This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all yellow highlighted areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).

Steering Committee: Complete all pink highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few subcriteria as indicated)

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MEASURE DESCRIPTIVE INFORMATION

De.1 Measure Title: Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)

De.2 Brief description of measure: The proposed long-stay pain measure reports the percent of long-stay residents of all ages in a nursing facility who reported almost constant or frequent pain and at least one episode of moderate to severe pain or any severe or horrible pain in the 5 days prior to the MDS assessment (which may be an annual, quarterly, significant change or significant correction MDS) during the selected quarter.

Long-stay residents are those who have had at least 100 days of nursing facility care. This measure is restricted to the long stay population because a separate measure has been submitted for the short-stay residents (those who are discharged within 100 days of admission).

De.3 Type of Measure: Outcome
De.4 National Priority Partners Priority Area: Care coordination
De.5 IOM Quality Domain: Patient-centered
De.6 Consumer Care Need: 

CONDITIONS FOR CONSIDERATION BY NQF

Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:

A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.

A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)?

A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
<table>
<thead>
<tr>
<th><strong>A.3 Measure Steward Agreement:</strong></th>
<th>Government entity and in the public domain - no agreement necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.4 Measure Steward Agreement attached:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B.</strong> The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years.</td>
<td>Yes, information provided in contact section</td>
</tr>
<tr>
<td><strong>C.</strong> The intended use of the measure includes both public reporting and quality improvement.</td>
<td></td>
</tr>
<tr>
<td>►Purpose: Public reporting, Internal quality improvement</td>
<td></td>
</tr>
<tr>
<td><strong>D.</strong> The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement.</td>
<td></td>
</tr>
<tr>
<td><strong>D.1 Testing:</strong> No, testing will be completed within 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>(for NQF staff use)</strong> Have all conditions for consideration been met?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Staff Notes to Steward (if submission returned):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Staff Notes to Reviewers (issues or questions regarding any criteria):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Staff Reviewer Name(s):</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 1. IMPORTANCE TO MEASURE AND REPORT

**Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)**

**1a. High Impact:**

**1a.1 Demonstrated High Impact Aspect of Healthcare:** Patient/societal consequences of poor quality

**1a.2**

**1a.3 Summary of Evidence of High Impact:** This measure is a high impact measure given the high proportion of residents with pain and the potentially serious physiological consequences of it not being treated. Research indicates that at least 40-85% of nursing facility residents have persistent pain. The percentage may be even higher; research suggests that pain is often not fully documented.(1, 2, 3, 4, 5, 6, 7)

Failure to identify the presence of pain or to assess its severity and functional impact can leave a potentially treatable symptom unrecognized and therefore unlikely to be addressed. Indeed, evidence suggests that pain is consistently under-treated, particularly among individuals with cognitive impairment.(3, 8, 9) A standard measure of resident pain is needed because of gaps in nursing staff’s knowledge of “best practice” pain management in hospitals and nursing homes.(4, 10, 11, 14, 15) A standard measure also provides a benchmark for pain management practices that vary widely across nursing homes.(13,14,15)

Among the potential adverse physiological and psychological effects of unrelieved pain are impaired gastrointestinal and pulmonary function; nausea and dyspnea; increased metabolic rate; including increased

**Rating:** C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
tumor growth and metastasis in cancer; impaired immune response; insomnia, delayed healing, increased blood clotting, loss of appetite, and inability to walk or move about; impairment of joint function with functional decline and increased dependency; and anxiety and depression.(16, 17, 18, 19) In the general population, unrelieved pain costs millions of dollars annually as a result of longer hospital stays, rehospitalizations, outpatient care, and emergency room visits.(20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31)

Resident pain in nursing facilities is a subject of great interest to the public. Pain management in nursing facilities is central to the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) mandate to promote “maximum practicable functioning” among residents, and failure to identify and address pain denies a resident the right granted in OBRA 87 to freedom from neglect.(32) Advancing Excellence in America’s Nursing Homes has made the management of resident pain one of its major goals. (33)


11. The measure focuses on chronic pain management practices among long-term stays, a group known to be at high risk for pain. Although the number of high-quality studies of pain management in nursing homes is limited, those studies agree that resident pain is under-recognized and under-treated. A recent record audit of 291 residents in 14 long-term care facilities found a significant gap between evidence-based pain management recommendations and facility practices. Assessment was particularly weak, only 32% of the cases reported chronic pain once or twice a week, and only 3% of the cases reviewed had reported that pain impacted functioning and quality of life twice or more times during the previous 30 days. (3) One study focusing on pain in cancer patients reported underuse of analgesics and hospice, along with nursing facility staffing patterns as key issues in inadequate pain treatment for this population. (4) Many studies and literature maintain that almost all pain, including pain at the end of life, can be managed with appropriate assessment and treatment, and research in pain management has identified the adoption of systematic implementation models, clinical decision-making algorithms, interdisciplinary approaches, and ongoing outcome evaluations as effective means to deliver effective pain relief in nursing facilities. (5, 6, 7, 8, 9)

1b. Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

A version of this quality measure has been in use by CMS since 2002, drawing on data from an MDS 2.0 item based on staff assessment. A study of variability for this measure by the University of Colorado showed that in the first quarter of 2006, the measure demonstrated a good degree of variability across facilities. (1) See attached Table 1: Measure Variability Across Facilities.

Although the number of high-quality studies of pain management in nursing homes is limited, those studies agree that resident pain is under-recognized and under-treated. (2) A recent record audit of 291 residents in 14 long-term care facilities found a significant gap between evidence-based pain management recommendations and facility practices. Assessment was particularly weak, only 32% of the cases reported chronic pain once or twice a week, and only 3% of the cases reviewed had reported that pain impacted functioning and quality of life twice or more times during the previous 30 days. (3) One study focusing on pain in cancer patients reported underuse of analgesics and hospice, along with nursing facility staffing patterns as key issues in inadequate pain treatment for this population. (4) Many studies and literature maintain that almost all pain, including pain at the end of life, can be managed with appropriate assessment and treatment, and research in pain management has identified the adoption of systematic implementation models, clinical decision-making algorithms, interdisciplinary approaches, and ongoing outcome evaluations as effective means to deliver effective pain relief in nursing facilities. (5, 6, 7, 8, 9)

1b. Opportunity for Improvement:

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Facilities can use this information to determine whether they need to improve their pain management practices for their long stay residents. Reduced pain among long stay nursing facility residents is the expected benefit of this measure.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

A version of this quality measure has been in use by CMS since 2002, drawing on data from an MDS 2.0 item based on staff assessment. A study of variability for this measure by the University of Colorado showed that in the first quarter of 2006, the measure demonstrated a good degree of variability across facilities. (1) See attached Table 1: Measure Variability Across Facilities.

Although the number of high-quality studies of pain management in nursing homes is limited, those studies agree that resident pain is under-recognized and under-treated. (2) A recent record audit of 291 residents in 14 long-term care facilities found a significant gap between evidence-based pain management recommendations and facility practices. Assessment was particularly weak, only 32% of the cases reported chronic pain once or twice a week, and only 3% of the cases reviewed had reported that pain impacted functioning and quality of life twice or more times during the previous 30 days. (3) One study focusing on pain in cancer patients reported underuse of analgesics and hospice, along with nursing facility staffing patterns as key issues in inadequate pain treatment for this population. (4) Many studies and literature maintain that almost all pain, including pain at the end of life, can be managed with appropriate assessment and treatment, and research in pain management has identified the adoption of systematic implementation models, clinical decision-making algorithms, interdisciplinary approaches, and ongoing outcome evaluations as effective means to deliver effective pain relief in nursing facilities. (5, 6, 7, 8, 9)

1b.3 Citations for data on performance gap:


1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population): Pain relief is associated with reduced physiologic complications and an increased quality of life. In addition to the discomfort associated with pain, pain leads to declines in autonomy and sense of well-being and increases of anxiety and depression.
1c.1 Type of Evidence: Randomized controlled trial, Observational study

1c.2 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome):

Pain has been shown to have a negative effect on quality of life; it is associated with declines in autonomy, security, and spiritual well-being and increases in anxiety and depression. (1) Studies reviewing the impact of pain relief interventions at the actor, decision-support, treatment, and system levels consistently demonstrate that pain relief leads to increased quality of life. (2, 3, 4)

1c.3 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):
The evidence has not been rated.

1c.4 Method for rating evidence:

1c.5 Summary of Controversy/Contradictory Evidence: No contradictory evidence has been identified.

1c.6 Citations for Evidence (other than guidelines):


1c.8 National Guideline Clearinghouse or other URL:


1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):

This guideline is for long-stay residents with dementia. It is cited because it addresses pain in the long-stay resident population.

The specific recommendation is the dementia care practice recommendations for assisted-living residences and nursing homes.


1c.11 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):
The strength of the recommendation is not rated.

1c.12 Method for rating strength of recommendation (if different from USPSTF system, also describe rating and how it relates to USPSTF):
The strength of the recommendation is not rated.

1c.13 Method for rating strength of recommendation (if different from USPSTF system, also describe rating and how it relates to USPSTF):
The strength of the recommendation is not rated.

1c.14 Rationale for using this guideline over others:

This guideline, registered with the National Guideline Clearinghouse, addresses pain management among residents with dementia, a group that is a significant part of the nursing home population.

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for importance to 1

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
Measure and Report?

<table>
<thead>
<tr>
<th>Steering Committee: Was the threshold criterion, Importance to Measure and Report, met?</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale:</td>
<td>N</td>
</tr>
</tbody>
</table>

2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)

2a. MEASURE SPECIFICATIONS

S.1 Do you have a web page where current detailed measure specifications can be obtained?  
S.2 If yes, provide web page URL:

2a. Precisely Specified

2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome):  
The numerator is the number of long-stay residents with an MDS assessment (which may be an annual, quarterly, significant change or significant correction assessment) during the selected quarter and who self-report (v200=1) almost constant or frequent pain on a scale of 1 to 4 (J0400 =1 or 2) AND at least one episode of moderate to severe pain (item J0600A = 5, 6, 7, 8, or 9 on a scale of 1-10, with 10 being the worst pain you can imagine, OR item J0600B = 2 or 3 on a scale of 0-4, with 4 being very severe, horrible pain) OR very severe/horrible pain of any frequency (item J0600A = 10 on a scale of 1 to 10 OR item J0600B = 4 on a scale of 0-4) in the 5 days prior to the assessment.

2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator):  
The numerator data are from an MDS annual, quarterly, significant change or significant correction assessments conducted during each quarter (3-month period).

2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions):  
Residents are counted if they are long-stay residents, defined as residents whose length of stay is greater than 100 days. Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero. The numerator includes the number of long-stay residents reporting almost constant or frequent pain on a scale of 1 to 4 for those who can self-report (J0200=1). These numeric ratings were defined as follows: 1 = the pain is experienced almost constantly (MDS 3.0 item J0400=1 or 2) AND at least one episode of moderate to severe pain (item J0600.A= 5,6,7,8, or 9 on a scale of 1-10, with 10 being the worst pain you can imagine, OR item J0600.B= 2 or 3 on a scale of 0-4, with 4 being very severe, horrible pain) OR very severe/horrible pain of any frequency (item J0600A=10 on a scale of 1 to 10 OR item J0600B= 4 on a scale of 0-4) in the 5 days prior to the assessment.

2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured):  
The denominator is the total of all long-stay residents in the nursing facility who have an MDS assessment which may be an annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.

2a.5 Target population gender: Female, Male
2a.6 Target population age range: The target population includes long-stay residents of all ages who reside in the nursing facility.

2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator):

Comment [KP8]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF’s Health Information Technology Expert Panel (HITEP).
Denominator data come from MDS 3.0 annual, quarterly, significant change or significant correction MDS assessments conducted during each quarter (3-month period).

2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):
Residents are counted if they are long-stay residents defined as residents whose length of stay is greater than 100 days. Residents who return to the nursing home following a hospital discharge will not have their day count reset to zero. The target population includes all long-stay residents with a completed annual, quarterly, significant change or significant correction MDS 3.0 assessment (A0310.A= 02, 03, 04, 05, 06) during the selected quarter, and who can self-report (J0200=1), except for those who meet the exclusion criteria.

2a.9 Denominator Exclusions (Brief text description of exclusions from the target population): A resident is excluded from the denominator if the MDS assessment was conducted within 14 days of admission or if there are missing data in the responses to the relevant questions in the MDS assessment.

If the facility sample includes fewer than 30 residents, then the facility is excluded from public reporting because of small sample size.

2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions):
If the MDS 3.0 assessment is an admission assessment (item A10a = 01, indicating that the resident has completed an assessment within 14 days of admission), or if there are missing or inconsistent data for pain in any of the following items: J0400, J0600A, or J0600B. Item J0400 is the question about frequency of pain in the resident interview, with a 1 to 4 numeric rating response scale (with 1 being almost constantly). Item J0600A is the numeric rating question about intensity of pain in the resident interview, with a 0 to 10 numeric rating response scale (with 10 being the worst pain you can imagine). Item J0600B is the verbal descriptor scale question about intensity of pain in the resident interview, with a 1-4 verbal descriptor response scale. Data is inconsistent if the resident reports any frequency of pain in J0400 while reporting a pain intensity of 0 in J0600A or is unable to answer J0600B (code 9). Data are also inconsistent if the resident is unable to answer J0400 (code 9) while reporting a pain intensity of 1 or greater in J0600A or any pain intensity in J0600B.

2a.11 Stratification Details/Variables (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):
This is not applicable.

2a.12-13 Risk Adjustment Type:

2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method):
Resident-level limited covariate risk adjustment was used for persons with independence or modified independence in daily decision making on prior MDS assessments (Item C1000—made decisions regarding tasks of daily life = 0 [independent—decisions consistent/reasonable] or 1 [modified independence—some difficulty in new situations only]).


2a.18-19 Type of Score: Ratio
2a.20 Interpretation of Score:
2a.21 Calculation Algorithm (Describe the calculation of the measure as a flowchart or series of steps):
Because the computed scores are not estimates, but include all residents who meet the measure criteria, in terms of discriminating performance, the computed scores can be used to make valid comparisons.

2a.22 Describe the method for discriminating performance (e.g., significance testing):
For each facility, the number of long-stay residents meeting the numerator criteria and the number of (non-excluded) residents meeting the denominator criteria are counted. These numbers are also counted for the covariate measure, which is independence or modified independence in daily decision making as reported on the resident’s prior MDS assessment. The numeric rating scale for the response is a score of 0 for residents whose decisions are consistent and reasonable and a score of 1 for residents who have some difficulty in new situations only.

The covariate scores are then entered into a logistic regression equation, and the result is an expected score for the resident for that quality measure. The logistic regression equations are of the form: where e is the base of natural logarithms and x is a linear combination of the logistic regression coefficients and the covariate scores of the form:

\[ C_0 + C_1 \cdot COVA + C_2 \cdot COVB + \ldots \]

where C0 is the logistic regression constant, C1 is the logistic regression coefficient for the first covariate (where applicable), COVA is the resident-level score for the first covariate, C2 is the logistic regression coefficient for the second covariate, and COVB is the resident-level score for the second covariate (where applicable), etc. The regression constant and regression coefficients are numbers obtained through statistical logistic regression analysis.

The expected score for the measure is then calculated as the expected number of residents in the facility meeting the numerator criteria divided by all non-excluded residents in the denominator.

2a.23 Sampling (Survey) Methodology If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
This is not applicable.

2a.24 Data Source (Check the source(s) for which the measure is specified and tested)
Electronic clinical data

2a.25 Data source/data collection instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):
The data source or collection instrument is the Nursing Home Minimum Data Set 3.0.


2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested)
Population: national, Facility/Agency

2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested)
Nursing home (NH) / Skilled Nursing Facility (SNF)

2a.38-41 Clinical Services (Healthcare services being measured, check all that apply)

**TESTING/ANALYSIS**

2b. Reliability testing

Comment [KP10]: 2b. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period.

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
The proposed measure is based on two pain items in MDS 3.0, Section J items J0400 and J0600, with the numerator including all those residents who have been assessed during the selected quarter and have almost constant or frequent pain (MDS 3.0 item J0400 = 1 or 2) and at least one episode of moderate to severe pain (item J0600A = 5, 6, 7, 8, or 9 OR item J0600B = 2 or 3) or very severe/horrible pain of any frequency (item J0600A = 10 OR item J0600B = 4) in the 5 days prior to the assessment.

Two major tests of the reliability of the current quality measure have been conducted. First, the MDS 2.0 measure items and the current quality measure were tested in the Data Assessment and Verification (DAVE 2) project conducted by Abt Associates. This project used a nationwide sample of randomly selected nursing homes using MDS assessments for the period from April 1 to December 31, 2006. During this project, 173 two-stage reviews were performed.(1)

Second, the University of Colorado used national facility-level quality measure data from the third quarter (Q3) of 2006, which came from the Quality Improvement and Evaluation System (QIES) MDS Express Reports on the CMS Intranet; and Online Survey, Certification, and Reporting (OSCAR) data related to facility characteristics (e.g., state, resident census, number of beds, staffing) and certification survey results were downloaded from the QIES Workbench.(2) A 10% random sample of all Medicare-certified nursing facilities was also downloaded from MDS assessment records. Analyses were based on complete MDS data from January 2005 through March 2006, nearly complete data for April 2006, and partial data for May and June 2006.


The DAVE 2 project used a two-stage cluster sample design to examine MDS reporting. A trained nurse reviewer selected a current resident with a recent assessment performed by the nursing facility within the past 14 days. In Stage 1 of this review, the nurse reviewer conducted a blind reassessment of the resident using standard MDS assessment and coding procedures (examination of the medical record; observation of the resident; interview of staff, resident, and family; and use of coding criteria). In Stage 2 of this assessment, the DAVE 2 nurse reviewer’s assessment was compared to the corresponding nursing facility assessment and each discrepancy was reconciled, with the nursing home assessor and the nurse reviewer agreeing on the appropriate response. In addition to data entering the facility MDS code, the DAVE 2 code, and the reconciled code into the MDS-QC data entry software, the DAVE 2 nurse reviewer entered a “reason code” to attribute the cause of the discrepancy, per MDS item reviewed, to an established list of reasons.

The national test of MDS 3.0 items by Saliba and Buchanan examined the agreement between assessors (reliability); the response rates for interview items; user satisfaction and feedback on changes; and the time to complete the assessment. The network of Quality Improvement Organizations was used to identify the gold-standard (research) nurses and recruit community nursing homes to participate in the national evaluation, including a representative sample of for-profit and not-for-profit facilities and hospital-based and free-standing facilities. The gold-standard nurses were trained in the MDS 3.0 instrument, and they, in turn, trained a facility nurse from each participating nursing home in their home states. Residents participating in the test were selected to capture a representative sample of short- and long-stay residents.

The DAVE 2 project found a two-stage discrepancy rate of 7.3% for the MDS 2.0 pain frequency item (J0400) and 9.1% for the MDS 2.0 pain intensity item (J0600).(1) These MDS 2.0 measure items correspond to J0400 and J0600 of MDS 3.0, which are essentially the same in scope, although they rely on a nurse assessment rather than a resident report.

The national pilot test of the MDS 3.0 items showed good reliability with little evidence of confusion. For the pain items, the average kappa for gold-standard nurse to gold-standard nurse agreement was .961, and the average kappa for gold-standard nurse to facility nurse agreement was .967.(2)
2c. Validity testing

2c.1 Data/sample (description of data/sample and size): The data came from two sources: national facility-level quality measure data from Q3 of 2003 through Q3 of 2006, which came from the QIES MDS Express Reports on the CMS Intranet; and OSCAR data related to facility characteristics (e.g., state, resident census, number of beds, staffing) and certification survey results were downloaded from the QIES Workbench. A 10% random sample of all Medicare-certified nursing facilities was also downloaded from MDS assessment records. Analyses were based on complete MDS data from January 2005 through March 2006, nearly complete data for April 2006, and partial data for May and June 2006.

Information for this response and the other responses in regard to Validity Testing is from:


2c.2 Analytic Method (type of validity & rationale, method for testing):
The analysis of the current measure evaluated measure validity to examine the expected positive influence of public reporting on quality of care, which is an assessment of the degree to which quality measure triggering rates have improved over time; evaluate convergent validity, which is an assessment of the correlation of the quality measure with all other measures; determine if the quality measure triggering rate was influenced by factors that are unrelated to facility quality, which is an evaluation of seasonal variations in triggering rates across the 13 quarters of data. The analysis also computed descriptive statistics and conducted a one-way analysis of variance (ANOVA) for the measure to examine the amount of variance in triggering rates explained by the state where a facility was located.

2c.3 Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted):
These results reflect the performance of the current chronic care pain measure and the underlying MDS 2.0 items for those measures, which measure the same pain factors as the MDS 3.0 items for the proposed measure. In the proposed measure, data will be collected directly from the resident. See attached Table 2: Measure Trends Over Time.

Correlations with other clinical measures are weak. Only 8.0% of the variance in report rate for the current measure was explained by the state where a facility was located. The analysis found that public reporting may have had some influence on the decreased level of reported pain over time due to the decline in the triggering rate. See attached table.

There is little evidence of seasonal variations, as shown by the previously mentioned triggering rates, and the analysis found that only 8% of the variance in report rate for this measure was explained by the state where a facility was located. The limited correlation to other clinical measures may reflect the multiplicity of causes and potential treatments for pain, and the limited variation in seasonal rate and rate among states makes this measure a reliable guide to the level of reported pain.

Comment [KP12]: 2c. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. If face validity is the only validity addressed, it is systematically assessed.

Comment [k13]: 9 Examples of validity testing include, but are not limited to: determining if measure scores adequately distinguish between providers known to have good or poor quality assessed by another valid method; correlation of measure scores with another valid indicator of quality for the specific topic; ability of measure scores to predict scores on some other related valid measure; content validity for multi-item scales/tests. Face validity is a subjective assessment by experts of whether the measure reflects the quality of care (e.g., whether the proportion of patients with BP < 140/90 is a marker of quality). If face validity is the only validity addressed, it is systematically assessed (e.g., ratings by relevant stakeholders) and the measure is judged to represent quality care for the specific topic and that the measure focus is the most important aspect of quality for the specific topic.
### 2d. Exclusions Justified

**2d.1 Summary of Evidence supporting exclusion(s):**

All residents in long-stay for which complete data exist are included. Excluding missing data for existing quality measures is standard practice and was initially endorsed by NQF. Missing data is excluded from the calculation of the quality measures for several reasons. 1) There are legitimate reasons for facility staff not to select a ‘dash’ rather than a response; for example, if a resident is discharged or transferred abruptly, the staff may not be able to complete all items, however, an assessment is required for payment. The intent of the ‘dash’ is to allow the facility to submit an assessment when the staff are unable to complete the entire assessment. 2) Historically there has been very little missing data. For example, the current quality measure “Percent of residents who were physically restrained”, is based on three fields on the MDS 3.0. For all of the non-admission target assessments for calendar year 2009, there were 5,242,022 such assessments and 629 assessments (0.012%) had a dash for one or more of the three fields for the physical restraint measure. 3) We remain concerned about a change in measure definition that may result in incentivizing the facility staff to fill in a response to avoid a missing item. We believe that the result will lead to decreased validity and usefulness of the measure.

**2d.2 Citations for Evidence:**

This is not applicable.

**2d.3 Data/sample (description of data/sample and size):**

This is not applicable.

**2d.4 Analytic Method (type analysis & rationale):**

This is not applicable.

**2d.5 Testing Results (e.g., frequency, variability, sensitivity analyses):**

This is not applicable.

### 2e. Risk Adjustment for Outcomes/ Resource Use Measures

**2e.1 Data/sample (description of data/sample and size):**

Samples for two “target periods” were drawn:

1. “Current Period” target sample for computing quality measures: all U.S. nursing facilities and residents selected from the target quarter.
2. “Prior Year” target sample for estimating logistic regressions: residents from a 20% random sample of all U.S. nursing facilities with a chronic care admission during the fourth quarter (Q4) of 2001 through Q3 of 2002.
3. CC resident records included, for each target period:
   1. A target assessment (most recent).
   2. A prior assessment preceding the target assessment, if available.
   3. A most recent full assessment, if available.

The information for risk adjustment is from:

**2e.2 Analytic Method (type of risk adjustment, analysis, & rationale):**

The approach involves using logistic regression to adjust quality measure scores directly. This method of adjustment uses resident-level covariates that have been found to increase the risks of an outcome. First, resident-level covariates were used in a logistic regression model to calculate a resident-level expected quality measure score (the probability that the resident will evidence the outcome, given the presence or absence of characteristics measured by the covariates). Then, an average of all resident-level expected quality measure scores for the nursing facility was calculated to create a facility-level expected quality measure score. The final facility-level adjusted quality measure score was based on a calculation that combines the facility-level expected score and the facility-level observed score.
A review by the University of Colorado used data from two sources: national facility-level quality measure data from Q3 of 2003 through Q3 of 2006, which came from the QIES MDS Express Reports on the CMS Intranet; and OSCAR data related to facility characteristics (e.g., state, resident census, number of beds, staffing) and certification survey results were downloaded from the QIES Workbench. A 10% random sample of all Medicare-certified nursing facilities was also downloaded from MDS assessment records. Analyses were based on complete MDS data from January 2005 through March 2006, nearly complete data for April 2006, and partial data for May and June 2006. The analysis evaluated the risk adjustment model at the resident level and the facility level, generating R-square and C statistics. R-square indicates the proportion of the variance in measure performance that is accounted for by the covariates. The C-statistic gives the percentage of the time the observed value and the expected value move in the same direction, ranging from 0.5 (poor, no better than chance) to 1.0 (observed and predicted always move in the same direction). The analysis found an R-square of 0.016 and a C of 0.615; neither statistic met the threshold for predictive adequacy (0.10 for R-square and 0.70 for C).

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: This is not applicable.

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use (description of data/sample and size): These results reflect the performance of the current chronic care pain measure and the underlying MDS 2.0 items for that measure, which measures the same pain factors as the MDS 3.0 items for the proposed measure. In this proposed measure, data will be collected directly from the resident.

The data came from two sources: national facility-level quality measure data from Q3 of 2003 through Q3 of 2006, which came from the QIES MDS Express Reports on the CMS Intranet; and OSCAR data related to facility characteristics (e.g., state, resident census, number of beds, staffing) and certification survey results were downloaded from the QIES Workbench. A 10% random sample of all Medicare-certified nursing facilities was also downloaded from MDS assessment records. Analyses were based on complete MDS data from January 2005 through March 2006, nearly complete data for April 2006, and partial data for May and June 2006.

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale):

For each facility, the number of long-stay residents meeting the numerator criteria and the number of (non-excluded) residents meeting the denominator criteria are counted. These numbers are also counted for the covariate measure, which is independence or modified independence in daily decision making as reported on the resident's prior MDS assessment. The numeric rating scale for the response is a score of 0 for residents whose decisions are consistent and reasonable and a score of 1 for residents who have some difficulty in new situations only.

The covariate scores are then entered into a logistic regression equation, and the result is an expected score for the resident for that quality measure. The logistic regression equations are of the form: where e is the base of natural logarithms and x is a linear combination of the logistic regression coefficients and the covariate scores of the form: 

\[ C_0 + C_1 \cdot COVA + C_2 \cdot COVB + \ldots \]

where \( C_0 \) is the logistic regression constant, \( C_1 \) is the logistic regression coefficient for the first covariate (where applicable), \( COVA \) is the resident-level score for the first covariate, \( C_2 \) is the logistic regression coefficient for the second covariate, and \( COVB \) is the resident-level score for the second covariate (where applicable), etc. The regression constant and regression coefficients are numbers obtained through statistical logistic regression analysis.

The expected score for the measure is then calculated as the expected number of residents in the facility meeting the numerator criteria divided by all non-excluded residents in the denominator.

2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):

For each facility, the number of long-stay residents meeting the numerator criteria and the number of (non-excluded) residents meeting the denominator criteria are counted. These numbers are also counted for the covariate measure, which measures the same pain factors as the MDS 3.0 items for the proposed measure. In this proposed measure, data will be collected directly from the resident.

This is not applicable.

Comment [KP18]: 2f. Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

Comment [K19]: 14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% v. 75%) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.
excluded) residents meeting the denominator criteria are counted. These numbers are also counted for the
covariate measure, which is independence or modified independence in daily decision making as reported on
the resident’s prior MDS assessment. The numeric rating scale for the response is a score of 0 for residents
whose decisions are consistent and reasonable and a score of 1 for residents who have some difficulty in new
situations only.

The covariate scores are then entered into a logistic regression equation, and the result is an expected score
for the resident for that quality measure. The logistic regression equations are of the form: where e is the
base of natural logarithms and x is a linear combination of the logistic regression coefficients and the
covariate scores of the form:
\[ C_0 + C_1 \cdot COVA + C_2 \cdot COVB + \ldots \]
where \( C_0 \) is the logistic regression constant, \( C_1 \) is the logistic regression coefficient for the first covariate (where applicable), \( COVA \) is the resident-level score for the first covariate, \( C_2 \) is the logistic regression coefficient for the second covariate, and \( COVB \) is the resident-level score for the
second covariate (where applicable), etc. The regression constant and regression coefficients are numbers
obtained through statistical logistic regression analysis.

The expected score for the measure is then calculated as the expected number of residents in the facility
meeting the numerator criteria divided by all non-excluded residents in the denominator.

An analytical team at the University of Colorado’s Health Sciences Center examined the triggering rates for
the measure at the facility level. Below are the measure scores from testing or current use (description of
scores [e.g., distribution by quartile, mean, median, standard deviation], identification of statistically
significant and meaningfully differences in performance). For 13,837 facilities, the mean triggering rate was
5.1%, with a standard deviation of 5.0%. The attached table reports the full results of the analysis. See
attached Table 1: Measure Variability Across Facilities.

2g. Comparability of Multiple Data Sources/Methods

2g.1 Data/sample (description of data/sample and size): This is not applicable.

2g.2 Analytic Method (type of analysis & rationale):
This is not applicable.

2g.3 Testing Results (e.g., correlation statistics, comparison of rankings):
This is not applicable.

2h. Disparities in Care

2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts): The
measure is not stratified.

2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities,
provide follow-up plans:
Although MDS 3.0 collects data on the resident’s race, there are no current plans to stratify the measure by race because facilities tend to be homogenous by race, making disparities generally evident in the rating of
the facility.(1, 2, 3)

Research has also identified disparities in pain management between cognitively intact residents and those
who are cognitively impaired. In the current MDS pain item, staff recording of cognitive status was inversely
proportional to pain report; the most cognitively impaired residents were recorded as suffering the least pain
and received the least pain therapy.(4) In the MDS 3.0, new pain items were included that focus on patient
interview and have been shown to be able to be answered by cognitively impaired residents.(5) However, the
sample size at the facility level may not support stratification, but this will be evaluated in the future as MDS
3.0 data become available.

1. Smith D, Feng Z, Zinn J, Mor V. 2008. Racial disparities in access to long-term care: the illusive pursuit of

TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Scientific Acceptability of Measure Properties?

Steering Committee: Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met?

Rationale:

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

3a. Meaningful, Understandable, and Useful Information

3a.1 Current Use: In use

3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years);

The predecessor version of this measure is currently used in Nursing Home Compare, and this measure is designed to replace it using the MDS 3.0 items instead of the MDS 2.0 items.

3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years);

CMS expects that the quality measure will be used by nursing facilities as a tool to monitor resident pain and improve pain management. The national level of pain reported by the current measure has remained constant at 7.8% in the Q1 of 2005 to the Q3 of 2009. (Data are available at http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True)

This measure is also cited by the Mission of the Advancing Excellence in America’s Nursing Homes Campaign, a cooperative quality program sponsored by long-term care providers; consumers and advocates; and nursing facility practitioners, including nurses, health care professionals, medical directors, nursing home administrators, government agencies, quality improvement organizations, and private organizations supporting nursing home education. Based on projection from MDS Quality Measure reporting data, the Advancing Excellence in America’s Nursing Homes Campaign outlined several goals to reduce the national level of
reported pain in long-term care by September 2008. The results to date on its Web site indicate that by the Q2 of 2009, two of the goals were achieved: (1) the national average of reported pain long-term care had reached 4% and (2) more than 30% of nursing facilities reported rates of pain in long-term care below 2%. However, two other goals were not met: (1) no nursing home reported a rate of pain in long-term care above 20% and (2) 40,000 fewer residents in long-term care have chronic pain.

http://www.nhqualitycampaign.org/star_index.aspx?controls=campaignReports

Testing of Interpretability  (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)

3a.4 Data/sample (description of data/sample and size): A recent study examined whether consumers could accurately interpret the quality information given for all the measures reported by Nursing Home Compare (1)

Data were collected from 4,754 family members of nursing facility residents.


3a.5 Methods (e.g., focus group, survey, QI project):
A comprehension index was used to examine whether the information contained in Nursing Home Compare for each quality measure was understood by family members.

3a.6 Results (qualitative and/or quantitative results and conclusions):
The study found that 31% of the consumers used the Internet to help them choose a nursing facility, 12% recalled using Nursing Home Compare, and, in general, the consumers’ comprehension index scores were high, indicating a good understanding. The comprehension index for the current chronic care pain measure was the highest, 5.87 on a scale of 1 to 8.

3b/3c. Relation to other NQF-endorsed measures

3b.1 NQF # and Title of similar or related measures:
The proposed measure is intended to replace the currently endorsed NQF #0186 Recently hospitalized residents who experienced moderate to severe pain at any time during the 7-day assessment period, as the data source has changed; (the MDS 2.0, the current source of data, is being replaced by the MDS 3.0) NQF #0192—Residents who experience moderate to severe pain during the 7-day assessment period (risk-adjusted), NQF #0177, NQF #0523 Pain Assessment Conducted, NQF #0420 Pain Assessment Prior to Initiation of Patient Therapy. NQF #0524 Pain Interventions Implemented

(for NQF staff use) Notes on similar/related endorsed or submitted measures:

3b. Harmonization
If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population-setting/data source or different topic but same target population):

3b.2 Are the measure specifications harmonized? If not, why?
No. All the above measures are based other instruments except for #0186 and #0192, which are based on a previous version of the MDS, version 2.0. NQF #0192 is scheduled to be replaced by this proposed measure and NQF #0186 Percent of residents with moderate or severe pain (post acute care) is scheduled to be replaced by a measure being proposed at the same time. The measures being proposed to replace NQF #0186 and #0192 are based on a different denominator definition than the current measures and on different pain assessment items.

3c. Distinctive or Additive Value
3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:
The proposed measure draws on revised items from the MDS 3.0 which are more reliable than those supporting

Comment [KP23]: 3b. The measure specifications are harmonized with other measures, and are applicable to multiple levels and settings.

Comment [K24]: 16 Measure harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., influenza immunization of patients in hospitals or nursing homes), or related measures for the same target population (e.g., eye exam and HbA1c for patients with diabetes), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

Comment [KP25]: 3c. Review of existing endorsed measures and measure sets demonstrates that the measure provides a distinctive or additive value to existing NQF-endorsed measures (e.g., provides a more complete picture of quality for a particular condition or aspect of healthcare, is a more valid or efficient way to measure).
the current measure from the MDS 2.0.

5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:

| TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Usability? | 3 |
| Steering Committee: Overall, to what extent was the criterion, Usability, met? | C P M N |

Rationale:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

| 4a. Data Generated as a Byproduct of Care Processes | 4a C P M N |
| 4a.1-2 How are the data elements that are needed to compute measure scores generated? | Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition). Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry) |

| 4b. Electronic Sources | 4b C P M N |
| 4b.1 Are all the data elements available electronically? | Elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims |
| 4b.2 If not, specify the near-term path to achieve electronic capture by most providers. | http://www.cms.gov/MDSPubQIandResRep/01_Overview.asp |

| 4c. Exclusions | 4c C P M N |
| 4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? | No |
| 4c.2 If yes, provide justification. | |

| 4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences | 4d C P M N |
| 4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. | The proposed MDS 3.0 measure, which relies on resident report, is designed to replace a current MDS 2.0 measure, which was based on staff assessment. The current measure reported consistently and sometimes dramatically lower rates than those found in nursing homes in randomized controlled trial studies involving self-reporting. The proposed measure may itself underreport pain because it excludes those nursing home residents who are unable to report their pain, generally due to dementia. However, patient self-report of the presence and severity of pain, which is incorporated in the MDS 3.0 items supporting the proposed measure, is considered the most reliable and accurate approach to pain assessment. Both the American Geriatrics Society |

Rating: C=Completely; P=Partially; M=Minimally; N=Not at all; NA=Not applicable
Panel on Persistent Pain in Older Persons and the Department of Veterans Affairs endorse this approach (1, 2). A growing number of studies and other literature demonstrate that even nursing home residents with moderate to severe cognitive impairment can reliably respond to questions about pain (3, 4, 5, 6, 7, 8). Several studies in elders with varying cognitive status suggest that some tools may be more reliable and “user friendly” than others for obtaining self-reports of pain from this population, and the new items in MDS 3.0 incorporate these more reliable and user-friendly approaches (9, 10, 11, 12, 13, 14). A national test of the MDS 3.0 items supporting the proposed measure found that 87% of the test sample of residents and 89% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0 upon which this measure is based (9). Further testing is needed though because at least one expert, Vincent Mor, believes that the number of residents who cannot be interviewed will be higher when MDS 3.0 is placed into general use (15).

Recent research has found a general decline in the percentage of residents with pain (as defined by this measure) admitted to nursing facilities for long-term care by approximately 13% after the first publication of the current pain measure in 2002. Analysis associated with this study suggests that nursing homes exhibited a tendency to avoid such residents to improve their rating for the measure, although the authors concede that, due to the difficulty in accurately measuring pain, it is possible that the decline was due to ascertainment bias (16).

The proposed measure addresses an additional significant issue with the current measure, in which pain is reported by the staff assessor, relying on the assessor’s own observations and those of other staff and without the use of a standard scale, and subject to ascertainment bias. The proposed measure employs a resident interview with a standardized scale of 1 (almost constantly) to 4 (rarely) for frequency of pain and a choice of standardized scales of 0 (no pain) to 10 (worst pain you can imagine) or 1 (mild) to 5 (very severe, horrible) for pain intensity (9).

An example of an unintended consequence of this measure may occur if residents report that pain frequency decreased, however, pain intensity increased; or the reverse occurs, if pain intensity decreased but pain frequency increased. As part of the validation testing for this measure, RTI will examine responses for change, lack of change, and direction of change as well as patterns of both the frequency and intensity to assess whether there is an effect on the face validity of the measure.

### 4e. Data Collection Strategy/Implementation

#### 4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/implementation issues:

The data collection method is already in operational use, and no issues are anticipated.

#### 4e.2 Costs to implement the measure (costs of data collection, fees associated with proprietary measures):

Data are collected as part of an existing process with no additional cost.

#### 4e.3 Evidence for costs:

This is not applicable.

#### 4e.4 Business case documentation:

The proposed measure relies on data from the MDS 3.0. As there is no change in the data collection method for the MDS 3.0 as compared with its predecessor, the MDS 2.0, we do not anticipate any additional burden to nursing facilities. MDS 2.0, and soon to be MDS 3.0, data are collected as part of an existing, federally mandated process used for payment and quality monitoring purposes.

### TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Feasibility?

#### Steering Committee: Overall, to what extent was the criterion, Feasibility, met?

Rationale:

#### RECOMMENDATION

(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.

#### Steering Committee: Do you recommend for endorsement?

Comments:

### CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner)

Co.1 Organization

Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, Maryland, 21244-1850

Co.2 Point of Contact

Judith, Tobin, PT, MBA, Judith.Tobin@cms.hhs.gov, 410-786-6892

Measure Developer if different from Measure Steward
### Co.3 Organization
RTI International, 1440 Main Street, Suite 310, Waltham, Massachusetts, 02451-1623

### Co.4 Point of Contact
Roberta, Constantine, RN, MBA, PhD, rconstantine@rti.org, 781-434-1700-1711

### Co.5 Submitter If different from Measure Steward POC
Roberta, Constantine, RN, MBA, PhD, rconstantine@rti.org, 781-434-1700-1711, RTI International

### Co.6 Additional organizations that sponsored/participated in measure development

#### ADDITIONAL INFORMATION

**Workgroup/Expert Panel involved in measure development**

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members’ names and organizations. Describe the members’ role in measure development.

See Table 4: Nursing Home Quality Measures Technical Expert Panel (January 2009)

This technical expert panel met during 2 days in January 2009 to review an environmental scan of the current quality measures and make recommendations regarding their transition from MDS 2.0 to MDS 3.0. The attached table provides a list of workgroup or panel member names and organizations.

Ad.2 If adapted, provide name of original measure: This measure was adapted from the measure of the same name derived from MDS 2.0 data.

Ad.3-5 If adapted, provide original specifications URL or attachment MedQIC Resource Manual. Available from http://www.qualitynet.org/dcs/ContentServer?cid=1138050766910&pagename=Medqic%2FOtherResource%2FOther ResourcesTemplate&bc=OtherResource

**Measure Developer/Steward Updates and Ongoing Maintenance**

Ad.6 Year the measure was first released: 2002
Ad.7 Month and Year of most recent revision: 02, 2010
Ad.8 What is your frequency for review/update of this measure? Every 3 years
Ad.9 When is the next scheduled review/update for this measure? 02, 2013

Ad.10 Copyright statement/disclaimers:

Ad.11 -13 Additional Information web page URL or attachment: Attachment. Moderate to Severe Pain Long Stay tables_FINAL-6340500671205000.doc

**Date of Submission (MM/DD/YY):** 10/08/2010