

Draft Measure Justification Forms

Development, Implementation, and Maintenance of Quality Measures for the Programs of All-Inclusive Care for the Elderly (PACE)

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Submitted To:

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Table of Contents

CHAPTER 1. FALL MEASURES.....	1
A. MEASURE JUSTIFICATION FORM FOR FALL AND FALLS WITH INJURY RATES	1
CHAPTER 2. PRESSURE ULCERS.....	10
B. MEASURE JUSTIFICATION FORM FOR PRESSURE ULCERS	10
C. MEASURE JUSTIFICATION FORM FOR PRESSURE ULCER PREVENTION	17
CHAPTER 3. 30-DAY ALL-CAUSE READMISSIONS.....	21
D. MEASURE JUSTIFICATION FORM FOR READMISSION.....	21

Chapter 1. Fall Measures

A. Measure Justification Form for Fall and Falls With Injury Rates

Project Title

Development, Implementation, and Maintenance of Quality Measures for PACE

Project Overview

The current health care system does not consistently deliver high-quality care for every participant at every opportunity, resulting in gaps in the quality of care provided. One way that CMS will carry out its obligation to drive improvement in the health care system is through the development and use of quality measures and related activities. The purpose of this project is to develop, implement, and align measures for PACE.

Descriptive Information

Date: April 14, 2015.

Measure Name: Fall and Falls With Injury Rates.

Type of Measure: Outcome.

Importance

Opportunity for Improvement

The PACE program serves a frail, elderly population with the goal of maintaining them in their homes. Along with other ambulatory settings, performance measurement has not yet been conducted for this population in this type of setting. So, as yet, there are no data with which to demonstrate importance.

Rationale

Fall and Falls With Injury Rates have been found to be important safety concerns in acute care and long-term care settings. There is evidence that falls are one of the most common adverse patient events in hospitals, and they are a source of significant injury, disability, and/or death. Several national health care organizations—including the National Quality Strategy, the Partnership for Patients, and the CMS Hospital-Acquired Condition (HAC) Reduction Program—have identified patient falls as a patient safety concern.

Falls With Injury may result in fatal and non-fatal injuries ranging from minor lacerations to severe head injuries (WHO, 2012). The majority of fall-related injuries are non-fatal. Several studies have demonstrated a difference in injurious fall rates for specific populations. Disparities have been identified according to age (Fhon et al., 2013) and disability, particularly cognitive impairment (Lavedan, 2014; Ranaweera et al., 2013; Lee & Stokic, 2008).

Every fall carries a risk of injury. Clinicians can reduce injuries in part by reducing the risk of falling. Focusing prevention efforts solely on falls with injury is a faulty approach for improving patient safety. To some extent, falls with injury are a function of patient frailty; by contrast, the total fall rate is not influenced by differences among patients' susceptibility to injury.

Many if not most falls may result in no injury or only minor injury. Nevertheless, any fall may result in emotional distress and increased risk of falling in the future. Preventing falls among the frail elderly contributes to the maintenance of the participant's functional status and place in the community and the prevention of costs of treatment associated with falls. It is important to monitor all falls, not just falls with injury.

Citations From Literature Review

Fhon, J. R., Rosset, I., Freitas, C. P., Silva, A. O., Santos, J. L., & Rodrigues, R. A. (2013). Prevalence of falls among frail elderly adults. *Rev Saude Publica*, 47(2), 266–273. doi: 10.1590/s0034-8910.2013047003468

Lavedan Santamaria, A., Jurschik Gimenez, P., Botigue Satorra, T., Nuin Orrio, C., & Viladrosa Montoy, M. (2014). Prevalence and associated factors of falls in community-dwelling elderly. *Aten Primaria*. doi: 10.1016/j.aprim.2014.07.012

Ranaweera, A. D., Fonseka, P., Pattiya Arachchi, A., & Siribaddana, S. H. (2013). Incidence and risk factors of falls among the elderly in the District of Colombo. *Ceylon Med J*, 58(3), 100–106. doi: 10.4038/cmj.v58i3.5080

World Health Organization. (2012). *Falls*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs344/en/index.html>.

Clinical Practice Guideline Recommendation

The most effective interventions are multifactorial, including the following:

- Participant and family education about fall prevention.
- Environmental modifications, such as increasing lighting, eliminating throw rugs, and establishing a home environment without stairs.
- Participant use of stability supports such as canes, walkers, grab bars, and nonslip footwear.
- Exercise.
- Modification of participant medications to improve orientation and alertness.
- Provision of physical and occupational therapy to strengthen the participant and to teach the participant new ways of accomplishing activities of daily living.

Scientific Acceptability

Information on the reliability and validity of the fall and falls with injury rate measures for PACE programs will be available upon the completion of the pilot study.

Feasibility

Information on the feasibility of data collection on falls and falls with injury for PACE programs will be available upon the completion of the pilot study.

Usability and Use

Information on usability and use will become available a year or more after implementation of routine data collection in PACE programs.

Related and Competing Measures

NQF has endorsed four fall rate measures. CMS, NQF, and the Measure Application Partnership (MAP) encourage harmonization of similar measures to promote standardized measurement across the Nation. Ideally, harmonization of the four fall rate measures would result in the same definitions for falls.

Harmonization may be difficult or impossible if health care regulators require different definitions of falls or if data systems differ among provider types (e.g., the Minimum Data Set (MDS) for long-term care facilities, the Outcome and Assessment Information Set (OASIS) for home health care, and discharge data for hospitals).

Detailed comparisons of the fall rate measures are given in Table 1, which describes the four measures and their NQF endorsement criteria. The measures being developed for the PACE program are closely aligned with NQF-endorsed measures 0141 and 0202. They use the same definition of falls and injury levels but different denominators that reflect fall exposure in PACE programs and in hospitals.

Table 1. Comparison of Falls Measures

NQF Number	Measure 1 0141	Measure 2 0202	Measure 3 0266	Measure 4 0674
Measure Title	Patient Fall Rate	Falls With Injury	Patient Fall	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Measure Description	<ul style="list-style-type: none"> Total Fall Rate: Total falls per 1,000 patient days. Unassisted Fall Rate: Unassisted falls per 1,000 patient days. <i>(Total number of falls / Patient days) x 1,000.</i> All documented falls, with or without injury, experienced by patients on eligible acute care inpatient unit types in a calendar month. 	<ul style="list-style-type: none"> Fall With Injury Rate: Injury falls per 1,000 patient days. <i>(Total number of injury falls / Patient days) x 1,000.</i> All documented patient falls with an injury level of minor or greater on eligible acute care inpatient unit types in a calendar month. 	<ul style="list-style-type: none"> Percentage of Ambulatory Surgery Center (ASC) admissions experiencing a fall within the ASC. 	<ul style="list-style-type: none"> Percent of long-stay nursing facility residents experiencing one or more falls with major injury (as defined in the MDS 3.0: bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period).
Fall Definition	A sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can).	Same as Measure 1.	A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object. (Source: National Center for Patient Safety.)	The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0141	0202	0266	0674
Numerator Statement	<p>Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by eligible reporting hospital unit during the calendar month x 1,000.</p> <ul style="list-style-type: none"> Eligible unit types: Adult critical care, adult step-down, adult medical, adult surgical, adult medical-surgical combined, critical access, adult rehabilitation inpatient. 	<p>Total number of patient falls with an injury level of minor or greater (whether or not assisted by a staff member) by eligible reporting hospital unit during the calendar month x 1,000.</p> <ul style="list-style-type: none"> Eligible unit types: Adult critical care, adult step-down, adult medical, adult surgical, adult medical-surgical combined, critical access, adult rehabilitation inpatient. 	<p>ASC admissions experiencing a fall in the ASC.</p>	<p>The number of long-stay nursing facility residents experiencing one or more falls, resulting in major injury (J1900c = 1 or 2) on any non-admission MDS assessment in the last 12 months, which may be annually, quarterly, significant change, significant correction, or discharge assessment.</p>
Denominator Statement	<p>Patient days by hospital unit during the calendar month.</p> <ul style="list-style-type: none"> Inpatients, short-stay patients, observation patients, and same-day surgery patients who receive care on eligible inpatient units for all or part of a day. 	<p>Same as Measure 1: Patient days by hospital unit during the calendar month.</p> <ul style="list-style-type: none"> Inpatients, short-stay patients, observation patients, and same-day surgery patients who receive care on eligible inpatient units for all or part of a day. 	<p>All ASC admissions.</p>	<p>The total number of long-stay residents in the nursing facility who were assessed during the selected time window and who did not meet the exclusion criteria.</p>

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0141	0202	0266	0674
Exclusions	Falls by: Visitors, students, staff members, patients on units not eligible for reporting, and patients from eligible reporting unit but not on unit at time of the fall.	Same as Measure 1.	ASC admissions experiencing a fall outside the ASC.	Residents with MDS admission assessments (Omnibus Budget Reconciliation Act or a 5-day Prospective Payment System (PPS) assessment) from the current quarter are excluded. Also excluded are residents for whom data from the relevant section of the MDS are missing. Residents must be present for at least 100 days to be included in long-stay measures.
Risk Adjustment	Yes by unit type	Yes by unit type	No	No

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0141	0202	0266	0674
Reliability/ Validity	<ul style="list-style-type: none"> Site coordinator interview: To identify core processes and key personnel in data collection. Evidence: No difference between hospital type and limited differences by hospital size and teaching status. Video review of fall scenarios: To assess consistency, sensitivity, and specificity. Evidence: A high rate of agreement (85%) on the classification of falls between raters and a group of experts, and a 91% sensitivity agreement in identifying falls. Examine threats to validity (underreporting issue). Evidence: There is substantial evidence that fall reporting is quite complete; based on the results of a survey, 93% of site coordinators said staff would submit reports on non-injury falls most or all of the time, and 92% of direct care providers said they would file an incident report on fall scenarios. 	<ul style="list-style-type: none"> Site coordinator interview: To identify core processes and key personnel in data collection. Evidence: No difference between hospital type and limited differences by hospital size and teaching status. Online written fall injury scenario survey: To determine inter-rater reliability and construct validity. Evidence: An intraclass correlation coefficient (ICC) was 0.85 for 13 scenarios, and confirmatory factor analysis results confirm the 2-factor structure that is appropriate for predicting severity of falls with injury. Patient days (denominator) reliability test. Evidence: High agreement between patient days computed using the multiple census data collected for the study (gold standard) and patient days as routinely reported to the National Database of Nursing Quality Indicators (ICC = 0.97). 	<ul style="list-style-type: none"> Retrospective chart auditing with a convenience sample of 22 ASCs. Evidence: Zero error rates for the numerator and denominator. A questionnaire: To rate characteristics of the measure. Evidence: A high level of agreement. 	Not available.

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0141	0202	0266	0674
Actual/Planned Use	<p>Quality improvement (internal to the specific organization and external benchmarking): About one-third of hospitals (1,634) nationwide are reporting on this measure.</p> <p>Public reporting: It is reported publicly in Colorado Hospital Report Card and Massachusetts Public Reporting – Patient Care Link, Norton Healthcare, and through Leapfrog in 39 States.</p>	Same as Measure 1.	<p>Quality improvement (internal to the specific organization and external benchmarking) and public reporting: The public report of ASC quality data from 1,373 ASCs is available on the ASC Quality Collaboration Web site (www.ascquality.org).</p> <p>CMS will be using this measure for public reporting.</p>	<p>Quality improvement (internal to the specific organization and external benchmarking) and public reporting: No specific information.</p>
Care Setting	<ul style="list-style-type: none"> Hospital/acute care facility. Post-acute/long-term care facility. Inpatient rehabilitation facility. 	<ul style="list-style-type: none"> Hospital/acute care facility. Post-acute/long-term care facility. Inpatient rehabilitation facility. 	Ambulatory care: ASC	Nursing home/skilled nursing facility
Target Population	Adult acute care inpatients and adult rehabilitation patients.	Adult acute care inpatients and adult rehabilitation patients.	ASC patients	Long-stay residents
Level of Analysis	Facility; Unit	Facility; Unit	Facility	Facility
Data Source	Electronic Clinical Data, Other, Paper Medical Records	Electronic Clinical Data, Other, Paper Medical Records	Paper Records	Electronic Clinical Data
Measure Type	Outcome	Outcome	Outcome	Outcome
Measure Steward	American Nurses Association	American Nurses Association	Ambulatory Surgical Centers Quality Collaborative	CMS

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Chapter 2. Pressure Ulcers

B. Measure Justification Form for Pressure Ulcers

Project Title

Development, Implementation, and Maintenance of Quality Measures for PACE

Project Overview

The current health care system does not consistently deliver high-quality care for every participant at every opportunity, resulting in gaps in the quality of care provided. One way that CMS will carry out its obligation to drive improvement in the health care system is through the development and use of quality measures and related activities. The purpose of this project is to develop, implement, and align measures for PACE.

Descriptive Information

Date: June 24, 2015.

Measure Name: Pressure Ulcer Prevalence Rate.

Type of Measure: Outcome.

Importance

Opportunity for Improvement

The PACE program serves a frail, elderly population with the goal of maintaining them in their homes. Along with other ambulatory settings, performance measurement has not yet been conducted for this population in this type of setting. So, as yet, there are no data with which to demonstrate importance.

Rationale

Pressure ulcers are a serious problem in the U.S. health care system, and their prevention has become a national policy issue. Several national health care improvement organizations—including the National Quality Strategy, the Partnership for Patients, and the CMS HAC Reduction Program—have identified pressure ulcers as a patient safety concern.

Reducing the occurrence of pressure ulcers is a goal of the Partnership for Patients. Pressure ulcers can cause pain and serious infections, prolong hospital stays for patients, and lead to increased health care costs.

Pressure ulcer incidence rates for the PACE program are not available. The expected range for pressure ulcer rates would lie between the rates for nursing home residents and the rates for persons receiving home care. The incidence of pressure ulcers ranges from 0.4 percent to 38 percent in acute care hospitals, from 2 percent to 24 percent in long-term care nursing facilities, and from 0 percent to 17 percent in home care settings.

Clinical Practice Guideline Recommendation

NQF considers Stage III and IV hospital-acquired pressure ulcers (HAPUs) “largely preventable, grave errors” (NQF, 2008). High rates and costs of HAPUs raised concerns on the quality of patient care. CMS stopped reimbursing hospitals for costs of treating Stage III and IV HAPUs on October 1, 2008.

The development of HAPUs places the patient at risk for other adverse events and increases resource consumption and health care costs. Recommendations from clinical practice guidelines on pressure ulcers include the identification of individuals at risk and early implementation of prevention interventions to prevent pressure ulcer occurrence.¹ In most at-risk patients, interventions to reduce pressure, friction, and shear and to mitigate other patient risk factors (immobility, incontinence, impaired nutrition, etc.) will decrease pressure ulcer development and the worsening of existing pressure ulcers.

Scientific Acceptability

Information on the reliability and validity of the pressure ulcer measure for PACE programs will be available upon the completion of the pilot study.

Feasibility

Information on the feasibility of data collection on pressure ulcers for PACE programs will be available upon the completion of the pilot study.

Usability and Use

Information on usability and use will become available a year or more after implementation of routine pressure ulcer data collection in PACE programs.

Related and Competing Measures

NQF has endorsed four pressure ulcer rate measures. CMS, NQF, and MAP encourage harmonization of similar measures to promote standardized measurement across the Nation. Ideally, harmonization of the four measures would result in the same definitions of pressure ulcers.

Harmonization may be difficult or impossible if health care regulators require different definitions of pressure ulcers or if data systems differ among provider types (e.g., MDS for long-term care facilities, OASIS for home health care, and discharge data for hospitals).

Detailed comparisons of the pressure ulcer rate measures are given in Table 2; this table describes the four rates, all of which vary in important ways from each other. The measures being developed for the PACE program are not closely aligned with any of the four endorsed measures. It appears that they all use the same conceptual definition of a pressure ulcer, although the data sources and methods differ enough from each other to result in concrete definitional differences.

¹ WOCN Guidelines Task Force. (2010). Guideline for Prevention and Management of Pressure Ulcers. Mount Laurel, NJ: Wound Ostomy and Continence Nurses Society.

Table 2. Comparison of NQF-Endorsed Pressure Ulcer Rate Measures

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0679	0678	0201	0538
Measure Title	Percent of High-Risk Residents With Pressure Ulcers (Long Stay)	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay)	Pressure Ulcer Prevalence (Hospital Acquired)	Pressure Ulcer Rate
Measure Description	<p>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 II–IV pressure ulcer(s). High-risk populations are those who are comatose, impaired in bed mobility or transfer, or suffering from malnutrition.</p> <p>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.</p>	<p>This measure reports the percent of short-stay residents or patients with Stage II–IV pressure ulcers that are new or worsened since the prior assessment.</p> <p>For residents in a nursing home, the measure is calculated by examining all assessments during an episode of care for reports of Stage II–IV pressure ulcers that were not present or were at a lesser stage on the prior assessment. For the Long-Term Care Hospital (LTCH) and the Inpatient Rehabilitation Facility (IRF) setting, this measure is calculated by review of a patient's discharge assessment for reports of Stage II–IV pressure ulcers that were not present or were at a lesser stage at the time of the admission assessment.</p>	<p>The total number of patients that have hospital-acquired (nosocomial) category/Stage II or greater pressure ulcers on the day of the prevalence measurement episode.</p>	<p>Percent of discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM code of pressure ulcer in any secondary diagnosis field and ICD-9-CM code of pressure ulcer Stage III or IV (or unstagable) in any secondary diagnosis field.</p>

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0679	0678	0201	0538
Numerator Statement	<p>The numerator is the number of long-stay residents who have been assessed with an OBRA, PPS, or discharge MDS 3.0 assessments during the selected time window and who are defined as high risk with one or more Stage II–IV pressure ulcer(s).</p>	<p>The numerator is the number of residents or patients with a target assessment during the selected time window, who have one or more Stage II–IV pressure ulcer(s) that are new or that have worsened compared with the prior assessment. Specifications for the three provider-type assessment tools are listed below:</p> <p>MDS 3.0: The numerator is the number of short-stay residents with an MDS 3.0 assessment during the selected time window who have one or more Stage II–IV pressure ulcer(s) that are new or worsened, based on examination of all assessments in a resident's episode for reports of Stage II–IV pressure ulcers that were not present or were at a lesser stage on prior assessment. Assessments may be discharge, PPS 5-, 14-, 30-, 60-, 90-day or readmission/return assessments or OBRA admission, quarterly, annual, or significant change assessments.</p> <p>LTCH CARE Data Set Version 1.01 and Version 2.01: The numerator is the number of patients with a LTCH CARE Data Set discharge assessment during the selected time window who have one or more Stage II–IV pressure ulcer(s) that are new or worsened, compared to the admission assessment.</p> <p>IRF-PAI Version 1.2: The numerator is the number of patients with a completed IRF-PAI assessment during the selected time window, who have one or more Stage II–IV pressure ulcer(s) that are new or worsened at discharge compared to admission.</p>	<p>Patients who have at least one category/Stage II or greater HAPU on the day of the prevalence measurement episode.</p>	<p>Discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM code of pressure ulcer in any secondary diagnosis field and ICD-9-CM code of pressure ulcer Stage III or IV (or unstagable) in any secondary diagnosis field.</p>

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0679	0678	0201	0538
Denominator Statement	The denominator includes all long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions.	All LTCH patients and IRF patients with an admission and discharge assessment and all short-stay nursing home residents with one or more assessments that are eligible for a look-back scan, except those who meet the exclusion criteria.	All patients surveyed for the measurement episode.	All surgical and medical discharges under age 18 defined by specific DRGs or MS-DRGs.
Exclusions	<p>A long-stay resident is excluded from the denominator if the MDS assessment in the current quarter is an OBRA admission assessment or a 5-day PPS assessment or a readmission/return PPS assessment, or if a resident did not meet the pressure ulcer conditions for the numerator AND any Stage II, III, or IV item is missing (M0300B1 = - OR M0300C1 = - OR M0300D1 =).</p> <p>The OBRA admission assessment and two PPS assessment types are excluded because pressure ulcers identified on them reflect care received in the previous setting and does not reflect the quality of care provided in the nursing home.</p> <p>Nursing homes with fewer than 30 residents in the sample are excluded from public reporting because of the small sample size.</p>	<p>A patient or short-stay resident is excluded from the denominator if missing data precludes calculation of the measure. Assessments or tracking records performed at the time of patient or resident death are excluded (i.e., NF tracking record [A0310F=12] is excluded).</p> <p>Nursing homes, LTCHs, and IRFs with denominator counts of less than 20 in the sample will be excluded from public reporting owing to small sample size.</p>	<ul style="list-style-type: none"> Patients who refuse to be assessed. Patients who are off the unit at the time of the prevalence measurement (i.e., surgery, x-ray, physical therapy, etc.). Patients who are medically unstable at the time of the measurement for whom assessment would be contraindicated at the time of the measurement (i.e., unstable blood pressure, uncontrolled pain, or fracture waiting repair). Patients who are actively dying and pressure ulcer prevention is no longer a treatment goal. 	<p>Exclude cases:</p> <ul style="list-style-type: none"> Neonates With length of stay of less than 5 days. With preexisting condition of pressure ulcer (see Numerator) (principal diagnosis or secondary diagnosis present on admission). In MDC 9 (Skin, Subcutaneous Tissue, and Breast). With an ICD-9-CM procedure code for debridement or pedicle graft before or on the same day as the major operating room procedure (surgical cases only). With an ICD-9-CM procedure code of debridement or pedicle graft as the only major operating room procedure (surgical cases only). Transfer from a hospital (different facility). Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Transfer from another health care facility. MDC 14 (pregnancy, childbirth, and puerperium). With missing discharge gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing).
Risk Adjustment	Yes	Yes	Yes	Yes
Care Setting	Post-acute, long-term care facility or skilled nursing facility.	<ul style="list-style-type: none"> Long Term Care facilities. Inpatient Rehabilitation facilities. Long Term Care Hospital facilities. 	Acute Care Hospitals	Pediatric Hospitals

	Measure 1	Measure 2	Measure 3	Measure 4
NQF Number	0679	0678	0201	0538
Level of Analysis	Facility	Facility	Facility	Facility
Data Source	Minimum Data Set. CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage I ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage I ulcers from the definition.	The measure is based on data from the MDS 3.0 assessments of nursing home residents, IRF-PAI Version 1.2 for IRF patients, and the LTCH Continuity Assessment Record & Evaluation (CARE) Data Set Version 1.01 and Version 2.01 assessments of LTCH patients. Data are collected in each of the three settings using standardized items that have been harmonized across the MDS 3.0, IRF-PAI Version 1.2, and LTCH CARE Data Set Version 1.01 and Version 2.01.	Special data collection. Pressure Ulcer Prevalence Survey, examining patients and their medical records.	
Measure Type	Outcome	Outcome	Outcome	Outcome
Measure Steward	CMS	CMS	The Joint Commission	

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DRAFT

C. Measure Justification Form for Pressure Ulcer Prevention

Project Title

Development, Implementation, and Maintenance of Quality Measures for PACE

Project Overview

The current health care system does not consistently deliver high-quality care for every participant at every opportunity, resulting in gaps in the quality of care provided. One way that CMS will carry out its obligation to drive improvement in the health care system is through the development and use of quality measures and related activities. The purpose of this project is to develop, implement, and align measures for PACE.

Descriptive Information

Date: April 14, 2015.

Measure Name:

Pressure Ulcer Prevention Set.

- Days since last pressure ulcer risk assessment.
- For those at risk, pressure ulcer prevention is included in plan of care.
- For those at risk and with a plan of care, pressure ulcer prevention plan of care has been implemented.

Type of Measure: Process.

Importance

Opportunity for Improvement

The PACE program serves a frail, elderly population with the goal of maintaining them in their homes. Along with other ambulatory settings, performance measurement has not yet been conducted for this population in this type of setting. So, as yet, there are no data with which to demonstrate importance.

Rationale

Pressure ulcers are a serious problem in the U.S. health care system, and their prevention has become a national policy issue. Several national health care improvement organizations—including the National Quality Strategy, the Partnership for Patients, and the CMS HAC Reduction Program—have identified pressure ulcers as a patient safety concern.

Reducing the occurrence of pressure ulcers is a goal of the Partnership for Patients. Pressure ulcers can cause pain and serious infections, prolong hospital stays for patients, and lead to increased health care costs.

Clinical Practice Guideline Recommendation

NQF considers Stage III and IV HAPUs “largely preventable, grave errors” (NQF, 2008). High rates and costs of HAPUs raised concerns on the quality of patient care. CMS stopped reimbursing hospitals for costs of treating Stage III and IV HAPUs on October 1, 2008.

The development of HAPUs places the patient at risk for other adverse events and increases resource consumption and health care costs. Recommendations from clinical practice guidelines on pressure ulcers include the identification of individuals at risk and early implementation of prevention interventions to prevent pressure ulcer occurrence.² In most at-risk patients, interventions to reduce pressure, friction, and shear and to mitigate other patient risk factors (immobility, incontinence, impaired nutrition, etc.) will decrease pressure ulcer development and the worsening of existing pressure ulcers.

Scientific Acceptability

Information on the reliability and validity of pressure ulcer prevention measures for PACE programs will be available upon the completion of the pilot study.

Feasibility

Information on the feasibility of data collection on pressure ulcer prevention measures for PACE programs will be available upon the completion of the pilot study.

Usability and Use

Information on usability and use will become available a year or more after implementation of routine pressure ulcer prevention data collection in PACE programs.

Related and Competing Measures

NQF has endorsed one pressure ulcer prevention measure. CMS, NQF, and MAP encourage harmonization of similar measures to promote standardized measurement across the Nation. Ideally, harmonization of all measures would result in the same definitions of pressure ulcers.

Harmonization may be difficult or impossible if health care regulators require different definitions of pressure ulcers or if data systems differ among provider types (e.g., MDS for long-term care facilities, OASIS for home health care, and discharge data for hospitals).

A detailed description of the NQF-endorsed measure is presented in Table 3. The measure being developed for the PACE program is conceptually similar to the endorsed measure. Some differences do exist, and a deeper comparison is warranted for measure harmonization.

² WOCN Guidelines Task Force. (2010). Guideline for Prevention and Management of Pressure Ulcers. Mount Laurel, NJ: Wound Ostomy and Continence Nurses Society.

Table 3. Comparison of NQF-Endorsed Pressure Ulcer Prevention Measures

NQF Number	Measure 1 0538
Measure Title	Pressure Ulcer Prevention and Care
Measure Description	<p>Three measures:</p> <p>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.</p> <p>Pressure Ulcer Prevention Included in Plan of Care: Percentage of home health episodes of care in which the physician-ordered plan of care included interventions to prevent pressure ulcers.</p> <p>Pressure Ulcer Prevention 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.</p>
Numerator Statement	<p>Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers, either via an evaluation of clinical factors or using a standardized tool, at start/resumption of care.</p> <p>Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care in which the physician-ordered plan of care included interventions to prevent pressure ulcers.</p> <p>Pressure Ulcer Prevention Implemented: Number of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented.</p>
Denominator Statement	<p>Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.</p> <p>Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.</p> <p>Pressure Ulcer Prevention Implemented: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.</p>
Exclusions	<p>Pressure Ulcer Risk Assessment Conducted: No measure-specific exclusions.</p> <p>Pressure Ulcer Prevention Included in Plan of Care: Episodes in which the patient is not assessed to be at risk for pressure ulcers.</p> <p>Pressure Ulcer Prevention Implemented: Number of home health episodes in which the patient was not assessed to be at risk for pressure ulcers or the home health episode ended in transfer to an inpatient facility or death.</p>
Risk Adjustment	No
Care Setting	Home care
Level of Analysis	Home Health Program
Data Source	(Not stated; presumably OASIS)
Measure Type	Process
Measure Steward	CMS

Additional Information**Co.1.—Measure Steward Point of Contact**

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DRAFT

Chapter 3. 30-Day All-Cause Readmissions

D. Measure Justification Form for Readmission

Project Title

Development, Implementation, and Maintenance of Quality Measures for PACE

Project Overview

The current health care system does not consistently deliver high-quality care for every participant at every opportunity, resulting in gaps in the quality of care provided. One way that CMS will carry out its obligation to drive improvement in the health care system is through the development and use of quality measures and related activities. The purpose of this project is to develop, implement, and align measures for PACE.

Descriptive Information

Date: April 14, 2015.

Measure Name: 30-Day All-Cause Readmission Rate.

Type of Measure: Outcome.

Importance

Opportunity for Improvement

The PACE program serves a frail, elderly population with the goal of maintaining them in their homes. Along with other ambulatory settings, performance measurement has not yet been conducted for this population in this type of setting. So, as yet, there are no data with which to demonstrate importance.

Rationale

Hospital readmissions are a serious problem in the U.S. health care system and their prevention has become a national policy issue. Several national health care organizations—including the CMS HAC Reduction Program, the National Quality Strategy, and the Partnership for Patients—have identified hospital readmissions as an issue reflecting quality of care and resource use. The total cost of readmissions is more than \$15 billion per year (MedCAP, 2012).

Reduced hospital admissions are thought to reflect higher levels of care coordination in non-acute settings and the use of other appropriate types of residential care. Reduced hospitalizations lower the risk of hospital-based infections and other adverse events for PACE participants. Reduced hospitalizations also lower the cost of participant health care.

Scientific Acceptability

Information on the reliability and validity of the readmission measure for PACE programs will be available upon the completion of the pilot study.

Feasibility

Information on the feasibility of data collection on the readmission measure for PACE programs will be available upon the completion of the pilot study.

Usability and Use

Information on usability and use will become available a year or more after implementation of routine readmission data collection in PACE programs.

Related and Competing Measures

NQF has endorsed 42 readmission-related measures. The discussion here will be limited to 30-Day All-Cause Readmission measures. Table 4 presents information on 12 readmission measures for which CMS is the measure steward. All are defined as readmission to a hospital within 30 days of an index discharge. All are based on Medicare claims data and all are risk adjusted.

The PACE readmission measure will share many of the defining elements with the CMS measures. An index discharge will be identified, and unplanned readmissions within 30 days will be captured. The PACE measure will differ from the CMS measures in that the measurement process starts with PACE participants in community-based care, rather than with hospitalized patients. Further, the PACE measure will not be risk adjusted, having only small numbers of participants per program and data from only a small number of the Nation's hospitals. Finally, the data source will be PACE clinician records, not hospital claims data.

Table 4. NQF-Endorsed 30-Day All-Cause Readmission Measures

NQF	Title	Numerator	Denominator	Risk Adjusted	Steward
2504	30-Day Rehospitalizations for Medicare Fee-for-Service (FFS) Beneficiaries	Number of rehospitalizations within 30 days of discharge from an acute care hospital (PPS or Critical Access Hospital).	Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).	Yes	CMS

NQF	Title	Numerator	Denominator	Risk Adjusted	Steward
2502 2501 is a companion measure for Long-Term Care Hospitals	All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs	Risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix.	Number of readmissions that would be expected for that patient population at the average IRF. The measure includes all the IRF stays in the measurement period that are observed in national Medicare FFS data and do not fall into an excluded category.	Risk Standardized	CMS
0505 Companion measures for: Vascular Procedures (2513), Pneumonia (2015), PCI (0695), COPD (1891), CABG (2515); HF (0330), Total Hip/Knee (1551)	Hospital 30-day all-cause risk-standardized readmission rate following acute myocardial infarction (AMI) hospitalization	Inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index AMI admission.	Currently publicly reported by CMS for those 65 years and older who are either Medicare FFS beneficiaries admitted to non-Federal hospitals or patients admitted to VA hospitals.	Yes	CMS
1789	Hospital-Wide All-Cause Unplanned Readmission Measure	Inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission.	Currently publicly reported by CMS for those 65 years and older who are Medicare FFS beneficiaries admitted to non-Federal hospitals.	Yes	CMS

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