NATIONAL
QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0035
De.2. Measure Title: Fall Risk Management (FRM)
Co.1.1. Measure Steward: National Committee for Quality Assurance
De.3. Brief Description of Measure: Assesses different facets of fall risk management:

Discussing Fall Risk. The percentage of adults 75 years of age and older, or 65–74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

Managing Fall Risk. The percentage of adults 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
1b.1. Developer Rationale: Encouraging falls risk management in older adults helps prevent injury susceptibility and risk of death. Falls are the leading cause of death due to injury for the 65 and older population as well as the most common cause of nonfatal injuries and trauma related hospital admissions. In 2007, 18,000+ adults above the age of 64 died due to unintentional fall injuries. In 2008, over two million older adults required emergency care as a result of a fall, 559,000 of which needed hospitalization (CDC, 2010).

S.4. Numerator Statement: This measure has two rates.
Discussing Fall Risk: The number of patients in the denominator who indicated they discussed falls or problems with their current provider.

Managing Fall Risk: The number of patients in the denominator who indicated their provider provided fall risk management.
S.7. Denominator Statement: Each rate has a different denominator.

The Discussing Fall Risk rate has two denominators:
- Adults age 75 and older who had a provider visit in the past 12 months
- Adults age 65-74 who had a provider visit in the past 12 months and report either falling or having a problem with balance or walking in the past 12 months.

The Managing Falls Risk measure has only one denominator: Adults age 65 and older who had a provider visit in the past 12 months and report either falling or having a problem with balance or walking in the past 12 months.
S.10. Denominator Exclusions: N/A

De.1. Measure Type: Process
S.23. Data Source: Patient Reported Data/Survey
S.26. Level of Analysis: Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Dec 14, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. *Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.*

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
0035_Evidence_MSF5.0_Data.doc

1b. Performance Gap
Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:
- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure *(e.g., the benefits or improvements in quality envisioned by use of this measure)*
Encouraging falls risk management in older adults helps prevent injury susceptibility and risk of death. Falls are the leading cause of death due to injury for the 65 and older population as well as the most common cause of nonfatal injuries and trauma related hospital admissions. In 2007, 18,000+ adults above the age of 64 died due to unintentional fall injuries. In 2008, over two million older adults required emergency care as a result of a fall, 559,000 of which needed hospitalization (CDC, 2010).

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included).*
This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.
The data below show the two rates (Discussing falls and managing falls risk) for Medicare Advantage Plans. The "N" below is the number of plans reporting. The mean is the average rate across plans.

Discussing Fall Risk	2009	2008	2007				
N	463	416	355				
MEAN	32.4	30.9	31.1				
STDEV	7.11	6.38	6.98	STDERR	0.33	0.31	0.37
MIN	19.6	19.5	18.8				
MAX	62.3	55.6	57.6	P10	25.3	24.6	24.7
P25	27.9	26.7	26.2				
P50	30.3	29.4	29.1				
P75	35	32.9	34.7				
P90	43.3	40.3	41.3				

Managing Fall Risk	2009	2008	2007				
N	458	406	339				
MEAN	58.7	56.9	56.8				
STDEV	8.44	7.42	7.79				
STDERR	0.39	0.37	0.42				
MIN	40.4	40.9	40.8				
MAX	88.8	80.2	83.8				
P10	49.7	48.2	47.9				
P25	53	52.2	51.4	P50	57.5	56	55.8
P75	62.7	61	61				
P90	69.5	67	67.3				

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of

measurement.

Section 1b.2 references data from the most recent three years of measurement for this measure. The data in section 1b.2 includes percentiles, mean, min, max, standard deviations and errors.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

This measure is not stratified for disparities. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

N/A

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, High resource use, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Falls are a serious public health problem for older adults. Moreover, the rate of falls increases with age (Dykes et al., 2010). Older adults are five times more likely to be hospitalization for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (CDC, 2010). In those over age 80, the rate of falls increases to fifty percent (Doherty et al., 2009).

The injuries older adults could sustain after falling can have very severe and life-limiting affects on an individual. Between 20% and 30% of people who fall experience an injury (CDC, 2010). Roughly 10% of all falls cause major injuries such as fractures, serious soft tissue damage and traumatic brain injury (Tinetti, 2010). Lacerations are another common, and sometimes severe, injury incurred by falling. The majority of fractures among older adults are caused by falling, fracturing the spine, hip, forearm, leg, pelvis, upper arm, and/or hand (CDC, 2010). Of fall-related fractures, hip fractures are one of the more serious, often resulting in long-term functional limitation, nursing home admission and increased mortality. Over 90% percent of hip fractures result from falls (CDC, 2010). Hip fractures have a significant impact on older adults' independence and quality of life. Only half of older adults hospitalized for a hip fracture are able to return home or live independently after the injury (Wolinsky et al., 2009).

Falls can also have serious psychological and social consequences. Developing a fear of falling is another common outcome even if no injury was sustained in the first fall. Living in fear of a fall can limit an older adult's quality of life because it causes them to limit their activities, leading to reduced mobility and loss of physical fitness, which ultimately increases their risk of falling (CDC, 2010). Recurrent falls are a common reason for long-term care admissions (Soriano et al., 2007). According a statistical brief released by the

Agency for Healthcare Research and Quality, falls were a significant factor in 40.9 percent of admissions to long-term care facilities (Owens et al., 2009). Adults 75 and older are about 5 times more likely to be admitted to a long-term care facility for a year or longer than those between 65 and 74 (CDC, 2010).

Falls have a significant economic cost. In 2005, total direct cost of fall injuries for adults age 65 and older was over $34 billion (NCOA, 2010). The direct costs for fall-related care include fees for hospital and nursing home care, doctors and other professional services, rehabilitation, community-based services, use of medical equipment, prescription drugs, changes made to the home, and insurance processing. It is estimated that by 2020, the annual direct and indirect cost of fall injuries is expected to reach $54.9 billion (CDC, 2010).

1c.4. Citations for data demonstrating high priority provided in 1a.3
Centers for Disease Control and Prevention. Injury Prevention & Control: Home and Recreational Safety. Falls Among Older Adults: An Overview. September 13, 2010.

Doherty M, Crossen-Sills J. Bonus Content Geriatric Care Fall Risk: Keep your patients in balance. The Nurse Practitioner: The American Journal of Primary Health Care. December 2009. Vol.34(12):46 – 51.

Dykes PC, Carroll DL, Hurley A, Lipsitz S, Benoit A, Chang F, Meltzer S, Tsurikova R, Zuyov L, Middleton B. Fall Prevention in Acute Care Hospitals. JAMA. 2010;304(17):1912-1918.

National Council on Aging (NCOA). Improving the Lives of Older Americans. May 13, 2010. Found at: http://www.ncoa.org/press-room/press-release/ncoa-and-phi-launch-falls.html

Owens PL, Russo CA, Spector W, Mutter R. Agency for Healthcare Research and Quality. H-CUP Statisitical Brief #80: Emergency Department Visits for Injurious Falls among the Elderly, 2006. October 2009.

Soriano TA, DeCherrie LV, Thomas DC. Falls in the community-dwelling older adult: A review for primary-care providers. Clin Interv Aging. 2007 December; 2(4): 545–553.

Tinetti, ME. The Patient Who Falls: "It's Always a Trade-off". JAMA. 2010;303(3):258-266.

Wolinsky FD, Bentler SE, Liu L, Obrizan M, Cook EA, Wright KB, Geweke JF, Chrischilles EA, Pavlik CE, Ohsfeldt RL, Jones MP, Richardson KK, Rosenthal GE, Wallace RB. Recent Hospitalization and the Risk of Hip Fracture Among Older Americans. J Gerontol A Biol Sci Med Sci. 2009 February; 64A(2): 249–255.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. *(Describe how and from whom their input was obtained.)*

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area *(check all the areas that apply):*
 Musculoskeletal

De.6. Cross Cutting Areas *(check all the areas that apply):*
 Prevention

S.1. Measure-specific Web Page *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)
This is not an eMeasure **Attachment:**

S.2b. Data Dictionary, Code Table, or Value Sets *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*
No data dictionary **Attachment:**

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)*
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
This measure has two rates.
Discussing Fall Risk: The number of patients in the denominator who indicated they discussed falls or problems with their current provider.

Managing Fall Risk: The number of patients in the denominator who indicated their provider provided fall risk management.

S.5. Time Period for Data *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)*
The measurement year (12 month period).

S.6. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
This measure is collected through the Medicare Health Outcomes Survey - a national survey of Medicare Advantage Organization members. The survey is collected through mail with a telephone follow up. The two rate for this measure are collected through the following questions.
Discussing Fall Risk:
Q50: "A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?"
Answer choices: Yes, No, I had not visits in the past 12 months. (an answer of "Yes" is required for the numerator)

Managing Fall Risk:
Q53: "Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: Suggest that you use a cane or walker, check your blood pressure lying or standing, suggest that you do an exercise or physical therapy program, and suggest a vision or hearing testing."
Answer choices: Yes, No, I had not visits in the past 12 month. (an answer of "Yes" is required for the numerator)

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*
Each rate has a different denominator.

The Discussing Fall Risk rate has two denominators:

- Adults age 75 and older who had a provider visit in the past 12 months
- Adults age 65-74 who had a provider visit in the past 12 months and report either falling or having a problem with balance or walking in the past 12 months.

The Managing Falls Risk measure has only one denominator: Adults age 65 and older who had a provider visit in the past 12 months and report either falling or having a problem with balance or walking in the past 12 months.

S.8. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
 Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions, Senior Care

S.9. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses , code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
This measure is collected through the Medicare Health Outcomes Survey - a national survey of Medicare Advantage Organization members. The survey is collected through mail with a telephone follow up. The questions used to identify the denominator are:

Discussing Fall Risk (patients aged 65-74):
Q50: "A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?" Answer choices: yes, no, I had not visits in the past 12 months (Answer choice of yes or no is required for denominator inclusion).

AND

Q51: "Did you fall in the past 12 months?" Answer choices: Yes, No (answer choice of yes for denominator inclusion)

OR

Q52: "In the past 12 months, have you had a problem with balance or walking?" Answer choice: Yes, No (answer choice of yes for denominator inclusion)

Discussing Fall Risk (patients aged 75+):

Q50: "A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?" Answer choices: yes, no, I had not visits in the past 12 months (Answer choice of yes or no is required for denominator inclusion).

Managing Fall Risk:
Q50: "A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?" (Answer choice of yes or no is required for denominator inclusion)

AND
Q51: "Did you fall in the past 12 months?" Answer choices: Yes, No (answer choice of yes for denominator inclusion) OR Q52: "In the past 12 months, have you had a problem with balance or walking?" Answer choice: Yes, No (answer choice of yes for denominator inclusion)

AND

Q53: Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: Suggest that you use a cane or walker; Check your blood pressure lying or standing; suggest that you do an exercise or physical therapy program; suggest a vision or hearing testing. Answer choices: yes, no, I had not visits in the past 12 months (Answer choice of yes is required for denominator inclusion).

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*
N/A

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
N/A

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*
N/A

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)
No risk adjustment or risk stratification
If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*
N/A

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*
Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (*if not provided in excel or csv file at S.2b*)

S.16. Type of score:
Rate/proportion
If other:

S.17. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*
Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*
Discussing Falls
Step 1: Determine the eligible population: The eligible population is all adults aged 65 and older.

Step 2: Determine the number of patients meeting the denominator criteria. The denominator includes all patients aged 65-74 with a self-reported provider visit in the past year (Q50) who report having had a fall (Q51) or problem with balance or walking in the past year (Q52) OR all patients aged 75 and older with a self-reported provider visit in the past year (Q50).

Step 3: Determine the number of patients meeting the numerator criteria. The numerator includes all patients in the denominator population who reported discussing falls or a problem with walking or balance with a provider in the past year (Q50).

Step 4: Calculate the rate by dividing the total from step 3 by the total from step 3.

Managing Falls Risk
Step 1: Determine the eligible population: The eligible population is all adults aged 65 and older.

Step 2: Determine the number of patients meeting the denominator criteria. The denominator includes all patients aged 65 and older with a self-reported provider visit in the past year (Q50) who report having had a fall (Q51) or problem with balance or walking in the past year (Q52).

Step 3: Determine the number of patients meeting the numerator criteria. The numerator includes all patients in the denominator population who indicated their provider provided suggestions for falls risk management (Q53).

Step 4: Calculate the rate by dividing the total from step 3 by the total from step 3.

S.19. **Calculation Algorithm/Measure Logic Diagram URL or Attachment** *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

S.20. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF a PRO-PM, identify whether (and how) proxy responses are allowed.
The measure is collected in the Medicare Health Outcomes Survey (HOS). Medicare Advantage Organizations (MAOs) reporting the measure must contract with a NCQA-Certified HOS Survey Vendor to administer the survey. A minimum of 1,200 members per MAO are randomly selected for the survey. Plan-level results are calculated by NCQA using data collected in the combined HOS Baseline and Follow-Up Survey samples from the same measurement year. MAOs must achieve a denominator of at least 100 to obtain a reportable result. If the denominator is less than 100, NCQA assigns a measure result of NA.

NCQA outlines the sampling criteria for all HOS measures. The complete data collection method and sampling guidelines are outlined in NCQA's HEDIS Technical Specifications for the HOS, Volume 6.

S.21. **Survey/Patient-reported data** *(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)*
IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. **Missing data** (specify how missing data are handled, e.g., imputation, delete case.)
Required for Composites and PRO-PMs.

S.23. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.24.
Patient Reported Data/Survey

S.24. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)*
IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
Medicare Health Outcomes Survey (HOS)

S.25. **Data Source or Collection Instrument** *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*
URL

S.26. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Health Plan, Integrated Delivery System

S.27. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility
If other:

S.28. **COMPOSITE Performance Measure** - Additional Specifications *(Use this section as needed for aggregation and weighting rules,*

or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form
2b. Validity – See attached Measure Testing Submission Form
0035_MeasureTesting_MSF5.0_Data.doc

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes
　　For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.
Other
If other: Patient-reported health survey

3b. Electronic Sources
　　The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? *(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)*
No data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.
Data are collected via a patient mail (or telephone) survey. Electronic surveys may be available in the future.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.
　Attachment:

3c. Data Collection Strategy
　　Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.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 and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.
IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.
This measure is precisely specified using the survey data collection method. This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified *(e.g., value/code set, risk model, programming code, algorithm).*

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current _and_ Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting Payment Program Quality Improvement with Benchmarking (external benchmarking to multiple organizations) Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (_e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?_)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (_Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting._)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)
Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:
- **Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)**
- **Geographic area and number and percentage of accountable entities and patients included**

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of

initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.
The HEDIS Compliance Audit addresses the following functions:
1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures
Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)
0101 : Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0141 : Patient Fall Rate
0202 : Falls with injury
0537 : Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate
1730 : Falls: Risk Assessment for Falls
1733 : Falls: Plan of Care for Falls

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;
OR
The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed

measure(s):
Are the measure specifications completely harmonized?
No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.
NQF# 0141 measures patient fall rate in the hospital setting during one month. This measure is related but not competing. The target population overlap but are different in focus (#0035 – all adults; #0141 – adults in the hospital setting) and the measure concept is different (#0035 discussing and managing fall risk with provider; #0141 rate of falls outcome measure).;NQF #0202 measures patient fall with injury rate in the hospital setting. This measure is related by not competing. The target population overlap but are different in focus (#0035- all adults; #0202 – adults in the hospital setting) and the measure concept is different (#0035 – discussing and managing fall risk with provider; #0202 – rate of falls with injury outcome measure).

5b. Competing Measures
The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);
OR
Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):
Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)
NQF #0537 measures risk assessment for falls in the home health setting. This measure could be considered competing. The target population overlap but are different in focus (#0035-all adults; #0537 – adults in the home health setting) and the measure concept is similar (#0035 – discuss and manage fall risk with provider (no structured risk assessment defined); #0537 – multi-factorial risk assessment for falls).

NQF #0101, #1730, #1733 may also be considered competing. The target population is the same, however the measure concept is different (#0101 – Screening of for falls risk; #1730 – Multifactorial falls risk assessment; #1733 – Plan of care for falls prevention documented; #0035 patient report of discussing balance, walking or falls problem and receiving an intervention). NQF #0035 is a health plan level measure and uses a different data source (patient reported) from #1733 (administrative claims).

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.
  Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance
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Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance
Co.4 Point of Contact: Jill Marie, Farrell, farrell@ncqa.org, 202-955-3599-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development
Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
List the workgroup/panel members´ names and organizations.
The NCQA Geriatric Measurement Advisory Group advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from medical research and education, health plans, the federal

Medicare program, and older adult associations. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP.

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Jane E. Sisk, PhD, Division of Health Care Statistics
Kevin Weiss, MD, FACP, American Board of Medical Specialties

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.2 Year the measure was first released: 2006
Ad.3 Month and Year of most recent revision: 01, 2011
Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure?
Ad.6 Copyright statement: © 2011 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005 **Ad.7 Disclaimers:** These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.
Ad.8 Additional Information/Comments: