

Technical Expert Panel (TEP) Charter

TEP Title: Functional Status

Name of Measure Contractor Convening the TEP: University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)

Measure Project:

The Centers for Medicare & Medicaid Services (CMS) has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) to develop functional status measurement tools for use in the assessment of Medicare beneficiaries on chronic dialysis. Ideally, the developed measurement tools will effectively harmonize with those tools developed for other acute and post-acute care settings, contributing to a standardized tool set across these diverse settings.

Why the standardization of function?

The concept of functional status in the area of activities has not been measured directly. Unlike height or weight, which are measured in a uniform manner using established standardized units of measure (i.e., inches, centimeters, pounds, and kilograms), functional status has no standard unit of measure or scale. Instead, functional status has traditionally been documented using subsets of specific daily activities such as eating, bathing, walking, stair climbing, and a person's performance while completing these daily activities. A patient's level of performance for each daily activity is reported using a rating or response scale, which is a multiple-point response option set that ranks the patient's performance level.

Although many functional assessment instruments exist, only a few instruments or items have been used to construct functional status quality metrics for performance measurement at the facility level. Additionally, no measures related to function exist for cross-setting use. Each post-acute care provider collects patient assessment data that are unique to that type of provider. Although similar clinical and functional status data are collected on the MDS, IRF-PAI, and OASIS, the item definitions, measurement scales, data collection procedures, and time frames differ such that data are not directly comparable. Without a standardized data set for use across settings, or for use in multiple settings, there is limited ability to implement multi-setting quality measurement harmonization or standardization.

The standardization of functional status measures are derived from the Continuity Assessment Record and Evaluation (CARE) Tool. The Deficit Reduction Act of 2005

mandated the use of standardized assessments across acute and post-acute settings. The Post-Acute Care Payment Reform Demonstration (PAC-PRD), developed from the DRA mandate, included testing the reliability of the standardized items when used in several Medicare settings (NHs, HHAs, LTCHs, and IRFs). The idea for standardization across PAC settings would create a generalizable “language” across all PAC settings in which care coordination, care transition, and a more detailed tracking of quality and performance is feasible. Standardized assessment data would communicate the same data across care settings, ensuring the increased reliability and validity of the data, facilitating patient centered care, improving outcomes, and reducing provider burden.

While dialysis facilities were not among the settings included in the PAC-PRD, functional status remains an important aspect of patient quality of life as recognized in the KDQOL-36 assessment tool. The purpose of this Technical Expert Panel is develop quality measures assessing the functional status of the ESRD population that are aligned with similar measure development efforts being undertaken in other Medicare settings.

TEP Objectives:

The Technical Expert Panel will include dialysis stakeholders, experts in biostatistics, care disparity experts, and experts in the field of functional status assessment. Functional status experts will provide knowledge and perspective regarding function assessment in other acute and post-acute care settings for which functional status assessment has been defined. Members of the TEP are tasked with advising the Measure contractor on the appropriateness of currently available functional status assessment tools for use in the chronic dialysis setting and the need for revision or additional development of these tools prior to implementation in the dialysis care setting. As part of this evaluation, the TEP will consider opportunities to harmonize dialysis functional status tools and data elements with similar tools and data elements previously developed for other care settings. If appropriate, the TEP will provide specifications for draft functional status quality measure(s), including recommendations for data collection requirements, which will be used to facilitate the collection of the necessary elements for the development of a future outcome driven functional status measure.

Specifically, this TEP will be charged with developing recommendations to advise CMS and the Measure Contracture in future development of an outcome measure focusing on Functional Status for Medicare dialysis patients in the United States. The recommendations should, at a minimum, include 1) identification of high-impact functional status areas for development, 2) assessment of data collection feasibility, and 3) recommendations for risk adjustment strategy, if indicated.

Scope of Responsibilities:

The TEP members' role is to provide input to UM-KECC in the development of a Functional Status Measure for the US ESRD population.

Role of UM-KECC: As the CMS measure contractor, UM-KECC has a responsibility to support the development of quality measures for ESRD patients. The UM-KECC moderators will work with the C-TEP chair to ensure that the panel discussion focuses on the development of measure specifications that the C-TEP will recommend to the contractor. During discussions, UM-KECC moderators may advise the C-TEP on the needs and requirements of the contract, and may provide specific guidance to the C-TEP chair and panel during the discussion.

Role of C-TEP chair: Prior to the first teleconference, one TEP member is designated as the chair by the measure contractor and CMS. The C-TEP chair is responsible, in partnership with the moderator, for directing the TEP to meet the expectations for C-TEP members, including provision of effective advice to the contractor regarding measure specifications.

Duties and Role of C-TEP members: According to the CMS Quality Measure Blueprint, C-TEPs are advisory to the measure contractor. In this advisory role, the primary duty of the C-TEP is to propose specifications for candidate measures, and if applicable, review existing measures, to determine if there is sufficient evidence to support the proposed candidate measures. The supporting evidence is expected to vary by measure area.

C-TEP members are expected to attend one in-person meeting (held over 2 days during the week of April 28 or May 5, 2014, in Baltimore, MD), participate in two to three pre-meeting teleconferences during March and April 2014, and be available for additional follow-up teleconferences and correspondence as needed in order to support the submission and review of the candidate measures by NQF.

During teleconference(s) prior to the in-person meeting (March through April 2014): Each C-TEP will review, edit (if necessary), and adopt this charter at the first teleconference. A discussion of the overall tasks of the C-TEPs, and the goals/objectives of the ESRD quality measurement project will be described. C-TEP members will be provided with a summary of current guidelines and literature prior to the in-person meeting. C-TEP members will be asked to submit additional studies to be included in the literature review. A review of the CMS and NQF measure development criteria will also be covered during the teleconference.

During the In-Person Meeting (held over 2 days during the week of April 28 or May 5, 2014, in Baltimore, MD): Each C-TEP will review evidence to determine basis of support for proposed measures within each of the measure areas. The key deliverables of each C-TEP at the in-person meeting include: 1) to propose candidate measures if there is sufficient evidence to support the measures, 2) recommend measure specifications, and assist in completing the necessary documentation forms to support submission of the measures to

CMS for review, and to the NQF for endorsement. At the end of the two day meeting, both TEPs will convene as a full group and the C-TEP chair from each measure area will deliver a summary of recommendations. As necessary, the C-TEP chair will have additional contact with UM-KECC moderators before and after the in-person meeting to work through any other issues.

After the In-Person Meeting (approximately May – August, 2014): C-TEP members will review a summary report of C-TEP discussions and recommendations, measure specifications, and other necessary documentation forms required for submission to the NQF for endorsement.

Guiding Principles:

Potential TEP members must be aware that participation on the Technical Expert Panel is voluntary. As such, individuals wishing to participate on the TEP should understand that their input will be recorded in the meeting minutes. Proceedings of the TEP will be summarized in a report that is disclosed to the general public. If a participant has disclosed private, personal data by their own choice, then that material and those communications are not deemed to be covered by patient-provider confidentiality. If potential patient participants (only) wish to keep their names confidential, that request can be accommodated. Any questions about confidentiality will be answered by the TEP organizers.

All potential TEP members must disclose any current and past activities that may pose a potential conflict of interest for performing the tasks required of the TEP. All potential TEP members must also commit to the anticipated time frame needed to perform the functions of the TEP.

All issues which are included in the TEP summary report will be voted on by the TEP members. Counts of these votes will be included as well as written opinions of the TEP members, if requested.

Estimated Number and Frequency of Meetings:

- ◆ TEP members should expect to convene for one to three conference calls prior to the in-person meeting (held over 2 days during the week of April 28 or May 5, 2014, in Baltimore, MD).
- ◆ After the in-person meeting an additional conference call may be convened, as necessary.

Member Composition:

Attach the Technical Expert Panel Roster form.

Subgroups (if needed):**Date Approved by TEP:**