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.
0521 Endorsed	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.
521 Endorsed	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	

NQF Measure # and Status	Measure Name	Description
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 I:

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

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

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

Core Measure Concepts	IRF Quality Reporting Program	LTCH Quality Reporting Program
Infection rates	• Surgical site infections • Multidrug resistant organism infection • Urinary catheter-associated urinary tract infections (CAUTI)*	• Central line bundle compliance • Surgical site infection rate • Ventilator bundle • Multidrug resistant organism infection • Ventilator-associated pneumonia • Urinary catheter-associated urinary tract infections (CAUTI)* • Central line catheter-associated bloodstream infection (CLABSI)*
Avoidable admissions	• Unplanned acute care hospitalizations • All-cause risk-standardized readmission	• Unplanned acute care hospitalizations
Inappropriate medication use		
Measures not mapped to a core set concept	• Incidence of venous thromboembolism (VTE), potentially preventable • VTE prophylaxis • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization	• Restraint prevalence (vest and limb only) • Practice environment scale-nursing work index • Voluntary turnover for RN, APN, LPN, UAP • Patient immunization for influenza • Patient immunization for pneumonia • Staff immunization • Mortality • Blood incompatibility • Foreign object retained after surgery • Manifestation of poor glycemic control • Air embolism • Venous thromboembolism • Injuries related restraint use • Skill Mix (Registered Nurses [RN], Licensed Vocational/Practical Nurse [LPN/LVN], unlicensed assistive personal [UAP], and contract)

APPENDIX J:
Public Comments

Commenter Organization	Commenter Name	Comment Category	Comment
	Sue Kandler	Alignment	Alignment would only be feasible if the funding resources could agree on what information is required for payment. Many people carry multiple coverages because one agency won't pay for something that hopefully is picked up by some other coverage. Somewhere, information that is required for payment needs to be equal, no matter how the information is acquired (MDS, OASIS,etc.)
	Sue Kandler	General	After reviewing draft, the assessment tools in place all lead to some type of payment source. MDS may be the only one submitted to 2 sources, but the funds are needed to provide quality care to the recipients. All tools have the same goals but use different ways to survive regulations to supply funding. A review of each tool should be required to see what system best fits the needs of the agency using it. Which tool provides more funding? Are these tools reviewed on basis that sees improvements or backslides due to illnesses? Also,the professionals that use these tools are not actively involved in the changes that are being considered. This is a very critical project and requires more time to investigate the benefits of what is being proposed.
Academy of Managed Care Pharmacy	Edith Rosato	General	There is substantial constructive guidance in the Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care report. The report indicates that the longstanding performance measurement programs for nursing homes and home health agencies lack measures that assess care longitudinally and across settings, such as transition planning. The report also indicates that there is a need for a coordinated approach to filling measure gaps. It is unclear how the National Quality Forum, the Measure Application Partnership and the Department of Health and Human Services intend to address these gaps.
Academy of Managed Care Pharmacy	Edith Rosato	Priority Areas for Measurement	AMCP congratulates the MAP on the significant work accomplished on the Performance Measurement Coordination Strategy for PAC and LTC. The report identifies priority areas for measurement in the PAC and LTC settings: function, goal attainment, patient and family engagement, care coordination, safety and cost access. Adverse drug events are mentioned as one area of focus for in the area of safety. AMCP recommends that the MAP draw additional attention to the issue of adverse drug events and medication errors during transitions of care. Medication errors harm an estimated 1.5 million people each year in the United States, costing the nation at least $3.5 billion annually. An estimated 60 percent of medication errors occur during times of transition: upon admission, transfer, or discharge of a patient. Medication errors result in readmissions to the hospital, greater use of emergency, post-acute, and ambulatory services, and duplication of services that needlessly increase the cost of care. Such errors can involve underuse, overuse, or misuseof medication. In other words, an important therapy can be missed or a prescribed therapy can contribute directly to patient harm. Contributing factors may include patient misunderstanding of instructions, drug-drug interactions, drug-food interactions, and duplicative therapy. AMCP strongly encourages the MAP to include additional information on adverse drug events in the final draft of the report.

Commenter Organization	Commenter Name	Comment Category	Comment
American Academy of Family Physicians	Janet Leiker on behalf of the Commission on Quality and Practice	General	With 6 NQS priority categories used to evaluate six priority areas for measurement, and then further broken down into 12 core concepts, the format is not very user-friendly.
American Academy of Family Physicians	Janet Leiker on behalf of the Commission on Quality and Practice	Priority Areas for Measurement	The AAFP has concerns with two important issues that the committee decided not to include in the core measurement concepts: 1. unnecessary services and appropriate level of care and 2. mental health assessment. Adequate performance measurement for PAC and LTC should address both of these topics.
American Geriatrics Society	Susan Sherman	Core Set of Measure Concepts	Generally, AGS is supportive of the measure concepts outlined in the draft report. While implementation of these standards will likely improve the quality of care provided, facility size and other factors may make meeting these standards difficult for some well-meaning facilities. Additionally, we support those concepts that were considered important, but not adopted as core, outlined in the draft report.
American Geriatrics Society	Susan Sherman	General	The American Geriatrics Society believes this document is a reasonable first step. It is an increased regulatory burden on a number of entities that many of our members work in or with- such as the skilled nursing facility or rehabilitation home. Despite this, we believe it is driving better quality and new ways of looking at costs. An important recommendation however, is that the document more clearly outline a definition of 'case mix' when comparing different entities on costs and outcomes. That will be an essential step in comparing entities that provide care.
American Geriatrics Society	Susan Sherman	General	The American Geriatrics Society supports the work of the MAP and believes this document serves as a positive first step. We see this as an opportunity to drive better quality and new ways of looking at costs (patient-focused episodes of care across settings or home health episodes ending in admissions). An important recommendation however, is that the document more clearly outline a definition of 'case mix' when comparing different entities on costs and outcomes. That will be an essential step in comparing entities that provide care. Additionally, we offer some additional recommendations that we feel would further enhance this effort.
American Geriatrics Society	Susan Sherman	Path Forward	We have outlined below, several points that we urge the work group to consider as it works on its final report. 1. It will be important to clarify exclusion criteria for many of these proposed elements, especially when taking into consideration the rising frail, multi-morbid population in long term care facilities. 2. We encourage the work group to continue to hone in on those points that are palliative in overall focus but not specifically in hospice, or those with very advanced illness. 3. An important issue to contemplate is regarding measures that rely on self-reporting. The large dementia burden of this population, which may not be diagnosed, should be taken into account.

Commenter Organization	Commenter Name	Comment Category	Comment
American Geriatrics Society	Susan Sherman	Priority Areas for Measurement	AGS believes that the report should incorporate a measure which addresses provider or clinician engagement, to serve the high risk population that geriatrics health professionals work with. We recommend a measure which supports clinicians to be present at a facility as opposed to telephonic care. Strong collaboration with clinicians will help to eliminate avoidable events such as hospitalization. Additionally, goals of care and shared decisions regarding next steps of care and determining points of contact and family satisfaction must involve the clinicians in a strongly engaged way. This should apply to both home care and institutional long-term care.
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	Alignment	The American Medical Rehabilitation Providers Association appreciates that harmonization of measures among post-acute care (PAC) and long-term care (LTC) settings has the potential to improve care coordination activities between these settings which could result in improved patient outcomes. However, because the various settings provide different levels and types of care and collect patient data through different data collection tools, complete harmonization may be difficult to achieve. For instance, skilled nursing facilities collect data through the Minimum Data Set, home health providers collect data through the Outcome and Assessment Information Set, and inpatient rehabilitation hospitals and units (IRH/Us) collect data through the inpatient rehabilitation facility patient assessment instrument. While there are commonalities among these tools there are also differences reflective of the different levels and types of care these providers deliver. Also, as noted in the draft report, there is a great deal of heterogeneity among patients treated in the various PAC and LTC settings. For example, IRH/U patients require a minimum of three hours of rehabilitation services a day at least five days a week. A similar requirement does not exist in other PAC settings. This requirement demonstrates the complexity and heightened care needs of IRH/U patients. Therefore, to assume that harmonized measures would be applicable across these settings in all instances would be inaccurate.
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	Core Set of Measure Concepts	The American Medical Rehabilitation Providers Association is generally supportive of the draft core set of measures; but we have concerns regarding function, patient goals, and readmissions. Our Quality Committee notes the importance for risk-adjustment of readmissions measures for both payment and outcomes purposes. Such adjustment is necessary to assure that measures reflect the true picture of the provider reporting data on a measure. Additionally, the measure's description needs to assure that there are no disincentives to access. Using risk-adjustment will help explain differences between levels of care so that the outcome rates can be compared. If measures are not so adjusted, there is no reasonable, fair, or accurate way to compare data among measures or providers. The functional measures category should be further developed to ensure functional status can be measured adequately. Function addresses critical concepts including restoration, maintenance, and prevention of deterioration. Function should include motor (mobility and self-care) and cognitive elements. The final report should reflect that while important to capture, measures of cognitive function are elusive as measures to date are not sensitive to the degree of cognitive impairment and improvement. Finally, measuring goal attainment is difficult to do and easy to manipulate. We believe that rather than a provider quality improvement measure, goal attainment should be a measure of patient satisfaction.

Commenter Organization	Commenter Name	Comment Category	Comment
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	Data Source and HIT Considerations	The American Medical Rehabilitation Providers Association appreciates the draft report's recognition of data collection issues specific to post-acute care (PAC) and long-term care (LTC) providers with regard to a uniform data collection tool and information technology (IT). The draft report discusses the data collection tools in use in PAC settings and development of a common tool, the Continuity Assessment Record and Evaluation (CARE) tool. The report notes that the CARE tool could be a common assessment tool but that additional testing and evaluation is needed. We agree with this observation. We also have our concerns about the administrative burden of this tool. The report also mentions improvements in care coordination that could be achieved by the use of IT by PAC/LTC providers. It is correct that adoption by these providers is limited by the cost to train staff and the ongoing maintenance required. We appreciate the report's acknowledgment that PAC/LTC providers are further hampered by their exclusion from the Medicare/Medicaid incentives grants to select providers that use electronic health records and meet the criteria for meaningful use. Finally, the report highlights the importance of data collection and IT adoption as a way to provide quality improvement feedback to providers and the public reporting of this data. We believe timely feedback is crucial to ensure that providers have an opportunity to correct inaccuracies before publicly reporting.
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	General	Due to varied treatment goals and the medical and functional complexities of PAC and LTC patients it is unlikely that a core set of measures for all such settings would enable an end user of the data to be able to discern a quality outcome without regard to setting. Care is required in measured development as well as education to enable users of quality data to understand that variances in outcomes are a result of the patient population admitted not the quality of care delivered. For example both PAC and LTC settings treat patients who have experienced a stroke. However these patients may be vastly different and hence an average change in function for a stroke patient would be expected to be lower than an average change in function in an IHR/U. The results are different because the LTR stroke patient would likely be more medically complex and not be able to tolerate intensive therapy leading to a similar level of functional improvement. This outcome does not necessarily reflect a lower quality of care at the LTC but rather the nature of the population served. An IRH/U to LTC comparison in this case would not be appropriate. While functional change is considered a strong indicator of quality in the IRH/U it is not likely a strong quality indicator in the LTC setting.
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	Path Forward	The American Medical Rehabilitation Providers Association (AMRPA) agrees with the gaps identified in the draft report including the need to prevent undesirable, unintended consequences. We also support the report's focus on the need to improve transitions of care. However, as mentioned in comments we submitted on the "Alignment" section of the report, AMRPA continues to have concerns about the ability to achieve complete alignment or harmonization of measures based on the differences in the level and type of care needed by patients in different post-acute care (PAC) and long-term care (LTC) settings.
American Medical Rehabilitation Providers Association	Bruce Gans, M.D.	Priority Areas for Measurement	Priority areas established in the report include function, goal attainment, patient engagement, care coordination, safety, and access. The American Medical Rehabilitation Providers Association (AMRPA) is supportive of these priority areas for measurement as we believe they have the ability to improve patient care.

Commenter Organization	Commenter Name	Comment Category	Comment
American Nurses Association	Maureen Dailey	Alignment	The American Nurses Association (ANA) applauds the comprehensive and insightful PAC/LTC report. The ANA supports a patient-centered performance measurement approach. The ANA also recommends harmonization of measures with current Office of the National Coordinator (ONC) Healthcare Information Technology (HIT) measure/standards work. The strategic planning for implementation of new proposed quality measures for PAC/LTC should be coordinated with concurrent realalted ONC work. Specifically, the Standards and Interoperability Framework workgroups (e.g., PAC/LTC and Transitions of Care [TOC]) are developing concepts of standardized data elements (e.g., care plans) to be captured with standardized tools and shared across the care continuum. Improved interprofessional collaboration and integration of lateral measure work will better promote performance improvement through cascading measures, harmonized measures or families of measures for application at each level of the system and across interprofessional teams. The predicted shortage of healthcare professionals and ancillary workers and the growth in chronically ill and frail elderly populations in PAC/LTC heightens the need for high performing, accountable, interprofessional teams in PAC/LTC. These teams will best be evaluated by meaningful, important, integrated quality measures for public reporting and pay for quality programs.
American Nurses Association	Maureen Dailey	Core Set of Measure Concepts	The ANA supports key nursing structural measures that support patient safety (i.e., nurse staffing, skill mix, and turnover, however, does not support minimal staffing ratios. The ANA supports a dynamic process of principled-centered nurse staffing, considering nurse, setting, and population attributes (ANA, 2010). Acute care nurse structural measures were submitted to the NQF Nursing Home Project. Although these measures have been associated with patient safety in acute care, they were not approved for time-limited endorsement to allow for testing in this population. Valid nurse structural measures are needed across PAC/LTC settings to inform the public and ensure safety. Turnover and low staffing in nursing homes is related to poor nursing home outcomes. Turnover rates for RNs in multiple PAC/LTC settings remains high: 1) 22.9 % in home healthcare is (Dailey, 2010) and 56.1% in nursing homes (Donoghue, 2010). Turnover is related to a lack of experienced nurses, discontinuity in care coordinators, higher cost, and poor quality outcomes. The ANA's staffing principles also identifies the need to assess the proportion of RNs working on a casualized basis (e.g., fee for service or contract staff) and the impact on quality and total cost outcomes.
American Nurses Association	Maureen Dailey	Data Source and HIT Considerations	The use of electronic health record (EHR) systems in PAC/LTC is basic and essential to enabling the providers in PAC/LTC to use these data standards. Specifically, the EHR use will enable the automatic generation of the quality measure proposed as a by-product of clinical care delivery (i.e., captured within the context of care). Without this infrastructure in place, the burden of collecting data needed for quality reports will fall on nurses and other interprofessional team members. The burden can undermine the feasibility and make the undertaking too expensive for PAC/LTC care providers to support. The ANA and the Alliance for Nursing Informatics (ANI) has identified nurses who are knowledgeable about clinical workflows and HIT standards, who have joined the ONC's PAC/LTC and Transitions of Care Workgroups to support this work.
American Nurses Association	Maureen Dailey	General	The ANA cautions the Workgroup against characterizing all the home healthcare Outcome and Assessment Information Set (OASIS) and the nursing home MDS, the CMS minimum data set measures for these settings, as "generated from data collected at a single point in time" (pg 9 Summary). For example, the functional quality indicators generated from the OASIS date are the delta between measurement at admission compared to measurement at discharge or reassessment.

Commenter Organization	Commenter Name	Comment Category	Comment
American Nurses Association	Maureen Dailey	Path Forward	The report diplomatically calls attention to the need to update the content and focus of the minimum data sets in PAC/LTC to broaden the measures. For example, the current focus perpetuated by the home healthcare quality measures based on the OASIS-C data collection reflects a home healthcare industry that worked in isolation from other health care providers and lacked a patient participant focus (i.e., patient/caregiver engagement such as caregiver-centered care planning and successful self-care activation and management). The reality of today's PAC/LTC market is that the care coordination required for care transitions, bundled care, and accountable care organizations means that the PAC/LTC providers must work in partnership with healthcare provider organizations in other settings in their community. Capturing and reporting of quality measures required to meet evolving continuum of care regulations/standards and care models becomes a mutual deliverable owned by each provider, across settings in the partnership. Moreover, the current priority areas quality metrics are not solely indicators generated by the current PAC/LTC minimum data sets, but rather broadens the current clinical quality focus, such as safety-focused measures (e.g., healthcare acquired conditions); that are coupled with other key indicator areas (e.g., care coordination, patient engagement, and structural supports).
American Nurses Association	Maureen Dailey	Priority Areas for Measurement	The ANA supports the six areas identified by the PAC/LTC Workgroup. Key areas for patient engagement should include measures of patient/caregiver-centered care planning and patient self-care management (i.e., activation through maintenance). Cross cutting composite care coordination measures are needed for high volume/high cost conditions that assess performance across care settings and interprofessional teams (i.e., shared accountability), within episodes of care. Patient patient/caregiver satisfaction with care should be measures for each discipline as well as for the team. Dynamic transitional care measures, with two-way communication, will better evaluate the quality of transitional care from acute care to the PAC/LTC settings as well as upon discharge home are important. The ANA support the National Transition of Care Coalition's criteria for comprehensive transitional care measures. When readmissions or emergency room use occur from PAC/LTC settings, evaluation of the quality of care transitions should also be occur (e.g., advanced directives and patient-centered care plans).
American Occupational Therapy Association	Charles Willmarth	Core Set of Measure Concepts	Overall, AOTA is supportive of the 12 core measurement concepts, though we find that a few items could use further development. Specifically, the core measure for "Function" focuses on assessment. It seems that in looking at outcomes, it would also be important to have measures that focus on intervention and treatment standards to address identified care issues. Interventions that improve function can decrease safety risk and the injuries that can result in death or increased morbidity. Consider for instance, again a frail elderly person who after a fall, dies from secondary complications or infection, or one who suffers a traumatic brain injury as the result of a fall. In regard to the NQS priority, such a measure would correlate well with: Make Care Safer Effective Prevention and Treatment of the Leading Causes of Mortality

Commenter Organization	Commenter Name	Comment Category	Comment
American Occupational Therapy Association	Charles Willmarth	Core Set of Measure Concepts	For "Goal Attainment," a couple of other measures for which core measures could provide meaningful data might include: • A measure that looks at use of assessment tools that objectively measure a baseline, progress/decline and maintenance (where appropriate) • A measure of that looks at whether interventions are in line with accepted standards of practice • Another measure that could be meaningful is to whether goals are typically achieved within anticipated/planned timelines In regard to the NQS priority, such a measure would correlate well with: • Ensuring Patient- and Family-Centered Care • Promoting Effective Communication and Coordination of Care • Making Quality Care More Affordable
American Occupational Therapy Association	Charles Willmarth	Core Set of Measure Concepts	For the "Cost/Access" concept, it seems that another measure should look at preventative interventions (e.g. vaccines, diabetes monitoring) that would address the SNF and Home Health measures that are not currently mapped core set concept. Other interventions, such as restorative nursing programs, or rehabilitation services to establish maintenance programs may also be considered as preventative interventions the impact quality of life and cost of service. In regard to the NQS priority, such a measure would correlate well with: • Effective Prevention and Treatment of the Leading Causes of Mortality • Enable Healthy Living • Making Quality Care More Affordable
American Occupational Therapy Association	Charles Willmarth	Data Source and HIT Considerations	Data Collection Methodologies AOTA is glad to see consideration given to common elements across settings and some of the adjustment that is needed to enable a measure to apply across settings. We ask, however, whether consideration been given to the impact of various data collection methodologies and the impact of recent changes in some of the tools? For instance, the Minimum Data Set (MDS) 3.0 now includes more patient/family interview and is a tool that is usually completed by the interdisciplinary team. The OASIS process includes the fairly recent changes to therapy visit requirements and is typically completed by one team member. We ask that the Work Group put this issue on the agenda going forward.
American Occupational Therapy Association	Charles Willmarth	General	The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students. We are pleased to be a member of the National Quality Forum (NQF). The practice of occupational therapy is science-driven and evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners provide critical occupational therapy services to clients in post-acute care and long-term care (PAC/LTC) settings. AOTA believes that it is important to have a wide range of performance measures available for use in these settings. A large percentage of occupational therapy practitioners work in PAC/LTC settings, and AOTA is thus well-positioned and appreciative of the opportunity to provide comment on the NQF Measure Applications Partnership (MAP) Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care released earlier this month.

Commenter Organization	Commenter Name	Comment Category	Comment
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	"Function" is the ability to perform needed and/or desired tasks at a level which permits some level of participation in daily routines and roles. This priority would better capture a patient's abilities and participation in life/community if it were expanded to include "participation" and "executive function" in the definition and if it were broken down into performance skill areas related to self-care, activities of daily living (ADLs) and instrumental activities of daily living (IADLs), functional mobility/transfers, community mobility, etc. Without the inclusion of participation and executive function, the focus leans to a medical model and disease-oriented approach to patient assessment, treatment and overall function. While appropriate measures are in various stages of approval and development, AOTA also encourages NQF to call for more performance measures related to participation and executive function.
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	In the priority description on page 4 of the report, it is indicated that "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." It is then further stated, "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." It seems that the first part of this description is meant to state the typical focus of past functional measures. The second half of the description appears to define necessary considerations for future functional measures, but there seems to lack a clear description of what outcomes would be assessed as part of function. AOTA supports the direction of addressing issues such as cognition and behavior but argues that this must be very clearly explicated.
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	AOTA's official document Occupational Therapy Practice Framework: Domain and Process, 2nd edition defines and guides occupational therapy practice. The Framework was developed to articulate occupational therapy's contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation. Based on the Framework, AOTA urges the NQF to consider that functional outcomes should include consideration of at least the following 4 areas of occupation: • Activities of Living (ADLs) • Instrumental ADLs (IADLs) • Rest and Sleep • Social Participation (Education is another aspect but is covered under Patient and Family Engagement. Although occupational therapy practice include 3 other areas of occupation—work, play and leisure—as important, they are not areas typically considered in the PAC/LTC setting in relation to quality.)

Commenter Organization	Commenter Name	Comment Category	Comment
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	In looking at the areas of function measured with the various PAC/LTC setting assessment tools that exist, it could be suggested that functional outcomes should include specific consideration of the following areas of function: • Communication • Cognition • Mobility/Locomotion • Self-care ADLs • Swallowing/Nutrition • Respiratory Function • Mental Health • Recreation • IADLS • Medication and Equipment Management
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	From an International Classification of Functioning, Disability and Health (ICF) approach, functional outcomes could be considered from the following perspective: • Activities and participation • Learning and Applying Knowledge • General tasks and demands • Communication • Mobility • Self-care • Domestic Life • Interpersonal interactions relationships • Major life areas • Community, social and civic life
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	In terms of correlation with the NQS priority, function might also have an impact on the following NQS items: Making Care Safer(Improved function often leads to improved safety. For example, a person who is able to independently use lower extremity adaptive devices has a decreased risk falling while bending.) Effective Prevention and Treatment of the Leading Causes of Mortality(Increased function that allows for effective self-management of disease processes can lend to prevention and wellness.) Making Quality Care More Affordable(Increased function often decreases care needs and caregiver burden.)

Commenter Organization	Commenter Name	Comment Category	Comment
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	2. Goal Attainment It would be important to consider goal setting within the context of both the current setting of care and the setting to which the patient will go next. Also critical to include are patient involvement in determining goals, patient/family counseling, and goal re-evaluation and adjustment, as needed. Goal Attainment should also be considered across other NQS elements as follows: • Promoting Effective Communication and Coordination of Care(Working toward collaborative goal attainment promotes communication and coordination of care; achievement of goals is also dependent upon communication and coordination.) • Enable Healthy Living (Working toward effective self-management and other self-care skills will enable healthy, ongoing living.) • Making Quality Care More Affordable(Working toward collaborative goal attainment can promote efficient and effective care that may reduce cost by reducing resource utilization and possibly length of post-acute care services.)
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	4. Care Coordination The description appears to be a good one. However, it might be important to address the need to assess movement back and forth between PAC/LTC settings and between home and such settings. Readmission to a higher level of care is already a factor that is tracked and is a major concern for the various providers on the health care spectrum, especially when the measures are associated with payment or penalties. For example, when a patient goes from a SNF to Home Health and back to a SNF a few days later, the question of whether the readmission was due to an action or lack thereof of the provider must be considered: Did the SNF discharge too soon? Did the HHA fail to identify and/or address a new or existing problem quickly enough? Were there other factors?
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	5. Safety "Safety" should also be broadened beyond the narrow and very physical scope of falls, pressure ulcers, adverse drug events, and infections in order to best reflect patient needs and NQF priorities. Intervention to appropriately and adequately address impairment of cognitive as well as motor ability and sensory function in relation to safe performance ADLs, IADLs, communication and mobility tasks should be reflected in what is measured. In terms of correlation with the NQS priority, there may be additional impacts that should be considered for the following NQS item. Effective Prevention and Treatment of the Leading Causes of Mortality(Attention to safety issues such as falls, pressure ulcers, adverse drug events, and infections, can help in prevention and treatment. Consider the frail elderly person who falls and breaks a hip, and develops severe pneumonia after hip replacement surgery. Safety can also impact morbidity. Sometimes falls, pressure ulcers, adverse drug events, and infections result in increased morbidity because of compounded medical issues.)
American Occupational Therapy Association	Charles Willmarth	Priority Areas for Measurement	6. Cost/Access The description on page 5 seems to address the keys points, but should also possibly include a consideration of ways to measure increased cost due to factors that increase burden of care within PAC/LTC and following such care.

Commenter Organization	Commenter Name	Comment Category	Comment
American Physical Therapy Association	Heather Smith	Alignment	The American Physical Therapy Association (APTA) supports the alignment of performance measures across the PAC and LTC settings; however, we do feel that this may be a difficult task given the heterogeneity of the patient populations included in these settings. The lack of a uniform data collection tool also will be a challenge in the alignment of this data. Lastly, APTA would recommend alignment of the data definitions for measures in multiple settings in the future.
American Physical Therapy Association	Heather Smith	General	The American Physical Therapy Association (APTA) believes that the Post-Acute and Long-Term Care Draft Report establishes the foundation for coordinated quality measurement in these settings with careful thought of the inherent setting challenges. We believe there remains a great deal of work in further defining and addressing identified gap areas, as well as creating a unified data set in an effort to harmonize measures. We look forward to working with the Measure Applications Partnership to advance these ideas in the future.
American Physical Therapy Association	Heather Smith	Priority Areas for Measurement	The American Physical Therapy Association (APTA) agrees with the identified priority areas of measurement. Physical therapy services are integral to achieving and maintaining function in these patient populations. We believe that measures of function will need to be sensitive enough to reflect changes in this heterogeneous population. As the report discusses, based on the setting type and the patients' condition some patients in this population will be focused on improvement goals while others may be focused on maintenance. Measures that reflect maintenance goals or the prevention of deterioration will need to be different than those measures aimed at functional improvement. Lastly, with respect to safety measures, APTA feels that these are essential patient measures but would advocate for risk adjustment for these measures given the variation in severity of illness for the PAC and LTC patient populations.
American Psychiatric Institute for Research and Education	Robert Plovnick	Core Set of Measure Concepts	We are supportive of the current core set of measure concepts, but stress the necessity of including the management of co-occurring mental illness with physical illness in all treatment settings. Major depression, which appears on the top of the High-Impact Conditions list (Table Number Two in the report), and other persistent mental illness can create further obstacles to maintaining physical health. As George Niederehe, PhD, chief of the National Institute of Mental Health (NIMH) geriatrics research branch noted recently, "there's growing evidence that depression reduces longevity and makes it harder for treatment of chronic physical illnesses to succeed" [Pittsburgh Post-Gazette, November 21, 2011]. A 2010 study found that people with severe mental illness have higher rates of mortality and reduced life expectancy, with deaths from common physical illnesses representing the largest number of excess deaths [Lawrence D, Kisely S: Inequalities in healthcare provision for people with severe mental illness. J Psychopharmacol. 2010 November; 24 (4 supplement): 61-6]. While we agree that universal assessment for depression, as mentioned on page 7 of the report, would not necessarily be appropriate in all circumstances, we suggest that the assessment for mental illness and attention to the treatment of established mental illness are essential to the care of patients in PAC and LTC settings and should be included as core measure concepts.
California HealthCare Foundation	Stephanie Teleki	Data Source and HIT Considerations	A brief but important comment: It is striking that in a report on long term care, there is virtually no data about assisted living facilities-- one of the fastest growing segments of the long term care provider market. We encourage NQF and others to work to ensure that this important, but not well regulated, long term care provider type be "brought into the fold" of quality measurement and accountability.

Commenter Organization	Commenter Name	Comment Category	Comment
National Assoc. for the Support of Long Term Care	Cynthia Morton	Alignment	The National Association for the Support of Long Term Care (NASL) appreciates the opportunity to comment on the MAP PAC/LTC report. NASL agrees with the use of harmonized measures across a patient's entire episode but recognizes the difficulty given the varied patient populations in long term and post acute care settings. A robust risk-adjustment methodology is needed to take this into account across the PAC and LTC settings. SNFs provide rehabilitation care to more frail elders than any other post-acute setting. NASL has worked with the Office of the National Coordinator's HIT Standards and Interoperability Framework workgroup and their work should be coordinated with this project. Additionally, work done on the CARE tool should also be coordinated with this project. We would suggest changing this statement, "...care may be driven by Medicare and Medicaid payment policies and regulations, rather than patient goals" because it may lead the reader to believe reimbursement policy determines care. Payment policy can influence care but it is driven by patient need. Perhaps use the word influence instead.
National Assoc. for the Support of Long Term Care	Cynthia Morton	Core Set of Measure Concepts	Core Set of Measure Concepts: NASL would include consistent staff assignment and staff competency recognizing there are operational challenges with both of these. Measuring depression and treating it is very important to therapy outcomes. Perhaps the "decision" to address it should be based upon length of stay or level of cognition. Also, if one setting does not address it and leaves it to the next setting, who is to say they will?
National Assoc. for the Support of Long Term Care	Cynthia Morton	Data Source and HIT Considerations	HIT Considerations: NASL appreciates that the report recognizes some of the barriers faced by LTPAC providers in the adoption of electronic health records and other health IT. LTPAC providers are integral to achieving such goals as avoiding unnecessary re-hospitalizations yet LTPAC providers were left out of the HITECH Act that provides incentive monies to hospitals and physicians for the meaningful use of health IT. LTPAC providers are moving forward regardless by working with ONC committees and other groups to create standards for interoperability. LTPAC providers may be more sophisticated than mentioned in this report as they are required to exchange data with CMS specifically on patient assessments (MDS, OASIS, IRF-PAI, etc.). Unpredictable reimbursement policy is also a hindrance to LTPAC providers, especially SNFs, to adopting health IT. NASL is watching closely the CARE tool and its potential use in this areaits work should also be coordinated with this project. As stated previously, NASL has worked with the Office of the National Coordinator's HIT Standards and Interoperability Framework workgroup and their work should be coordinated with this project.
National Assoc. for the Support of Long Term Care	Cynthia Morton	Priority Areas for Measurement	NASL agrees that function is an essential baseline assessment. Therapy is integral to achieving improved function and maintaining current levels of function. Therapy is vital to the patient progressing safely in their environment through the slope from frailty to function and back again. The job of "defining population subsets with particular care needs" will be key to this process. There is a large part of the population in long term care where "improvement" is relative and may require very sensitive measures. How can we correlate the improvement/prevention of deterioration to receipt of therapy? NASL would wish to be involved in defining these. GOAL ATTAINMENT: NASL agrees. However, there needs to be recognition and ability to understand that some patient's goals may not be realistic/ achievable. PATIENT & FAMILY ENGAGEMENT: NASL agrees. CARE COORDINATION: NASL Agrees. Communication should be both verbal & written. SAFETY: NASL agrees. The issue of avoidable & unavoidable falls needs to be risk - adjusted. In LTC settings, a falls measurement metric might inadvertently reverse the progress made with OBRA. Patients cannot be restrained and therefore some falls cannot be avoided. At end of life as organ failure and nutritional issues arise, some pressure ulcers may be unavoidable. COST/ACCESS: NASL agrees.

Commenter Organization	Commenter Name	Comment Category	Comment
National Patient Advocate Foundation	Rene Cabral-Daniels	Alignment	NPAF commends the Measure Applications Partnership (MAP) report because it is in the best interest of patients as it assures consistent outcome measurements for them, irrespective of setting. While the benefits to the patients are of paramount importance, there are other benefits that indirectly benefit patients. The alignment of performance measures in a coordinated fashion promotes efficient data collection and usage. Data need only be collected once, yet its utility transcends care settings. This approach has an indirect, yet important benefit to patients as it promotes coordination of outcome measures. The coordination also creates a pathway to improve measure application and identify emerging quality challenges in patient care. While NPAF applauds the underlying approach, it also cautions MAP to consider likewise creating site-specific performance measures in areas where site commonalities may not be great or when their development offers the potential to improve patient care. For example, while the use of "cascading measures," which are harmonized measures that could be used to assess care across a patient's entire episode while providing a comprehensive picture of quality offer great promise, the specificity needed to address a particular need in one setting should not be forsaken to promote cascading measures. NPAF encourages unique measure development in areas where lack of site commonalities frustrates measurement harmonization.
National Patient Advocate Foundation	Rene Cabral-Daniels	Core Set of Measure Concepts	NPAF is in agreement that access to community supports is important for all patients yet encourages MAP to reconsider the conclusion that merely providing information about available community supports could be considered as an alternative to ensuring access to community resources. Access to care is of paramount importance to patients. Patient advocates work diligently to assure patient access to care. For example, NPAF's companion organization, the Patient Advocate Foundation (PAF) provides professional case management assistance to patients with chronic, debilitating or life-threatening conditions. PAF case managers work with patients and their providers to identify programs that provide assistance for their individual needs, ensure appropriate reimbursement for healthcare services by their insurers and educate them on their employment rights during an illness. In 2010, PAF resolved 82,963 patient cases and received more than four million additional inquiries from patients nationally. PAF's ability to improve patient access to care is an important resource and illustrates its importance as a core measure concept. Performance measurement should recognize the importance of access to care by identifying a measurement that requires providers to direct patients to competent patient advocate organizations rather than merely providing a list of resources.
National Patient Advocate Foundation	Rene Cabral-Daniels	Path Forward	Priority measure gaps should be given great attention. While the report demonstrates a number of great opportunities to improve patient care, the gaps identify areas where patient care could be enhanced as quantified by appropriate measures. NPAF agrees that 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. The measures should be developed to identify patient groups that experience the greatest challenges in accessing quality care. Thus, their bifurcation may be necessary to drill down to outcomes that reflect disparate populations, particularly medically underserved populations.

Commenter Organization	Commenter Name	Comment Category	Comment
National Patient Advocate Foundation	Rene Cabral-Daniels	Priority Areas for Measurement	MAP identified six priority areas for measurement - function, goal attainment, patient and family engagement, care coordination, safety, and access. NPAF concurs with the six priority measures, yet encourages the definition of patient and family engagement to be expanded to accommodate a broader spectrum of caregivers. As noted in the report, Patient and Family Engagement is a vital part of delivering quality care generally. The delivery of care is often predicated upon the services covered under the patient's health insurance plan. Often, patients and families are so preoccupied with the receipt of care that they do not have time nor the resources to determine the nexus between the care they are receiving versus the care to which they may be entitled pursuant to their Explanation of Medical Benefits. Patient advocates assist patients and families to ensure the patients receive the care covered by their health insurance policies. As such, they are often a trusted source by both patients and families. NPAF believes this section should consider the ability of patients to access the care they need by adding patient advocate engagement to this priority area for measurement. NPAF agrees that, as stated in the report, consideration should be given to defining caregivers, as this role may extend beyond traditional family support. Likewise, those who are engaged in assuring the patient has access to care may be beyond caregivers and include patient advocates.
Society of Hospital Medicine	Jill Epstein	General	The American Medical Directors Association supports the MAP draft report for Post-Acute Care and Long Term Care.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Core Set of Measure Concepts	Overall, AOTA is supportive of the 12 core measurement concepts, though we find that a few items could use further development. Specifically, the core measure for "Function" focuses on assessment. It seems that in looking at outcomes, it would also be important to have measures that focus on intervention and treatment standards to address identified care issues. Interventions that improve function can decrease safety risk and the injuries that can result in death or increased morbidity. Consider for instance, again a frail elderly person who after a fall, dies from secondary complications or infection, or one who suffers a traumatic brain injury as the result of a fall. In regard to the NQS priority, such a measure would correlate well with: • Make Care Safer • Effective Prevention and Treatment of the Leading Causes of Mortality For "Goal Attainment," a couple of other measures for which core measures could provide meaningful data might include: • A measure that looks at use of assessment tools that objectively measure a baseline, progress/decline and maintenance (where appropriate) • A measure of that looks at whether interventions are in line with accepted standards of practice

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The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Core Set of Measure Concepts	• Another measure that could be meaningful is to whether goals are typically achieved within anticipated/planned timelines In regard to the NQS priority, such a measure would correlate well with: • Ensuring Patient- and Family-Centered Care • Promoting Effective Communication and Coordination of Care • Making Quality Care More Affordable For the "Cost/Access" concept, it seems that another measure should look at preventative interventions (e.g. vaccines, diabetes monitoring) that would address the SNF and Home Health measures that are not currently mapped core set concept. Other interventions, such as restorative nursing programs, or rehabilitation services to establish maintenance programs may also be considered as preventative interventions the impact quality of life and cost of service. In regard to the NQS priority, such a measure would correlate well with: • Effective Prevention and Treatment of the Leading Causes of Mortality • Enable Healthy Living • Making Quality Care More Affordable
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Data Source and HIT Considerations	AOTA is glad to see consideration given to common elements across settings and some of the adjustment that is needed to enable a measure to apply across settings. We ask, however, whether consideration been given to the impact of various data collection methodologies and the impact of recent changes in some of the tools? For instance, the Minimum Data Set (MDS) 3.0 now includes more patient/family interview and is a tool that is usually completed by the interdisciplinary team. The OASIS process includes the fairly recent changes to therapy visit requirements and is typically completed by one team member. We ask that the Work Group put this issue on the agenda going forward.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	General	The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students. We are pleased to be a member of the National Quality Forum (NQF). The practice of occupational therapy is science-driven and evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners provide critical occupational therapy services to clients in post-acute care and long-term care (PAC/LTC) settings. AOTA believes that it is important to have a wide range of performance measures available for use in these settings. A large percentage of occupational therapy practitioners work in PAC/LTC settings, and AOTA is thus well-positioned and appreciative of the opportunity to provide comment on the NQF Measure Applications Partnership (MAP) Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care released earlier this month. The draft strategic plan aims to coordinate and align PAC/LTC quality performance measures across public and private initiatives, with a focus on defining measure priorities and highlighting the need for common data sources.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	General	In the report, NQF explains how the Working Group set six "Measurement Priorities" and developed twelve "Core Measure Concepts" to address these priorities. An appendix and separate spreadsheet comprehensively catalog the performance measures already in existence and highlight measure gaps and areas where uniformity could support better outcomes. 'AOTA looks forward to working closely with NQF and the MAP PAC/LTC Work Group on a quality performance measure strategy.

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The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	The six Measurement Priorities are: Function, Goal Attainment, Patient and Family Engagement, Care Coordination, Safety, and Cost/Access. While these do seem to align well with National Quality Strategy (NQS) goals, AOTA does find that some Measurement Priorities are overly broad, while others need to be modernized. 1. Function "Function" is the ability to perform needed and/or desired tasks at a level which permits some level of participation in daily routines and roles. This priority would better capture a patient's abilities and participation in life/community if it were expanded to include "participation" and "executive function" in the definition and if it were broken down into performance skill areas related to self-care, activities of daily living (ADLs) and instrumental activities of daily living (IADLs), functional mobility/transfers, community mobility, etc. Without the inclusion of participation and executive function, the focus leans to a medical model and disease-oriented approach to patient assessment, treatment and overall function. While appropriate measures are in various stages of approval and development, AOTA also encourages NQF to call for more performance measures related to participation and executive function.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	In the priority description on page 4 of the report, it is indicated that "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." It is then further stated, "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." It seems that the first part of this description is meant to state the typical focus of past functional measures. The second half of the description appears to define necessary considerations for future functional measures, but there seems to lack a clear description of what outcomes would be assessed as part of function. AOTA supports the direction of addressing issues such as cognition and behavior but argues that this must be very clearly explicated.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	Following are a few possible perspectives to consider separately and/or collectively. AOTA's official document Occupational Therapy Practice Framework: Domain and Process, 2nd edition defines and guides occupational therapy practice. The Framework was developed to articulate occupational therapy's contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation. Based on the Framework, AOTA urges the NQF to consider that functional outcomes should include consideration of at least the following 4 areas of occupation: • Activities of Living (ADLs) • Instrumental ADLs (IADLs) • Rest and Sleep • Social Participation (Education is another aspect but is covered under Patient and Family Engagement. Although occupational therapy practice include 3 other areas of occupation—work, play and leisure—as important, they are not areas typically considered in the PAC/LTC setting in relation to quality.)

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The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	In looking at the areas of function measured with the various PAC/LTC setting assessment tools that exist, it could be suggested that functional outcomes should include specific consideration of the following areas of function: • Communication • Cognition • Mobility/Locomotion • Self-care ADLs (Grooming, Bathing, Dressing, Toileting) • Swallowing/Nutrition • Respiratory Function • Mental Health • Recreation • IADLS • Medication and Equipment Management
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	From an International Classification of Functioning, Disability and Health (ICF) approach, functional outcomes could be considered from the following perspective: • Activities and participation, o Learning and Applying Knowledge, o General tasks and demands, o Communication, o Mobility, o Self-care, o Domestic Life, o Interpersonal interactions relationships, o Major life areas, o Community, social and civic life. In terms of correlation with the NQS priority, function might also have an impact on the following NQS items: • Making Care Safer (Improved function often leads to improved safety. For example, a person who is able to independently use lower extremity adaptive devices has a decreased risk falling while bending.) • Effective Prevention and Treatment of the Leading Causes of Mortality (Increased function that allows for effective self-management of disease processes can lend to prevention and wellness.) • Making Quality Care More Affordable (Increased function often decreases care needs and caregiver burden.)

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The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	2. Goal Attainment It would be important to consider goal setting within the context of both the current setting of care and the setting to which the patient will go next. Also critical to include are patient involvement in determining goals, patient/family counseling, and goal re-evaluation and adjustment, as needed. Goal Attainment should also be considered across other NQS elements as follows: • Promoting Effective Communication and Coordination of Care (Working toward collaborative goal attainment promotes communication and coordination of care; achievement of goals is also dependent upon communication and coordination.) • Enable Healthy Living (Working toward effective self-management and other self-care skills will enable healthy, ongoing living.) • Making Quality Care More Affordable (Working toward collaborative goal attainment can promote efficient and effective care that may reduce cost by reducing resource utilization and possibly length of post-acute care services.) 3. Patient and Family Engagement "Patient and Family Engagement" should more specifically include provider-patient collaboration that reflects cultural sensitivity, respects autonomy, and may be geared to literacy abilities. AOTA also recommends that a reference be added to significant others or friends/unrelated caregivers who could be involved parties.
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	There are also ways in which a broader perspective could positively impact this category – see as follows: • Making Care Safer (Patient and family engagement encourages informed decisions and promotes understanding of compliance with care processes that promote safety. For example, helping the patient and family to understand the steps to do a safe wheelchair transfer, e.g., locking brakes, providing assistance/supervision at the required level, and other practices, can promote safe transfers and/or requests for assistance as needed.) • Effective Prevention and Treatment of the Leading Causes of Mortality (Patient and family engagement can help to promote compliance with medication, exercise, and other remediation or management strategies) • Making Quality Care More Affordable (Patient and family engagement can positively affect cost by helping to speed progress and recovery, reduce length of stay/services, decrease caregiver burden, and/or reduce resource utilization.) 4. Care Coordination The description appears to be a good one. However, it might be important to address the need to assess movement back and forth between PAC/LTC settings and between home and such settings. Readmission to a higher level of care is already a factor that is tracked and is a major concern for the various providers on the health care spectrum, especially when the measures are associated with payment or penalties.

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The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	For example, when a patient goes from a SNF to Home Health and back to a SNF a few days later, the question of whether the readmission was due to an action or lack thereof of the provider must be considered: Did the SNF discharge too soon? Did the HHA fail to identify and/or address a new or existing problem quickly enough? Were there other factors? 5. Safety "Safety" should also be broadened beyond the narrow and very physical scope of falls, pressure ulcers, adverse drug events, and infections in order to best reflect patient needs and NQF priorities. Intervention to appropriately and adequately address impairment of cognitive as well as motor ability and sensory function in relation to safe performance ADLs, IADLs, communication and mobility tasks should be reflected in what is measured. In terms of correlation with the NQS priority, there may be additional impacts that should be considered for the following NQS item. • Effective Prevention and Treatment of the Leading Causes of Mortality (Attention to safety issues such as falls, pressure ulcers, adverse drug events, and infections, can help in prevention and treatment. Consider the frail elderly person who falls and breaks a hip, and develops severe pneumonia after hip replacement surgery. Safety can also impact morbidity. Sometimes falls, pressure ulcers, adverse drug events, and infections result in increased morbidity because of compounded medical issues.)
The American Occupational Therapy Association, Inc.	Jennifer Hitchon	Priority Areas for Measurement	6. Cost/Access The description on page 5 seems to address the keys points, but should also possibly include a consideration of ways to measure increased cost due to factors that increase burden of care within PAC/LTC and following such care.
The Arc	Maureen Fitzgerald	General	The Arc appreciates the opportunity to offer comments concerning the draft report, Performance Measurement Coordination Strategy for Post-Acute Care and Long-Term Care. The Arc is a membership organization of over 700 state and local chapters made up of people with intellectual, developmental and other disabilities, their families, friends, interested citizens, and professionals in the disability field. The Arc has advocated full inclusion and participation of people with intellectual and developmental disabilities (I/DD) for over 60 years. In reviewing the workgroup's interim report, we noted the absence of quality indicators specific to long-term services and supports needed by people with disabilities, in particular people with I/DD. The report is limited to a subset of post-acute care and long-term care settings: short- and long-stay nursing facilities, home health care, inpatient rehabilitation facilities, and long-term care hospitals. The report states that performance measures for hospice care will be addressed in a subsequent MAP report. We are concerned that the workgroup did not focus on the home and community-based long term care settings where services and supports are provided to individuals with disabilities, or state that those settings would be addressed in subsequent MAP reports.

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The Arc	Maureen Fitzgerald	General	The Affordable Care Act included numerous opportunities for states to increase their use of home and community-based settings for the delivery of long-term services and supports to people with disabilities. Most people want their long-term services and supports in their homes and communities, and there is general consensus that delivery of care in community-based settings is more cost effective than delivery of care in institutional settings. Many states are designing models of managed care in order to integrate and coordinate health care and long term services and supports across settings in order to improve health outcomes for people and reduce use of costly institutionalization. Thus, the absence of quality measures in this important area constitutes a large gap. There are gaps in quality measures for home and community-based long-term services and supports for people with disabilities in several areas, including: • Person centered planning and plan implementation (for example, timely access to all needed services and supports; coordination with physical and behavioral health services); • Self determination and choice (which includes individualized accommodations, such as accessible information, educational, and self-management materials and supports); • Community integration and inclusion (including physical and programmatic accessibility; access to housing, transportation; access to assistive technology; vocational/educational participation; social/recreational participation); • Quality of Life, including freedom from abuse/neglect (for example, inappropriate use of psychotropic medications and restraint/seclusion; inappropriate use of psychiatric or emergency department hospitalization in lieu of appropriate behavioral supports). Although, states use a variety of tools to measure quality of their home and community based services, there is no uniform set of measures by which programs can be compared.
The Arc	Maureen Fitzgerald	General	Numerous factors are influencing the growing use of home and community based services for people with disabilities – the U.S. Supreme Court's Olmstead decision, the Affordable Care Act, the Center for Medicare and Medicaid Services policy, consumer preference, and the need to reduce the trajectory of the health care cost curve. Home and community-based services and settings are in need of comprehensive, meaningful quality measures. The Arc respectfully requests that the National Quality Forum through its Measure Applications Partnership impress upon the Secretary of Health and Human Services the need for quality measures that address the attainment of person-centered goals through the provision of home and community based services and supports across the continuum of providers and settings.
University of California - San Francisco	Charlene Harrington	Alignment	On page 10, the definition of LTC should include residential care/and assisted living. Perhaps we should add a sentence explaining why they are not included in the report because they are not regulated by the federal government but rather by states.

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University of California - San Francisco	Charlene Harrington	Core Set of Measure Concepts	p. 14 bullet regarding staffing ratios. The bullet should be changed to say "Staffing ratios and turnover rates were considered important but have not yet been developed across settings. Other workforce considerations, ..., are also important and should be examined at a later time." This needs to be edited because staffing levels have more of a research evidence base than the measures of turnover, consistent assignment and staff competency. p. 14 Bullet 3 on access. Change the text to say "Providing information about available community supports is an important alternative." p. 14 Change the bullet to say: "Mental health assessment, including depression identification, is important but measures have not yet been developed across settings." Drop the last sentence.
University of California - San Francisco	Charlene Harrington	Data Source and HIT Considerations	P. 17 Nursing home compare. The section needs to say that NH compare currently has three types of measures: facility deficiencies, staffing levels, and resident quality measures from the MDS. This section is only addressing the resident quality measures from the MDS. Change "the workgroup noted that not all the included measures have been endorsed." Add "because data are not available" to the end of the sentence for those measures. Add to key populations not included: "individuals with mental illness" p. 18 8. Strike in NHC Compare. This is only referring to the resident quality measures from the MDS.
University of California - San Francisco	Charlene Harrington	Data Source and HIT Considerations	Home Health Compare p. 18 Add "individuals with mental illness." 8. Change "multiple" programs to "other programs" and strike "or applications." P. 18. % with short-stay residents who have delirium is being removed from the MDS and NH Compare It should be removed from here or a footnote made. p. 21 systematic review of data... change "integrity" to "accuracy" p. 21 priority Measure Gaps remove the word "longitudinally". All the measures on the MDS and OASIS are measured over time
University of California - San Francisco	Charlene Harrington	General	In general we needed more time to discuss the path forward. The work at the present is incomplete.
University of California - San Francisco	Charlene Harrington	Path Forward	Path Forward Gaps Add a section stating that structural measures related to staffing and visits need to be developed in the future.
University of California - San Francisco	Charlene Harrington	Priority Areas for Measurement	p. 14 bullet regarding staffing ratios. The bullet should be changed to say "Staffing ratios and turnover rates were considered important but have not yet been developed across settings. Other workforce considerations, ..., are also important and should be examined at a later time." This needs to be edited because staffing levels have more of a research evidence base than the measures of turnover, consistent assignment and staff competency. p. 14 Bullet 3 on access. Change the text to say "Providing information about available community supports is an important alternative." p. 14 Change the bullet to say: "Mental health assessment, including depression identification, is important but measures have not yet been developed across settings." Drop the last sentence.

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VISN 8 Patient Safety Center	Patricia Quigley	Core Set of Measure Concepts	I would like to suggest that Falls as an core measure of safety is too aggregated. There are different types of falls, and not all falls are preventable. The types of falls that are preventable should be the focus here: Accidental Falls (related to environment of care), and Anticipated Physiological Falls (sensitive to multifactorial assessment and interdisciplinary management). Additionally, I request consideration for Fall-related Injury (severity of) be added as a core, separate measure under safety. The injury associated with a fall results in loss of function and loss of life. The consequences of injury are serious and the approaches to injury reduction or protection from injury are different than fall prevention. Thus, this new core measurement is a separate and important primary outcome of care in acute and long term care settings.
VISN 8 Patient Safety Center	Patricia Quigley	Priority Areas for Measurement	I would like to suggest that Fall Related Injury be added as a priority area of measurement in the Safety Domain. While falls is listed, it is the injury from falls that result in loss of function and loss of life. Injury, severity of injury, is a separate safety indicator. Evidence exists in LTC settings that hip protectors and floor mat usage reduce fall-related trauma. Persons entering LTC settings from acute care should be protected from fall-related injuries. Also, not all falls are preventable. So, if a patient has an unpreventable fall, such as due to a syncopal episode, and still had injury reduction measures in place, a serious fall-related injury can be prevented.

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