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# Technical Expert Panel Summary Report: Development and Maintenance of Quality Measures for Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

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TECHNICAL EXPERT PANEL SUMMARY REPORT:  
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CARE HOSPITAL QUALITY REPORTING PROGRAM (LTCH QRP)

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## CONTENTS

SECTION 1 Introduction and Overview .....	1
1.1 Introduction.....	1
1.2 Background.....	1
1.3 Process of TEP Meeting.....	1
1.3.1 TEP Nomination Process .....	1
1.3.2 Pre-TEP Call .....	3
1.3.3 TEP Meeting .....	3
1.4 Organization of the Report.....	4
SECTION 2 Readmission Measures.....	5
2.1 Measure Overview: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs (NQF #2512) .....	5
2.1.1 Overview of Measure.....	5
2.1.2 Overview of Measure Specifications .....	5
2.2 Measure Overview: Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP .....	6
2.2.1 Overview of Measure.....	6
2.2.2 Overview of Measure Specifications .....	6
2.3 TEP Discussion and Recommendations .....	7
2.3.1 Need for More-Detailed Information.....	7
2.3.2 Feedback on Use and Usability.....	8
2.3.3 Other Feedback on Measure Specifications.....	8
SECTION 3 Discharge to Community–PAC LTCH QRP .....	9
3.1 Measure Overview: Discharge to Community–PAC LTCH QRP .....	9
3.1.1 Overview of Measure.....	9
3.1.2 Overview of Measure Specifications .....	9
3.2 TEP Discussion and Recommendations .....	9
3.2.1 Measure Importance.....	9
3.2.2 Site-Neutral vs. Standard LTCH PPS Patients .....	9
3.2.3 Risk Adjustment for Social Supports.....	10
3.2.4 Burden of Care.....	10
3.2.5 Challenges of Cross-Setting Comparisons.....	11
3.2.6 Risk Adjustment for Clinical Factors During LTCH Stay.....	11
3.2.7 Discharge to Community Measure Distribution .....	11
3.2.8 Baseline Nursing Facility Residents .....	11
SECTION 4 Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP .....	13
4.1 Measure Overview: Medicare Spending Per Beneficiary–PAC LTCH QRP.....	13

4.1.1	Overview of Measure.....	13
4.1.2	Overview of Measure Specifications.....	13
4.2	TEP Discussion and Recommendations.....	13
4.2.1	Measure Purpose.....	13
4.2.2	Beneficiary Impact.....	13
4.2.3	Data Sources.....	14
SECTION 5 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680).....15		
5.1	Measure Overview: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680).....	15
5.1.1	Overview of Measure.....	15
5.1.2	Overview of Measure Specifications.....	15
5.2	TEP Discussion and Recommendations.....	16
5.2.1	Tracking Status and Coordinating Care.....	16
5.2.2	Rehabilitation Context and Priorities.....	16
SECTION 6 Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).....17		
6.1.	Measure Overview: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).....	17
6.1.1	Overview of Measure.....	17
6.1.2	Overview of Measure Specifications.....	17
6.2	TEP Discussion and Recommendations.....	17
6.2.1	General Comments.....	17
6.2.2	Concern for Underreporting Falls and High Burden.....	18
6.2.3	Importance of Connecting Measure to Investment in Rehabilitation.....	18
SECTION 7 Drug Regimen Review Conducted with Follow-Up for Identified Issues— PAC LTCH QRP.....19		
7.1	Measure Overview: Drug Regimen Review Conducted with Follow-Up For Identified Issues—PAC LTCH QRP.....	19
7.1.1	Overview of Measure.....	19
7.1.2	Overview of Measure Specifications.....	19
7.2	TEP Discussion and Recommendations.....	20
7.2.1	Measure Importance.....	20
7.2.2	Process v. Outcome Measure.....	20
7.2.3	Process Duplication.....	20
7.2.4	Time Frame Requirements for Data Collection.....	20

7.2.5	Unintended Consequences and Burden .....	21
<b>SECTION 8 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) .....</b>		
		<b>23</b>
8.1	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) .....	23
8.1.1	Measure Overview .....	23
8.1.2	Overview of Measure Specifications .....	23
8.2	TEP Discussion.....	24
8.2.1	Gap in Current Measure Specifications .....	24
8.2.2	Need for Additional Training Materials .....	24
8.2.3	Risk Adjustment.....	24
8.2.4	“Pressure Ulcer” Versus “Pressure Injury” Terminology.....	24
8.2.5	Considerations for Public Reporting.....	25
<b>SECTION 9 Function Process and Outcome Quality Measures .....</b>		
		<b>27</b>
9.1	Measure Overview: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) and Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) .....	27
9.1.1	Overview of Measure.....	27
9.1.2	Overview of Measure Specifications .....	27
9.2	TEP Discussion.....	29
9.2.1	Overlap of Items .....	29
9.2.2	The Rating Scale in the LTCH CARE Data Set .....	29
9.2.3	The Role of Goals .....	29
9.2.4	Measure Purpose.....	30
9.2.5	Applicable or Designated LTCH Staff to Perform Functional Assessment.....	30
9.3	Measure Overview: Functional Outcome Measure: Change in Mobility Among LTCH Patients Requiring Ventilator Support (NQF #2632).....	31
9.3.1	Measure Overview .....	31
9.3.2	Overview of Measure Specifications .....	31
9.4	TEP Discussion.....	33
9.4.1	Benefits of the Measure .....	33
9.4.2	Risk Adjustment for the Measure .....	33
9.4.3	Quality Measure Score and Interpretation .....	33
9.4.4	Narrowly Focused Denominator for the Measure .....	34

SECTION 10 Future Measures .....	35
10.1 TEP Discussion and Recommendations .....	35
10.1.1 Transitions of Care Future Quality Measure .....	35
10.1.2 Mortality Future Quality Measure .....	35
10.1.3 Patient Satisfaction Future Measure .....	35
10.1.4 Adding Sepsis as a Risk Adjustor .....	36

Appendices

A	TEP In-Person Meeting Agenda .....	A-1
B	Development and Maintenance of Quality Measures For the Long-Term Care Hospital Quality Reporting Program (LTCH QRP) Technical Expert Panel .....	B-1
C	LTCH QRP TEP Slides .....	C-1

List of Tables

1.	Members of the TEP on the Development and Maintenance of Quality Measures for the LTCH QRP .....	2
2.	Covariates for Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632) Risk-Adjustment Model .....	33

## **SECTION 1 INTRODUCTION AND OVERVIEW**

### **1.1 Introduction**

RTI International, on behalf of the Centers for Medicare & Medicaid Services (CMS), convened a Technical Expert Panel (TEP) to seek expert input on the Development and Maintenance of Quality Measures for the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP). This all-day, in-person TEP meeting was held on March 28, 2017, in Baltimore, MD.

This report summarizes the TEP proceedings, detailing key issues related to each quality measure and TEP discussion around those issues. In this section of the report, we provide a summary of the background, the process for the TEP meeting, and the organization of the TEP report.

### **1.2 Background**

CMS has contracted with RTI to develop and maintain quality measures for the LTCH QRP. The contract name is Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I). As part of its measure development process, CMS asks measure developers to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure developer during quality measure development and maintenance.

The purpose of the contract is to develop measures reflective of quality of care for post-acute care (PAC) settings, which could be used to support CMS quality missions. Care settings included in this measure development project are skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and LTCHs. Measures developed are consistent with CMS's Strategic Vision, Goals, and Priorities.

The objectives of the TEP meeting were to obtain input on current LTCH QRP quality and resource use measures implemented in the program and obtain guidance and recommendations for future measures.

### **1.3 Process of TEP Meeting**

#### **1.3.1 TEP Nomination Process**

On January 26, 2017, a "Call for TEP" and a "TEP Nomination Form" were posted on the CMS Measures Management System website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Technical-Expert-Panels.html>) to recruit TEP members. The TEP nomination opportunity period was 29 days (January 26, 2017, to February 23, 2017). Information about the opportunity to participate as a TEP member was also disseminated to national provider and professional associations, measure development experts, patient advocacy groups, potential consumer/patient representatives, and other stakeholder organizations.

After the nomination period, RTI finalized the TEP composition by selecting 10 nominees who offered a variety of clinical, research, patient, and administrative expertise in the LTCH setting and who demonstrated knowledge of LTCH QRP quality measures. The selected TEP members offered a variety of perspectives related to quality improvement, patient outcomes, research methodology, data collection and implementation, and health care disparities. One TEP member was chosen to provide consumer perspectives. **Table 1** lists the selected TEP members.

**Table 1.**  
**Members of the TEP on the Development and Maintenance of Quality Measures for the LTCH QRP**

Name	Professional Role	Location
Susan Bowen, RN, CCRN, CPHQ, CLNC	Director, Quality/Outcomes/ Patient Safety Shepherd Center	Atlanta, GA
Jean M. de Leon, MD, FAPWCA	Professor, Physical Medicine and Rehabilitation; Medical Director, Wound Care & Hyperbaric Oxygen Therapy Clinic University of Texas Southwestern Medical Center	Dallas, TX
Karen Finerty, RN, BSN, MBA	Chief Quality Officer RML Specialty Hospital	Hinsdale, IL
Meg Hassenpflug, MS, RD, FCCM	Director of Outcomes and Value Barlow Respiratory Hospital	Los Angeles, CA
James Jewell, MD	Medical Director, Medical Acute Care Unit Hebrew Rehabilitation Center	Roslindale, MA
Steven Lichtman, EdD, MAACVPR	Patient Representative; Director, Cardiopulmonary Outpatient Services, Rehabilitation Research; Research Scientist Helen Hayes Hospital	Monroe, NY
Sean Muldoon, MD, MPH, MS	Corporate Senior Vice President and Divisional Chief Medical Officer Kindred Healthcare	Louisville, KY
William J. Reilly, MS OTR/L	Director of Inpatient Rehabilitation Spaulding Hospital for Continuing Care	Cambridge, MA

(continued)

**Table 1. (continued)**  
**Members of the TEP on the Development and Maintenance of Quality Measures for the LTCH QRP**

Name	Professional Role	Location
Mary Van de Kamp, MS/CCC-SLP	Senior Vice President of Quality Kindred Healthcare	Louisville, KY
John Votto, DO, FCCP	Executive Liaison and Professor of Clinical Medicine  Hospital for Special Care New Britain, CT  University of Connecticut School of Medicine Farmington, CT  Yale University School of Medicine New Haven, CT	New Haven, CT

### 1.3.2 Pre-TEP Call

Before the TEP, RTI held a 30-minute call with TEP members. The purpose of the call was to review the TEP Charter and TEP agenda (see *Appendix A* for meeting agenda) and to clarify TEP members’ roles and responsibilities.

In addition, RTI provided an opportunity for TEP members to review the LTCH QRP quality measures derived from the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set and Medicare claims before the meeting. Note that the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network measures were not discussed during this TEP. To support this activity, RTI developed and provided to TEP members a table summarizing the selected LTCH QRP quality measures (see *Appendix B* for LTCH QRP Quality Measures Summary Table).

### 1.3.3 TEP Meeting

The all-day, in-person TEP meeting took place in Baltimore, Maryland, on March 28, 2017. The 10 selected TEP members attended the meeting, in addition to CMS and RTI staff. Discussions were facilitated by RTI’s LTCH setting lead, Terry Eng, and RTI’s measure leads at the time of the TEP, Amy Helburn, Jill McArdle, Erin White, Julie Seibert, Laurie Coots, Anne Deutsch, Poonam Pardasaney, and Melissa Morley. Throughout the meeting, there were active discussions related to implementation, data collection, and specifications of the LTCH QRP quality and resource use measures. The meeting was audio recorded for the purpose of

summarizing TEP proceedings and TEP member input on LTCH QRP quality measures in this report.

#### **1.4 Organization of the Report**

The following sections of the report discuss the overview and specifications of LTCH QRP measures and summarize the input obtained from TEP members during the meeting:

- **Section 2:** Readmission measures.
- **Section 3:** Discharge to Community–PAC LTCH QRP.
- **Section 4:** Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP.
- **Section 5:** Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (National Quality Forum [NQF] #0680).
- **Section 6:** Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
- **Section 7:** Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC LTCH QRP.
- **Section 8:** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678).
- **Section 9:** Function process and outcome quality measures.
- **Section 10:** Future measures.

## SECTION 2 READMISSION MEASURES

### 2.1 Measure Overview: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs (NQF #2512)

#### 2.1.1 Overview of Measure

This claims-based measure calculates the facility-level all-cause unplanned risk-standardized readmission rate for 30 days following discharge from LTCHs. The goal of this measure is to improve patient care and transitions of care by monitoring hospital readmissions of patients using PAC. The measure is calculated on 2 calendar years of claims data.

This measure was first adopted into the LTCH QRP in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) Final Rule (78 FR 50868 through 50874). The measure was proposed and adopted again for the LTCH QRP in the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49730 through 49731) to reflect NQF endorsement. This measure is publicly reported on the CMS LTCH Compare website (<https://www.medicare.gov/longtermcarehospitalcompare/>).

#### 2.1.2 Overview of Measure Specifications

Data used to calculate this outcome quality measure are collected through Medicare Fee-for-Service (FFS) claims. The numerator is mathematically related to the number of patients in the target population who have an unplanned readmission in the 30-day post-discharge window.

An unplanned readmission is one in which the claim has a procedure code for a procedure that is not frequently planned. This measure typically uses the same definition for planned readmissions as the CMS Hospital-Wide Readmission measure (NQF #1789). We also include additional procedures determined to be suitable for a LTCH stay on the basis of input from a previous TEP.

The measure does not have a simple form for the numerator and denominator—that is, the risk-adjustment method does not make the observed number of readmissions the numerator and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days of discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix.

The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The “expected” number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average LTCH. This measure includes all the LTCH stays in the measurement period that do not fall into an excluded category. There are 10 denominator exclusion criteria:

- (1) Patients who died during the LTCH stay.
- (2) Patients less than 18 years old.

- (3) Patients who were transferred at the end of a stay to another LTCH or short-term acute care hospital.
- (4) Patients who were not continuously enrolled in Part A FFS Medicare for the 12 months before the LTCH admission date, and at least 30 days after LTCH discharge date.
- (5) Patients who did not have a short-term acute-care stay within the 30 days before a LTCH admission date.
- (6) Patients discharged against medical advice.
- (7) Patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer.
- (8) Patients who were transferred to a federal hospital from the PAC facility.
- (9) Patients who received care from a provider located outside of the United States, Puerto Rico, or a U.S. territory.
- (10) LTCH stays with problematic data (e.g., anomalous records for hospital stays that overlap wholly or in part, or are otherwise erroneous or contradictory).

## **2.2 Measure Overview: Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP**

### **2.2.1 Overview of Measure**

The Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCHs was developed to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. It calculates the facility-level unplanned and potentially preventable risk-standardized readmission rate for 30 days post-discharge from LTCHs. The measure is calculated on 2 calendar years of claims data. This measure was adopted into the LTCH QRP in the FY 2017 LTCH PPS Final Rule (81 FR 57215 through 57219).

### **2.2.2 Overview of Measure Specifications**

The post-PAC discharge potentially preventable readmission (PPR) measures are based on Medicare FFS claims data and include PAC discharges to non-hospital post-acute levels of care or to the community. For measure calculation, the numerator is mathematically related to the number of patients in the target population who have a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are further described in the measure specifications) during the 30 days following LTCH discharge.

Potentially preventable readmissions (PPRs) are defined on the basis of the principal diagnosis on the readmission claim. PPRs are unplanned readmissions that should be avoidable with adequately planned, explained, and implemented post-discharge instructions, including the establishment of appropriate follow-up ambulatory care. The categories of PPR are inadequate management of chronic conditions (e.g., congestive heart failure, hypertension), inadequate management of infections (e.g., septicemia, bacterial pneumonia), and inadequate management of other unplanned events (e.g., acute renal failure).

An unplanned readmission is one in which the claim has a procedure code for a procedure that is not frequently planned. This measure typically uses the same definition for planned readmissions as the CMS Hospital-Wide Readmission measure (NQF #1789). We also

include additional procedures determined to be suitable for an LTCH stay, using input from a previous TEP.

The measure does not have a simple form for the numerator and denominator—that is, the risk-adjustment method does not make the observed number of readmissions the numerator, and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of potentially preventable, unplanned readmissions that occurred within 30 days of LTCH discharge. This estimate starts with the observed readmissions and is then risk adjusted for patient characteristics and a statistical estimate of the facility effect, beyond patient case mix.

The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The “expected” number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average LTCH. This measure includes all the LTCH stays in the measurement period that do not fall into an excluded category. There are 10 denominator exclusion criteria:

- (1) Patients who died during the LTCH stay.
- (2) Patients less than 18 years of age.
- (3) Patients who were transferred at the end of a stay to another LTCH or short-term acute care hospital.
- (4) Patients who were not continuously enrolled in Part A FFS Medicare for the 12 months before the LTCH admission date, and at least 30 days after LTCH discharge date.
- (5) Patients who did not have a short-term acute-care stay within 30 days before a LTCH admission date.
- (6) Patients discharged against medical advice.
- (7) Patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer.
- (8) Patients who were transferred to a federal hospital from the PAC facility.
- (9) Patients who received care from a provider located outside of the United States, Puerto Rico, or a U.S. territory.
- (10) LTCH stays with problematic data (e.g., anomalous records for hospital stays that overlap wholly or in part, or are otherwise erroneous or contradictory).

## **2.3 TEP Discussion and Recommendations**

### **2.3.1 Need for More-Detailed Information**

CMS has received feedback over the years that more-detailed information (patient or stay level) is needed to use these readmission measures for quality improvement. Providers reiterated this during the TEP meeting, noting that they can see their readmission rate and their performance category, but need to understand why patients are readmitted to make an improvement.

CMS and RTI clarified that CMS supports the intent to seek information that will drive improved quality, but explained that we are not currently able to provide this level of information for the program because of Health Insurance Portability and Accountability Act (HIPAA)

concerns. CMS and RTI clarified that we are actively investigating avenues by which greater detail may be made available in the future.

### **2.3.2 Feedback on Use and Usability**

RTI requested input on ways that the measures could be more valuable to patients and families.

There was a question regarding whether measures are risk adjusted for socioeconomic status. RTI clarified that the all-cause measure entered a 2-year trial period after initial NQF endorsement. During this period, we tested risk adjustment of socioeconomic status using several patient-level and county-level indicators. The results were mixed, and there was not consistent evidence indicating that the measure specifications should be revised. RTI noted that we will continue to monitor this issue and welcome input from the provider community.

TEP members suggested that multiple measures are confusing to patients and providers, and that the unplanned readmission measure may not be useful for quality improvement initiatives. The potentially preventable measure was preferred by some TEP members.

In addition, it was suggested that the different readmission rates for the all-cause and PPR measure may confuse patients. The comparative facility results are more easily digestible for patients than the actual readmission rate. However, providers questioned whether it is misleading to categorize performance when most facilities are within 1 to 2 percent of the average.

### **2.3.3 Other Feedback on Measure Specifications**

RTI sought TEP input on any additional topics.

One commenter requested clarification regarding why the 30-day post-discharge window begins on day 2. The purpose is to ensure that the patient is fully discharged from the LTCH before looking for a readmission, and to have separate within-stay and post-discharge measures in which the windows do not overlap. There is a data limitation on the LTCH side that has limited our ability to create a within-stay LTCH readmission measure. CMS is working to resolve this issue.

RTI received a question on the stability of the all-cause measure given that the verification statistics for NQF submission were calculated on 2009–2011 data. RTI has continued to calculate the measure and conduct testing, and the measure is stable. There was a dry run for this measure on 2012–2013 data in 2015. Additionally, the 2013–2014 data for this measure are publicly reported on the CMS LTCH Compare website (<https://www.medicare.gov/longtermcarehospitalcompare/>).

Several providers requested clarification on the risk adjusters used for the LTCH measure that are targeted at the prior hospital stay instead of the LTCH stay. RTI continues to conduct testing to identify which source of information best predicts the risk of readmission. However, RTI also clarified that the risk-adjustment data should come from a uniform source and not be influenced by PAC providers.

## **SECTION 3 DISCHARGE TO COMMUNITY–PAC LTCH QRP**

### **3.1 Measure Overview: Discharge to Community–PAC LTCH QRP**

#### **3.1.1 Overview of Measure**

The Discharge to Community–PAC LTCH QRP measure reports an LTCH's risk-standardized rate of Medicare FFS patients who are discharged to the community following an LTCH stay, do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive in the 31 days following discharge to community. RTI provided an overview of the measure, including the measure description, data sources, exclusion criteria, risk adjusters, and measure calculation. RTI noted that LTCHs are not expected to achieve a 100 percent discharge to community rate, as we recognize that discharge to a community setting may not be appropriate for some PAC patients.

#### **3.1.2 Overview of Measure Specifications**

Data required for the calculation of this measure are collected via Medicare FFS claims. Community is defined as home or self-care with or without home health services based on the “Patient Discharge Status Code” from the PAC claim. The applicable Discharge Status Codes indicating community discharge include 01, 06, 81, and 86. The measure numerator is the *risk-adjusted predicted* number of discharges to community; this estimate starts with the observed discharges to community, and is risk adjusted for patient characteristics and a statistical estimate of the facility effect beyond case mix. The denominator is the risk-adjusted expected number of discharges to community; this estimate includes risk adjustment for patient characteristics with the facility effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility appropriate to the measure. The standardized risk ratio is calculated as the ratio of predicted to expected number of discharges to community. The risk-standardized discharge to community rate is calculated by multiplying the standardized risk ratio by the national patient-level discharge to community rate for the LTCH setting.

### **3.2 TEP Discussion and Recommendations**

#### **3.2.1 Measure Importance**

Two TEP members emphasized the importance of the discharge to community measure from a patient perspective and from an LTCH’s perspective, respectively. One TEP member stated that patients are focused on three things: getting discharged, discharge location, and their functional abilities.

#### **3.2.2 Site-Neutral vs. Standard LTCH PPS Patients**

One TEP member inquired whether the measure numerator and denominator were calculated using all LTCH patients, including site-neutral and standard LTCH patients. This TEP member stated that the discharge to community outcome would likely be different for standard LTCH admissions, and measure data could be skewed if some LTCHs were more heavily weighted toward site-neutral patients than standard patients.

RTI clarified that the measure includes all LTCH patients, and there is a risk adjuster for number of intensive care unit (ICU)/coronary care unit (CCU) days in acute care, which could serve as a proxy for site-neutral patients. Those with an ICU/CCU stay of 3 or more days would represent standard LTCH patients. RTI further clarified that it was not possible to estimate the impact of site-neutral vs. traditional LTCH patient distribution in the current data (calendar years 2012–2013), as the site-neutral policy came into effect in FY 2016. RTI stated that as part of ongoing measure monitoring, we could assess whether risk adjusting for ICU/CCU length of stay, along with other risk adjusters, was sufficient to capture the difference between site-neutral and standard LTCH patients. We could also assess the effect of the proportion of site-neutral vs. standard patients on the facility’s measure performance.

### **3.2.3 Risk Adjustment for Social Supports**

One TEP member referenced RTI’s analyses on the readmission measures, which found that socioeconomic variables were not strongly associated with outcomes. This TEP member reinforced the importance of social supports, stating that our measure of social supports may have been the limitation, and the lack of a significant finding should not be interpreted as an indication that social supports are not an important determinant of outcomes in the real world. The member stated that, empirically, one would expect geography and social supports to certainly have an impact on discharge to community rates. This TEP member suggested that we rethink our measure of social supports so we can detect their impact on discharge to community rates. Another TEP member stated that when a patient has no social supports, LTCHs often have no alternative but to discharge the patient to a SNF; the TEP member was concerned that this may be interpreted as poor discharge planning or an early discharge in this measure.

RTI noted that we have been unable to adjust for social supports in the discharge to community measure because claims data do not have information related to social supports. We asked TEP members for input on data sources to capture social support as a risk adjuster in the measure; for example, would a binary variable be sufficient, or should we consider multi-item measures? One TEP member said that there are standardized measures for social support but was concerned they may be too burdensome. Another TEP member suggested looking at literature from Europe and Canada, saying that Canada is dealing with telemedicine in rural areas and trying to capture information about outcomes of patients in rural areas.

Another TEP member wondered whether the availability of social supports could be captured by the CARE Tool; this TEP member said that LTCHs identify resources available to patients before the admission process, and would thus know if a patient had social supports at home to make home discharge a possibility. This TEP member also said that this could result in reduced access for patients who did not appear likely to be able to discharge to home during the pre-admission process. Another TEP member noted that they did not see the measure as a “ding” to the LTCH, but rather as a recognition of the complexity of LTCH patients and why there is a heavier investment from a quality standpoint.

### **3.2.4 Burden of Care**

One TEP member noted that for patients who do have caregiver support, once the patients’ discharge needs and burden of care become evident, caregivers often become unwilling to care for the patient at home. This TEP member stated that although the health care field has

not identified an effective measure of the burden of long-term care, this would be an important risk adjuster for an outcome such as discharge to community.

### **3.2.5 Challenges of Cross-Setting Comparisons**

One TEP member discussed the challenge presented by the IMPACT Act, as it did not differentiate settings and outcomes, and mandated assessment of the same outcomes across all post-acute settings. This TEP member did not think that the IMPACT Act required the same level of outcomes across settings. In contrast, another TEP member thought that cross-setting comparisons of resources and outcomes would become a reality moving forward. This TEP member stated that accountable care organizations discharging patients would evaluate PAC setting resources and choose to send their patients to the least-expensive site of care. The discussion then turned toward issues related to Medicare spending per beneficiary (MSPB), and RTI deferred these discussions to the MSPB measure discussion.

One TEP member noted that proper risk adjustment was key to examining costs and outcomes so that when assessing episode-of-care cost distributions, one could infer that hospitals on the left side of the distribution, as opposed to those on the right, were not sending their patients to the appropriate discharge destination.

### **3.2.6 Risk Adjustment for Clinical Factors During LTCH Stay**

One TEP member said that the measure should risk adjust for the patient's clinical experience in the LTCH, beyond adjustment for mechanical ventilation in the LTCH. This TEP member stated that events occurring during the LTCH stay would affect the patient's discharge destination; sicker patients would be more likely to need a SNF stay after their LTCH stay, and this should be adjusted for with clinical variables related to the LTCH stay.

### **3.2.7 Discharge to Community Measure Distribution**

One TEP member asked how LTCHs could have a 100 percent discharge to community rate, or even rates as high as 80 or 90 percent. RTI responded that the number of LTCH stays per facility ranged from 1 to 3,014, with some LTCHs having only one or a few stays. Some of the extreme or outlying discharge to community rates came from LTCH facilities with very few patient stays. For example, if an LTCH only had one patient stay that resulted in a discharge to the community, the LTCH would have a 100 percent discharge to community rate.

Another TEP member said he was pleased that the risk-standardized rate approached a normal distribution, and that risk adjustment did not narrow the distribution to such an extent that patients would be unable to discriminate among LTCHs. The presented spread of discharge to community rates allowed patients to differentiate among LTCHs.

### **3.2.8 Baseline Nursing Facility Residents**

Some TEP members stated that patients who lived in a nursing facility at baseline should be excluded from the measure because they are not expected to return to the community after the PAC stay. These TEP members stated that if a baseline nursing facility resident returned to a nursing home after their LTCH stay, they were returning to their baseline residence, and even though this was not a community setting, it was a good outcome for the patient. Another member

added there was an issue in defining “community”; for example, if a patient’s community is a nursing facility and they were discharged to that setting, this should count as a discharge back to the patient’s baseline “community.” However, if the current discharge to community measure defined “community” as a home or home-like environment, then baseline nursing facility residents should be excluded from the measure.

RTI responded that analyses using assessment data are currently being conducted to identify baseline nursing facility residents and the impact of excluding them from the measure across all PAC settings.

RTI asked TEP members what proportion of LTCH patients resided in a long-term nursing facility at baseline. One TEP member stated that 30 percent of the ventilator weaning population (340 patients/year) at their LTCH were nursing facility residents at baseline, and these patients were typically not discharged to community but rather back to a SNF with a tracheostomy. Another TEP member stated their analysis showed that fewer than about 15 percent of LTCH patients came from a nursing facility, which was surprisingly smaller than they expected.

## **SECTION 4 MEDICARE SPENDING PER BENEFICIARY (MSPB)–PAC LTCH QRP**

### **4.1 Measure Overview: Medicare Spending Per Beneficiary–PAC LTCH QRP**

#### **4.1.1 Overview of Measure**

The MSPB-PAC LTCH QRP measure evaluates LTCH providers' resource use relative to the resource use of the national median LTCH provider. Specifically, the measure assesses the cost to Medicare for services performed by the LTCH provider during an MSPB-PAC LTCH episode.

#### **4.1.2 Overview of Measure Specifications**

Data required for the calculation of this measure are collected via Medicare FFS claims. The measure is calculated as the ratio of the price-standardized, risk-adjusted MSPB-PAC amount for each LTCH divided by the episode-weighted median MSPB-PAC amount across all LTCH providers.

The numerator for a LTCH provider's MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all LTCH providers.

The denominator for a LTCH provider's MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all LTCH providers.

### **4.2 TEP Discussion and Recommendations**

#### **4.2.1 Measure Purpose**

Several TEP members questioned the purpose of the MSPB-PAC measure. Specifically, TEP members raised the issue of how this can be a measure of efficiency when it is based on Medicare payments. Is this measure focused on discharge planning to limit post-discharge utilization? Panel members noted that costs do not equal value and that this measure cannot stand alone. Other metrics are needed to make sure we are measuring value.

Panel members also noted that the time period over which the measure is constructed is important to consider. Is the time period sufficient to capture the potential benefits of high-cost providers such as LTCHs?

#### **4.2.2 Beneficiary Impact**

TEP panel members noted there may be unintended consequences for beneficiaries if the measure focuses only on cost. Panel members also noted that this measure may not influence beneficiary choices unless their copayment is affected.

### **4.2.3 Data Sources**

The panel raised the question of whether Medicare Advantage data could be incorporated into this measure in the future. Medicare Advantage is a large part of the Medicare program, and beneficiaries in Medicare Advantage do not use IRF and LTCH services as often as beneficiaries in traditional Medicare. It is not clear what the trajectory of service use is for Medicare Advantage beneficiaries, and it would be informative to examine these data in the context of this measure in the future.

**SECTION 5**  
**PERCENT OF RESIDENTS OR PATIENTS WHO WERE ASSESSED AND**  
**APPROPRIATELY GIVEN THE SEASONAL INFLUENZA VACCINE (SHORT STAY)**  
**(NQF #0680)**

**5.1 Measure Overview: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)**

**5.1.1 Overview of Measure**

The Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) is a NQF-endorsed process measure that reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season (IVS).

This measure is intended to encourage LTCHs to assess patients' seasonal influenza immunization status and to administer the immunization, as deemed clinically appropriate. This measure was first endorsed by the NQF as a short-stay nursing home measure in 2012. In June 2012, the resident influenza vaccine measure was expanded to include patients treated in IRFs and LTCHs. The measure is now endorsed by the NQF for all three settings. Data collection for this measure began on October 1, 2014, using the LTCH CARE Data Set Version 1.01. This measure will be publicly reported on the CMS LTCH Compare website (<https://www.medicare.gov/longtermcarehospitalcompare/>) in December 2017.

**5.1.2 Overview of Measure Specifications**

This stay-based influenza vaccine quality measure is based on data collected from the LTCH CARE Data Set for all LTCH patients.

The measure is based on the completion of two influenza vaccine assessment items:

**Item O0250A:** "Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season," with two responses: "Yes" and "No."

**Item O0250C:** "If influenza vaccine not received, state reason," with the following response options:

- Patient not in this facility during this year's IVS
- Received outside of facility
- Not eligible—medical contraindication
- Offered and declined
- Not offered
- Inability to obtain influenza vaccine because of a declared shortage
- None of the above

The measure numerator is an aggregate of three separately calculated submeasures to reflect the process by which a patient is "appropriately" assessed or given the influenza

vaccination during the stay. The numerator is the number of patients who were in the facility for one or more days during the IVS and meet one of the following criteria:

- (1) Received the seasonal influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a).
- (2) Were offered and declined the seasonal influenza vaccine (NQF #0680b).
- (3) Were ineligible because of contraindication(s) (NQF #0680c).

The numerator coincides with the most recently-completed IVS, which begins on October 1 of the current year or when the influenza vaccine becomes available (whichever comes first), and ends on March 31 of the following year.

The denominator consists of all LTCH patients 180 days of age or older on the target date of the assessment who had a discharge date within the current influenza season (July 1 to June 30) and were in the facility/hospital for at least one day during the IVS. Patient stays with a discharge date before April 1, 2016, that ended with a patient's death are excluded from the measure calculation. This is because the LTCH CARE Data Set Version 2.01, which was collected before April 1, 2016, did not include the influenza items in the expired assessment.

## **5.2 TEP Discussion and Recommendations**

### **5.2.1 Tracking Status and Coordinating Care**

One expert noted that it would be useful to track immunization status continually across care so providers do not have to spend time tracking down patient influenza vaccination status. Another noted that it is in part a documentation issue, commenting that it is hard to compare LTCHs across the board when LTCHs are so different. No matter how good training may be, staff may interpret things differently (e.g., one staff member indicates that a patient was not offered the flu vaccine, then another staff member later indicates that the patient refused it). Another expert suggested that individual states may be better positioned to track this process measure.

### **5.2.2 Rehabilitation Context and Priorities**

There was discussion as to whether the influenza vaccination is a quality measure well suited to the LTCH setting, given that it is a process measure. One expert suggested that the value of this measure is to focus on educating patients regarding the importance of influenza vaccination. Other experts countered that this measure is a quality measure because of the wellness piece; there are data to support why the influenza vaccine supports health; and if patients get the flu, it will affect their length of stay. Another noted that several other measures are process measures too (e.g., care plan, resource measure, readmission measure), and that such measures are needed to coordinate care across the continuum.

**SECTION 6**  
**APPLICATION OF PERCENT OF RESIDENTS EXPERIENCING ONE OR MORE**  
**FALLS WITH MAJOR INJURY (LONG STAY) (NQF #0674)**

**6.1. Measure Overview: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)**

**6.1.1 Overview of Measure**

The cross-setting quality measure Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) addresses the IMPACT Act domain of incidence of major falls. This quality measure reports the percentage of patients or residents who experience one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) during the SNF, LTCH, or IRF stay.

The measure was endorsed by the NQF in March 2011 for the long-stay nursing home population. The measure was finalized for use in the LTCH QRP in the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49736 through 49739). Data collection for the measure began April 1, 2016, using the LTCH CARE Data Set Version 3.00.

**6.1.2 Overview of Measure Specifications**

This quality measure is based on data reported for two items on the LTCH CARE Data Set:

**Item J1800:** “Has the patient had any falls since admission,” with two responses: “Yes” and “No.”

**Item J1900C:** “Number of falls since admission: Major injury,” which allows providers to respond “None”, “One,” or “Two or more” to indicate the number of falls since admission that resulted in a major injury to the patient.

For measure calculation, the numerator is the number of patient stays with a planned or unplanned discharge or expired assessment during the selected time window who experienced one or more falls that resulted in major injury (J1900C = [1] or [2]). The denominator is the total number of stays with a discharge or expired assessment (A0250 = 10, 11, or 12) that did not meet the exclusion criteria. Patient stay is excluded if falls with major injury data is missing (J1900C = [-]) on the unplanned or planned discharge or expired assessment during the selected time window. This measure is not risk adjusted or stratified.

**6.2 TEP Discussion and Recommendations**

**6.2.1 General Comments**

TEP members generally agreed that the measure is straightforward and major injury is clearly defined. One member stated that they liked that the focus of the measure is not falls, but falls with major injury. Several members commented that, as therapy should include challenging patients’ balance and improving mobility, it is common and even expected to have falls or

assisted falls during rehabilitation. These falls are typically in a safe environment and should not result in major injury. Falls with major injury are a more serious safety issue that may be indicative of poor quality of care, and therefore, they are an important outcome to measure.

### **6.2.2 Concern for Underreporting Falls and High Burden**

There is some concern that falls may be underreported (other than falls with major injury), as per the definition, because of the lack of human resources available to capture this information.

### **6.2.3 Importance of Connecting Measure to Investment in Rehabilitation**

One member expert commented that patients who receive longer rehabilitation are less likely to fall when they go home and stated that it would be valuable if this measure could affect investment in rehabilitation.

**SECTION 7**  
**DRUG REGIMEN REVIEW CONDUCTED WITH FOLLOW-UP FOR IDENTIFIED**  
**ISSUES—PAC LTCH QRP**

**7.1 Measure Overview: Drug Regimen Review Conducted with Follow-Up For Identified Issues—PAC LTCH QRP**

**7.1.1 Overview of Measure**

Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC LTCH QRP is a patient assessment–based process quality measure that assesses whether LTCH providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the time of admission and throughout the patient stay. Specifically, this measure reports the percentage of patient stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that stay.

CMS adopted this measure to address the IMPACT Act quality measure domain, medication reconciliation. The measure was finalized for use in the LTCH QRP in the FY 2017 IPPS/LTCH PPS Final Rule (81 FR 57219 through 57223). Data collection for the measure will begin July 1, 2018, using standardized items that have been added to the LTCH CARE Data Set Version 4.00.

**7.1.2 Overview of Measure Specifications**

This quality measure is calculated using data collected on items N2001, N2003, and N2005 on the LTCH CARE Data Set Version 4.00 for all LTCH patients.

The numerator is the number of stays for which all of the following are true:

- (1) The facility conducted a drug regimen review at the admission (N2001 = [0,1]) or patient is not taking any medications (N2001 = [9]); and
- (2) If potential clinically significant medication issues were identified at the admission (N2001 = [1]), the facility contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/recommended actions in response to the identified issues (N2003 = [1]); and
- (3) The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]), or no potential clinically significant medications issues were identified since the admission (N2005 = [9]).

Please note that if data are missing on any of the three items used to calculate the numerator of the measure (specifically, N2001 = [-] or N2003 = [-] or N2005 = [-]), the patient's stay will not be included in the numerator count, but will still be counted in the denominator.

The denominator is the number of patient stays with a discharge or expired assessment (A0250 = 10, 11, 12) during the reporting period. The measure has no denominator exclusions for LTCHs.

## **7.2 TEP Discussion and Recommendations**

### **7.2.1 Measure Importance**

The TEP members noted the importance of the measure, especially surrounding patient safety and outcomes. Several TEP members noted that the measure will lead to improved processes for communication and information sharing across facilities—including better communication between requesting clinicians and discharging facilities—leading to an improvement in discharge information sharing and a reduced workload for requesting clinicians over time. Some members conveyed the value of the measure in its broader context as a cross-setting measure, noting that the measure will improve medication safety across PAC settings.

### **7.2.2 Process v. Outcome Measure**

The TEP members recognized the importance of this process measure—as a starting point for bringing attention to medication issues and ensuring that necessary universal processes are in place across PAC settings. Several TEP members suggested that the measure eventually be developed into an outcome measure to track the number of successful interventions and then tie a cost of bad care to these interventions.

### **7.2.3 Process Duplication**

Several TEP members suggested capturing the measure through current LTCH processes, rather than asking LTCHs to duplicate current processes—many of which are best practices—to meet measure requirements. One TEP member suggested developing an alternative measure to capture the number of adverse events identified throughout the stay.

### **7.2.4 Time Frame Requirements for Data Collection**

The TEP members mentioned several potential data collection issues, including potential difficulty in determining whether actions took place “by midnight of the next calendar day,” especially if the clinician does not record the time of completion for every identified medication issue or misinterprets the meaning of “midnight of the next calendar day.”

The TEP members conveyed concern that the measure’s time frame requirements do not align with current technology and the current flow of information between facilities and among clinicians. The TEP members noted several factors that may impede the flow of information, including low patient medication literacy, incomplete medical records from referring facilities, lack of access to electronic medical records, and unaligned electronic medical record systems between facilities. As such, the TEP members conveyed concern regarding clinician access to adequate resources for obtaining data within the measure’s time frame requirements. One TEP member suggested introducing categories of drugs with frequent overlap or intervention to improve process efficiency for clinicians.

### **7.2.5 Unintended Consequences and Burden**

One TEP member expressed concern regarding unintended consequences surrounding self-identification and self-reporting. The TEP member noted that each time clinicians choose to self-identify about an issue, they will know they are setting the facility up for the potential of a less-than-perfect score, in which case all other work to resolve additional medication issues for the patient would be “for nothing,” as the numerator is not triggered unless the requirements of all three items are met. The TEP member further stated that, by modifying the measure to include only items N2001 and N2003, the measure would capture 80 percent of the current data at 20 percent of the current burden. For these reasons, the TEP member suggested the measure be modified to include items N2001 and N2003 only, removing item N2005.

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**SECTION 8**  
**PERCENT OF RESIDENTS OR PATIENTS WITH PRESSURE ULCERS THAT ARE**  
**NEW OR WORSENERD (SHORT STAY) (NQF #0678)**

**8.1 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**

**8.1.1 Measure Overview**

The Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) is a NQF-endorsed (NQF #0678) outcome measure that reports the percentage of patients or short-stay residents with Stages 2 through 4 pressure ulcers that are new or have worsened since admission. This measure is a cross-setting IMPACT Act measure and addresses the domain of skin integrity or changes in skin integrity. This measure is intended to encourage LTCHs to focus on this important clinical and patient safety issue to prevent pressure ulcers and to closely monitor and promote healing of existing pressure ulcers.

This measure was implemented for the short-stay nursing home population in the nursing home and SNF settings in 2010 and was first endorsed by the NQF in 2011. This measure was finalized for use in the LTCH QRP in the FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51748 through 51751). Data collection for this measure began October 1, 2012, using the LTCH CARE Data Set Version 1.01. This measure is publicly reported on the CMS LTCH Compare website (<https://www.medicare.gov/longtermcarehospitalcompare/>).

**8.1.2 Overview of Measure Specifications**

This stay-based pressure ulcer quality measure is based on data collected from the LTCH CARE Data Set for all LTCH patients, regardless of payer. Data are collected separately in each of the three settings using standardized items that have been harmonized across the Minimum Data Set, LTCH CARE Data Set, and IRF Patient Assessment Instrument. For LTCHs, this measure reports the percentage of patients with reports of Stages 2 through 4 pressure ulcers that were not present or were at a lesser stage on admission.

The numerator is the number of stays for which the LTCH CARE Data Set discharge assessment indicates one or more new or worsened Stages 2 through 4 pressure ulcers compared to the LTCH CARE Data Set admission assessment.

The denominator is the number of patient stays with both an admission and discharge LTCH CARE Data Set assessment, except those that meet the following exclusion criteria:

- (1) Data on new or worsened Stages 2, 3, and 4 pressure ulcers are missing on the planned or unplanned discharge assessment.
- (2) The patient died during the LTCH stay.
- (3) No admission assessment is available.

The measure is risk adjusted for mobility limitations, bowel incontinence, diabetes or peripheral vascular disease, and low body mass index (BMI).

## **8.2 TEP Discussion**

### **8.2.1 Gap in Current Measure Specifications**

Upon review of the specifications for the pressure ulcer quality measure, one TEP member stated that a gap existed in the current specifications because the numerator currently includes patient stays with one or more new or worsened Stages 2 through 4 pressure ulcers and does not include unstageable pressure ulcers or deep tissue injuries. The TEP member also indicated the importance of including unstageable pressure ulcers in the quality measure, as these pressure ulcers are very costly to LTCHs and the health care system.

### **8.2.2 Need for Additional Training Materials**

RTI sought TEP feedback on the need for additional training materials and guidance regarding the pressure ulcer quality measure for the LTCH QRP. One TEP member commented on the need for additional training and suggested using other formats, such as pictures, videos, and interactive Web-based training materials, to supplement the existing training materials. One TEP member cautioned against changing the pressure ulcer terminology included in data collection tools, manuals, and training materials to conform with current National Pressure Ulcer Advisory Panel (NPUAP) guidance without additional education and training to reduce any anxiety that patients may feel in response to the terminology change from “ulcer” to “injury.” Several TEP members agreed on the need to align terminology and guidance across the training materials and across the various stakeholder groups. Furthermore, several TEP members encouraged CMS to add additional training following any measure terminology or staging changes.

### **8.2.3 Risk Adjustment**

The cross-setting pressure ulcer measure is currently risk adjusted for four factors: functional limitation (bed mobility), bowel incontinence, diabetes or peripheral vascular disease/peripheral arterial disease, and low BMI. One TEP member encouraged CMS to revisit risk adjustment more often for this measure, and to specifically consider adding hemodialysis and very high BMI as risk adjusters for this measure. Several TEP members agreed that the risk adjustment should be updated for this measure.

### **8.2.4 “Pressure Ulcer” Versus “Pressure Injury” Terminology**

One TEP member cautioned CMS against adopting any terminology changes without giving thoughtful and careful consideration and advised CMS to adopt terminology that will reduce patient anxiety as much as possible. Several TEP members strongly recommended that additional training and guidance accompany any terminology changes.

Although TEP members reached no consensus regarding the appropriate terminology to be used, they recognized that the term “pressure injury” had been adopted by the NPUAP and the National Healthcare Safety Network. The TEP members did agree on the importance of terminology being aligned across medical settings and different QRPs, citing many examples in which the change in terminology prevented pressure ulcers from being appropriately documented. The TEP members encouraged CMS to consider aligning any terminology changes with NPUAP and International Classification of Diseases, 10<sup>th</sup> revision (ICD-10) codes.

### **8.2.5 Considerations for Public Reporting**

The TEP was asked to provide feedback on how CMS might make this measure more valuable to patients and families. One TEP member encouraged CMS to increase awareness among patients and families regarding the CMS LTCH Compare website (<https://www.medicare.gov/longtermcarehospitalcompare/>) and awareness of how the public data available to patients and families should be interpreted. Another TEP member agreed and specifically noted that patients and families need better education on the meaning of the measures and how to interpret risk adjustment within the measure data. Another TEP member advocated for information to be presented in the simplest, most specific way possible, and encouraged CMS to consider that the caregiver will be the primary user of the public data. Several TEP members agreed that there is a stigma surrounding PAC and end-of-life events, and that CMS should highlight the differences between avoidable and unavoidable events so that patients and families can better understand their options.

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## SECTION 9 FUNCTION PROCESS AND OUTCOME QUALITY MEASURES

### **9.1 Measure Overview: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) and Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**

#### **9.1.1 Overview of Measure**

In the FY 2014 IPPS/LTCH PPS Final Rule (79 FR 50291 through 50298), the LTCH QRP adopted the quality measure Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). This quality measure was developed and tested using data from the CARE Item Set from the PAC Payment Reform Demonstration. Subsequently, a modified cross-setting version of the quality measure was developed and implemented in the LTCH QRP, as well as the IRF QRP and the SNF QRP, to meet the requirements of the IMPACT Act. The cross-setting version of this measure is known as the Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), and it was adopted in the LTCH QRP in the FY 2016 IPPS/LTCH PPS Final Rule (80 FR 49739 through 49747).

Both of these process quality measures report the percentage of patients with admission and discharge functional assessments and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient. These functional status quality measures are calculated using clinical data collected at the time of admission and discharge. The LTCH CARE Data Set Version 3.00 contained the data elements necessary to collect the data that are required to calculate the quality measures. CMS offered LTCH CARE Data Set coding training to clinicians in November of 2015 (in-person training) and February 2016 (webinar). Ongoing clinical coding support has been available to LTCHs via a help desk (email) and question-and-answer documents posed on the LTCH QRP website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Help.html>). LTCHs began data collection for both functional status quality measures on April 1, 2016, using LTCH CARE Data Set Version 3.00.

#### **9.1.2 Overview of Measure Specifications**

The process quality measures report the percentage of all LTCH patients with an admission and discharge functional assessment and a treatment goal that addresses function. Both measure denominators include the number of LTCH patients discharged during the targeted 12-month (i.e., four-quarter) performance period. These measures have no exclusion criteria and do not require risk adjustment.

The numerator is the number of LTCH patients with complete admission and discharge functional assessment data and at least one self-care or mobility discharge goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator:

- (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the admission assessment;
- (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility discharge goal item on the admission assessment; and
- (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the discharge assessment.

For patients with an incomplete stay—for example, if the patient is discharged before completing the LTCH stay because of a medical emergency—collection of discharge functional status data might not be feasible. Therefore, discharge data are not required for patients whose stay is incomplete. For patients with an incomplete stay, the following are required for the patients to be counted in the numerator:

(1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the admission assessment; and

(2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

The valid codes and code labels for the admission and discharge self-care and mobility functional assessment items are as follows:

- 06—Independent.
- 05—Setup or clean-up assistance.
- 04—Supervision or touching assistance.
- 03—Partial/moderate assistance.
- 02—Substantial/maximal assistance.
- 01—Dependent.
- 07—Patient refused.
- 09—Not applicable.
- 88—Not attempted due to medical condition or safety concerns.

Only codes 01 through 06 are valid for coding the self-care and mobility discharge goal items.

The measure Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) includes several items that are not included on the measure Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). The additional items are Understanding Verbal Content, Expression of Ideas and Wants, Signs and Symptoms of Delirium, Bladder and Bowel Continence, Wash Upper Body, and Roll Left and

Right. The cross-setting measure, which is an application of the LTCH process function measure, focuses on self-care and mobility activities.

## **9.2 TEP Discussion**

### **9.2.1 Overlap of Items**

TEP members gave feedback on the overlap of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) and Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

One TEP member stated that patients would find it confusing to see two quality measures that essentially address the same process and suggested that too much information could lead to data fatigue.

One TEP member pointed out that the original LTCH measure took into account the complexity of LTCH patients. The original measure includes items appropriate for LTCH patients, and these items are not included in the cross-setting measure. This TEP member cautioned against removing the original measure and keeping only the cross-setting measure, stating it would not capture some of the information that is collected specifically for LTCHs.

Some TEP members added that LTCHs previously did not have standardized items to assess function and expressed concern that trying to fit one set of items for all settings could limit the measure's ability to appropriately capture patient functioning for the LTCH population.

Some TEP members questioned whether having two similar functional process measures would be burdensome for providers. RTI responded that having the additional cross-setting measure does not increase burden because the items are already collected in the original LTCH measure.

### **9.2.2 The Rating Scale in the LTCH CARE Data Set**

One TEP member noted the functional assessment items use a six-level rating scale. The TEP member added that education for clinicians is important because the rating scale is different than other functional assessment instruments, which may be confusing for clinicians. RTI responded by stating that the rating scale was designed to range from totally dependent (level 1) to independent (level 6) and allow for measurable improvements by discharge for patients who were totally dependent on admission. Clinicians gave feedback that a scale from total dependency to independent was necessary.

### **9.2.3 The Role of Goals**

One TEP member stated that there is a disconnect between the assessment of functional performance and the requirement for only one goal. For example, the TEP member said this may occur if the patient needs assistance with walking, but the provider reports a goal for eating, rather than walking. RTI noted that while only one goal is needed to meet the measure requirements, CMS encourages providers to work with patients and their families to co-create appropriate discharge function goals. The measure is designed to be flexible. For example, eating

independently may be the most important co-created goal for one patient while walking is the most important co-created goal for another patient.

One TEP member said clinicians may hold back on inputting goals because they are nervous that CMS is keeping track of whether the provider met the goal. The TEP member added that there needs to be education regarding goal setting. RTI responded that the process measure does not report the percentage of people who reached their goals. The goal items for the process measure are intended to capture that a treatment goal that addresses function was established during the admission assessment period.

Most TEP members agreed that gaming could be involved in goal setting. Some TEP members responded that outcome measures that are actionable are an important complement to the function process quality measures.

#### **9.2.4 Measure Purpose**

One TEP member pointed out that the main goal of the cross-setting process measure was to get clinicians to get in the habit of completing the functional assessment items and to have standardized functional items across PAC settings. RTI agreed and stated that these items could lead to the development of additional functional outcome measures. Another TEP member agreed that the data from the process measure is a starting point, and the data could be used to develop outcome measures.

One TEP member cautioned against developing cross-setting outcome measures from the process measure. The TEP member added that development of these outcome measures requires significant deliberation for the measures to be comparable across LTCHs.

Another TEP member stated that the LTCH outcome measures should focus more on medical outcomes than on rehabilitation. The TEP member also cautioned that if LTCH patients are truly the most medically complex outside of the intensive care unit, then providers should not be held accountable for admitting a bedridden patient that is not able to walk by discharge. The TEP member noted that, if functional improvement is the desirable and primary outcome, then the patient should have been admitted to an IRF. One TEP member stated that patients and families want to see that LTCHs are attentive to functional ability to ensure that functioning is not ignored because the patient is critically ill.

#### **9.2.5 Applicable or Designated LTCH Staff to Perform Functional Assessment**

One TEP member asked whether the functional assessment can only be performed by licensed individuals. RTI responded by stating that there are state regulations, and CMS instructs providers to follow any facility, state, and federal policies. Other direct care staff can provide information about a patient's ability to participate in daily activities to the licensed clinicians.

One TEP member asked whether the functional assessment code would vary depending on what type of LTCH staff is performing the assessment. There were many questions on who completes the assessment, and who would be the best clinician to complete the assessment. One TEP member stated that they ended up changing staff coverage to allow physical therapists to perform the functional assessments.

### **9.3 Measure Overview: Functional Outcome Measure: Change in Mobility Among LTCH Patients Requiring Ventilator Support (NQF #2632)**

#### **9.2.1 Measure Overview**

LTCH patients often have functional limitations and receive rehabilitation therapy services so that they can become more independent when performing daily activities. Functional improvement is particularly relevant for patients who require ventilator support because these patients have traditionally had limited mobility due to cardiovascular and pulmonary instability, delirium, sedation, and lack of rehabilitation therapy. Section 1206(c) of Division B of Public Law 113–67, the Pathway to Sustainable Growth Rate Reform Act of 2013, required the Secretary to establish “a functional status quality measure for change in Mobility among inpatients requiring ventilator support.” As a result, in the FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50298 through 50301), the LTCH QRP adopted Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632). This quality measure was developed and tested using the CARE Item Set data from the PAC Payment Reform Demonstration.

This functional outcome measure is calculated using clinical assessment data collected at the time of admission and discharge. The LTCH CARE Data Set Version 3.00 is used to collect the data necessary to calculate the quality measure. CMS offered LTCH CARE Data Set training to clinicians in November 2015 (in-person training) and February 2016 (webinar). Ongoing coding support has been available to LTCHs via a help desk email address and question-and-answer documents posed on the LTCH QRP website. LTCHs began data collection for this functional outcome quality measure on April 1, 2016, using LTCH CARE Data Set Version 3.00.

#### **9.2.2 Overview of Measure Specifications**

This measure estimates the risk-adjusted change in mobility score between admission and discharge among LTCH patients requiring ventilator support on admission. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.

The following mobility items are included on the LTCH CARE Data Set Version 3.00 to allow LTCHs to submit data that are used to calculate the admission and discharge mobility score:

- GG0170A. Roll Left and Right.
- GG0170B. Sit to Lying.
- GG0170C. Lying to Sitting on Side of Bed.
- GG0170D. Sit to Stand.
- GG0170E. Chair/Bed-to-Chair Transfer.
- GG0170F. Toilet Transfer.
- GG0170J. Walk 50 Feet with Two Turns.
- GG0170K. Walk 150 Feet.

The valid codes and code definitions for the admission and discharge mobility items are:

- 06—Independent.
- 05—Setup or clean-up assistance.
- 04—Supervision or touching assistance.
- 03—Partial/moderate assistance.
- 02—Substantial/maximal assistance.
- 01—Dependent.
- 07—Patient refused.
- 09—Not applicable.
- 88—Not attempted due to medical condition or safety concerns.

To obtain the admission and discharge mobility scores, item codes 01 through 06 were used, and items that had codes of 07, 09, or 88 were recoded to Dependent, 01, to calculate the mobility score. Walking items that were skipped (^) because of the patient's status were also recoded to Dependent. The sum of the scores for the eight mobility items becomes the mobility score for admission and discharge. The mobility score ranges from 8 through 48. For this measure, the change in mobility score is calculated as the difference between the admission and discharge mobility scores.

In addition, there are several exclusion criteria:

- Patients with incomplete stays.
- Patients discharged to hospice.
- Patients younger than 21 years of age.
- Patients with coma, persistent vegetative state, complete tetraplegia, or locked-in syndrome.
- Patients with progressive neurological conditions, including amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, and Huntington's chorea.
- Patients who are coded as independent on all the LTCH CARE Data Set mobility items at admission.

The covariates in the risk-adjustment model are presented in **Table 9.3.B**.

**Table 2.**  
**Covariates for Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632) Risk-Adjustment Model**

Age Group: younger than 55 years; 55–64 years; 65–74 years (reference group); 75–84 years; 85 years and older
Communication Impairment: Moderate to severe
Prior Functioning: Indoor Ambulation: Dependent; some help
Prior Device Use: Wheelchair/scooter; mechanical lift
Primary Medical Condition Category: Chronic respiratory condition; acute onset and chronic respiratory conditions; chronic cardiac condition; other medical condition
Stage 3, 4, or Unstageable Pressure Ulcer: Presence
Total Parenteral Nutrition on Admission: Yes
Comorbidities: Severe and metastatic cancers; dialysis and chronic kidney disease, stage 5; acute renal failure; major infections: septicemia, sepsis, systematic inflammatory response syndrome/shock, central nervous system infections, opportunistic infections, or bone/joint/muscle infections or necrosis; diabetes mellitus; major lower limb amputation; stroke, hemiplegia, or hemiparesis; dementia; paraplegia, incomplete tetraplegia, or other spinal cord disorder or injury; malnutrition (protein or calorie)

## 9.4 TEP Discussion

### 9.4.1 Benefits of the Measure

Some TEP members expressed support for NQF #2632 because it is measurable, logical, and accounts for critically ill patients. One TEP member stated a preference to keep the outcome measure and remove the other two process measures. One TEP member supported the measure, but was concerned about linking provider performance to payment.

### 9.4.2 Risk Adjustment for the Measure

One TEP member asked whether the risk-adjusted covariates were weighted. RTI responded by stating that hierarchical condition categories were used to code for comorbidities, and each one has its own weight. Another TEP member said that risk adjustment is very important because of the medical complexity of the LTCH population.

### 9.4.3 Quality Measure Score and Interpretation

One TEP member asked what data will be reported to the consumer, and RTI said that the change score will be reported. The TEP member followed up and asked whether this score is a measure of average improvement. The TEP member further inquired whether a change of 5 units for a sick patient is similar to a change of 5 units for a healthier patient, and whether these 5 units are equivalent for both patients. RTI responded that the development of the items and rating scale included Rasch analysis, and the raw scores and Rasch measures were highly correlated.

The use of Rasch measures was discussed previously as an alternative to raw summed scores. However, the Rasch scores were considered to be difficult to interpret and were not transparent. As noted, testing showed that the summed raw scores and the Rasch scores were highly correlated.

#### **9.4.4 Narrowly Focused Denominator for the Measure**

After learning that 15% of admitted LTCH patients were on mechanical ventilation, one TEP member asked why the first LTCH outcome measure is for a relatively small proportion of the population. Another TEP member responded that mechanical ventilation is the most common admission diagnosis for LTCHs, and it is an easy diagnosis to identify.

## **SECTION 10 FUTURE MEASURES**

### **10.1 TEP Discussion and Recommendations**

The TEP was solicited for input on potential future quality measures to be added to the LTCH QRP.

#### **10.1.1 Transitions of Care Future Quality Measure**

A few TEP members agreed that a quality measure to capture transitions of care would be useful. One TEP member supported this as a potential future measure, as it would not be expensive to implement and would help with medication reconciliation, care coordination, and readmissions. Additionally, the TEP member said that this measure could be implemented through electronic communication and promote the integration of health information technology. Another TEP member agreed and stated that the quality measure would need to be more comprehensive than a discharge summary and that the improved communication between referring and accepting physicians would reduce the number of errors when transferring a patient. Another TEP member argued that direct verbal communication would be burdensome. Instead, all receiving care providers should access a centralized electronic health record or paper form that documents the patient's transfer, goals, and care plan and reflects quality of care. This would effectively hold the accepting physician or facility accountable. The TEP member went on to say that this would be more difficult to do for unplanned discharges. One TEP member also advocated for the implementation of electronic health records to improve care transitions, reduce burden, and increase interoperability.

#### **10.1.2 Mortality Future Quality Measure**

The TEP members were solicited for feedback on the addition of a mortality quality measure. Two TEP members strongly disagreed, stating that mortality data would be tricky to capture. One TEP member stated that these data would not be useful, as the presumption is that no patient should die. Additionally, the TEP member stated that any facility with an exceptionally high mortality rate, even after risk adjusting, should not be operating. Therefore, mortality data are not particularly discriminatory or useful for identifying quality of care. Another TEP member agreed and stated that a mortality measure would bias against aggressive end-of-life care and would not be appropriate or useful for differentiating any PAC facilities by quality of care.

#### **10.1.3 Patient Satisfaction Future Measure**

One TEP member recommended the addition of a quality measure to capture patient satisfaction and mental health, particularly to address depression, anxiety, mood, and other mental illnesses among patients. The TEP member argued that this measure would be useful because mental health is often linked to the patient's physical health and recovery. The TEP member specifically noted that a patient with depression is more likely to suffer a recurrent event than a patient not diagnosed with depression. Another TEP member agreed with the importance of adding a mental health quality measure, but argued that all mental health illnesses should be captured and addressed as a single unit, referred to as post-intensive care syndrome.

#### **10.1.4 Adding Sepsis as a Risk Adjustor**

The TEP was solicited for feedback on adding a quality measure to capture sepsis diagnosis among patients. One TEP member disagreed with the idea of a sepsis quality measure, and instead recommended that sepsis be added as a risk adjustor because sepsis diagnosis usually reflects another underlying condition that has been missed.

**APPENDIX A  
TEP IN-PERSON MEETING AGENDA**

**Development and Maintenance of Quality Measures for  
Long-Term Care Hospitals Quality Reporting Program (LTCH QRP)**

**Technical Expert Panel Meeting Agenda**

**Monday, March 28, 2017**

**8:30 AM – 5:00 PM EST**

**BWI Marriot 1743 W Nursery Rd, Linthicum Heights, MD 21090**

**Dial-in Information**

**AT&T line: 1-888-706-0584**

<b>Time</b>	<b>Agenda Item</b>	<b>Lead(s)</b>
8:30AM - 8:45 AM	Welcome and Introductions Review of Agenda	Laurie Coots Terry Eng
8:45 AM - 9:45 AM	<ul style="list-style-type: none"> <li>▪ All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs (NQF #2512)</li> <li>▪ Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP</li> </ul>	Laurie Coots
9:45 AM - 10:00 AM	<b>BREAK</b>	
10:00 AM - 10:45 AM	<ul style="list-style-type: none"> <li>▪ Discharge to Community–PAC LTCH QRP</li> <li>▪ Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP</li> </ul>	Poonam Pardasaney Melissa Morley
10:45 AM - 11:45 AM	<ul style="list-style-type: none"> <li>▪ Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)</li> <li>▪ Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</li> <li>▪ Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP</li> </ul>	Amy Helburn Jill McArdle Erin White
11:45 AM - 12:45 PM	<b>LUNCH BREAK (lunch not provided)</b>	
12:45 PM - 1:45 PM	<ul style="list-style-type: none"> <li>▪ Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)</li> </ul>	Julie Seibert
1:45 PM - 3:00 PM	<ul style="list-style-type: none"> <li>▪ Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</li> <li>▪ Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</li> <li>▪ Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)</li> </ul>	Anne Deutsch
3:00 PM - 3:15 PM	<b>BREAK</b>	
3:15 PM - 4:45 PM	<ul style="list-style-type: none"> <li>▪ Future Measures</li> </ul>	Terry Eng
4:45 PM – 5:00 PM	<b>Concluding Remarks &amp; Meeting Summary</b>	Terry Eng

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**APPENDIX B**  
**DEVELOPMENT AND MAINTENANCE OF QUALITY MEASURES FOR THE LONG-TERM CARE HOSPITAL QUALITY**  
**REPORTING PROGRAM (LTCH QRP)**  
**TECHNICAL EXPERT PANEL**

**LTCH QRP Quality Measures\***

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
1.	<p><b>All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs (NQF #2512)</b></p> <p>This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients discharged from an LTCH who were readmitted to a short-stay acute-care hospital or an LTCH, within 30 days of an LTCH discharge.</p>	Communication and care coordination	Outcome	<p>The numerator is mathematically related to the number of patients in the target population who have the event of an unplanned readmission in the 30- day post-discharge window. The measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method does not make the observed number of readmissions the numerator and a predicted number the denominator. Instead, the numerator is the 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.</p>	<p>The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The “expected” number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average LTCH. This measure includes all the LTCH stays in the measurement period that do not fall into an excluded category.</p>	Y	Y	Medicare FFS claims	<a href="http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2512">http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2512</a>

(continued)

\* CDC NHSN measures not listed

**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
2.	<p><b>Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP</b></p> <p>This measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients who were readmitted to a short-stay acute-care hospital or an LTCH, within 30 days of an LTCH discharge.</p>	Communication and care coordination	Outcome	<p>The numerator is mathematically related to the number of patients in the target population who have a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are further described in the measure specifications) during the 30 days following LTCH discharge. The measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method does not make the observed number of readmissions the numerator, and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of potentially preventable, unplanned readmissions that occurred within 30 days of LTCH discharge. This estimate starts with the observed readmissions, and is then risk-adjusted for patient characteristics and a statistical estimate of the facility effect, beyond patient case mix.</p>	<p>The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The “expected” number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average LTCH. This measure includes all the LTCH stays in the measurement period that do not fall into an excluded category.</p>	Y	Y	Medicare FFS Claims	<p>Pages 17-31:  <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf</a>                      (pp. 17-31; 57-105)</p>

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### LTCH QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
3.	<b>Discharge to Community– PAC LTCH QRP</b> This claims-based measure assesses successful discharge to the community from an LTCH setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge.	Communication and care coordination	Outcome	The measure numerator is the risk-adjusted estimate of the number of patients/residents who are discharged to the community, do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. This estimate starts with the observed discharges to community, and is risk-adjusted for patient/ resident characteristics and a statistical estimate of the facility effect beyond case mix.	The denominator for the discharge to community measure is the risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient/resident characteristics with the facility effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients/residents were treated at the average LTCH.	Y	Y	Medicare FFS Claims	<a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf</a> (pp. 3-17; 43-54)

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**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
4.	<p><b>Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP</b></p> <p>The MSPB-PAC measures evaluate PAC providers’ resource use relative to the resource use of the national median PAC provider of the same type.</p>	Making care affordable	Cost/ Resource Use	The numerator for a PAC provider’s MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all PAC providers in the same setting.	The denominator for a PAC provider’s MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all PAC providers in the same setting.	Y	Y	Medicare FFS Claims	<a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/2016_07_20_mspb_pac_ltch_irf_snf_measure_specs.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/2016_07_20_mspb_pac_ltch_irf_snf_measure_specs.pdf</a> and <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Copy-of-2016_04_06_mspb_pac_ltch_service_exclusions.xlsx">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Copy-of-2016_04_06_mspb_pac_ltch_service_exclusions.xlsx</a>

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**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
5.	<p><b>Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)</b></p> <p>This measure reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season.</p>	Effective prevention and treatment	Process	The numerator is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0681a); (2) those who were offered and declined the seasonal influenza vaccine (NQF #0681b); or (3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.	The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window.	N	Y	LTCH CARE Data Set	<a href="http://www.qualityforum.org/QPS/0680">http://www.qualityforum.org/QPS/0680</a>
6.	<p><b>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</b></p> <p>This quality measure reports the percentage of patients/residents who experience one or more falls with major injury during the SNF, LTCH, or IRF stay.</p>	Making care safer	Outcome	The numerator is the number of patient stays with planned or unplanned discharge or expired assessment during the selected time window who experienced one or more falls that resulted in major injury.	The denominator is the number of patient stays with a discharge or expired assessment (A0250=10, 11, 12) during the selected time window, except those who meet the exclusion criteria.	N	Y	LTCH CARE Data Set	<a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf</a> (pp. 23-27)

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**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
7.	<p><b>Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP</b></p> <p>This patient assessment-based process quality measure evaluates whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the admission and throughout the stay.</p>	<p>Making care safer; Communication and Care Coordination</p>	<p>Process</p>	<p>The numerator is the number of stays for which the LTCH CARE Data Set indicated all of the following are each true: 1) The facility conducted a drug regimen review at the admission (N2001= [0,1]) or patient is not taking any medications (N2001= [9]); and 2) If potential clinically significant medication issues were identified at the admission (N2001 = [1]), then the facility contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues (N2003= [1]); and 3) The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]) or no potential clinically significant medication issues were identified since the admission (N2005 = [9]).</p>	<p>The denominator is the number of patient stays with a discharge or expired assessment (A0250=10, 11, 12) during the reporting period.</p>	<p>N</p>	<p>N</p>	<p>LTCH CARE Data Set</p>	<p><a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf</a> (pp. 33-40; 107-111)</p>

(continued)

**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
8.	<p><b>Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)</b></p> <p>This quality measure reports the percent of patients/short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission.</p>	Making care safer	Outcome	The numerator is the number of stays for which the discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers compared to the admission assessment.	The denominator is the number of patient stays with both an admission and discharge LTCH CARE Data Set assessment, except those who meet the exclusion criteria.	Y	Y	LTCH CARE Data Set	<a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf</a> (pp. 11-22)
9.	<p><b>Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</b></p> <p>This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident.</p>	Patient and family engagement	Process	The numerator is the number of patient/ resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.	The denominator is the number of LTCH patient stays.	N	N	LTCH CARE Data Set	Pages 3-10: <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-QRP-Measure-Specifications_August-2015.pdf</a> (pp. 3-10; 29-34)

(continued)

**LTCH QRP Quality Measures (continued)**

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
10.	<p><b>Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</b></p> <p>This quality measure reports the percentage of all LTCH patients with an admission and discharge functional assessment and a care plan that addresses function.</p>	Patient and family engagement	Process	The numerator for this quality measure is the number of LTCH patients with complete functional assessment data and at least one self-care or mobility goal.	The denominator is the number of LTCH patients discharged during the targeted 12-month (i.e., 4 quarters) time period.	N	N	LTCH CARE Data Set	<a href="http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2631">http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2631</a>
11.	<p><b>Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)</b></p> <p>This measure estimates the risk-adjusted change in mobility score between admission and discharge among LTCH patients requiring ventilator support at admission.</p>	Effective prevention and treatment	Outcome	The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in mobility score between admission and discharge among LTCH patients requiring ventilator support at admission. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.	The target population (denominator) for this quality measure is the number of LTCH patients requiring ventilator support at the time of admission to the LTCH.	Y	Y	LTCH CARE Data Set	<a href="http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2632">http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2632</a>

**APPENDIX C**  
**LTCH QRP TEP SLIDES**

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## Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

### Technical Expert Panel BWI Marriott, MD

Tuesday, March 28, 2017  
8:30 AM – 5:00 PM ET

RTI International

Development and Maintenance of Symptom Management Measures, HHSM-500-2013-130151

1

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[www.rti.org](http://www.rti.org)

## Welcome and Housekeeping Issues

### Welcome

### Housekeeping

- Wi-Fi password: CMS2017
- Phone line for CMS and RTI staff
- Audio recording of meeting for notetaking
- Materials
- Lunch (on our own)
- Restrooms

2

## Introductions: TEP Members

1. Susan Bowen, RN, CCRN, CPHQ, CLNC
2. Jean M. de Leon, MD, FAPWCA
3. Karen Finerty, RN, BSN, MBA
4. Meg Hassenpflug, MS, RD, FCCM
5. James Jewell, MD
6. Steven Lichtman, EdD, MAACVPR
7. Sean Muldoon, MD, MPH, MS
8. William J. Reilly, MS OTR/L
9. Mary Van de Kamp, MS-CCC/SLP
10. John Votto, DO, FCCP

3

## Introductions: CMS and RTI Teams

### CMS

Lorraine Wickiser  
Christine Grose  
Alan Levitt  
Stacy Mandl  
Tara McMullen  
Kelly Miles  
Teresa Mota  
Charles Padgett  
Mary Pratt  
Charlayne Van

### RTI

Karen Reilly  
Laura Smith  
Laurie Coots  
Terry Eng  
Sarrah Sabouri  
Tri Le  
Lindsey Free  
Anne Deutsch  
Magda Ignaczak  
Holly Neumann  
Lauren Palmer  
Jessica Craig  
Debbie Kulik

4

## TEP Charter

- The TEP Charter orients members to their roles and responsibilities
- Meeting Objective: Obtain input on current quality measures implemented in the LTCH QRP as well as future measures
- List of TEP members
- Any questions about the TEP Charter?

5

## Setting the Stage for Today's Discussion

- Measuring the quality of care for patients treated in LTCHs using the measures adopted for the LTCH QRP
  - Importance of the quality topic
  - Scientific soundness (data elements, exclusion criteria, numerator/denominator definitions, risk adjustors)
  - Usability by consumers and providers
- Future measures
  - We have set aside time to hear your ideas about future measures
  - Several measures are undergoing testing at this time and these measures have their own TEPs
- We have different experiences and may have different perspectives on one or more of the quality measures

6

## Agenda

8:30–8:45 am	Welcome and Introductions
8:45–9:45 am	Review of All-Cause Unplanned Readmission and Potentially Preventable Readmission Measures
9:45–10:00 am	Break
10:00–10:45 am	Review of Discharge to Community and MSPB Measures
10:45–11:45 am	Review of Influenza, Falls, and Drug Regimen Review Quality Measures
11:45–12:45 pm	Break
12:15–1:45 pm	Review of Pressure Ulcer Quality Measure
1:45–3:00 pm	Review of Function and Functional Outcome Quality Measures
3:00–3:15 pm	Break
3:15–4:45 pm	Discussion of Future Measures
4:45–5:00 pm	Concluding Remarks and Meeting Debrief

7

## Long-Term Care Hospital Quality Reporting Program Overview

- LTCH QRP was established under Section 3004(a) of the Patient Protection and Affordable Care Act of 2010
- Under the LTCH QRP, CMS requires Medicare-certified LTCHs to submit data for quality measures
- Requirement applies to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under Medicare
- Failure to submit quality data may result in a 2 percentage point reduction to the LTCH's applicable fiscal year (FY) annual payment update

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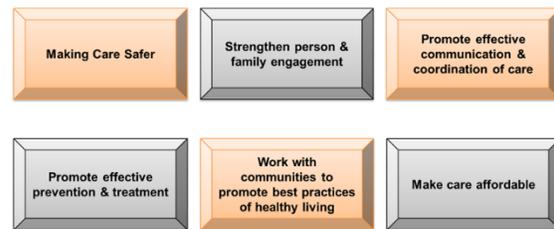
## National Quality Strategy Promotes Better Health, Healthcare, and Lower Cost

The strategy is to concurrently pursue three aims:



9

## The Six Priorities Have Become the Goals for the CMS Quality Strategy



10

## Long-Term Care Hospital Quality Reporting Program Overview (continued)

- CMS has adopted 17 measures for the LTCH QRP:
  - 7 LTCH Continuity Assessment Record and Evaluation (CARE) Data Set measures
  - 4 Medicare Fee-For-Service claims-based measures
  - 6 Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) measures
- LTCH QRP measures are prioritized under the National Quality Strategy (NQS) quality measure domains:

NQS Primary Measure Domain	# of LTCH QRP Finalized Measures
Making Care Safer	9
Person and Family Engagement	2
Effective Communication and Coordination of Care	3
Effective prevention and treatment practices	2
Working with communities	0
Making quality care more affordable	1

11

## Readmission Measures

12

## Readmission Measures Adopted for the LTCH QRP

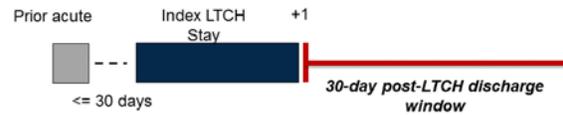
- 1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs
  - NQF endorsed in 2014 (NQF #2512)
  - Adopted FY 2016
  - Publicly reported on *LTCH Compare*
- 2) Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCHs
  - IMPACT Act measure
  - Adopted FY 2017
  - Confidential feedback reports – Oct 2017
  - Public reporting – Oct 2018

\*Specifications for both measures are aligned

13

## Overview of Readmission Measure Specifications

### Readmission window



- Measures exclude patients (not exhaustive list)
  - With no hospital stay prior to LTCH admission
  - Who died during LTCH stay
  - Were transferred at end of LTCH stay
  - Not continuously enrolled in Part A FFS Medicare
- Measures calculated on 2 CYs of claims data

14

## Risk-Adjustment

- Models compute probabilities of readmission with explanatory variables (i.e., risk adjusters)
- Source of principal diagnosis is the prior acute hospital claim
- Comorbidities from either the secondary diagnoses on the prior acute hospital claim or other claims in year prior to LTCH admission

### Risk Adjusters:

- Demographics: Age/sex and original reason for Medicare entitlement
- Principal diagnosis, grouped clinically using AHRQ's CCS codes
- Surgical indicators; procedures grouped using AHRQ's Clinical Classification Software (CCS)
- Comorbidities, clustered using CMS Hierarchical Condition Categories (HCCs)
- Prior Utilization: prior hospital LOS; prior acute ICU/CCU utilization; count of prior short-term discharges in the prior year
- Prolonged ventilator use in LTCH

15

## Measure Calculation

- Consistent with other PAC and hospital readmission measures
- Use a hierarchical modeling approach to estimate a multi-level model with patient-stays clustered at the LTCH level. A provider effect is estimated.
- Calculate a standardized risk ratio (SRR) as:
  - Numerator: the risk-adjusted number of *predicted* readmissions for an LTCH's patient-stays, including a provider effect
  - Denominator: the risk-adjusted *expected* number of readmissions for same patients, excluding the provider effect
- SRR is then multiplied by the mean observed readmission rate in order to calculate the Risk-Standardized Readmission Rate (RSRR)

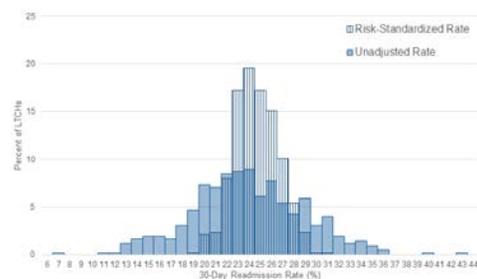
16

## Definition of Planned Readmissions

- Both LTCH QRP hospital readmission measures **exclude** planned readmissions
- We use the CMS Planned Readmission Algorithm
  - List of procedure codes (ICD-9/ICD-10) that constitute planned admissions. If any of a defined set of acute principal diagnoses is present the admission reverts to unplanned.
- With TEP input, RTI International developed list of additional procedures common to PAC population for which readmissions would be considered planned.

17

## Distribution of Observed and Risk-Standardized All-Cause Readmission Rates Post-LTCH Discharge



	All LTCHs (N=436) Mean (SD)
Observed readmission rate	23.7% (5.8%)
Risk-standardized readmission rate	24.6% (2.0%)

Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: j21)

18

## Definition of Potentially Preventable Readmissions (PPR)

In order for a readmission to be considered potentially preventable, it must be:

- Unplanned
- Coded as the principal diagnosis on readmission claim (some exceptions)

**Conceptual framework:** PPR refers to a readmission that should be avoidable with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care

Grouped PPRs:

1. Inadequate management of chronic conditions (e.g. CHF, hypertension)
2. Inadequate management of infections (e.g. septicemia, bacterial pneumonia)
3. Inadequate management of other unplanned events (e.g. acute renal failure)

19

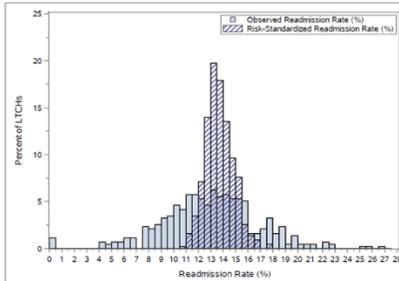
## LTCH Post-Discharge PPRs

PPR Category	Number of PPR in LTCH Sample	% PPR in LTCH Sample	% of PPR
<b>Inadequate management of chronic conditions</b>	<b>4,569</b>	<b>2.64%</b>	<b>19.29%</b>
Adult asthma*	156	0.09%	0.66%
Chronic obstructive pulmonary disease (COPD)*	1,097	0.63%	4.63%
Congestive heart failure (CHF)*	2,605	1.50%	11.00%
Diabetes short-term complication*	430	0.25%	1.82%
Hypertension*/Hypotension	281	0.16%	1.19%
<b>Inadequate management of infections</b>	<b>15,022</b>	<b>8.67%</b>	<b>63.42%</b>
Influenza	56	0.03%	0.24%
Bacterial pneumonia*	2,120	1.22%	8.95%
Urinary tract infection*/ Kidney infection	1,390	0.80%	5.87%
C. difficile infection	627	0.36%	2.65%
Septicemia (except in labor)	10,161	5.86%	42.90%
Skin and subcutaneous tissue infections	668	0.39%	2.82%
<b>Inadequate management of other unplanned events</b>	<b>4,094</b>	<b>2.38%</b>	<b>17.29%</b>
Dehydration*/ Electrolyte imbalance	573	0.39%	2.84%
Aspiration pneumonitis (food/vomitus)	1,340	0.77%	5.66%
Acute renal failure*	1,394	0.80%	5.89%
Arrhythmia	379	0.22%	1.60%
Intestinal impaction	44	0.03%	0.19%
Pressure ulcers	264	0.15%	1.11%
<b>Total - Post-Discharge Potentially Preventable Readmissions</b>	<b>23,685</b>	<b>13.65%</b>	<b>100.00%</b>
<b>Total - All Cause, Unplanned Readmissions</b>	<b>42,633</b>	<b>24.61%</b>	-

Notes: N = 173,258 in 2013-2014 LTCH Sample. \* Ambulatory Care Sensitive Condition  
Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: RTI program reference: nc10)

20

## Distribution of Observed and Risk-Standardized PPR Rates Post-LTCH Discharge



	All LTCHs (N=436) Mean (SD)
Observed readmission rate	13.0% (3.9%)
Risk-standardized readmission rate	13.7% (1.1%)

Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: nc07 & nc09)

21

## LTCH QRP Readmission Measures TEP Discussion Questions

1. We have received feedback that more detailed information (i.e. patient- or stay-level) is needed to use these readmission measures for quality improvement. CMS is working on this issue, but we would benefit from your feedback. What specific information would be most useful and how would it be useful?
2. Are there ways that these measures could be more valuable to patients and families?
3. Other questions and/or comments?

22

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23

## Discharge to Community– PAC LTCH QRP

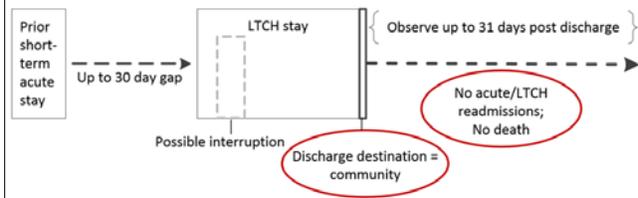
24

## Discharge to Community–PAC LTCH QRP: Measure Description

- IMPACT Act measure implemented October 1, 2016
- Reports an LTCH's risk-standardized rate of Medicare FFS patients who are discharged to the community (DTC), and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge, and who remain alive during the 31 days following discharge.
- Claims-based
- Dichotomous outcome (DTC = yes/no)
- Some patient exclusions applied to maintain data integrity & measure validity (e.g., discharges to psychiatric hospital or hospice, AMA discharges)
- The measure does not benchmark a 100% DTC rate

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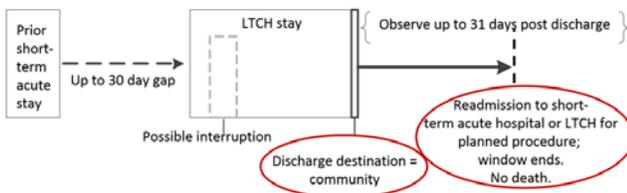
## Discharge to Community Outcome = YES



Discharge destination is community; there is no acute/LTCH readmission or death in the post-discharge observation window.

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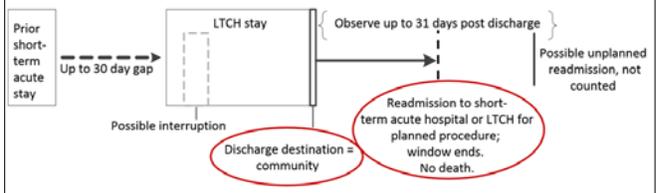
## Discharge to Community Outcome = YES



Discharge destination is community and there is a planned acute/LTCH readmission in the post-discharge observation window; no death.

27

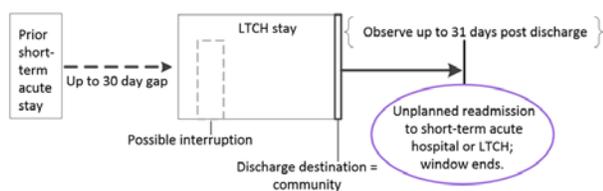
## Discharge to Community Outcome = YES



Discharge destination is community followed by a planned acute/LTCH readmission in the observation window. Only the first readmission post-discharge is assessed; an unplanned readmission following a planned readmission is not counted. Patient remained alive during the window.

28

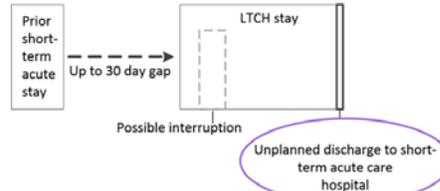
## Discharge to Community Outcome = NO



Discharge destination is community but there is an unplanned acute/LTCH (re)admission in the post-discharge observation window.

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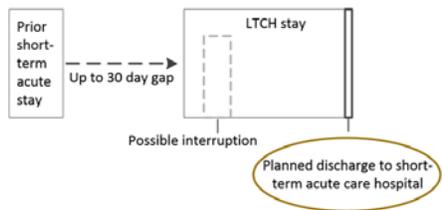
## Discharge to Community Outcome = NO



Unplanned discharge to a short-term acute care hospital determines the discharge to community outcome (No). There is no post-discharge observation period.

30

## Planned Acute Care Discharges Excluded from the Measure



Observation excluded from the measure because the patient has a planned discharge from LTCH to an acute care hospital.

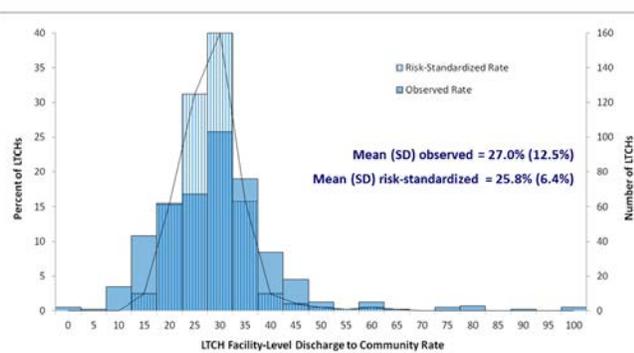
31

## Discharge to Community–PAC LTCH QRP: Calculation

- **Numerator = Risk-adjusted predicted number of DTC:**
  - Sum of predicted probability of DTC for each patient, risk-adjusted for patient characteristics & facility effect.
- **Denominator = Risk-adjusted expected number of DTC:**
  - Represents the risk-adjusted predicted number of DTC if the same patients were treated at the average facility.
- **Standardized Risk Ratio (SRR):**
  - Ratio of predicted-to-expected number of DTC
  - Measure of degree to which DTC rate is higher or lower than what would otherwise be expected.
- **Risk-standardized DTC rate for each facility:**
  - SRR \* national patient-level DTC rate

32

## LTCH Discharge to Community Rates, 2012-2013



Based on CY 2012-2013 Medicare FFS claims data from 439 LTCHs. Facility-level number of LTCH stays ranged from 1 to 3,014, with a mean of 445.2 and median of 370.0. Source: RTI analysis (RTI pgm reference: EG08 DTC-LTCH\_RA model\_01)

33

## Discharge to Community–PAC LTCH QRP: Discussion

1. Do you have any suggestions for future refinements of the discharge to community measure, including additional risk adjusters?
2. In your experience, do SES factors affect the DTC outcome, including determination of discharge destination? If yes:
  - a. Please discuss how;
  - b. How could this be captured in existing data sources?
3. On average, what proportion of LTCH patients reside in a long-term nursing facility at baseline, prior to their hospitalization and LTCH stay?

34

## Medicare Spending per Beneficiary–PAC LTCH QRP

## Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP Description

The MSPB-PAC measures evaluate PAC providers' resource use relative to the resource use of the national median PAC provider of the same type.

35

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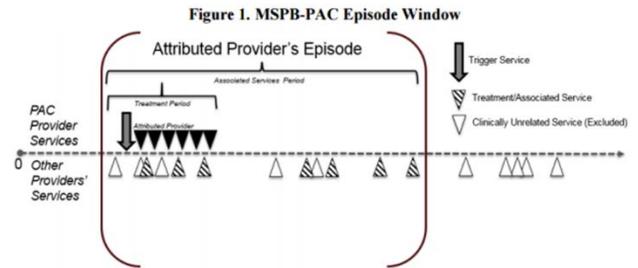
**Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP  
Numerator and Denominator Definitions**

**Numerator:** The numerator for a PAC provider's MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all PAC providers in the same setting.

**Denominator:** The denominator for a PAC provider's MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all PAC providers in the same setting.

37

**Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP  
Episode Window**



38

**Medicare Spending per Beneficiary (MSPB)–PAC LTCH QRP  
Discussion**

1. What characteristics are important to measure and include in risk adjustment for this measure?
2. Other comments or questions?

39

**Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)**

40

**Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)  
Description**

This measure reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season.

41

**Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)  
Numerator and Denominator Definitions**

**Numerator:** Number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria:

- (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a);
- (2) those who were offered and declined the seasonal influenza vaccine (NQF #0680b); or
- (3) those who were ineligible due to contraindication(s) (NQF #0680c).

The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.

**Denominator:** The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window.

42

**Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)**  
Discussion

1. For the last two influenza vaccine seasons, approximately three fourths of LTCH patients are assessed and, where appropriate, immunized for influenza. This means that about one quarter of LTCH patients are not assessed for the influenza vaccine and/or reported to have received the vaccine. This rate is lower than that for other PAC settings.
  - a. Do you think that this reflects a performance gap for LTCHs?
  - b. What do you think are some of the main reasons that LTCH patients are not assessed and where appropriate, immunized?
  - c. Are there other ways that LTCHs can increase patient influenza vaccination rates?
2. Are there ways that this measure could be more valuable to patients and families?
3. Do you have any other comments or questions about this measure?

43

**Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)**

44

**Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)**  
Measure Description

This quality measure reports the percentage of patients/residents who experience one or more falls with major injury during the SNF, LTCH, or IRF stay.

45

**Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)**  
Numerator and Denominator Definitions

**Numerator:** The numerator is the number of patient stays with planned or unplanned discharge or expired assessment during the selected time window who experienced one or more falls that resulted in major injury.

**Denominator:** The denominator is the number of patient stays with a discharge or expired assessment (A0250=10, 11, 12) during the selected time window, except those who meet the exclusion criteria.

46

**Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)**  
Discussion

1. Do you have suggestions for additional training opportunities or training materials?
2. Do you have any other comments or questions about this measure?

47

**Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP**

48

**Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP**  
Description

This patient assessment-based process quality measure evaluates whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the admission and throughout the stay.

49

**Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP**  
Numerator and Denominator Definitions

**Numerator:** The numerator is the number of stays for which the LTCH CARE Data Set indicated all of the following are each true:

1. The facility conducted a drug regimen review at admission (N2001= [0,1]) or patient is not taking any medications (N2001= [9]); and
2. If potential clinically significant medication issues were identified at admission (N2001 = [1]), then the facility contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues (N2003= [1]); and
3. The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]) or no potential clinically significant medication issues were identified since the admission (N2005 = [9]).

**Denominator:** The denominator is the number of patient stays with a discharge or expired assessment (A0250=10, 11, 12) during the reporting period.

50

**Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC LTCH QRP**  
Discussion

1. Do you have any suggestions for future refinements of the drug regimen review measure?
2. How do you currently monitor adverse events related to medications of high-risk medications?
3. Do you have any other comments or questions about this measure?

51

**Agenda**

8:30–8:45 am	Welcome and Introductions
8:45–9:45 am	Review of All-Cause Unplanned Readmission and Potentially Preventable Readmission Measures
9:45–10:00 am	Break
10:00–10:45 am	Review of Discharge to Community and MSPB Measures
10:45–11:45 am	Review of Influenza, Falls, and Drug Regimen Review Quality Measures
11:45–12:45 pm	Break
12:15–1:45 pm	Review of Pressure Ulcer Quality Measure
1:45–3:00 pm	Review of Function and Functional Outcome Quality Measures
3:00–3:15 pm	Break
3:15–4:45 pm	Discussion of Future Measures
4:45–5:00 pm	Concluding Remarks and Meeting Debrief

52

**Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**

**Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**  
Description

This quality measure reports the percent of patients/short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission.

53

54

**Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**  
 Numerator and Denominator Definitions

**Numerator:** The numerator is the number of stays for which the discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcer(s) that are new or worsened at discharge compared to admission.

**Denominator:** The denominator is the number of patient stays with both an admission and discharge LTCH CARE Data Set assessment, except those who meet the exclusion criteria.

55

**Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**  
 Discussion

1. From your perspective, are there additional training needs regarding the pressure ulcer quality measure?
2. What types of training or training materials would be helpful to providers regarding completion of pressure ulcer assessment items?
3. This measure is currently reported on IRF/LTCH Compare. Are there ways that this measure could be more valuable to patients and families?

56

**Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**

57

**Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**  
 Description

This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident.

58

**Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**  
 Numerator and Denominator Definitions

**Numerator:** The numerator is the number of patient/resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.

**Denominator:** The denominator is the number of LTCH patient stays.

59

**Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**

60

Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) Description
This quality measure reports the percentage of all LTCH patients with an admission and discharge functional assessment and a care plan that addresses function.
61

Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631) Numerator and Denominator Definitions
<b>Numerator:</b> The numerator for this quality measure is the number of LTCH patients with complete functional assessment data and at least one self-care or mobility goal.
<b>Denominator:</b> The denominator is the number of LTCH patients discharged during the targeted 12-month (i.e., 4 quarters) time period.
62

Discussion
<ol style="list-style-type: none"> <li>1. Do you have suggestions for additional training opportunities or different types of training materials?</li> <li>2. Can you tell us about goal-setting in your LTCH?</li> <li>3. Do you have any other comments or questions about this measure?</li> </ol>
63

Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)
64

Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632) Description
This measure estimates the risk-adjusted change in mobility score between admission and discharge among LTCH patients requiring ventilator support at admission.
65

Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632) Numerator and Denominator Definitions
<b>Numerator:</b> The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in mobility score between admission and discharge among LTCH patients requiring ventilator support at admission. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.
<b>Denominator:</b> The target population (denominator) for this quality measure is the number of LTCH patients requiring ventilator support at the time of admission to the LTCH.
66

**Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632) Discussion**

- Do you have suggestions for additional training opportunities or different types of training materials?

67

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68

**Future Measures**

69

**Future Measures - Discussion**

62

**THANK YOU**

71