Care Coordination Measures: 2016-2017

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Executive Summary

Care coordination is a multidimensional concept and a critical aspect of healthcare that spans the continuum of care by ensuring quality care and better patient outcomes. It encompasses effective communication between patient, caregiver, and provider, and it facilitates linkages between the community and healthcare system. Coordination of care ensures that accountable structures and processes are in place for communication and integration of a comprehensive plan of care across providers and settings in alignment with patient and family preferences and goals.

Considered a fundamental component for the success of the healthcare system and patient outcomes, care coordination is essential to reducing preventable hospitalizations, a significant factor in controlling healthcare costs. In 2010, preventable hospital admissions accounted for nearly $32 billion for adults with selected chronic and acute diseases.[1] The coordination of care is essential to reduce preventable hospitalizations, achieve better patient outcomes, and lower costs in today's healthcare system.

Currently, NQF's care coordination portfolio includes measures for hospitalizations, emergency department (ED) use, timely transfer of information, medication reconciliation, advance care planning, and e-prescribing. Some of these measures date back to 2007, and several are currently in use in accountability and quality improvement programs.

Recognizing the importance of care coordination measurement, the National Quality Forum (NQF) launched its first care coordination project in 2006. Through subsequent work, NQF endorsed a framework for care coordination, commissioned a paper examining electronic capabilities, conducted an environmental scan, aligned work with the related NQF project—Prioritizing Measure Gaps: Care Coordination, and updated the definition of care coordination.

For the 2016-2017 phase of care coordination work, the Care Coordination Standing Committee evaluated two newly submitted measures and five measures undergoing maintenance review against NQF's updated standard evaluation criteria. Of these measures, one measure is endorsed and the remaining six measures are not endorsed.

The endorsed measure is:

- 0326 Advance Care Plan

The six measures not endorsed are:

- 0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

- 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
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Brief summaries of the measures reviewed are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Care coordination is a multidimensional concept and a critical aspect of healthcare that spans the continuum of care by ensuring quality care and patient outcomes. It encompasses effective communication between patient, caregiver, and provider, and it facilitates linkages between the community and healthcare system. Coordination of care ensures that accountable structures and processes are in place for communication and integration of a comprehensive plan of care across providers and settings in alignment with patient and family preferences and goals.

Poorly coordinated care may lead to negative, unintended consequences including medication errors and preventable hospital admissions.[2,3] The Agency for Healthcare Research and Quality (AHRQ) estimates that adverse medication events cause more than 770,000 injuries and deaths each year, more than half of which affect those over age 65.[4] The cost of treating patients harmed by these events is estimated at $5 billion annually.[5] For example, individuals with chronic conditions whose care relies on effective coordination through a complex healthcare system, managed by multiple providers in multiple settings, often find it difficult to navigate the system of care. For these individuals, the difficulty in managing these multiple care transitions can contribute to poor outcomes and hospitalizations. In 2010, preventable hospital admissions accounted for nearly $32 billion of costs for adults with selected chronic and acute diseases.[6] The coordination of care is essential to reduce preventable hospitalizations, improve patient outcomes, and lower costs in today's healthcare system.

A variety of tools and approaches, when leveraged, can improve care coordination. Electronic health records (EHRs) can reduce unnecessary and costly duplication of patient services.[7] Patient education and the reconciliation of medication lists could also reduce costs by decreasing the number of serious medication events.[8] The Institute of Medicine (IOM) indicates that care coordination initiatives such as patient education and the development of new provider payment models could result in an estimated $240 billion in savings.[9] Care coordination is also positively associated with patient- and family-reported receipt of family-centered care, resulting in greater satisfaction with services, lower financial burden, and fewer emergency department visits.[10]

Recognizing the importance of care coordination measurement, the National Quality Forum (NQF) launched its first care coordination project in 2006. Through subsequent work, NQF endorsed a definition and framework for care coordination.[11] NQF initially defined care coordination as a: "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time." In 2010, NQF endorsed 10 performance measures and 25 preferred practices related to care coordination. These measures or consensus standards provide the foundation required to assess impact and progress towards patient outcomes. Beginning in July 2011, NQF launched a multiphase Care Coordination project focused on healthcare coordination across episodes of care and care transitions. The first phase of the project sought to address the lack of cross-cutting measures in the NQF measure portfolio by developing a path forward to advance the field of care coordination measurement. A commissioned paper examining electronic capabilities to support care coordination measurement as well as an environmental scan informed the path forward and the goals for future measures. During the next two phases, the Committee continued to endorse measures—12 measures in phase 2 and five measures in phase 3.

Work also continued on identification of gaps in the portfolio, primarily the lack of cross-cutting components of care coordination within measures. During phase 3, the Care Coordination Standing Committee, in concert with the NQF Measure Prioritization Committee, produced a report prioritizing measure gaps in care coordination. Recommendations from this work can be found in the final report entitled Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination. This report also includes an updated definition of care coordination as "…the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."

In addition to the phases described previously, during which the Committee reviewed measures, NQF's Measure Applications Partnership (MAP) identified an initial Care Coordination Family of Measures related to the National Quality Strategy (NQS) priorities and high-impact conditions. This Family of Measures includes addressing avoidable admissions and readmissions, system infrastructure support, care transitions, communication, care planning, and patient surveys related to care coordination.

Measurement Topics

For the current phase of Care Coordination work, the measures submitted focused on plan of care, medication reconciliation, timely transitions, and connections to clinical care management. Key measurement topics that emerged during this phase include:

Plan of Care

Care plans, specifically, advance care plans aim to ensure that care near the end of life aligns with the patient's wishes.[12] Advance care planning is associated with improved health outcomes for older adults, including reducing admissions and lengths of stay.[13,14,15,16] Advance directives are widely recommended as a strategy to improve compliance with patient wishes at the end of life, and thereby ensure appropriate use of healthcare resources. However, the majority of older adults do not have advance care planning conversations with their clinicians.[17,18] Furthermore, a recent systematic review found only a few studies that addressed advance care planning in palliative care.[19] Although the results are promising, additional high-quality studies are needed.

Medication Reconciliation

Medication reconciliation refers to the process of avoiding inadvertent inconsistencies during transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the medication regimen in the new care setting. A study examining medication errors at hospital admission found that over a third of patients in the study (35.9 percent) experienced 309 order errors; 85 percent of patients had errors originate in medication histories, and almost half were omissions, highlighting the need for medication reconciliation at transitions of care.[20]

Timely Transitions

Poorly managed and untimely transitions can diminish health and increase healthcare costs. Researchers have estimated that inadequate care coordination, including inadequate management of care transitions, was responsible for $25 to $45 billion in wasteful spending in 2011 for avoidable

complications and unnecessary hospital readmissions.[22] Without effective, timely communication between physicians, both the quality of care and the patient experience can decline. Establishing efficient and effective approaches to transitions is essential to not only improving patient and family experiences but also helping to minimize readmission rates.

Connections to Clinical Care Management

Management and coordination of connections can enhance outcomes and lower costs. These connections include visits to a primary care practitioner and clinical management of medications. Literature reviews indicate that asthma is a prevalent chronic condition in children. Emergency department (ED) visits for asthma care are a common, costly, and potentially preventable health service that may serve as a marker for both insufficient primary care and clinical management of asthma. A study by Pearson et al. found that approximately 629,000 ED visits for pediatric asthma for Medicaid/CHIP enrollees cost $272 million in 2010; the average cost per visit was $433.[21]

Trends and Performance

The 2015 National Healthcare Quality and Disparities Report identified several trends and disparities related to measures of care coordination.[22] AHRQ data on the 37 measures used to assess the NQS priority of care coordination through 2013, found that fewer than half of the measures showed improvement in performance. AHRQ also reported that although disparities were more common among measures of care coordination than the other priority areas, about 45 percent of disparities related to care coordination were decreasing.

Refining the NQF Measure Evaluation Process

To improve the periodic evaluation of currently endorsed measures, NQF has streamlined its process for maintenance of endorsement. This change took effect beginning October 1, 2015. NQF's endorsement criteria have not changed, and all measures are evaluated using the same criteria. However, under the current approach, there is a shift in emphasis for evaluation of currently endorsed measures:

- **Evidence:** If the developer attests that the evidence for a measure has not changed since its previous endorsement evaluation, there is a decreased emphasis on evidence, meaning that a committee may accept the prior evaluation of this criterion without further discussion or need for a vote. This applies only to measures that previously passed the evidence criterion without an exception. If a measure was granted an evidence exception, the evidence for that measure must be revisited.
- **Opportunity for Improvement (Gap):** For re-evaluation of endorsed measures, there is increased emphasis on current performance and opportunity for improvement. Endorsed measures that are "topped out" with little opportunity for further improvement are eligible for Inactive Endorsement with Reserve Status.
- **Reliability**
  - Specifications: There is no change in the evaluation of the current specifications.
  - Testing: If the developer has not presented additional testing information, a committee may accept the prior evaluation of the testing results without further discussion or need for a vote.

- **Validity:** There is less emphasis on this criterion if the developer has not presented additional testing information, and a committee may accept the prior evaluation of this subcriterion without further discussion and vote. However, a committee still considers whether the specifications are consistent with the evidence. In addition, for outcome measures, a committee discusses questions required for the SDS Trial without any change in testing for validity.
- **Feasibility:** The emphasis on this criterion is the same for both new and previously endorsed measures, as feasibility issues might have arisen for endorsed measures since implementation.
- **Usability and Use:** For re-evaluation of endorsed measures, there is increased emphasis on the use of the measure, especially use for accountability purposes. There also is an increased emphasis on improvement in results over time and on unexpected findings, both positive and negative.

Endorsement Decision and Appeals Process

In August 2016, NQF's Board of Directors approved changes to its ratification and appeals process. Following public comment and voting by the NQF membership, the Consensus Standards Approval Committee (CSAC) makes the final measure endorsement decision, without ratification by another body. Additionally, the Board requested that NQF establish a five-member Appeals Board that will adjudicate all submitted appeals regarding measure endorsement decisions. These changes apply to NQF measure endorsement projects with in-person meetings scheduled after August 2016.

The newly constituted Appeals Board, composed of NQF Board members and former CSAC and/or committee members, adjudicates appeals to measure endorsement decisions without a review by the CSAC. The decision of the Appeals Board is final.

All submitted appeals are published on the NQF website. Staff compiles the appeals for review by the Appeals Board, which evaluates the concerns raised and determines if the appeal should warrant overturning the endorsement decision. Decisions on an appeal of endorsement are publicly available on NQF's website.

Throughout the process, project staff serve as liaisons between the CSAC, the Appeals Board, the committee, developers/stewards, and the appellants to ensure the communication, cooperation, and appropriate coordination is in place to complete the project efficiently.

NQF Portfolio of Performance Measures for Care Coordination Conditions

The Care Coordination Standing Committee (see Appendix D) oversees NQF's portfolio of care coordination measures that includes measures for emergency department transfers, plan of care, e-prescribing, timely transitions, medication management, and transition records (see Appendix B). This portfolio contains 14 measures: 11 process measures and three outcome measures (see table below). During this phase of work, the Care Coordination Standing Committee evaluated five of these previously endorsed measures.

Table 1. NQF Care Coordination Portfolio of Measures

	Process	Outcome/Resource Use	Structural	Composite
Emergency Department Transfers	4	0	0	0
Plan of Care	1	0	0	0
e-Prescribing	0	0	0	0
Timely Transitions	1	2	0	0
Medication Management	2	1	0	0
Transition Records	3	0	0	0
Medical Home	0	0	0	0
Total	11	3	0	0

Additional measures related to care coordination are in other projects. These include diabetes assessment and screening measures (Health and Well-Being/Behavioral Health projects), eye care measures (Eye Care and Ear, Nose, and Throat Conditions project), ACEI/ARB medication measures (Cardiovascular project), complications and outcomes measures (Health and Well-Being/Surgery projects), and one cost and resource use measure (Cost and Resource Use project).

National Quality Strategy

NQF-endorsed measures for care coordination support the National Quality Strategy (NQS). NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, state, and national) to improve the quality of healthcare in the U.S. The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person- and Family- Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care.*

Quality measures for care coordination align with several of the NQS priorities, including:

- Making care safer
- Communication and care coordination

Safe care is fundamental to improving quality. More than half of patients have greater than one medication discrepancy at hospital admission, placing patients at risk for adverse drug events. Accrediting bodies (e.g., The Joint Commission) recognized the importance of medication reconciliation and included this as a 2017 National Patient Safety Goal. Effective care coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Use of Measures in the Portfolio

Endorsement of measures by NQF is valued due to the rigor and transparency of the process conducted by multistakeholder committees. Committee members include clinicians and experts from the full range of healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best available measures and reflect the current science. Importantly, federal law requires that preference be given to NQF-endorsed measures for use in selected federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Many measures in NQF's care coordination portfolio are in use in at least one federal program. For example, two measures are currently in use in the Home Health Value-Based Purchasing (pilot program) and three in Hospital Compare, the Hospital Inpatient Quality Reporting, and the Hospital Outpatient Quality Reporting programs. Finally, several of the care coordination measures have been included in the Care Coordination Family of Measures by the NQF-convened MAP. See Appendix C for details of federal program use for the measures in the portfolio.

Improving NQF's Care Coordination Portfolio

During discussions at the February 22, 2017 in-person meeting and the May 16, 2017 post-meeting call, the Committee identified numerous gaps. They discussed the current state of measurement, which includes aspects of the continuum of care: the information, transactions, or documentation—such as the transfer of information including reconciled medications. Several committee members spoke to the importance of measures that include specifics on the transfer of information at critical transitions. Other members discussed the importance of up-to-date evidence to support these and other care coordination measures.

To approach care coordination from a team-based perspective, one member suggested that care providers think about what information the next provider needs. Additionally, the Committee suggested the creation of a plan of care or treatment plan that includes the basic elements needed to ensure continuity of care and a prioritized list of patients' concerns. One committee member discussed the American College of Physicians' (ACP) High Value Care Coordination Toolkit that connects primary care physicians with specialty groups. Another member suggested that care coordination could be a "test case" for moving the field forward in capturing patient preferences and goals that can be incorporated into care plans. The Committee suggested that the path forward could be to create the building blocks in a care plan—a short list of items that are common to most care plans and treatment plans—as well as an individual list of concerns. The Committee also suggested that ACP as well as other groups' work could help to inform this work.

Specific suggestions from the Committee on the types of measures needed in the care coordination portfolio include measures that:

- Reflect patient preferences as they move through the healthcare system;

- Incorporate the care plan as the core document in the patient record including the basic elements for all providers across the continuum, inclusive of the patient's voice and goals;
- Encompass some of the practical and basic elements of transition such as medication reconciliation; and
- Are evidence-based for the specific measure focus.

Care Coordination Measure Evaluation

On February 22, 2017, the Care Coordination Standing Committee evaluated two new measures and five measures undergoing maintenance review against NQF's standard evaluation criteria. To facilitate the evaluation, the Committee performed a preliminary review of the measures against the evaluation criteria. This preliminary work prepared both the Committee and the developers for the review by the entire Standing Committee.

Table 2. Care Coordination Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	5	2	7
Measures endorsed	1	—	1
Measures not endorsed	4	2	6
Measures withdrawn from consideration	1	—	1
Reasons for not recommending	Importance – 2 Scientific Acceptability – 2 Overall – 0 Competing Measure – 0	Importance – 1 Scientific Acceptability – 1 Overall – 0 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from January 9 to January 23, 2017 for the seven measures under review. No pre-evaluation comments were received.

Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged and were factored into the Committee's ratings and recommendations for multiple measures. These issues are not repeated in detail for each individual measure.

Insufficient Evidence

According to NQF's measure evaluation criteria, both process measures and intermediate clinical outcome measures should be supported by a systematic review and grading of the body of empirical evidence, which demonstrates that the measure process or intermediate clinical outcome leads to a desired health outcome. Four of the measures in this project focused on medication reconciliation and

transition records, and were supported by expert opinion only. For some measures, developers presented evidence tangential to the measure focus that was not graded; for other measures, developers did not summarize the quantity, quality, and consistency of the evidence. While developers augmented systematic reviews with brief descriptions of additional studies, these did not always match the measure focus. Because the Committee confirmed the importance of the measure concepts, Committee members invoked the exception to the evidence subcriterion for the four measures not supported by empirical evidence.

Lack of Uptake of Measures and Unavailability of Data

Many of the measures evaluated in this project are not in use, and planned use is unclear. This hindered the measure developers' ability to provide current performance information as well as information addressing improvement over time, both of which receive increased emphasis in NQF's new maintenance process for evaluating previously endorsed measures.

Need for Better Measures

Committee members noted that the measurement world has changed dramatically since the Committee first started evaluating measures several years ago. The Committee highlighted the need for measures that "raise the bar" to further improve care and demand a higher level of performance. In addition, the Committee noted a need for more measures of outcomes that matter to patients and families. Committee members also acknowledged the challenges of developing strong care coordination measures.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

0326 Advance Care Plan (National Committee for Quality Assurance): Endorsed

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Clinician Office/Clinic; **Data Source**: Claims (Only), EHRs Hybrid

The aim of advance care planning is to ensure that care near the end of life aligns with the patient's wishes. This measure, initially endorsed in 2007 and re-endorsed in 2012, is in use in the CMS Medicare Physician Quality Reporting System (PQRS) and the Quality Payment Program Merit-Based Incentive Payment System (MIPS). The Committee noted the lack of standard defined components that make up the care plan as well as the lack of disparities information. The developer indicated that performance rates have increased over time. The Committee also noted the small number of sites used to conduct testing, but agreed that the results indicated strong reliability of the measure. To demonstrate validity of the measure, an expert panel met to assess face validity of the measure concept. The Committee

agreed that the testing information provided remains sufficient and meets the validity criterion. In the future, the Committee would like to see a measure that addresses planning documented in the record that aligns with patient preferences. Overall, the Committee recognized the importance of documenting an advance care plan and recommended the measure for continued endorsement.

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI Foundation): Not Endorsed

Description: Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long-Term Acute Care, Nursing Home/SNF; **Data Source**: EHRs Hybrid, Paper Records

The goal of medication reconciliation is to prevent communication errors and ensure that the patient has a correct list of medications to prevent adverse drug events due to changes in medication, changes in medication dosage, or omission of medications. This measure was last endorsed in 2012. The Committee acknowledged the absence of updated, empirical evidence for this measure, but agreed to invoke an exception to the evidence criterion because the measure is important and the evidence presented is still relevant. Although the California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016, performance results are not yet available. While the Committee recognized the importance of reconciling medications, the Committee did not recommend the measure for continued endorsement due to the absence of performance scores and disparities data.

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI Foundation): Not Endorsed

Description: Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long Term Acute Care, Nursing Home/SNF; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of a transition record to patients at the time of discharge from an inpatient facility. The intent of the measure is to reduce communication gaps, help patients comply with treatment plans, and improve patient outcomes by providing detailed discharge information. Originally endorsed in 2010 and re-endorsed in 2012, this measure is in use in the CMS Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Committee members agreed that empirical evidence is not required to hold providers accountable and agreed to invoke the exception to the evidence subcriterion. The Committee was unable to reach consensus on the performance gap subcriterion, noting concerns with the lack of current data on opportunity for improvement. Committee members were concerned about the generalizability of the reliability testing, as testing of the measure was performed using data from only one site's electronic health record (EHR). Ultimately, the Committee did not accept the reliability testing and did not recommend the measure for continued endorsement.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI Foundation): Not Endorsed

Description: Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long-Term Acute Care, Nursing Home/SNF; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of a transition record to a patient's primary care physician or other healthcare professional within 24 hours of discharge from an inpatient facility. The intent of this measure is to improve the continuity of care and reduce hospital readmissions by ensuring that the patient's discharge information is available at the first post-discharge physician visit. Originally endorsed in 2010 and re-endorsed in 2012, the measure is currently in use in the CMS IPFQR and PRIME programs.

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Committee members agreed that empirical evidence is not required to hold providers accountable for the measure and agreed to invoke the exception to the evidence subcriterion. The Committee was unable to reach consensus on the performance gap subcriterion, noting concerns with the lack of current data on opportunity for improvement. Committee members were concerned about the generalizability of the reliability testing, as testing of the measure was performed using data from only one site's electronic health record (EHR). Ultimately, the Committee did not accept the reliability testing and did not recommend the measure for continued endorsement.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care) (PCPI Foundation): Not Endorsed

Description: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at

the time of ED discharge including, at a minimum, all of the specified elements. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Emergency Department; **Data Source**: EHRs Hybrid, Paper Records

This measure assesses the transmission of a transition record to patients at the time of discharge from an emergency department. The intent of the measure is to reduce communication gaps, help patients comply with treatment plans, and improve patient outcomes by providing detailed discharge information. Originally endorsed in 2010 and re-endorsed in 2012, this measure is not reported publicly or in use in any known accountability programs.

The evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the evidence is not specific to the focus of the measure. Similar to measures #0647 and #0648, Committee members agreed that empirical evidence is not required to hold providers accountable for the measure. Therefore, the Committee agreed to invoke the exception to the evidence subcriterion. The Committee expressed concerns with the lack of current data provided on opportunity for improvement. Because performance scores were not available, the Committee was unable to determine if there are opportunities for improvement. Ultimately, the measure did not pass the performance gap subcriterion, and the Committee did not recommend the measure for continued endorsement.

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit (University Hospitals Cleveland Medical Center): Not Endorsed

Description: This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2 to 21 who can be identified as having asthma, using the specified definitions. **Measure Type**: Composite; **Level of Analysis**: Population:Community, County or City, Population:Regional and State; **Setting of Care**: Clinician Office/Clinic, Emergency Department, Hospital; **Data Source**: Claims (Only)

Visits to the ED for asthma care are a potentially preventable health service that may serve as a marker for both insufficiency of primary care and insufficiency of clinical management of asthma. The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. The Committee agreed that the evidence presented through the graded Guidelines from the National Asthma Education and Prevention Programs (NAEPP) supported all three components of the measure, and the additional studies supported the use of primary care visits and prescribing of medication in the reduction of ED use/hospitalization.

The performance rate for the measure was 16.5 percent based on 2009-2011 data from New York State (NYS) Medicaid. The additional data on disparities from NYS Medicaid, specifically by race, urbanicity, and poverty gap, demonstrated that performance varies across these populations. The developer described the three components of this newly submitted all-or-none measure as “key determinants” of connections to the primary care system that can occur prior to ED visits/hospitalizations. Several

Committee members stated that this measure is a "good start" and that the components are available and feasible to obtain. However, because the developer was unable to provide reliability testing at the measure score level (a requirement for composite measures), the Committee did not recommend the measure for endorsement.

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection (University Hospitals Cleveland Medical Center): Not Endorsed

Description: This measure seeks to capture important aspects of follow-up after ED visits for asthma, including prompt follow-up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows emergency department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2 to 21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit. **Measure Type**: Composite; **Level of Analysis**: Population: Community, County or City, Population: Regional and State; **Setting of Care**: Clinician Office/Clinic, Emergency Department, Hospital; **Data Source**: Claims (Only)

Visits to the ED for asthma care are a potentially preventable health service that may serve as a marker for both insufficiency of primary care and insufficiency of clinical management of asthma. This newly submitted measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.

This composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit, and one fill of an asthma controller medication within two months after the ED visit. The Committee agreed that the evidence from the graded Guidelines of the National Asthma Education and Prevention Programs (NAEPP) supported the two components of the measure, and the additional studies supported use of primary care visits and prescribing of medication reducing ED use/hospitalization. This measure passed the evidence criterion. The performance rate for the measure was 16.5 percent based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The developer suggested that further data would clarify the information on this measure but stated that the data were not yet available. However, there were data on disparities specifically by race, urbanicity, and poverty that demonstrated differences across these population groups. For this measure, the Committee did not reach consensus on the performance gap criterion.

One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED, and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and the feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an "Or" instead of an "And." Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure did not pass the composite construct subcriterion, a must-pass criterion; therefore, the Committee did not continue the review.

References

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Measure Endorsed

0326 Advance Care Plan

Submission | **Specifications**

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Denominator Statement: All patients aged 65 years and older.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), EHRs Hybrid

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure meets the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted;** 1b. Performance Gap: **H-4; M-12; L-1; I-0**

Rationale:

- In the 2012 evaluation, the developer provided evidence supported by the National Hospice and Palliative Care Organization (NHPCO) that states that an advance care plan (ACP) positively impacts the quality of end of life care.
- For the current review, the developer referenced a 2014 systematic review that evaluates the effect of ACP on hospitalization and length of stays. Evidence from the 21 studies showed that use of an ACP is linked to a decreased rate of hospitalizations.
- Committee members acknowledged the importance of an ACP, and referenced updated information. This additional information supported the prior evidence. The Committee agreed that the updated evidence is directionally the same since the last NQF endorsement evaluation,

and therefore the Committee accepted the prior evaluation of this criterion without further discussion or vote.

- Some Committee members expressed concern that there is missing disparities information.
- The Committee strongly encouraged the developer to collect and provide the disparities information in the future, but noted this lack of information does not change the evidence supporting the performance gap, which showed increased performance rates from 62.3% to 67.2% on documentation of the advance care plan from 2012 to 2014.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted;** 2b. Validity: **Previous Validity Evaluation Accepted**

<u>Rationale</u>:

- The developer did not provide updated reliability testing for this maintenance review. Committee members noted that the previous testing is from a small sample of records from only four sites of care. However, the results indicated strong reliability with an overall kappa score of 0.97.
- Although the Committee noted that the previous testing was based a small number of testing sites, the Committee agreed the results indicated strong reliability and accepted the prior evaluation of the reliability subcriterion without further discussion.
- The Committee accepted a motion to carry over votes from the previous evaluation on reliability.
- An expert panel of 33 members assessed face validity of the measure. The panel rated their agreement based on the statement, "the scores obtained from the measure as specified will accurately differentiate quality across providers." Results from the expert panel indicated an average rating of 4.35 on a 5-point scale.
- Several Committee members noted that a significant reconsideration of validity was not warranted unless there is evidence that the use of CPT codes for ACP have changed substantially since testing was first conducted.
- The Committee accepted a motion to carry over votes from the previous evaluation on validity.

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3. Feasibility: H-1; M-13; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- This measure is currently in use in the CMS Medicare Physician Quality Reporting System (PQRS); Committee members expressed no concerns with the measure's feasibility.

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4. Usability and Use: H-1; M-14; L0-; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

- The measure is in use in both CMS' Medicare PQRS and the Quality Payment Program Merit-Based Incentive Payment System (MIPS). Members noted that the results from the measures used in an accountability program could advance goals of high quality healthcare.
- The developer noted an increased rate of performance (62.3% to 67.2%) from the eligible physicians who reported continuously from 2012-2014, which suggests physicians are initiating and documenting discussion of ACP with patients, family, and caregivers at a higher rate.
- The Committee did not voice concerns about unintended consequences or potential harms to patients as a result of this measure.

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5. Related and Competing Measures

- This measure is related to two other measures:
    - 1626: Patients Admitted to ICU who Have Care Preferences Documented
    - 1641: Hospice and Palliative Care –Treatment Preferences

The Committee discussed some pertinent issues including that information on advance care planning moves across settings. There was a suggestion to harmonize the measures by using standardized terminology for the numerator population to capture information about an individual's advanced care decisions and planning across the continuum of care. The Committee suggested that this could be the first step towards making a plan portable.

Standing Committee Recommendation for Endorsement: **Y-15; N-0**

6. Public and Member Comment

- NQF received two post-evaluation comments supporting the Committee's recommendation to endorse the measure. However, the commenters noted the implementation challenges and unintended consequences of using claims data to reliably capture care plans, and the lack of consistency with providers billing for this service.

Developer Response: We appreciate your support of endorsement for #0326: Advance Care Plan as a clinician/group practice level measure. We understand the challenges of retrieving this information through claims data and have expanded the list of codes that count toward the numerator for this measure. This list includes the CPT II codes: 1123F, 1124F and the CPT codes 99497, or 99497 and 99498. Medicare began allowing reimbursement for advance care planning discussions through codes 99497 and 99498 effective January 1, 2016. We expect this will encourage more physicians to record these codes when providing this service.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Appeals

No Appeals received.

Measures Not Endorsed

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient, regardless of age, or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories

Numerator Statement: Discharges in which the patient or their caregiver(s) received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories:

Medications TO BE TAKEN by Patient

- Continued*

Medications prescribed before inpatient stay that patient should continue to take after discharge, AND

- Changed*

Medications prescribed before inpatient stay with a change in dosage or directions after discharge that differs from what the patient was taking prior to the inpatient stay, AND

- New*

Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge

* Prescribed dosage, instructions, and intended duration must be included for each continued, changed and new medication listed

Medications NOT TO BE TAKEN by Patient

- Discontinued

Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND

- Allergies and Adverse Reactions

Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long-Term Acute Care, Nursing Home/SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-3; L-4; I-9;** Revote**: H-0; M-6; L-4; I-6;** Evidence Exception: **Y-13; N-3**

<u>Rationale</u>:

- During the 2012 review, the developer cited the evidence from the 2006 Transitions of Care Consensus Conference (TOCCC) development of principles, guidelines, and standards. The developer did not provide a systematic review of the body of evidence that matches the measure focus or reconciled medication lists at the time of discharge, nor did the developer provide information on the quantity, quality, or consistency of the evidence. The TOCCC expert opinion based guidelines were ungraded and were based on evidence related to transitions of care between the inpatient and outpatient settings.
- For the current evaluation, the developer attested that there have been no changes in the evidence since the 2012 review. During the Committee review, a Committee member identified several studies (Mueller et al., 2012, Vedel and Khanassov 2015, Kansagara 2015, Michaelsen 2015, and Mekonnen et al., 2016) that were relevant to the measure focus. However, the developer noted that the updated studies were discussing different types of interventions and not specifically discussing the current measure— reconciled medication list received by the patient.
- The Committee acknowledged the absence of updated, empirical evidence for this measure, however, noted the importance of the measure. The Committee agreed to invoke the exception to the evidence subcriterion.
- The developer did not present performance scores. The California Department of Health Care Services administered this measure in the CMS Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program in 2016. The developer noted that there is a two-year delay before data are available to measure developers.
- The developer provided additional evidence during the in-person meeting regarding medication discrepancies by gender (Lindquist et al., 2013); however, the Committee determined that these disparities data were still insufficient.
- This measure ultimately did not pass the performance gap subcriterion.

0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, in which the patient,

regardless of age, or their caregiver(s), received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements

Numerator Statement: Discharges in which the patient or their caregiver(s) received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:

Inpatient Care

- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management

- Current medication list, AND
- Studies pending at discharge (eg, laboratory, radiological), AND
- Patient instructions

Advance Care Plan

- Advance directives or surrogate decision maker documented OR
- Documented reason for not providing advance care plan

Contact Information/Plan for Follow-up Care

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other healthcare professional, or site designated for follow-up care

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long-Term Acute Care, Nursing Home/SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: <u>This measure did not reach consensus on the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-15**; 1b. Performance Gap: **H-0; M-8; L-3; I-4;**

Evidence Exception: **Y-15; N-1**

Rationale:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and based on evidence related to transitions of care between the inpatient and outpatient settings.
- One Committee member noted that, although the evidence provided is not specific to the measure focus, it does support that the of providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee noted that communication of essential patient information is critical to continuity of appropriate, quality care. Committee members stated that this should be a basic standard of practice and agreed that empirical evidence is not required to hold providers accountable for the measure. Because of the absence of empirical evidence to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- The developer was not able to provide any data on current performance. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature were not recent.
- The developer also summarized a prospective study that tracked the frequency of occurrence of certain elements that are included within the measure. Although performance scores varied on whether the required elements were provided to patients or not.
- Furthermore, Committee members noted that the sample size of the study was small (1 facility and 377 patients) and remained concerned that data were not provided on the measure as specified. Performance scores on the measure as specified (current and over time) at the specified level of analysis are required for maintenance of endorsement. The Committee was unable to reach consensus on the performance gap subcriterion.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-4; L-6; I-5**

Rationale:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR were compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (88% agreement, kappa=.69). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element prior to the meeting (numerator, denominator and exceptions).

- Committee members noted concerns about the generalizability of the validity testing, as the empirical testing of the measure was done using data from only one site's EHR, which was customized to facilitate the review and printing of the transition record. The developer clarified that the measure was not specified as an eMeasure because every facility may have a different template for a transition record in their EHR. The Committee noted that the measure is most likely to be implemented in EHRs; additionally, EHRs have evolved since the testing was last conducted; and there is significant variation in EHR documentation.
- The Committee encouraged the developer to conduct updated testing that would include multiple sites to demonstrate how the measure would perform on a national scale versus just one facility. The Committee did not find the reliability testing sufficient enough to pass the reliability subcriterion.

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Submission

Description: Percentage of discharges from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, of patients, regardless of age, for which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Numerator Statement: Discharges in which a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge

Denominator Statement: All discharges for patients, regardless of age, from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

Exclusions: Patients who died

Patients who left against medical advice (AMA) or discontinued care

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Hospital: Acute Care Facility, Ambulatory Surgery Center, Hospital: Critical Care, Hospital, Behavioral Health: Inpatient, Inpatient Rehabilitation Facility, Long-Term Acute Care, Nursing Home/SNF

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure did not reach consensus on the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-0; L-1; I-14**; 1b. Performance Gap: **H-0; M-7; L-1; I-7;**

Evidence Exception: **Y-13; N-2**

Rationale:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and based on evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. The Committee recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- Similar to measure 0647, the developer was not able to provide any data on current performance of the measure. To demonstrate opportunity for improvement, the developer provided a summary of data from the literature showing that delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common. However, Committee members noted that the data from the literature were not recent.
- A Committee member noted that, although no performance data were provided for this specific measure, data exist that show performance gaps in this area of measurement. The Committee was unable to reach consensus on the performance gap subcriterion.

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2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-4; L-4; I-7**

Rationale:

- For the 2012 endorsement evaluation, data from a report automatically generated from one EHR were compared to manual abstraction from patient records to calculate parallel forms of reliability for the measure. One overall statistic was provided (95% agreement, kappa=.49). Because it was unclear what the overall statistic was referring to, the developer provided additional testing results on each data element (numerator, denominator and exceptions) prior to the Committee's meeting.
- The Committee agreed to apply the previous discussion about the reliability testing for measure #0647 to this measure, as the testing methodology was the same. The Committee remained concerned about the small sample size (1 facility and 377 patients) and did not pass the measure on the reliability subcriterion.

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Submission

Description: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements

Numerator Statement: Discharges in which the patient or their caregiver(s) received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:

- Summary of major procedures and tests performed during ED visit, AND

- Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND

- Patient instructions, AND

- Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND

- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

Denominator Statement: All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care

Exclusions: Exclusions:

Patients who died

Patients who left against medical advice (AMA) or discontinued care

Exceptions:

Patients who declined receipt of transition record

Patients for whom providing the information contained in the transition record would be prohibited by state or federal law

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Emergency Department

Type of Measure: Process

Data Source: EHRs Hybrid, Paper Records

Measure Steward: PCPI

STANDING COMMITTEE MEETING [02/22/2017]

1. Importance to Measure and Report: The measure does not meet the Importance to Measure and Report criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-2; L-1; I-12**; 1b. Performance Gap: **H-0; M-2; L-1; I-12;**

Evidence Exception: **Y-11; N-4**

Rationale:

- For the 2012 evaluation, the evidence provided by the developer included the 2009 Transitions of Care Consensus Conference (TOCCC) development of standards. The standards were a result of a consensus conference convened in 2006 by the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM), with representation from the Emergency Medicine community. The TOCCC expert opinion based guidelines were ungraded and based evidence related to transitions of care between the inpatient and outpatient settings.
- Committee members agreed that the evidence supporting this measure demonstrates that providing an inclusive discharge summary and reviewing the content with the patient/caregiver is one component of programs that are successful in reducing negative post-discharge events. However, the Committee also recognized that the evidence is not specific to the focus of the measure. Considering the absence of empirical evidence provided to support this important measure concept, the Committee agreed to invoke the exception to the evidence subcriterion.
- Similar to measures #0647 and #0648, the developer was not able to provide any data on current performance of the measure. The Committee was also concerned that data looking at emergency department discharges related to this measure were not available to support an opportunity for improvement. Ultimately, the measure did not pass the performance gap subcriterion.

3170 Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit

Submission

Description: This measure describes the incidence rate of emergency department visits for children ages 2 to 21 who are being managed for identifiable asthma. This measure characterizes care that precedes Emergency Department visits for children ages 2- 21 who can be identified as having asthma, using the specified definitions. The developers sought to identify children with ongoing asthma who should be able to be identified by their healthcare providers and/or healthcare plans as having asthma. The operational definition of an identifiable asthmatic is a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. Specifically, this measure identifies the use of primary care services and medications prior to ED visits and/or hospitalizations for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system prior to first ED visit and/or hospitalization that has a primary or secondary diagnosis of asthma among children whom our specifications identify with asthma.

Denominator Statement: All first ED visits and/or hospitalizations, in which asthma was a primary or secondary diagnosis in children age 2-21 who meet criteria for being managed for identifiable asthma in the assessment period and have been enrolled for the 6 consecutive months prior to the ED visit/admission.

Exclusions: Children with specific concurrent or pre-existing diagnosis, as specified in S.9.

Children who have not been consecutively enrolled with the reporting entity for at least six months prior to the index reporting month.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Stratification for reasons beyond risk adjustment

Level of Analysis: Population: Community, County or City, Population: Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

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STANDING COMMITTEE MEETING 02/22/2017

1. Importance to Measure and Report: <u>The measure meets the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-1; M-10; L-5; I-1**; 1b. Performance Gap: **H-4; M-11; L-1; I-1;** 1c. Composite Performance Measure-Quality Construct: **H-1; M-10; L-6; I-0**

<u>Rationale</u>:

- The evidence base for this composite measure is the connection to the primary care system, including use of primary care services and medications prior to an ED visit/hospitalization for children with asthma. Composite measures require that the evidence subcriteria (1a.) is met is for each component.
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control were recommended (graded at a category B and C). Secondly, evidence (graded at a category A), was provided to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma. Lastly, evidence that supports Short Acting Beta Agonist (SABAs) as the drug of choice for treating acute asthma symptoms and exacerbations is graded at a category A.
- The developer provided three additional studies that support the use of primary care; primary care with medication management; and asthma guidelines to improve care and reduce ED use, especially in minority children.
- The Committee discussed the strength of the evidence for each component based on the guideline-based care for asthma and concluded that the evidence is strong.
- The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. The Committee agreed this demonstrated a substantial opportunity for improvement.
- Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences across population groups.
- The developer described the three components of this all-or-none measure as “key determinants” of connections to the primary care system that can occur prior to ED visits/hospitalizations.
- The Committee discussed whether the measure could be broader and include other elements such as the effects of the environment. Members also discussed whether these are the best components for the construct. Other Committee members commented that this measure is a “good start” and the components are available and feasible to obtain.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2d. Composite)

2a. Reliability: **H-0; M-2; L-1; I-14**

Rationale:

- NQF requires composite measures be tested for reliability at the measure score level. The developer indicated that testing is complete at both the county and plan level using data in New York State. However, the developer was unable to provide this testing during the in-person meeting.
- The developer articulated plans to obtain these data to present to the Committee at the post comment call. Because measure level testing was not available, the measure did not pass on reliability.
- The review of the measure did not continue because reliability is must pass criterion.

3171 Percentage of Asthma ED visits followed by Evidence of Care Connection

Submission

Description: This measure seeks to capture important aspects of follow up after ED visits for asthma, including prompt follow up with primary care clinicians and prescription fills for controller medications. This measure characterizes care that follows Emergency Department (ED) visits with a primary or secondary diagnosis of asthma for children ages 2-21 that occur in the Reporting Year and who are enrolled in the health plan for two consecutive months following the ED visit.

The developer stated visits were stratified into those that occurred for children who can or cannot be identified as having asthma, using the specified definitions. Identifiable asthmatic was operationalized as a child who has utilized healthcare services that suggest the healthcare system has enough information to conclude that the child has an asthma diagnosis that requires ongoing care. A 2 year look back period before the reporting year was also incorporated into the measure.

Specifically, this measure describes the connection with the primary care system (timely visits to primary care providers and filling of controller asthma medications) following ED visits for children with asthma.

Numerator Statement: Evidence of connection to the primary care medical system following ED visits that have a primary or secondary diagnosis of asthma among children, overall and stratified by whether the child had identifiable asthma at the time of the ED visit.

Denominator Statement: All ED visits in which asthma was a primary or secondary diagnosis in children who are continuously enrolled for at least the 2 months following the ED visit.

Exclusions: Children with concurrent or pre-existing diagnosis.

Children who have not been consecutively enrolled with the reporting entity for at least two months following the ED visit.

Children who do not meet the denominator criteria.

Adjustment/Stratification: Other Strtification for reasons other then risk adjustment

Level of Analysis: Population: Community, County or City, Population: Regional and State

Setting of Care: Clinician Office/Clinic, Emergency Department, Hospital

Type of Measure: Composite

Data Source: Claims (Only)

Measure Steward: University Hospitals Cleveland Medical Center

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STANDING COMMITTEE MEETING 02/22/2017

1. Importance to Measure and Report: <u>The measure does not meet the Importance to Measure and Report criteria</u>

(1a. Evidence, 1b. Performance Gap; 1c. Composite)

1a. Evidence: **H-2; M-14; L-1; I-0**; 1b. Performance Gap: **H-0; M-8; L-2; I-6;** 1c. Composite: **H-0; M-6; L-9; I-2**

<u>Rationale</u>:

- This composite measure includes two components: visit(s) to a primary care provider that occurred within 14 days following the ED visit and have at least one fill of an asthma controller medication within 2 months after the ED visit (including the day of visit).
- The Guidelines from the National Asthma Education and Prevention Programs (NAEPP) provided graded evidence for regular follow up and the medication management approach. Specifically, evidence supporting periodic assessment and ongoing monitoring (at 1-6 month) intervals of asthma control was graded at a category B and C. Evidence (graded at a category A) was provided to support the daily use of long-term control medications on a long-term basis to achieve and maintain control of persistent asthma.
- The developer provided additional studies that support the use of primary care for asthma management. The studies focused on primary care with medication management; asthma guidelines to improve care and reduce ED use, especially in minority children; and several studies support that after an exacerbation, follow-up with a primary care physician is central for ongoing management.
- During the Committee discussion, one member noted that a strength of the measure is that it assesses a subsequent event of care provided --a substantive event.
- The performance rate for the measure was 16.5% based on 2009-2011 data from New York State (NYS) Medicaid. However, the Committee raised concerns about the accuracy of these data. The developer suggested that further data would clarify the information on this measure and articulated plans to provide these data at the post-comment call.
- Additionally, data on disparities specifically by race, urbanicity and poverty demonstrated differences across these population groups.
- The developer described the two components of this all-or-none measure as “key determinants” of connections to the primary care system that can occur following ED visits for children with asthma.
- The Committee discussed the components of the composite measure. One member suggested that some patients may receive medications in locations that do not bill for these prescription refills such as an ED and another member offered that some patients might not need a refill as early as two months. Other members discussed the importance of an asthma care plan and feasibility of obtaining one. Additionally, one member suggested that the measure may improve if the two components in this measure were constructed as an “Or” instead of an “And”. Due to the multiple concerns by members of the Committee on the components and because the measure was an all-or-none composite, the measure failed on 1c. Composite construct. Because the measure failed on a must pass criterion, the Committee did not continue the review.

Measure Withdrawn from Consideration

A single measure previously endorsed by NQF has not been re-submitted for maintenance of endorsement during the endorsement evaluation process. Endorsement for this measure will be removed.

Measure	Reason for withdrawal
0526 Timely Initiation of Care	Developer did not resubmit this measure for maintenance review; therefore, NQF has removed endorsement.

Appendix B: NQF Care Coordination Portfolio and Related Measures

*Denotes measures that are applicable to care coordination, but are not included in the Care Coordination Portfolio.

Communication

Measure Number	Measure Title
0291	Emergency Transfer Communication
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
0649	Transition Record with Specified Elements Received by Discharged Patients (ED Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Transitions or Handoffs

Measure Number	Measure Title
0097	Medication Reconciliation
0171	Acute care hospitalization (risk-adjusted)
0173	Emergency Department Use without Hospitalization
0495	Median time from ED arrival to ED departure for admitted ED patients
0496	Median time from ED arrive to ED departure for discharged ED patients
0497	Admit decision time to ED departure time for admitted patients
0553	Care for Older Adults – Medication Review
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

Proactive Plan of Care and Follow-Up

Measure Number	Measure Title
0326	Advance Care Plan
1626*	Patients Admitted to ICU who Have Care Preferences Documented
1641*	Hospice and Palliative Care – Treatment Preferences

Appendix C: Care Coordination Portfolio—Use in Federal Programs

*Denotes measures that are under review in this project.

NQF #	Title	Federal Programs: Finalized as of February 14, 2017
0097	Medication Reconciliation	Medicare Physician Quality Reporting System (PQRS), Merit-Based Incentive Payment System (MIPS) Program, Physician Compare, Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM), Medicare Shared Savings Program (MSSP)
0171	Acute care hospitalization (risk-adjusted)	Home Health Quality Reporting, Home Health Value Based Purchasing
0173	Emergency Department Use without Hospitalization	Home Health Quality Reporting, Home Health Value Based Purchasing
0291	Emergency transfer Communication	No federal program usage specified for this measure.
0326	Advance Care Plan*	Home Health Value Based Purchasing, Merit-Based Incentive Payment System (MIPS) Program, Medicare Physician Quality Reporting System (PQRS), Physician Feedback/Quality and Resource Use Reports (QRUR), Physician Value-Based Payment Modifier (VBM)
0487	EHR with EDI prescribing used in encounters where a prescribing event occurred	No federal program usage specified for this measure.
0495	Median time from ED arrival to ED departure for admitted ED patients	Hospital Compare, Hospital Inpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0496	Median time from ED arrive to ED departure for discharged ED patients	Hospital Compare, Hospital Outpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0497	Admit decision time to ED departure time for admitted patients	Hospital Compare, Hospital Inpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0553	Care for Older Adults – Medication Review	Medicare Part C Star Rating
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)*	No federal program usage specified for this measure.
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)*	Hospital Compare, Inpatient Psychiatric Facility Quality Reporting

NQF #	Title	Federal Programs: Finalized as of February 14, 2017
0648	Timely Transmission of Transition Record (Discharged from an Inpatient Facility to Home/Self Care or Any other Site of Care)*	Hospital Compare, Inpatient Psychiatric Facility Quality Reporting, Medicaid
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharged to Ambulatory Care or Home Health Care)*	No federal program usage specified for this measure.
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	No federal program usage specified for this measure.

Appendix D: Care Coordination Standing Committee and NQF Staff

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Appendix E: Measure Specifications

0326 Advance Care Plan

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

TYPE

Process

DATA SOURCE

Claims (Only), EHRs Hybrid None

No data collection instrument provided. No data dictionary

LEVEL

Clinician: Group/Practice, Clinician: Individual

SETTING

Clinician Office/Clinic

NUMERATOR STATEMENT

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

NUMERATOR DETAILS

Report the CPT Category II codes designated for this numerator:

- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

- 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.

DENOMINATOR STATEMENT

All patients aged 65 years and older.

DENOMINATOR DETAILS

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

*Clinicians indicating the place of service as the emergency department will not be included in this measure.

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older.

Step 2: Determine number of patients meeting the denominator criteria as specified in Question S.7. above.

Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. Rate/proportion

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5.1 Identified measures: 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF#0647 targets all age groups and focuses specifically on transition of care to another facility or to the home. This measure, NQF#0326, focuses specifically on older adults and creating an advanced care plan or identifying a designated surrogate decision maker to dictate care to be provided, including but not limited to transitions.

5b.1 If competing, why superior or rationale for additive value: N/A

Appendix F1: Related and Competing Measures (tabular format)

Comparison of NQF #0326, NQF #1626 and NQF #1641

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
Steward	National Committee for Quality Assurance	The RAND Corporation	University of North Carolina-Chapel Hill
Description	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Percentage of patients with chart documentation of preferences for life sustaining treatments.
Type	Process	Process	Process
Data Source	Claims (Only), EHRs Hybrid None No data collection instrument provided. No data dictionary	Paper Records Medical record abstraction tool	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data
Level	Clinician: Group/Practice, Clinician: Individual	Facility	Clinician: Group/Practice, Facility
Setting	Clinician Office/Clinic	Hospital: Hospital	Hospice; Hospital: Hospital
Numerator Statement	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.	Patients whose medical record includes documentation of life sustaining preferences
Numerator Details	Report the CPT Category II codes designated for this numerator:	Edits indicated by [brackets] Patients whose medical record includes documentation of care preferences within 48	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity,

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record - 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.	hours of admission to ICU. Care preferences may include any of the following: - Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR - Documentation that a care preference discussion was attempted and/or reason why it was not done [Simply having an advance directive or other advance care planning document or POLST in the medical record does not satisfy this criterion. However, a notation in the record during the allotted time period referring to preferences or decisions within such a document satisfies this requirement.]	discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
Denominator Statement	All patients aged 65 years and older.	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Denominator Details	Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342,	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission. "Vulnerable" is defined as any of the following: - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001) - Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke,

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439 *Clinicians indicating the place of service as the emergency department will not be included in this measure.		HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	N/A	N/A	Patients with length of stay < 1 day in hospice or palliative care
Exclusion Details	N/A	N/A	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older. Step 2: Determine number of patients meeting the denominator criteria as specified in Question S.7. above. Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission 2. Examine the medical record for evidence of a statement of patient care preferences OR attempt to elicit these or other reason why this was not done within 48 hours of ICU admission.	Chart documentation of life sustaining preferences: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital b.Step 2- Exclude patients if length of stay is < 1 day. c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments. Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2

	0326 Advance Care Plan	1626 Patients Admitted to ICU who Have Care Preferences Documented	1641 Hospice and Palliative Care – Treatment Preferences
	Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. Rate/proportion		
Submission items	5.1 Identified measures: 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: NQF#0647 targets all age groups and focuses specifically on transition of care to another facility or to the home. This measure, NQF#0326, focuses specifically on older adults and creating an advanced care plan or identifying a designated surrogate decision maker to dictate care to be provided, including but not limited to transitions. 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: No 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided. 5b.1 If competing, why superior or rationale for additive value:	5.1 Identified measures: No 5a.1 Are specs completely harmonized? N/A 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle. 5b.1 If competing, why superior or rationale for additive value: Attachment

Appendix F2: Related and Competing Measures (narrative format)

Comparison of NQF #0326, NQF #1626, and NQF #1641

0326 Advance Care Plan
1626 Patients Admitted to ICU who Have Care Preferences Documented
1641 Hospice and Palliative Care – Treatment Preferences

Steward

0326 Advance Care Plan

National Committee for Quality Assurance

1626 Patients Admitted to ICU who Have Care Preferences Documented

The RAND Corporation

1641 Hospice and Palliative Care – Treatment Preferences

University of North Carolina-Chapel Hill

Description

0326 Advance Care Plan

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

1626 Patients Admitted to ICU who Have Care Preferences Documented

Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.

1641 Hospice and Palliative Care – Treatment Preferences

Percentage of patients with chart documentation of preferences for life sustaining treatments.

Type

0326 Advance Care Plan

Process

1626 Patients Admitted to ICU who Have Care Preferences Documented

Process

1641 Hospice and Palliative Care – Treatment Preferences

Process

Data Source

0326 Advance Care Plan

Claims (Only), EHRs Hybrid None

No data collection instrument provided. No data dictionary

1626 Patients Admitted to ICU who Have Care Preferences Documented

Paper Records

Medical record abstraction tool

1641 Hospice and Palliative Care – Treatment Preferences

Electronic Health Record (Only), Other

Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data

Level

0326 Advance Care Plan

Clinician: Group/Practice, Clinician: Individual

1626 Patients Admitted to ICU who Have Care Preferences Documented

Facility

1641 Hospice and Palliative Care – Treatment Preferences

Clinician: Group/Practice, Facility

Setting

0326 Advance Care Plan

Clinician Office/Clinic

1626 Patients Admitted to ICU who Have Care Preferences Documented

Hospital: Hospital

1641 Hospice and Palliative Care – Treatment Preferences

Hospice; Hospital: Hospital

Numerator Statement

0326 Advance Care Plan

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

1626 Patients Admitted to ICU who Have Care Preferences Documented

Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.

1641 Hospice and Palliative Care – Treatment Preferences

Patients whose medical record includes documentation of life sustaining preferences

Numerator Details

0326 Advance Care Plan

Report the CPT Category II codes designated for this numerator:

- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

- 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.

1626 Patients Admitted to ICU who Have Care Preferences Documented

Edits indicated by [brackets]

Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following:

- Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR

- Documentation that a care preference discussion was attempted and/or reason why it was not done

[Simply having an advance directive or other advance care planning document or POLST in the medical record does not satisfy this criterion. However, a notation in the record during the allotted time period referring to preferences or decisions within such a document satisfies this requirement.]

1641 Hospice and Palliative Care – Treatment Preferences

Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.

Denominator Statement

0326 Advance Care Plan

All patients aged 65 years and older.

1626 Patients Admitted to ICU who Have Care Preferences Documented

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

1641 Hospice and Palliative Care – Treatment Preferences

Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.

Denominator Details

0326 Advance Care Plan

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

*Clinicians indicating the place of service as the emergency department will not be included in this measure.

1626 Patients Admitted to ICU who Have Care Preferences Documented

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

"Vulnerable" is defined as any of the following:

- >74 years of age

- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)

- Poor prognosis/terminal illness defined as life expectancy of <6 months

- Stage IV cancer

1641 Hospice and Palliative Care – Treatment Preferences

The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

Exclusions

0326 Advance Care Plan

N/A

1626 Patients Admitted to ICU who Have Care Preferences Documented

N/A

1641 Hospice and Palliative Care – Treatment Preferences

Patients with length of stay < 1 day in hospice or palliative care

Exclusion Details

0326 Advance Care Plan

N/A

1626 Patients Admitted to ICU who Have Care Preferences Documented

N/A

1641 Hospice and Palliative Care – Treatment Preferences

Calculation of length of stay; discharge date is identical to date of initial encounter.

Risk Adjustment

0326 Advance Care Plan

No risk adjustment or risk stratification

1626 Patients Admitted to ICU who Have Care Preferences Documented

No risk adjustment or risk stratification

1641 Hospice and Palliative Care – Treatment Preferences

No risk adjustment or risk stratification

Stratification

0326 Advance Care Plan

N/A

1626 Patients Admitted to ICU who Have Care Preferences Documented

N/A

1641 Hospice and Palliative Care – Treatment Preferences

N/A

Type Score

0326 Advance Care Plan

Rate/proportion

better quality = higher score

1626 Patients Admitted to ICU who Have Care Preferences Documented

Rate/proportion

better quality = higher score

1641 Hospice and Palliative Care – Treatment Preferences

Rate/proportion

better quality = higher score

Algorithm

0326 Advance Care Plan

Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older.

Step 2: Determine number of patients meeting the denominator criteria as specified in Question S.7. above.

Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. Rate/proportion

1626 Patients Admitted to ICU who Have Care Preferences Documented

1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission

2. Examine the medical record for evidence of a statement of patient care preferences OR attempt to elicit these or other reason why this was not done within 48 hours of ICU admission.

1641 Hospice and Palliative Care – Treatment Preferences

Chart documentation of life sustaining preferences:

a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital

b.Step 2- Exclude patients if length of stay is < 1 day.

c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments.

Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2

Submission Items

0326 Advance Care Plan

5.1 Identified measures: 0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF#0647 targets all age groups and focuses specifically on transition of care to another facility or to the home. This measure, NQF#0326, focuses specifically on older adults and creating an advanced care plan or identifying a designated surrogate decision maker to dictate care to be provided, including but not limited to transitions.

5b.1 If competing, why superior or rationale for additive value: N/A

1626 Patients Admitted to ICU who Have Care Preferences Documented

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.

5b.1 If competing, why superior or rationale for additive value:

1641 Hospice and Palliative Care – Treatment Preferences

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.

5b.1 If competing, why superior or rationale for additive value: Attachment

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