National Quality Forum

Comments on Draft Report: National Voluntary Consensus Standards for Nursing Homes

The Steering Committee reviewed the submitted comments and proposed responses in a conference call on October 4, 2010.

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
206	P	Erica Koser, PANPHA	A PANPHA member commented that, "I agree with those (comments) included but would strongly advocate the requirement to include yearly staff turnover. This should include the methodology as to how staff turnover is calculated so that we are comparing apples with apples. I have observed over the years that those facilities that have low turnover of staff have a higher "star" rating and fewer antipsychotic medications. Geriatric education continues to be the number one need in nursing homes and is exacerbated by high turnover of staff." Another PANPHA member commented that, "I would like to see that the items related to infection are correlated with the identifiers in Act #52 reporting structure."	Add to research recommendations: Turnover for measure development Identification of factors related to infection rates	general
155	P	Loren Haynes Haynes, Harber Laman LLC	It seems it would be a good idea to remove residents from calculations for any long-term measure when the OBRA assessment providing the data is combined with a PPS assessment, because so much of the data on this type of assessment is related to acute conditions that a facility "inherits" post-hospital and may not have had adequate time to intervene and show positive results. Anytime a quarterly or annual is combined with a PPS, and this data is compared with a prior OBRA assessment, quality measures are never going to be favorable for the facility, regardless of whether the facility is providing the best practices for improving care or not.	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0 data as well as for further refinement of the quality measures.	general
181	P	Jane Pederson, Stratis Health	Overall the measures reflect key issues in LTC.	No response needed.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
207	P	Erica Koser, PANPHA	As an association of more than 360 non-profit senior services providers, we are continually attentive to the process of identifying nursing facilities that provide quality care for their residents and we applaud the National Quality Forum's latest attempt in their updated Performance Measures. It is our hope that these measures strive for simplicity in practice and validity in results to highlight excellence in quality across the Commonwealth. We mirror the concerns that many Committee members expressed and discussed within the definition of each measure in the National Quality Forum document. We are comfortable with adjusting specific definitions along the way as we learn more, but at the present time are pleased with the process and the valid measures it will likely produce. One area we would like to further inquire about is how the data collected will be used. We understand that the goal of these measures are to both inform the public and improve quality, but we find it hard to conceptualize how this will be presented in a way that serves both the facility and consumer. In theory, the data should afford entities the opportunity to privately discover and correct a problem and allow consumers to fairly assess how the facility is performing. To accomplish both goals, we are curious as to how the data will be provided to each of the differing groups. Thank you for the opportunity to comment.	CMS response: Several entities, in addition to CMS, developed Nursing home quality measures and submitted them to NQF for endorsement consideration. Regarding CMS' use of data it collects, nursing home quality measures have four intended purposes: 1. to provide information about the care at nursing homes to help consumers choose a nursing home for themselves or others; 2. to provide information about the care at nursing homes where family members or significant others already live; 3. to get consumers to talk to nursing home staff about the quality of care; and 4. to give data to the nursing home to help them with their quality improvement efforts. The Nursing Home Quality Initiative (NHQI) website provides consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare website (medicare.gov), which allows consumers, providers, States and researchers to compare information on nursing homes. Many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organization staff. For example, using recent data from July to September, 2009 - the national average for Percent of Residents Who Were Physically Restrained was 3.3%, with average ranging from 0.2% to 6.7%. For further information, please refer to http://www.cms.gov/NursingHomeQualityInits/ and the Nursing Home Compare website http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
211	P	Linda Spokane, NYAHSA	Although generally speaking, we feel the definitions for short (< or = 100days) and long stay (> 100 days) residents are an improvement over previous definitions, there is the potential of quarterly assessments being completed during the "short stay" period and not being reported in the long stay calculations. For example, if a resident is admitted (day 1) and their admission assessment ARD is set for day 7, a quarterly would be due prior to day 99. Therefore, this quarterly would be in the short stay sample and not the long stay sample. If an Admission is completed on day 14 and a quarterly completed 92 days later as per regulation, it would be used in the long stay calculations. If the intent of this definition was to exclude admission assessments and the first quarter assessments from being counted in the denominator of the long-stay quality measures, we suggest extending the definition of long stay to >106 days. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0 data as well as for further refinement of the quality measures. Please note that the stay starts from the date of arrival at the facility and not the ARD for the admission assessment.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
212	P	Linda Spokane, NYAHSA	Several proposed quality measures address seasonal variation by calculating a 2-quarter or 6 month facility average. We feel seasonal variation can not be eliminated by averaging the data for 2 quarters or 6 months. For example, the rate based on assessments from October to March will be affected by the winter season, while the rate based on assessments from April to September will be affected by the summer season. To account for seasonal variation, we suggest that a facility average be calculated based on 4 quarters, or one full year. There is a lack of consistency in the types of assessments used in several of the short stay measures. For example, some measures use OBRA assessments; others use only PPS assessments and discharge assessments. We would like to see a more consistent approach when defining types of assessments used for short-stay measures. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN□	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0 data as well as for further refinement of the quality measures.	general

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213	P	Linda Spokane, NYAHSA	There is a lack of risk adjustment for most of the proposed quality measures. This means that facility rates are largely determined by the types of residents they admit, regardless of their acuity level, whereas if they were properly adjusted for resident population characteristics a better comparison could be made between facilities. Important quality of care problems can be easily missed or buried in these unadjusted or poorly adjusted rates. Although we appreciate the Committee's desire to incorporate resident and family satisfaction information into publicly reported quality measures, we feel the cost to facilities of administering these surveys ($32-$51 per survey as reported on page 23 of the Draft Report for Comments) is prohibitively expensive, especially for not-for-profit and public facilities. Federal and state funding for long term care services continues to be reduced and this additional requirement will place a significant financial and administrative burden on these organizations. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	**1. SC response:** The Committee re-reviewed the justification for not risk adjusting the relevant outcome measures, and agreed with the developer's rationale. The Committee discussed the cost issue extensively during their deliberations of the CAHPS measures but decided to recommend the measures despite these concerns. The Committee's discussions are summarized in the project report and detailed in the Committee's meeting and conference call notes. 2: **ARHQ response**: The sponsor implementing a resident or family experience survey may be other entities besides the federal government, such as a state agency or even a provider itself either for public reporting or for quality improvement. CMS has no current plans to implement these surveys but does desire that these surveys are in the public domain. There are at least 3 examples where states (Ohio, Rhode Island and Georgia) have provided funds for either the resident or family member surveys and/or charged a modest fee to the nursing home in return for providing comparative information to all providers as well as the public.	general

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214	P	Linda Spokane, NYAHSA	There are several quality measures missing from these initial proposed measures that are important indicators of quality of care and quality of life for nursing home residents. They include antipsychotic use, falls that result in injury (except major), behaviors that affect others, pain measures that include residents who can't self-report pain, and low-risk residents with pressure ulcers. We hope these measures will be developed and validated in the very near future.Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	NQF is launching a Palliative Care project that will address pain issues, among other topics. Additional recommendations for measure development will be added to the revised draft report.	general
228	P	Tammy Barker, HCR ManorCare	The MDS 3.0 provides a valuable opportunity to create Quality Measures that reflect the heterogeneity of the LTC industry today. Post-acute providers have suffered from the limits of the current system due to the lack of post-acute indicators currently available. In the draft of measures available for comment this is still a very valid concern. 1.Five of the 21 measures are short stay – defined as patients who are in the center for 100 days or less. Of these five, two relate to vaccination status. While this information is beneficial to the public it does not necessarily permit the center to evaluate or improve quality. 2.The evaluation of pain management is the only measure that indicates the improvement or decline in a specific population for the short stay customer. The other two measures represent a population within the center (moderate to severe pain) or a flawed measure (pressure ulcers).	NQF is limited to considering measures that are submitted. Additional recommendations for future measure development will be added to the revised version of the draft report.	general

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230	P	Tammy Barker, HCR ManorCare	4.The remainder of the 21 measures are for long stay patients or those who remain in the center for greater than 100 days. This significantly hampers the provider of short term rehabilitation whose average length of stay is less than 100 days for the majority of their population.	NQF is limited to recommending measures that are submitted. Additional recommendations for future measure development will be added to the revised version of the draft report.	general
233	P	Tammy Barker, HCR ManorCare	7.Concentrating on functional outcome measures rather than prevalence measures would allow the center to improve their evaluation of quality and assist in planning quality improvement initiatives.	Additional recommendations for measure development will be added to the revised draft report.	general
234	P	Teresa Lewis, MN Dept of Human Services	Overall, the use of the MDS 3.0 should improve many of the proposed QMs as compared to their 2.0 counterparts, especially in resident-reported areas and those using standardized tools. The recommendation to use CAHPS survey instruments is another important improvement. However, I can share some concerns based on the experiences of a University of MN research team as they developed a MN-specific set of risk-adjusted quality indicators for public reporting, quality improvement, and research purposes, and of MN care providers as they have utilized and commented on the usefulness of these measures. (I would be glad to provide documents describing the MN-specific indicators on request.)	In the future, you might consider submitting your measures for NQF endorsement.	general

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235	P	Teresa Lewis, MN Dept of Human Services	Across many if not most measures, we would recommend more comprehensive risk adjustment. The proposed measures make no changes in risk adjustment strategies or items compared to their 2.0 counterparts. While the selection and use of a risk-adjustment scheme can be challenging or controversial, we have found in MN that doing so is vitally important for the fairness of cross-facility comparisons. We have also found making strong efforts to include all stakeholder groups in a dialogue on risk-adjustment rationale allowed them to view adjustment as fair and acceptable.	The Committee examined the rationale for not risk adjusting each of the non-adjusted measures, and found it acceptable. Risk adjustment is frequently not helpful in a nursing home population, as the Committee and measure developers did not want to adjust away for variables that should be monitored. Dissenting Committee members agreed with the commenter that the measure should be risk adjusted and were concerned with possible unintended adverse consequences. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls.	general
240	P	Barbara Yody, Genesis HealthCare	Need clarity around the definition of short and long stay. A length of stay is typically not calculated until you have a discharge. It seems unlikely that the QMS will wait until the resident leaves so (1) what are the new residents that are in a long stay program included as short stay before they hit 100 days, or does it also depend if a PPS assessment is done? (some measures indicate PPS or OBRA assessments.also, the RAI manual release removed the requirement to modify a Discharge Return Anticipated to a Discharge Return Unanticipated if the individual is out for more than 30 days. Discharge Return Not Anticipated is the only trigger that closes a stay and starts the days of stay count over at 1 for QMs so in order to maintain the correct short or long stay category, centers would need to perform this modification. QM specs to clarify sample definition of long versus short stay across discharges and reentry versus the MDS 3.0 definition of reentry.	CMS response: For the MDS 3.0, an entry tracking record is required every time the resident enters the facility. The QM definition of long stays will use the MDS 3.0 definition for an "admission" entry type (Item A1700 = 1). Note that MDS 3.0 instructions are to code an entry type of admission in the following cases: • The initial entry into the nursing home. • The resident had been discharge return not anticipated (A0310F = 10). • The resident has been discharged return anticipated (A0310F = 11) but does not return within 30 days. This definition does not just rely on whether return is anticipated after discharge but also whether the resident returns within 30 days. Whenever an admission entry type occurs then a new start of stay has occurred, and the days count for a potential new long stay is started over with the entry date. The potential long stay will continue until one of the following conditions occurs: • Discharge return not anticipated (A0310F = 10). • Discharge return anticipated (A031F = 11) but does not return within 30 days. • Death in facility record (A0310F = 12).	general

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262	M, Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Nursing Homes: A Consensus Report. The AMA supports NQF's efforts to advance the development of measures for nursing homes. We believe these measures will help further the goal of achieving quality and safe patient care for those in the nursing homes setting. □ We appreciate the opportunity to comment on this report.	No response needed.	general
263	M, Purchaser Council	Gaye Fortner, HC21	I appreciate the opportunity to comment on the nursing home measures put forward by the steering committee for consideration. The importance of having nursing home quality measures that are meaningful to consumers, patients, and family caregivers cannot be underestimated.	No response needed.	general
272	M, QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	The Physician Consortium for Performance Improvement(R) (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Nursing Homes: A Consensus Report. The PCPI supports NQF's efforts to advance the development of measures for nursing homes. We believe these measures will help further the goal of achieving quality and safe patient care for those in the nursing homes setting. We appreciate the opportunity to comment on this report.	No response needed.	general

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284	M, Health Professional Council	Lea Anne Gardner RN, PhD (on behalf of the Performance Measurement Committee), American College of Physicians	There seems to be no apparent systematic evaluation and grading of the evidence behind these measures.	Measure evaluation criteria 1c calls for the evidence supporting the measure focus. Each measure form includes information provided by the developer about the type of evidence, rating, and the method for rating strength of recommendation. The Steering Committee reviewed the evidence submitted for each measure and determined if it was adequate.	general

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285	M, Health Professional Council	Diane Carter, AANAC	1 of 3 I am concerned that the definition of short term and long term residents set forth for these quality measures is not compatible with the RAI process. The proposed measures lists 100 days as the definition of a long stay MDS. Admission MDSs are completed with ARDs usually around day 7 of the resident's stay. Since with MDS 3.0, the ARD of the first quarterly must be set within 92 days of the ARD of the admission assessment, the resident may have a quarterly MDS completed less than 100 days from admission. Should the definition of long term resident be changed to either use 90 days as the criteria or else state that long term residents are those that have been in the facility long enough to have had a quarterly assessment completed? The use of the "100 days" to designate short stay or long stay does not comply with current MDS coding. The use of the arbitrary days will cause confusion and question the use of the first quarter MDS which occurs 92 days from the admission ARD. Short stay residents should be defined using the scheduled PPS assessments. This will correspond to the use of the OBRA assessments (quarterly, annual, significant change and significant correction) for the long stay residents.	Your comment is noted and will be considered when we analyze the MDS 3.0 data as well as for further refinement of the quality measures. The stay starts from the date of arrival at the facility and not the ARD for the admission assessment.	general

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286	M, Health Professional Council	Diane Carter, AANAC	2 of 3 Several of the measures are based on long time frames that are then updated quarterly. For facilities to use this to improve their care the extended time frames will delay the showing of measures that have been implemented to improve the care which could give the public a negative feedback when in reality the care has improved. Removed issues: End-of-life-care issues: advanced care directives; and timely and appropriate referral to hospice. This is an extremely important measure and should include if the resident has a living will and if the LW was provided by the resident and/or their family. Hospitalization issues - rehospitalization rates; and unnecessary hospital admissions. Since ehospitalization rates are going to be monitored by the hospital this is a measure that should be monitored by LTC facilities. Many times LTC facilities will admit residents that should not have left the hospital. Medication issues: antipsychotic medications - This should be addressed due to the over-use of AP drugs without the appropriate specific documentation for the use of these types of drugs. A harmonized set of measures about MRSA for all types of facilities; This is an important measure along with any other type of infectious disease processes that are antibiotic resistant.	NQF is beginning a Palliative Care project that will address end-of-life care measures, advanced care directives, and hospice referral. Additional recommendations for measure development will be added to the revised draft report.	general

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287	M, Health Professional Council	Diane Carter, AANAC	3 of 3 Other comments: I have looked at the measures and here are some comments. I did not spend time trying to research these from a statistical or some 'research' validity status but rather based on experiences from the 200 or so CHSRA QIs and discussions in whittling those down based on consensus and common sense. One issue that arose over and over in the development of the QIs was that they were very hard to understand for the lay person including clinicians. Using different denominators for every single measure was confusing and made the entire set of results with no common ground. 1. While I know the Appendix indicates the measures are reported as submitted/amended by the sponsor, I would strongly encourage a standardized presentation that consistently and clearly identifies source records (e.g. MDS annual, MDS quarterly, etc.) and data items used for the measure calculation. 2. CMS has submitted several measures that are calculated based on a non-admission assessment (annual, quarterly, significant change, significant correction) being submitted within the quarter. These measures should document how computations will be handled in instances where multiple targeted record types (e.g. quarterly & significant change, annual and significant correction) are submitted in the same quarter. Are both records counted? Only the most recent? Etc.	**NQF response comment 1:** The source records and data item information is included in the full measure forms, available on the NQF site. We will consider adding that information to future reports. **CMS response comment 2**: Your comment that the QMs are difficult for the lay person and clinician to understand is noted and we will strive to ensure that the CMS website for public reporting provides clear and concise information regarding the criteria for as well as the limitations of the quality measures. One recent study by Castle examined whether consumers could accurately interpret the quality of care information for all the measures reported by Nursing Home Compare. Of a total of 200 facilities participating in the study, a total of 4,754 surveys were returned from family members with elders living in a nursing facility. A comprehensive index was developed with a possible 0–8 range and overall comprehension scores averaged about 5 indicating good understanding. (Castle, Nicholas G.(2009)'The Nursing Home Compare Report Card: Consumers' Use and Understanding', Journal of Aging & Social Policy,21:2,187 — 208. CMS response, comment 2. In the event that there are more than one assessments submitted within the quarter, the most recent assessment is used for the measure.	general

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312	M, Health Professional Council	Jacqueline Vance, AMDA	One AMDA member writes, "Regarding the standards that were approved for comment, I was hoping for ones that would correspond to potential new PQRI standards for MD use – which none of these had. LTC physicians still need a PQRI Measures group that will work for any patient they serve, that doesn't require lots of planning/coordination to satisfy. There are measures groups (e.g. CAD) that are easy to use, and the frequency of eligible patients is low. Other groups have high frequencies, but require outside testing to meet the 'best practice' standard (e.g. Heart failure). While the new EHR 'meaningful use' standards require a built-in set of quality measures (in lieu of PQRI), most of AMDA's members will take several years to make the transition. Our goal should be to advocate for a program that makes satisfactory participation as easy as possible.	NQF is only able to consider the measures that are submitted.	general

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322	M, Consumer Council	Debra Ness, National Partnership for Women & Families	The Natl Partnership for Women & Families appreciates the opportunity to comment on the nursing home measures put forward by the steering committee for consideration. The importance of having nursing home quality measures that are meaningful to consumers, patients, and family caregivers cannot be underestimated. According to a 2006 Urban Institute Study, between 2000 and 2050, the size of the population age 85 and older will soar from 4.3 million to 20.9 million, increasing the number of people in need of care. Research by the Agency for Healthcare Research and Quality found that approximately 40 percent of all elderly patients will spend at least some time in a nursing home. These statistics, which may not even account for the increase in dementia patients, point to the significant need for strong nursing home quality metrics to give family caregivers and other consumers the information they need to make the best decisions. In general, we support many of the measures in this set, but have some concerns regarding the lack of measures on how nursing homes interact with palliative care provision in general, and hospice services in particular. The literature indicates that when nursing homes have formal relationships with hospice services, there is a correlation between that relationship and appropriate pain management for nursing home residents.	NQF is beginning a Palliative Care project that will address palliative and hospice measures. Additional recommendations for measure development will be added to the revised draft report.	general

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323	M, Consumer Council	Debra Ness, National Partnership for Women & Families	Further, we strongly support measures be developed that quantify timely and appropriate referral to hospice from a nursing home, and measures of unnecessary hospitalization for nursing home patients. Finally, for some of the measures in this set, we feel that risk-adjustment is needed to account for residents with dementia, for whom certain process and/or outcome measures may result in unintended consequences. More detail on these concerns is noted in our comments on specific measures.	Added to research recommendations: Development of measures for timely and appropriate referral to hospice and unnecessary hospitalization	general
344	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	The points made (for the individual measues) regarding the data sets being easily extractable from the EHR is to illustrate the need for NQF and other measures reporting organizations to work with the EHR vendors to make these quality reporting measures part of the automated reporting tools that are now finding their way into most EHR's. In most cases, there are tools built in that can be configured to report these measures, but the measures groups need to make them part of the standard set and CCHIT/ONCHIT/HITSP need to make them part of the certification requirements. The new or updated quality measures reports can be pushed out with interval updates to the product or upgrades.	Quality measures derived form EHRs is a goal of NQF and NQF has projects currently underway regarding quality measures and health information technology including re-specifying measures for EHRs, development of a quality data set, and development of a measuring authoring tool for EHRs.	general

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355	M, Provider Council	Sandra Fitzler, American Health Care Association	The MDS is only an assessment, not a diagnostic tool. Measure outcomes reflect patient assessment data during the short period of time (look-back period) and cannot be considered a reliable source measuring patient change from one assessment to another. Many intervening condition, treatments abating symptoms and flare-ups can arise between assessments. This important fact is being lost as the MDS and measures are updated. Measure developers and policy makers need to understand the limitations of the data, be responsible users of the data, and convey data limitations to consumers and other users of MDS data. The measure developers did not consider proposed measures in relation to coding instruction for MDAS 3.0 with regard for "missing data" for each data items having a dash, a blank, or code 9. Depending on the MDS item, the dash or blank data do not always equate to missing data. For example: Section I, I2300 is left blank if no UTI is present. A dash can mean "not assessed." A skip pattern may remove the ability to answer a question that triggers a measure element. The following 8 measures are impacted by this issue:	CMS response: Your comment is noted regarding the MDS 3.0 limitations and we will strive to ensure that the CMS website for public reporting provides clear and concise information regarding the limitations of the quality measures. Pertaining to your comment regarding missing data and skip patterns, please refer to responses to your questions for each quality measure.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
356	M, Provider Council	Sandra Fitzler, American Health Care Association	(Continued) 008 Percent of residents experiencing one or more fall with major injury. 012 Percent of residents with pressure ulcers that are new or have not improved. 018 Percent of residents with a urinary tract infection. 019 Percent of low risk residents who lose control of their bowels or bladder. 020 Percent of residents who have/had a catheter inserted and left in their bladder. 021 Percent of residents who were physically restrained. 022 Percent of residents whose need for help with daily activities has increased. 024 Percent of residents who loose too much weight. All of these measures need to be re-evaluated to make sure missing data is not misinterpreted and valid data does not get excluded from measures. While AHCA appreciates the one or two new attempts to state the measure in the positive (#003 Falls and #009 Schedule Pain Medication), we are disappointed that more of an effort has not been made – particularly since we were reassured by CMS that as many measures as possible would be stated in the positive. Currently, only the immunization measures state the desired goal. As a result, only 6, at most, out of 18 measures (33%) are stated in the positive. Two of the proposed measures (018 Percent of residents with urinary tract infections – long stay and 024 Percent of residents who lose too much weight – long stay) are reported to be effected by seasonal variations.	NQF response: The Committee discussed the missing data issue for each of these measures and agreed to allow CMS time to further review the data during testing. CMS response: CMS is currently considering revising the measures to be reported in the positive.	general

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357	M, Provider Council	Sandra Fitzler, American Health Care Association	(Continued) Since the onset of utilizing MDS data to report QMs, CMS has reported the QM average on a quarterly basis. As shown in the chart (sent under separate email), the quarterly QMs have a very prominent seasonal component with a clear pattern for year to year. This pattern exists in for both chronic and post-acute care. AHCA along with other organizations have made this an issue of concern to CMS and since January 2010, CMS has begun to calculate the QM average score using the most recent three quarters of QM data available. While this does begin to smooth out the seasonal (quarterly) variability in data it does not fully remove the seasonality issue, AHCA feels CMS should move toward a 4-quarter average that will eliminate the seasonality issue. Patients discharge to the hospital with return anticipated but who do not return to the facility, and then return to the facility up to a year latter following another hospitalization will be picked up in the measures as if the discharge never occurred. That is because many of the numerator details state "Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero." The measure developers need to look again at the numerator details to ensure admissions based on a new episode of care are not inappropriately categorized.	CMS response: Your comment is noted when we analyze the MDS 3.0 data and for further refinement of the quality measures. We will specifically examine the impact of a 2 quarter versus 4 quarter facility average on the quality measure outcome. To clarify, residents who return to the nursing home following a hospital discharge will not have their stay reset to zero if they return within 30 days. The potential long stay will continue until one of the following conditions occurs: • Discharge return not anticipated (A0310F = 10). • Discharge return anticipated (A031F = 11) but does not return within 30 days. • Death in facility record (A0310F = 12). Any one of these conditions represents the end of stay for the potential long stay as of the discharge date. Note that a long stay can span time out of the nursing home involving temporary discharges with return anticipated (A0310F = 11) and reentries within 30 days.	general

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358	M, Provider Council	Sandra Fitzler, American Health Care Association	(Continued) The reliability, accuracy and validity of the new, additional assessments like Discharge Assessment, were not tested during MDS 3 development nor during the STRIVE project. The new assessments were not tested for the impact on the frequency of assessment and the impact of frequent assessment on measurement. Frequent assessments (less than every 7 days) will lead to overlapping look-back period data from which short stay measures are drawn. As a result, it is questionable whether short stay measure will have the ability to measure change as intended.	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0; we will specifically examine new assessments as well as the ability for the relevant short-stay quality measures to examine change.	general
379	M, Health Professional Council	Sharon McCauley, American Dietetic Association	The American Dietetic Association supports the 21 measures recommended for endorsement by NQF as voluntary standards suitable for public reporting and quality improvement pertaining to Nursing Homes. The American Dietetic Association agrees with the issues related to food, eating, weight, and therapeutic care addressed within the applicable measures as NH-012-10 (pressure ulcers), NH-013-10 (pressure ulcers), NH-022-10 (Activities of Daily Living), NH-024-10 (weight loss), NH-026-10 (Discharged Resident Instrument), NH-027-10 (Long-Stay Resident Instrument), and NH-028-10 (Family Member Instrument).	No response needed.	general

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380	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	On behalf of the 74,000 members of the American Physical Therapy Association (APTA), I would like to thank you for the opportunity to comment on the National Voluntary Consensus Standards for Nursing Homes. APTA is a professional association representing physical therapists, physical therapist assistants, and students of physical therapy. APTA members provide services to patients in a variety of health care settings including nursing homes. As a result, the development of these quality measures have significant implications for our members and the patients they serve. APTA is committed to the development and application of quality measures developed on clinical evidence that improve quality of care and care coordination among all members of the health care delivery team. In reviewing the proposed measures in their totality we applaud NQF for seeking endorsement of measures that cover a wide spectrum of quality issues such as falls, assistance with the activities of daily living, and treatment of pressure ulcers. Not only do these measures address a wide variety of important health care issues but these types of measures are inclusive of a variety of health care providers, including physical therapists. We also appreciate that some measures, such as the pressure ulcer measures, were delineated for use with both short and long stays in the nursing home. We also believe that these measures have the potential to improve the quality of care patients receive.	No response needed.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
389	M, Health Professional Council	Susan Sherman, American Geriatrics Society	AGS appreciates the opportunity to comment on proposed measures for Nursing Homes. We recognize that these measures are based upon reporting in MDS 3.0 and CAHPS. The intent is that all approved measures, including those with time-limited endorsement will be reported for the Medicare Compare public reporting process. These measures are not the sole basis of evaluating nursing home quality, but are part of a process that includes certification/inspection (surveys) and institution specific quality improvement activities. We believe it is important to use sufficient numbers of measures so that several domains of quality are assessed and so that any institution specific patient population differences are "smoothed" by having diverse measures. AGS strongly supports performance improvement and public reporting. We understand than there is a need to replace measures based on MDS 2.0.	No response needed.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
397	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	The American Nurses Association (ANA) finds the proposed measures to encompass clinical, functional, and psychosocial aspects of long term care and therefore capable of serving as a core set of measures for an appraisal of long term care quality at a given facility. It is important to note that the measure stewards have reached agreement on the long term and short term care definitions. This will assist in data interpretation and clarify actions necessary for quality improvement. The measures as presented are meaningful indicators for long term care facilities and have the potential to provide profiles of these settings that can allow comparisons of quality of care. Furthermore, ANA appreciates the integration of summary research within the text as it contextualizes the importance of the measure. The inclusion of the debate by the Steering Committee is equally important in providing clarity. Since, if the measures were to stand on their own without the rationale of the discussion, it could leave the measures open to various forms of interpretation. However, if the measures are to be utilized by consumer for decision-making, additional interpretative detail will need to be provided so that the impact of these measures on quality of life can be appreciated by the average consumer.	No response needed.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
403	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	The American Nurses Association (ANA), too, supports the development of measures of Quality/level of care: •A number of organizations have designated "Specialized Dementia Units" which may imply there is added value in living on those units. The research in this area has been inconclusive and standards have not been established in order to evaluate the care. Research in this area is needed. •There is a need to gain a better understanding of the numbers of individuals being transferred out of facilities because the staff is not able to manage non-cognitive symptoms associated with dementia, specifically, agitation and aggressive behaviors. •Consideration should also be given to metrics around inoculation with the herpes zoster vaccine for those over age 65. Far too many elders suffer with shingles and post-herpetic neuralgia. Prevention with the vaccine is imperative. ANA also wishes to express two concerns. First, there is a need to address the status of the resident on admission to the long term care facility. Without a "present on admission" assessment, it may be difficult to interpret status change(s). The second concern is that an index of acuity is not included within the specifications which may raise quality concerns where there are none since a decline in status may be the natural progression of the disease process.	These suggestions will be added to the list of recommendations.	general

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
156	P	Darlene Thompson, Kindred Healthcare	Denominators are based upon consecutive quarterly MDSs which would be approximately a 180 day stay. This eliminates short stay residents by definitions. Recommend that the title should indicate Long Stay. It is recognized that there is no way to exclude from measure those residents who meet the balance problem criteria who refuse physical therapy or has physical therapy denied by payer. However this will result in a false lower percentage since these residents would still be a part of the denominator. QM will be based upon comparisons on MDS and Therapy billing in "4 months prior to through 1 month after the new balance problem "– ability to map these has not been proven since CMS does not receive therapy bills for those who are private pay or managed/insurance covered. This will result in a false lower percentage since residents who meet the balance criteria and are receiving PT paid by a non-government source would be counted in the denominator but not in the numerator. MDS COGS cognitive calculation is only based upon staff interview in MDS 3.0. There is no correlation listed to BIMS for resident interview of this area of the MDS COGS. CMS has indicated that approximately 85% of residents can answer the interviews. Residents who have a BIMS score of 0-7 have a severe cognitive impairment but would not be counted in the exclusions. Based on these flaws in the calculation of this measure, I strongly urge NQF to reconsider recommendation of this measure.	RAND response: Long stay: We agree that the eligibility requirements for this measure limit it to long-stay patients. Therefore, we would agree with adding "Long Stay" to the measure title. Refusals: The issue of undocumented patient refusals of treatment is a factor that affects other process measures as well as this one and potentially impacts measure results as indicated. Having said that, having implemented this measure using chart review in five different patient samples, we have found that documented refusals almost never are found, suggesting that refusals represent a small proportion of patients. Administrative data: The administrative data in our testing contributed little to the numerator in this measure. However, it is an additional source of information concerning treatments received for some patients and we suggest retaining these data in the measure. BIMS: We agree that the BIMS is an important alternative measure of advanced dementia. We would define advanced dementia as follows: Items B2a, B2b, B3b, B3d, B3e, B4, C4 in MDS 2.0 correspond to MDS 3.0 items C7, C8, C9b, C9d, C9e, C10, and B5 and would be scored as originally specified. Item G1Ag in 2.0 is now items G1h and G1i. A positive score for EITHER of these items (any response other than independent) would equal 1 point. The MD-COGS score of at least 5 represents severe dementia. If the BIMS is completed rather then the items indicated above, a BIMS score of 0-7 would also qualify as severe dementia.	NH-003-10: Physical therapy for new balance problem
179	P	Jane Pederson, Stratis Health	What if a practitioner orders for therapy to evaluate but therapy does not feel treatment is indicated? This should be counted as a practitioner actively engaging physical therapy as an intervention. It should not be assumed that therapy will always have an intervention or that an intervention is appropriate.	RAND response: The specified limitation of an order for therapy that the therapist does not feel is indicated is not limited to this measure, but is a risk with any recommended treatment. Based on our experience implementing this measure using medical records, we feel that this represents a small proportion of the eligible population.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
205	P	Christie Teigland, Foundation for Long Term Care	Concerned about timeliness of using administrative claims data in addition to MDS 3.0 data in past 14 months, by the time these data are matched and available the information could be more than 1 ½ years old. Recommend using MDS data only, and using O-00400c physical therapy in addition to 0-00500F, restorative nursing program in walking. Exclusions: Question whether there should be an exclusion when G0300 is coded as 8: activity did not occur on prior or most recent assessment. It is not specified a code indicating a one level decline (e.g., if resident was only able to stabilize with assistance on prior assessment, and then activity did not occur, is this a decline?) Recommend adding residents with Alzheimer's Disease to exclusions, in addition to MDS COG=5 or higher. Also, adding residents on Hospice (O-0010K) in addition to end stage disease which is rarely coded. Consider also adding residents with palliative care approach (? Is this measured?) Risk Adjustment: Certain chronic conditions/diseases (especially if there is an acute flare up) and/or treatment of the condition with certain medications may greatly increase risk of experiencing a new or worsening balance problem. Why is there no risk adjustment to reflect this increased risk? While residents with advanced dementia are excluded, residents with moderately severe impairment are at higher risk for balance problems. The measure should include a risk adjustment to reflect this increased risk for cognitively impaired residents that don't quite meet the exclusion criteria.	RAND response: MDS PT item: We would agree that item O4c should be added as indicative of PT in the prior 7 days when it occurred for at least 15 minutes and on at least 1 day in the prior 7 days. MDS PT/rehab data only: The administrative data provide additional information about the use of Physical Therapy between the MDS measurements. Timely availability of CMS claims can be feasible in measurement. Item G3a or G3b = code 8: The reviewer's concern is that patients for whom the activity did not occur should be excluded from this measure. The definition of eligibility for this measure (decline in balance steadiness) does not include code 8 and, therefore, these patients are excluded by definition. Alzheimer's disease diagnosis: The exclusion for dementia is "advanced or severe" dementia, and therefore, we would not exclude patients based on diagnosis alone. Using the MDS-COGS score and BIMS allows for the appropriate exclusion of just patients with advanced cognitive impairment. Hospice: Patients with hospice care are excluded from the denominator by an administrative data code for hospice care. However, we would agree with the suggestion to include MDS item O1j as indicative of hospice care in the last 14 days. Palliative care: Patients receiving palliative care are excluded if they are coded as receiving hospice care or having a poor prognosis. Risk adjustment: Since this is a process measure, it is less susceptible to influence due to case mix then many outcome measures. Prior work with the falls measure set that includes this proposed measure demonstrated that there was little variation by level of fear of falling in quality performance. (Min LC, Reuben DB, Keeler E, et al. Is patient-perceived severity of a geriatric condition related to better quality of care? Med Care. In press.)	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
210	P	Melody Malone, Independent Consultant	I am concerned that the short title will mislead the community that only "Physical Therapy" or an assistive device is appropriate for a new balance problem. I am requesting that the title include: Nursing Rehab/Restorative since this is a treatment option and included in the data specifications.	RAND response: Measure title: The title for this measure had already been changed; unfortunately, the posted documentation made this somewhat difficult to see. The title was changed to read: Physical therapy or nursing rehabilitation/restorative care for new balance problem.	NH-003-10: Physical therapy for new balance problem
215	P	Linda Spokane, NYAHSA	This measure is difficult to implement because it requires administrative claims data, which is not part of the MDS. We are concerned about the timeliness of using administrative claims data in addition to MDS 3.0 data in the past 14 months. By the time these data are matched and available the information could be more than 18 months old. Exclusions – no definition of "advanced" dementia and "poor prognosis" (not part of MDS). Where can we find the definition for these conditions? Suggestion: Eliminate the requirement of using administrative claims data and use the MDS 3.0 Item O0400C –Physical Therapy in addition to O0500F – Restorative Nursing Program in Walking. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	RAND response: Availability of data: A variety of measures use claims data as their source of information and can be implemented in a timely fashion. Advanced dementia: This has been defined. See response to Comment #156. Poor prognosis: Poor prognosis is included in the MDS and is defined as item J11 = yes. ADMIN DATA: See responses above in Comment 156.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
216	P	Linda Spokane, NYAHSA	The percent of residents who have worsening status by at least 1 level in the sum of balance problems while standing and sitting might be very small nationwide; in NYS, using MDS 2.0 data for the year 2009, the rate was only about 11%. This measure does not count therapy provided to residents who have balance problems, but whose balance problems are not new. The more a resident receives therapy, the less likely that resident will experience a new balance problem. Therefore, facilities that provide more therapy to their residents will have a smaller denominator for the subsequent assessment period. An extreme case example: if a facility provides good therapies (that improve or maintain balance problems) to all residents in the facility then the denominator for the subsequent period will be 0. Suggestion: Include all residents with balance problems, not only those with new balance problems. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	RAND response: PT for all balance problems: We agree that patients with old as well as new balance problems will likely benefit from ongoing PT. However, the clinical experts who developed this quality measure limited it to new balance problems as the threshold for distinguishing good care from not good care.	NH-003-10: Physical therapy for new balance problem
231	P	Tammy Barker, HCR ManorCare	5.Therapy outcomes becomes of utmost importance to the post-acute provider but the only true mention of therapy within the measures is NH-003-10 relating to physical therapy provided for a new balance problem. This overlooks all the positive outcomes associated with the post acute environment in addition limiting the measures to one discipline and one circumstance only.	**RAND response:** We agree that this measure addresses just one condition that is responsive to Physical Therapy. The development and testing of additional measures addressing other problems would be valuable. **NQF response:** NQF is limited to recommending measures that we receive. Additional recommendations for future measure development will be added to the revised version of the draft report.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
241	P	Barbara Yody, Genesis HealthCare	There is confusion in the documents as to the metric that is being proposed. The appendix of the report for comment entitles this metric as NH-003-10: Physical therapy for new balance problem. Metric does not differentiate short or long stay – recommend that the populations be separated. This is the only metric that differentiates on age, unclear whay and is not consistent with other publicly reported measures. Metric description in body of report different that the appendix. Most concerning is the description in the appendix that PT would be defined by the use of administrative claims data – need to us MDS to allow transparency to the centers •Denominator time window very broad – 14 months of MDS & claims data; so includes anyone with new balance problem in that time frame – so if balance issued appeared months ago due to a medication and that was adjusted and balance is restored, center would still get di nged for not having rehab •QM excludes persons with advance dementia – need to define how this is determined on the MDS (could reduce sample size)	RAND response: Long stay vs. short stay: See comments to prior question (comment 156). By definition, patients will need 2 MDS assessments for eligibility and therefore, are long-stay patients. We agree to the suggestion of adding "long-stay" to the measure title. Age: Our expert panel targeted this measure for the 65 and older age group. The number of patients less than 65 who are long stay and mobile would presumably represent a relatively small number. PT administrative data: See response to Comment #205 about adding MDS PT item O4c as satisfying the PT requirement. Time window: The broad time window was designed to account for therapy that might have occurred in the 4 months prior to or in the 1 month after the MDS assessment that documented the new balance problem. This is a 5-month window. The 14-month time frame referred to accommodating what is commonly a 1-year study period. It is true that there may not be a perfect concordance between the identified problem and the identified therapy. This is designed to avoid penalizing providers where ordered care may be administered after some delay that is outside of his/her control. With regard to other medical problems contributing to the balance problem: In our implementation of this measure using medical records, causes of falling that were addressed without involving physical therapy or assistive devices (such as stopping a medication) were rare. Advanced dementia: See definition above in response to Comment 156.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
270	M, Provider Council	Sandra Fitzler, AHCA	It is not clear if the measure pertains to long stay patients only since denominators are based upon 14 months of MDS and administrative data. Need to define "administrative data" and if measure data source is other than MDS, need to report source, evaluate data reliability/accuracy/validity, and resubmit measure for public comment. Also, if measure based on comparison between MDS and therapy billing, the ability to map the data sources has not been proven. CMS does not collect administrative claims data for private pay and managed insurance coverage. The absence of this information will also lead to lower patient percentages that meet the balance and therapy criteria. The numerator includes patients receiving PT or nursing rehab. The latter is not reflected in the measure title. The MDS is an assessment tool capturing information over a short period of time. It is not a diagnostic tool. New balance problems can be related to medications and other medical conditions. The MDS is not sensitive to adequately assess medication issues and changes. Thus, the measure can lead to a false conclusion about the need for PT or nursing rehab and lessen the focus on root cause for balance problems. The measure doesn't recognize those patients who meet the balance problem criteria and who refuse therapy or therapy denied by payer. This will result in lower patient percentage in the denominator. Based on the identified measure issues, we recommend that NQF reconsider the use of the measure	RAND response: Long stay: See responses above in comments 156, 241. Administrative data for PT: Administrative data definitions for PT and related detail were included in the supplemental documentation provided with the original submission of this measure. See responses above regarding the use of administrative data in this measure. Measure title: See above detail that indicates that measure title was changed in past documentation submitted to NQF. Medical reason for balance problem: We agree that this measure is not a diagnostic tool, however see our response concerning addressing other reasons for falls and mobility problems in response to comment 241. No single measure can fully address this problem. However, other measures such as avoiding certain medications in elderly patients or monitoring for side effects can contribute to maintaining a multifocused approach to assessing problems of NH patients. Therapy refusals: See above comments regarding this.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
288	M, Health Professional Council	Diane Carter, AANAC	1 of 2 Comment: The MDS 3.0 collects information about therapy only in the 7 days prior to and including the ARD. A resident's new balance problem may be identified during the observation window resulting in a therapy screen and treatment which may not be able to be started before the ARD. Also, it is not possible to note from the MDS whether Physical therapy is being provided for walking or balance. Any PT treatment would be noted on the MDS if provided during the look –back window. Comment: This measure as it is currently written is not likely to show the relationship of therapy to new balance problems. This is not a way to determine if the therapy was due to balance problems or some other reason. The changes in balance could be reflective of a bigger problem such as a recent stroke. The other question is, does the lack of therapy for a new balance problem indicate poor care again based on the MDS questions this conclusion cannot be determined. Comment: Limiting this to only those 65 or older seems to suggest that nobody has a balance issue until they are 65. Measure everyone.	RAND response: Claims issues: Claims data supplement MDS data in order to cover a broad time period surrounding the new balance or falls problem. Medical reason for balance problem that would not benefit from therapy or an assistive device: See responses above. Age: See response to this above.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
289	M, Health Professional Council	Diane Carter, AANAC	2 of 2 Comment: 1. It seems that change in balance can be due to causes that do not require PT (e.g. medications, orthostatic hypotension, etc.). I am sure this was discussed by the committee, but I would like to see some information included on the percentage of newly developed balance deficits that are NOT due to causes associated with the need for PT/nursing restorative services. 2. I assume that by using two consecutive quarterlies to calculate the denominator is a proxy for medical stability (see comment above) – but this should be fleshed out in the discussion as I think it could be a less than perfect proxy (e.g. increased dose of Cardizem could cause dizziness resulting in decreased stability when moving from seated to standing position – appropriate action is evaluate med, not PT). 3. As this measure is calculated based on consecutive quarterlies, I would recommend that the phrase "long-stay" be added to the title for ease in recognizing target population.	RAND response: Medical reason for balance problem: Please see our responses to Comment #241 above. Long stay: See above responses in comments 156, 241.	NH-003-10: Physical therapy for new balance problem
328	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-003-10: Is this just SNF, or does this also include ILF, ALF or both? This should be documented in the EHR and available as a report for ease of submission. Both should be extractable from the ICD, CPT or HCPCS codes. At the worst, the PT consult could be extracted from the orders.	RAND response: Other settings: This measure requires MDS data. EHR: We agree that an EHR could be configured to extract the data required to score this measure.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
381	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	We agree that the physical therapist is an integral aspect of strategies and interventions to identify and treat balance problems. Through timely and appropriate evaluation and intervention, physical therapists assist seniors and persons with disabilities by improving their strength, mobility, balance, ability to safely function, and fear of falling. For older adults, a balance issue can be a contributing factor in falls and the resulting injuries can diminish the ability to perform necessary ADL's and mobility and limit social participation. Falls are often the result of a complex, interdependent collection of factors, in which multiple causes interact to produce a fall. When patients are referred to physical therapy, thorough review of fall history and risk factors can effectively initiate referrals to other appropriate care providers. In addition to follow-up for medication issues, screening may indicate the need for vision or hearing checks, referral to a medical social worker or medical specialist such as a podiatrist. Assessment of the environment for safety issues is also essential. Elimination of hazards, both structural and habitual, and the addition of supportive features are important strategies in fall prevention. Specific instructions for hazard resolution, installation of safety equipment and resources for structural changes are often needed.	No response needed.	NH-003-10: Physical therapy for new balance problem

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
167	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 item J1900 (composing the quality measure) is completed with a dash or is left blank and J1800 is completed by a 1 (indicating the resident had a fall), dash, or is left blank. Item J1800 asks if the resident had any fall since admission or prior assessment (OBRA, PPS or Discharge), whichever is more recent. If item J1800 = 0(No), item J1900 is skipped.	NH-008-10: % of long stay residents experiencing one or more falls with major...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
217	P	Linda Spokane, NYAHSA	The time window is a 12-month look-back period and residents included in the calculation are those whose length of stay is greater than 100 days. These 2 requirements imply that residents whose length of stay is from 101 days to less than 12 months will have a shorter look-back period than those with a length of stay greater than 12 months. Residents with a shorter look-back period are less likely to be included in the numerator. Therefore, facilities with a large fraction of residents with a length of stay from 101 days to less than 12 months are expected to have a lower rate than other similar facilities with a smaller fraction of residents with a length of stay 101 days to 12 months. We also feel that a new measure should be added "Percent of residents experiencing 2 or more falls with injury (except major)". Falls resulting in skin tears, abrasions, lacerations, bruises, sprains or pain have similar detrimental effects on residents, including increased fear that may lead to reluctance to walk, a subsequent functional decline, depression, cognitive decline and other adverse outcomes. Suggestion: 1) Change the look back period to 3 months or since prior assessment, and 2) add a new measure that calculates 2 or more falls with injury (except major). Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: We appreciate your concern, however, facilities with a large fraction of residents having a length of stay 101 days to 12 months will have more residents in the denominator and therefore, more residents exposed to a risk of falls. We do not expect that to be a problem in the calculation of the measure but can certainly examine that as we conduct the analyses. We also note your recommendation regarding the addition of a measure for 2 or more falls with injury (non-major) and will consider such as a measure as we analyze the MDS 3.0 data.	NH-008-10: % of long stay residents experiencing one or more falls with major...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
237	P	Teresa Lewis, MN Dept of Human Services	We would concur with the NQF Committee that the 'Falls with major injury' QM (NH-008-10) be revised to *not* require a major injury. While the RAI definition of a fall creates a high number of total falls, counting whether a resident did or didn't fall in a given time seems like a fair approach to minimize the effect a so-called 'frequent faller' could have on a facility's score. Falls are considered to be a priority care area in MN and only counting injurious falls would send the wrong impression for quality improvement efforts.	CMS response: Your comment regarding a consideration of frequency of falls with minor injury as well as falls with major injury is noted and will be considered as we analyze the MDS 3.0 data. The data will be analyzed for all categories of falls; CMS wants to better understand the correlation with the adverse sequelae associated with falls.	NH-008-10: % of long stay residents experiencing one or more falls with major...
244	P	Barbara Yody, Genesis HealthCare	•Unclear in defn of numerator if any assessment in 12 months would be used or only the most recent •If all assessments are used and resident has multiple falls; this would increase the rates as the denominator is # long stay residents. If so,technically the denominator should not be # residents, instead it should be a rate per 1,000 patient dats. •Concern they may be some subjectivity in the definitions of the major injury.	CMS response: The numerator refers to a fall with major injury noted in any non-admission MDS assessment, which may be a an annual, quarterly, significant change, significant correction assessment, or discharge assessment. The denominator time window is a 12-month look-back period, updated quarterly. Your comment regarding expressing the quality measure as a rate per patient days was discussed during the Technical Expert Panel, however, the panel recommended that we maintain this measure as the number of falls per residents at risk. We note your recommendation and will consider the implications of modifying the rate calculation as we analyze the MDS 3.0 data for further refinement of the measure. Your concern regarding subjectivity in the definition of the MDS 3.0 falls with major injury is noted, however, we reviewed the major injuries included in the definition, e.g., bone fractures, joint dislocations, closed head injuries with altered level of consciousness and subdural hematoma, and believe that these would included in the medical record and diagnosed by the physician (or nurse practitioner, physician assistant, or clinical nurse specialist as allowable under state licensure laws).	NH-008-10: % of long stay residents experiencing one or more falls with major...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
271	M, Provider Council	Sandra Fitzler, AHCA	"Missing data" for each of the data items (a dash, blank or code 9) needs to be defined. Blanks and dashes do not always mean the information is "missing." For example, I12300 is left blank if no UTI present or a dash can mean "not assessed". Skip patterns need to be evaluated to make sure they don't remove the ability to answer a MDS question that triggers a QM data element. The measure will include those having a pathological fracture and then a fall. There is no way to account for this on the MDS and thus no way to distinguish the fracture. Need to explain "annual percentages are reported to ensure adequate sample size" before the denominator time window can be fully understood and comment made.	CMS response: For this measure, a missing data designation is made when the item J1900, composing the quality measure, is completed with a dash or left blank when J1800 is completed by a 1 (indicating the resident had a fall), dash, or left blank. Item J1800 asks if the resident had any fall since admission or prior assessment (OBRA, PPS or Discharge), whichever is more recent. If item J1800 = 0(No), item J1900 is skipped. We will be evaluating skip patterns as part of our analysis of the MDS 3.0 data. We appreciate your comment regarding the issue of pathological fractures, however, at this time there is no way of differentiating between a fall followed by an injury, or an injury resulting from a pathological fracture followed by a fall; we recognize that this is an issue of the limitation of data collection. The quality measure is calculated on an annual basis from data obtained quarterly due to the anticipated small numbers of falls with major injury.	NH-008-10: % of long stay residents experiencing one or more falls with major...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
303	M, Health Professional Council	Diane Carter, AANAC	Comment: The updating of this data only quarterly will give the public a false negative or positive and will not be reflective of current care in the building. Comment: • whether scope of the measure should be broadened to include all falls, as opposed to only falls with major injury—the Committee requested that the developer consider broadening the measure to include all falls; and • exclusion of comatose patients. This measure could be broken down into falls with and falls without major injury. The problem I have with this is that someone without a major injury can die within 6 months of the fall due to the body being traumatized by the event. Dying within 6 months of a fall or other related injury would be a marker for future studies on safety. Also, subdural hematomas do not necessarily show up for 1-3 weeks after a fall. This is due to atrophy of the brain, the bleeding or swelling continues until the bleeding or swelling fills up the cavity. How would this be coded for the quality indicator/measure?	CMS response: We will analyze the MDS 3.0 data for all categories of falls for future QM development, in this way we will examine both major and minor injury and their sequelae. As for diagnosing a fall-related subdural hematoma, we can only attribute this condition to a fall if it is documented in the medical record at the time of the completion of the assessment, which may be an annual, quarterly, significant change, significant correction assessment, or discharge assessment.	NH-008-10: % of long stay residents experiencing one or more falls with major...
313	M, Health Professional Council	Jacqueline Vance, AMDA	Older nursing home patients have multiple reasons for falls in nearly all cases (dementia, DJD, vision/sensory issues, muscle disuse, CVA, etc). Some of these factors may not be modifiable. The key is whether a risk was identified and a patient centered Care Plan was instituted and followed. If all these things were done and the patient still fell and injured, the facility should not be penalized since bad things happen even with the best of care. Ref: Clinical Practice Guideline, AMDA for Falls and Fall Risk. We believe as written this measure is well intentioned but lacks realization of the goal of maximizing autonomy in spite of high level of disability. As written we believe this measure is flawed	The Committee questioned the developer about this issue and the developer stated that the TEP that developed the measure had a multi-interventional approach in mind when developing the measure. In addition, the measure is intended for use in the long-stay population, which gives facilities time to work with new residents on fall prevention issues. The Committee's discussion of this issue is summarized in the project report and detailed in the meeting and conference call notes posted online.	NH-008-10: % of long stay residents experiencing one or more falls with major...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
338	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-008-10: Again, LOS congruence needs to be ensured between measures. Easily extractable via ICD and CPT codes from the EHR. Should be an automated report.	CMS response: Long Stay residents are defined as those whose length of stay in a facility is greater than 100 days. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-008-10: % of long stay residents experiencing one or more falls with major...
168	P	Darlene Thompson, Kindred Healthcare	We appreciate the measure being stated in a positive manner since pain management is a goal all clinicians have for their residents. The numerator details [page 8] states that a reduction in pain is defined as "one of the following: a reduced frequency in pain between the two assessments (J0400) or a reduced intensity of pain (J0600A) or a reduced verbal descriptor of pain (J0600B)." This can be interpreted to mean that a resident going from a pain intensity of 3 to a 2 is a reduction and therefore be included in the numerator. However, the reliability testing [page 10] states the numerator "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 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. The data elements for the numerator are different. This same example may exclude the resident from the numerator based on the reliability testing numerator criteria. NQF needs to have the developer clarify the numerator details.	CMS response: We appreciate your comment regarding the need to clarify the numerator for this newly proposed measure to be generated from MDS 3.0 data. The numerator details for this quality measure are as listed on the NQF submission (page 8). The reference to the numerator in the reliability section (page 10) refers to the quality measure generated from the MDS 2.0 data 'Percent of Residents with Moderate to Severe Pain" which relies on the same pain items (J400 and J0600A or B). Reliability testing was conducted for the quality measure generated from the MDS 2.0 data and can be applied to a limited extent to the proposed measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
169	P	Darlene Thompson, Kindred Healthcare	It is recognized that there is no means to take resident's personal pain tolerance into consideration. Residents who come to the center at their pain tolerance level and remains at their tolerance level in the subsequent MDS for this measure would meet the requirement for inclusion in the denominator but would not be in the numerator or excluded so this could result in a false lower percentage for this measure. This measure also excludes any short stay resident who can not self-report pain so recommend title be edited to "The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (short stay)".	CMS response: Your comment is noted and will be considered as we analyze the MDS 3.0 data as well as for further refinement of the quality measures. Residents reporting the same pain frequency based on item J0400 categories and same intensity based on item J0600 using the numeric scale or verbal descriptor scale will not be included in the numerator. We will specifically examine the impact of residents who come to the facility at their pain tolerance level and remain at their tolerance level in the subsequent MDS assessment on the quality measure outcome. The proposed measure based on MDS 3.0 data excludes any short stay resident who can not self-report pain and the title will be revised to "The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (short stay)".	NH-009-10: % of short stay residents with effective pain management
192	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 1 of 2 This measure is fundamental in the quality of life of nursing home residents. Unfortunately it carries a potential for quite varied practice. The area is such a complex one and the Steering Committee touched on some aspects. But standardization of practice, which includes many specific details, should be emphasized as an expected part of these measures. It would lessen any potential for more favorable management of reported outcomes. Pain scales that are used should be consistent across nursing homes. Non-verbal residents, among the most vulnerable, should all be assessed for pain both regularly and using only a tool which is validated for their clinical circumstances. This may be similar to standardization expected with use of the Patient Health Questionnaire-9 for depressive findings in the Minimum Data Set version 3.0. For example, using Pain Assessment in Advanced Dementia (PAINAD) as a tool for nonverbal residents with Dementia may help advance this challenging area. – continued in Part 2 –	In regards to your comment concerning placing emphasis on standardization of practice, we refer you to the Scientific Reliability Section of this NQF submission (measure criterion 2b) as well as to the RAND report regarding the development of the MDS 3.0 for complete details regarding the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the cited report, a standard method of assessment "likely reflecting CMS national initiatives to increase pain assessment with standardized scales in NHs, most of the facilities in our sample reported that they routinely used pain severity scales to assess their residents. Eighty percent used the 0-10 scale and 25% reported using other pain scales." Dr. Debra Saliba, lead researcher for the development for the MDS 3.0, also tested inter-rater reliability as part of the nursing home validation study. This national test of the MDS 3.0 examined the agreement between assessors; both gold-standard (research nurses) to gold standard nurses as well as gold standard nurses to facility nurses. (response cont'd on next page)	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
192	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 1 of 2 This measure is fundamental in the quality of life of nursing home residents. Unfortunately it carries a potential for quite varied practice. The area is such a complex one and the Steering Committee touched on some aspects. But standardization of practice, which includes many specific details, should be emphasized as an expected part of these measures. It would lessen any potential for more favorable management of reported outcomes. Pain scales that are used should be consistent across nursing homes. Non-verbal residents, among the most vulnerable, should all be assessed for pain both regularly and using only a tool which is validated for their clinical circumstances. This may be similar to standardization expected with use of the Patient Health Questionnaire-9 for depressive findings in the Minimum Data Set version 3.0. For example, using Pain Assessment in Advanced Dementia (PAINAD) as a tool for nonverbal residents with Dementia may help advance this challenging area. – continued in Part 2 –	(response con'td) For the pain items, the average kappa for the gold-standard nurse to gold-standard nurse agreement was 0.961 and the average kappa for gold-standard nurse to facility nurse was 0.967. Patient self-report of the presence and severity of pain, which is incorporated in the MDs 3.0 items supporting this proposed measure, is considered the most reliable and accurate approach to pain assessment. Your comment concerning the vulnerability of non-verbal residents and the use of a tool validated for their clinical circumstance is noted for future refinement of the MDS 3.0 and this quality measure. For staff observed pain behaviors, average kappas were 0.936 for the gold-standard nurse to gold-standard nurse and 0.956 for gold-standard nurse to facility nurse. Currently, as stated in the RAI Manual, Chapter 3, Section J - "If a resident cannot communicate (e.g., verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used." Finally, as stated in the RAND report, "Observation items proposed for the MDS 3.0 are similar to a number of newly-developed scales for estimating pain in non-communicative NH residents" Please refer to the Rand report for a complete set of references.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
193	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 2 of 2 Times of pain assessment should be similarly standardized. Again this would prevent a potential for favorable management of the quality measures. In our experience the occasions of greatest pain intensity, which should be sought, are times of wound care, transferring or moving residents with activities of daily living and during rehabilitation therapy sessions. Where pre-medicated and post-medicated pain intensities are documented, selective reporting of favored data only may bias the value of the measure, as would a practice that notably fails to assess during those times of maximally expected pain. Tolerance of pain is another aspect that would enhance understanding of what could be interpreted too simplistically, if severity alone were used. Stoic residents with high intensity pain may endure or are possibly seen to make significant gains in their rehabilitation program. Conversely, individuals with moderate intensity pain and poor tolerance may have significant non-physical characteristics that are inadequately addressed. A comprehensive measure of pain, beyond an understanding of 'physical' severity, remains challenging and would be enhanced with tolerance incorporated in the characteristics of this measure, including psychological impact on those affected. Thank you for the opportunity to provide the above comments, among many complexities. Simon Kassabian, MD, Director of Palliative Care Liz Weingast,RN,MSN,NP Marie Rosenthal,RN	CMS response: Your comment is noted and will be considered as we analyze the MDS 3.0 data as well as during further refinement to this measure. The underlying pain items for this measure are standardized in the sense that residents are asked about their worst pain over the last five days. Therefore, residents are asked to think back to when their worse pain occurred (whether during wound care, physical therapy etc.)	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
218	P	Linda Spokane, NYAHSA	This measure does not capture the effectiveness of pain management on residents who have pain but are not able to self-report their pain. This represents a potentially serious flaw b/c many residents who do not have the ability to self-report pain have cognitive impairment. Research has shown pain is underreported in residents with cognitive impairment. The new MDS 3.0 pain items capture non-verbal pain indicators and, thus, both a self-report and staff assessment measure for pain should be calculated. We also agree with concerns expressed by the committee related to the definition of what constitutes "effective pain management".□ □ Suggestion: In addition to a measure that calculates effective pain management for short-stay residents that can self-report pain, another measure should be added that calculates the same rate for residents who cannot self-report pain. Also, this measure should be used together with NH-010-10 (Percent of Residents with Moderate to Severe Pain) to portray a more accurate picture of how the facility takes care of residents with pain.□ □ Linda Spokane, MS□ Zulkarnain Pulungan, PhD□ Kathleen Pellatt, RN□	CMS response: We appreciate your comment regarding the limitation of this quality measure for residents with cognitive impairment. As stated in section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed measure, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered as we analyze the MDS 3.0 data as well as for ongoing refinement of this measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
245	P	Barbara Yody, Genesis HealthCare	•QM does not recognize any non-pharmacological interventions for pain that may be the residents preferred method of pain management •Definition of improvement could result in a resident with an increase in intensity but a decrease in frequency still qualifying as an improvement •Look back is only 5 days so if first PPS assessment uses the grace days (to day 8) and resident had a scheduled pain medication regime that was discontinued on Day 2 as pain has stabilized, this resident would not count in the measure even though the title of the QM states "on admission"	CMS response: Your comments concerning the exclusion of non-pharmacological interventions for pain and the example of the resident whose scheduled pain medication regime was discontinued on Day 2 as pain has stabilized in this measure as well as the inclusion of a resident reporting an increase in intensity but a decrease in frequency and exclusion are noted; your concerns will be considered when we analyze the MDS 3.0 data as well as for ongoing refinement of this quality measure. RTI will examine the change, lack of change, and direction of change and patterns for both the frequency and intensity as part of the validation testing of the measures to examine whether this affects the face validity of the measure. CMS will explore how best to link resident preferences with concepts like pain management in future enhancements to quality measures collected and reported to CMS.	NH-009-10: % of short stay residents with effective pain management
304	M, Health Professional Council	Diane Carter, AANAC	Comment: Remove the discussion regarding short stay residents of less than 100 days as it is not relevant when using the MDS 5 day compared to the 14 day or discharge assessment whichever comes first.	The discussion related to the definition of a short stay resident. A short stay resident is one who is in the facility for less than 100 days.	NH-009-10: % of short stay residents with effective pain management
339	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-009-10: There could be significant variability in reporting methods and unintended outcomes by focusing on pain control (opioids and constipation/bowel obstruction). Need to ensure standard methods of assessment that are reproducible and valid. Need to be able to account for patient preference (referenced the accompanying text) and cognitive status. The final comment/question is about the measure itself. Is this the measure that is most important regarding pain management? Is not as valid a question that the patient reports no increase in pain over baseline?	CMS response: Regarding your comment about ensuring standard methods of assessment that are reproducible and valid, we refer you to the Scientific Reliability Section of this NQF submission (measure criterion 2b) as well as to the RAND final report on the development of the MDS 3.0 for details about the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the final report, a standard method of assessment "likely reflecting CMS national initiatives to increase pain assessment with standardized scales in NHs, most of the facilities in our sample reported that they routinely used pain severity scales to assess their residents. (response con't on next page)	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
339	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-009-10: There could be significant variability in reporting methods and unintended outcomes by focusing on pain control (opioids and constipation/bowel obstruction). Need to ensure standard methods of assessment that are reproducible and valid. Need to be able to account for patient preference (referenced the accompanying text) and cognitive status. The final comment/question is about the measure itself. Is this the measure that is most important regarding pain management? Is not as valid a question that the patient reports no increase in pain over baseline?	(response cont'd) Eighty percent used the 0-10 scale and 25% reported using other pain scales." Dr. Debra Saliba, lead researcher for the development for the MDS 3.0, also tested inter-rater reliability as part of the nursing home validation study. This national test of the MDS 3.0 examined the agreement between assessors; both gold-standard (research nurses) to gold standard nurses as well as gold standard nurses to facility nurses. For the pain items, the average kappa for the gold-standard nurse to gold-standard nurse agreement was 0.961 and the average kappa for gold-standard nurse to facility nurse was 0.967. We agree that including patient preference is very important, however, patient preference is not collected by the MDS 3.0 (the data source for this measure). CMS will explore how best to link resident preferences with concepts like pain management in future enhancements to quality measures collected and reported to CMS. We agree that cognitive status is important to measure, and it is evaluated as part of the MDS 3.0, however, it has not been included in the development of this pain measure. We will examine the association between cognitive status and reported pain when we test the measure using MDS 3.0 data. Finally, your comment regarding the measure not including residents reporting that their pain has stayed the same is noted and will be considered as we analyze the measure using the MDS 3.0 data as well as for further refinement of this measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
362	M, Provider Council	Sandra Fitzler, American Health Care Association	AHCA appreciate the measure being stated in a positive. The presence of pain and pain management on admission may not be the same source of pain on a subsequent assessment or on discharge. Example: admitting pain related to knee replacement and on subsequent assessment or discharge, knee pain improved but patient now bother by arthritis flare-up or shingles. The measure does not account for these common situations and will leads to misconceptions/erroneous report of inadequate pain management. The numerator details [page 8] states that a reduction in pain is defined as "one of the following: a reduced frequency in pain between the two assessments (J0400) or a reduced intensity of pain (J0600A) or a reduced verbal descriptor of pain (J0600B)." This can be interpreted to mean that a patient going from a pain intensity of 3 to a 2 is a reduction and therefore be included in the numerator. However, the reliability testing [page 10] states the numerator "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 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. The data elements for the numerator are different. This same example may exclude the patient from the numerator based on the reliability testing numerator criteria. NQF needs to have the developer clarify the numerator details.	CMS response: Your comment concerning pain present on admission may not be the same source of pain on a subsequent assessment or on discharge is noted. However, providers are obligated to address pain regardless of the source of the pain, which includes the pain the resident may have had on admission or pain of new origin. We appreciate your comment and will clarify the numerator for this newly proposed measure generated from MDS 3.0 data. The numerator details for this quality measure are as listed on the NQF submission (page 8). The reference to the numerator in the reliability section (page 10) pertains to the quality measure generated from MDS 2.0 data 'Percent of Residents with Moderate to Severe Pain" which utilizes the same pain items (J400 and J0600A or B). Reliability testing was conducted for the quality measure generated from MDS 2.0 data and can be applied to a limited extent to the proposed measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
363	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) MDS does not capture the patient's pain tolerance level. Patient admitted at a pain tolerance level and remains at that tolerance level in the subsequent MDS, would meet the requirement for inclusion in the denominator but would not be in the numerator or excluded and will lead to a false lower percentage for this measure. This measure also excludes any short stay resident who can not self-report pain. Due to the measure construction issues, AHCA recommends the measure be reconsidered.	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0 data as well as for further refinement of the quality measures. We will specifically examine the impact of this circumstance on the quality measure outcome. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered when we analyze the MDS 3.0 data as well as for ongoing refinement of this measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
384	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	APTA agrees with the intent of this pain measure. Adequate and consistent assessment of pain signs / symptoms and the appropriate management of pain in this population are critical to the well-being of the resident as documented in the measure description. We would also comment that pain and pain management are complex issues and a variety of interventions are required to meet these complex needs. The management of pain should be a multifaceted and interprofessional process. Medications are often a first line intervention for pain management. In some instances, medications, especially multiple medications can results in various side-effects and raise a residents risk for other problems (i.e. falls). Some pain, especially pain of musculoskeletal origin can be treated effectively with various types of positioning, activity and at times modalities administered by a physical therapist. These interventions might include splinting, gentle stretching, myofascial release techniques, assisted or non assisted movement or electrical stimulation. One factor to consider with regards to pain management of short term residents may be that the reporting of pain may alter significantly with a change in their function and participation in activity. If a patient is admitted to the nursing home at a low level of functioning, yet through the short term stay they gradually increase their level of functioning at the same level of pain, this may not be a result of improper pain management.	CMS response: Your comment is noted concerning the inclusion of non-medication interventions for the management of pain. During the technical expert panel, it was decided to focus initially on medication management. This information is captured on the MDS 3.0 and will be analyzed using the MDS 3.0 data and considered for ongoing refinement of this quality measure. Your comment that pain for short term residents may be reported at the same level yet the resident may be increasing their level of functioning rather than a result of improper pain management is noted. RTI will examine the change, lack of change, and direction of change and patterns for both the frequency and intensity as part of the validation testing of the measures to examine whether this affects the face validity of the measure.	NH-009-10: % of short stay residents with effective pain management

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
395	M, Health Professional Council	Susan Sherman, American Geriatrics Society	We do not endorse this measure. The construction of the measure looking for pain reduction, irrespective of pain level seems to lack face value logic. We noted the negative comments in the NQF draft. We believe the two other pain measures (NH-010-10 and NH-011-10) address pain in a more effective manner and are sufficient at this time.	The Committee discussed this measure in detail, but ultimately decided the need for a measure that addresses pain management outweighed their concerns on the construction of the measure, which they recommended for time-limited endorsement. Dissenting Committee members strongly agreed with the commenter and were concerned with possible unintended adverse consequences. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls. This measure differs from the other two pain measures in that it specifically focuses on the effectiveness of a pain management regime, as opposed to measuring the percent of residents in pain.	NH-009-10: % of short stay residents with effective pain management
398	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	The American Nurses Association (ANA) wishes to offer specific comments on the following measure: •NH-009-10: Percent of residents with effective pain management (short stay) (CMS) ~ ANA is pleased to see that the Steering Committee recommended evaluating the patient's cognitive status when reporting on pain. However, ANA believes placing greater emphasis on documented observable signs of pain in cognitively impaired patients to be of value.	CMS response: Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered when we analyze the MDS 3.0 data analysis as well as for ongoing refinement of this measure.	NH-009-10: % of short stay residents with effective pain management
170	P	Darlene Thompson, Kindred Healthcare	This measure excludes any short stay resident who can not self-report pain so recommend title be edited to "Percent of Residents Who Self-Report Moderate to Severe Pain (short stay)".	CMS response: Your comment is noted and the quality measure title will be revised to "Percent of Residents Who Self-Report Moderate to Severe Pain (short stay)".	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
194	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 1 of 2 This measure is fundamental in the quality of life of nursing home residents. Unfortunately it carries a potential for quite varied practice. The area is such a complex one and the Steering Committee touched on some aspects. But standardization of practice, which includes many specific details, should be emphasized as an expected part of these measures. It would lessen any potential for more favorable management of reported outcomes. Pain scales that are used should be consistent across nursing homes. Non-verbal residents, among the most vulnerable, should all be assessed for pain both regularly and using only a tool which is validated for their clinical circumstances. This may be similar to standardization expected with use of the Patient Health Questionnaire-9 for depressive findings in the Minimum Data Set version 3.0. For example, using Pain Assessment in Advanced Dementia (PAINAD) as a tool for nonverbal residents with Dementia may help advance this challenging area. - continued in Part 2 -	CMS response: Regarding your comment about ensuring standard methods of assessment that are reproducible and valid, we refer you to the Scientific Reliability Section of this NQF submission (measure criterion 2b) as well as to the RAND report regarding the development of the MDS 3.0 for complete details regarding the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the cited report, a standard method of assessment "likely reflecting CMS national initiatives to increase pain assessment with standardized scales in NHs, most of the facilities in our sample reported that they routinely used pain severity scales to assess their residents. Eighty percent used the 0-10 scale and 25% reported using other pain scales." Dr. Debra Saliba, lead researcher for the development for the MDS 3.0, also tested inter-rater reliability as part of the nursing home validation study. This national test of the MDS 3.0 examined the agreement between assessors; both gold-standard (research nurses) to gold standard nurses as well as gold standard nurses to facility nurses. For the pain items, the average kappa for the gold-standard nurse to gold-standard nurse agreement was 0.961 and the average kappa for gold-standard nurse to facility nurse was 0.967. Patient self-report of the presence and severity of pain, which is incorporated in the MDs 3.0 items supporting this proposed measure, is considered the most reliable and accurate approach to pain assessment.	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
195	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 2 of 2 Times of pain assessment should be similarly standardized. Again this would prevent a potential for favorable management of the quality measures. In our experience the occasions of greatest pain intensity, which should be sought, are times of wound care, transferring or moving residents with activities of daily living and during rehabilitation therapy sessions. Where pre-medicated and post-medicated pain intensities are documented, selective reporting of favored data only may bias the value of the measure, as would a practice that notably fails to assess during those times of maximally expected pain. Tolerance of pain is another aspect that would enhance understanding of what could be interpreted too simplistically, if severity alone were used. Stoic residents with high intensity pain may endure or are possibly seen to make significant gains in their rehabilitation program. Conversely, individuals with moderate intensity pain and poor tolerance may have significant non-physical characteristics that are inadequately addressed. A comprehensive measure of pain, beyond an understanding of 'physical' severity, remains challenging and would be enhanced with tolerance incorporated in the characteristics of this measure, including psychological impact on those affected. Thank you for the opportunity to provide the above comments, among many complexities. Simon Kassabian, MD, Director of Palliative Care Liz Weingast,RN,MSN,NP Marie Rosenthal,RN,MSN	CMS response: A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your comment regarding the timing of the pain assessment and the importance of noting the resident's pain tolerance is noted and will be considered as part of the analysis of the MDS 3.0 data, as well as for further refinement of this measure. The underlying pain items for this measure are standardized in the sense that the residents are asked about their worst pain over the last five days. Therefore, residents are asked to think back to when their worse pain occurred (whether during wound care, physical therapy etc.).	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
219	P	Linda Spokane, NYAHSA	This measure does not indicate the quality of pain related care provided to residents who are not able to self-report their pain. This represents a potentially serious flaw b/c many residents who do not have the ability to self-report pain have cognitive impairment. Research has shown pain is underreported in residents with cognitive impairment. The new MDS 3.0 pain items capture non-verbal pain indicators and, thus, both a self-report and staff assessment measure for pain should be calculated. In addition, the time window states that the numerator data come from MDS 3.0 14–day PPS assessments conducted during the six months preceding each selected quarter (3-month period). What does "during the six months preceding each selected quarter (3-month period)" mean? Does it mean that the rate is computed over a 6-month period, or over a 9-month period? Is there any reason that this time window is different from the time window used for the similar measure for long-stay residents (NH-011-10)? Suggestion: In addition to a measure that calculates the percent of short-stay residents who have moderate to severe pain that can self-report pain, another measure should be added that calculates the same rate for residents who cannot self-report pain. Also, make the specs of this measure consistent with the similar measure for long-stay residents (NH-011-10) Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: We appreciate your comment regarding the limitation of this quality measure for residents with cognitive impairment. As stated in section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed measure based on MDS 3.0 data, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered as we conduct analyses using the MDS 3.0 data as well as for ongoing refinement of this measure. The rate is computed over a 6 month period, this measure focuses on one assessment, the 14-day PPS assessment, while the long-stay version of this measure uses an annual, quarterly, significant change or significant correction assessment.	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
238	P	Teresa Lewis, MN Dept of Human Services	The 'Pain' QMs (NH-010-10 and NH-011-10) only use information from the resident pain interview; they don't include a comparable calculation using the staff observation of pain within the measure or as a separate measure. While this would require some development, it is a concern that residents unable to communicate on this topic will not be accounted for.	CMS response: As stated in section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed measure, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....". A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered as we analyze the measure using the MDS 3.0 data as well as for ongoing refinement of this measure.	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
246	P	Barbara Yody, Genesis HealthCare	•Although the QM uses questions that are only answered when a resident can self report; the denominator includes all short stay residents who received a 14 day assessment – need to exclude from denominator residents who cannot self report (this qualifier is included in the same QM for long stay) •MDS 3.0 specifies that the assessment use only one way to describe the pain intensity; may be unreliable due to use of either a 1-10 scale or a verbal descriptor of 4.	CMS response: Your noted exclusion will be added to the specifications. Regarding your concern that the assessment uses only one way to describe the pain intensity and therefore may be unreliable due to the use of either a 1-10 scale or a verbal descriptor of pain, we refer you to the final report by RAND regarding the development of the MDS 3.0 for complete details regarding the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the final report (beginning on page 116) "Because there are compelling reasons to retain both pain intensity response formats in the MDS assessment, we conducted Item Response Theory (IRT) analyses to map the two response formats. Data for the analyses included N=815 respondents who used the verbal descriptor scale (VDS) only, N=813 who responded using the numeric only, and N=307 who responded with both scales. We used IRT to map the verbal descriptor of pain to the numeric descriptor scale by estimating item parameters". The RAND final report provides the crosswalk for the pain response items.	NH-010-10: % of short stay residents who have moderate to severe pain
305	M, Health Professional Council	Diane Carter, AANAC	Comment: Is 2 pain indicators for short stay residents necessary. This one should be a potential short lived until data is reviewed. It would be clinically significant if the numbers were elevated. If more concerning would be if the resident was on a pain management regime and still showing pain or an increase in the pain.	**NQF response:** NQF reviews all measures submitted to a project. This measure is only eligible for time-limited endorsement due to its untested status. **CMS response:** Your comment is noted; we will analyze the MDS 3.0 data for both short-stay pain measures and item responses in relation to each measure.	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
314	M, Health Professional Council	Jacqueline Vance, AMDA	AMDA members expressed the same concerns for many of the same reasons as indicated in the draft report raised by members of the review committee (e.g., potential for overuse of pain meds, lack of focus on non-pharmacologic management of pain, pressure to underreport pain). One main issue is that in the MDS 3.0, if in the time capture period, the patient experiences even one second of intense pain (e.g., they positioned themself badly), that is what must be recorded, even if the majority of the time thier pain is well controlled. The issue should be whether there is documentation that appropriate modalities were used for pain control and that was associated with decreased pain and increased quality of life. This should be modified or not endorsed	CMS response: Your comments are noted. This quality measure focuses on resident report of moderate to severe pain, not pain modalities. If a pain modality served to mitigate the resident's pain experience it will be noted as a decrease in the experience of pain.	NH-010-10: % of short stay residents who have moderate to severe pain
340	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-010-10 and NH-011-10: Similar to NH-009-10 and the same concerns apply.	CMS response: We note your comment regarding ensuring standard methods of assessment that are reproducible and valid, and refer to the Scientific Reliability Section of this NQF submission (measure criterion 2b) as well as the final report by RAND regarding the development of the MDS 3.0 for complete details regarding the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the final report, a standard method of assessment "likely reflecting CMS national initiatives to increase pain assessment with standardized scales in NHs, most of the facilities in our sample reported that they routinely used pain severity scales to assess their resident. Eighty percent used the 0-10 scale and 25% reported using other pain scales." Dr. Debra Saliba, lead researcher for the development for the MDS 3.0, also tested inter-rater reliability as part of the nursing home validation study. (response con't on next page)	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
340	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-010-10 and NH-011-10: Similar to NH-009-10 and the same concerns apply.	(cont'd) This national test of the MDS 3.0 examined the agreement between assessors; both gold-standard (research nurses) to gold standard nurses as well as gold standard nurses to facility nurses. For the pain items, the average kappa for the gold-standard nurse to gold-standard nurse agreement was 0.961 and the average kappa for gold-standard nurse to facility nurse was 0.967. We agree that including patient preference is very important, however, patient preference is not collected by the MDS 3.0 (the data source for this measure). CMS will explore how best to link resident preferences with concepts like pain management in future enhancements to quality measures collected and reported to CMS. We agree that cognitive status is important to measure, and it is evaluated as part of the MDS 3.0, however, it has not been included in the development of this pain measure..We will examine the association between cognitive status and reported pain when we further test the measure using MDS 3.0 data. Finally, your comment regarding the measure not including residents reporting that their pain has stayed the same is noted and will be considered as we analyze the measure using the MDS 3.0 data as well as during further refinement of this measure.	
360	M, Provider Council	Renee Demski, Johns Hopkins Medicine	Moderate to severe pain may occur given the illnesses of the nursing facility patients, but effective management of pain is a quality measure of care provided by the facility.	No response needed.	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
364	M, Provider Council	Sandra Fitzler, American Health Care Association	The presence of pain on the 14 day PPS may not be the same source of pain reported on the quarterly assessment. The measure does not account for this situation and will lead to misconceptions and erroneous report of patients having constant pain and inadequate pain management. This measure also excludes any short stay patients who cannot self report pain. AHCA recommends the title be changed to "Percent of Residents Who Self Report Moderate to Severe Pain During the 5-Day Assessment Periods (short stay)".	CMS response: This quality measure focuses on the 14-day PPS assessment only, not the quarterly. Your comment regarding the exclusion of residents who cannot self-report their pain is noted and will be considered as we analyze the measure using the MDS 3.0 data as well as for the ongoing refinement of this measure. Your comment is noted and the quality measure title will be revised to "Percent of Residents Who Self-Report Moderate to Severe Pain (short stay)".	NH-010-10: % of short stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
385	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	APTA agrees with the intent of this pain measure. Adequate and consistent assessment of pain signs / symptoms and the appropriate management of pain in this population are critical to the well-being of the resident as documented in the measure description. We would also comment that pain and pain management are complex issues and a variety of interventions are required to meet these complex needs. The management of pain should be a multifaceted and interprofessional process. Medications are often a first line intervention for pain management. In some instances, medications, especially multiple medications can results in various side-effects and raise a residents risk for other problems (i.e. falls). Some pain, especially pain of musculoskeletal origin can be treated effectively with various types of positioning, activity and at times modalities administered by a physical therapist. These interventions might include splinting, gentle stretching, myofascial release techniques, assisted or non assisted movement or electrical stimulation. While the need for proper and ongoing assessment and evidence-based management of pain is important for both populations: short stay and long stay residents, these often represent vary different patient populations. We commend the separation of residents into two different populations for this measure.	No response needed.	NH-010-10: % of short stay residents who have moderate to severe pain
171	P	Darlene Thompson, Kindred Healthcare	This measure excludes any long stay resident who can not self-report pain so recommend title be edited to "Percent of Residents Who Self-Report Moderate to Severe Pain (long stay)".	CMS response: Your comment is noted and the quality measure title will be revised to "Percent of Residents Who Self-Report Moderate to Severe Pain (long stay)".	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
196	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 1 of 2 This measure is fundamental in the quality of life of nursing home residents. Unfortunately it carries a potential for quite varied practice. The area is such a complex one and the Steering Committee touched on some aspects. But standardization of practice, which includes many specific details, should be emphasized as an expected part of these measures. It would lessen any potential for more favorable management of reported outcomes. Pain scales that are used should be consistent across nursing homes. Non-verbal residents, among the most vulnerable, should all be assessed for pain both regularly and using only a tool which is validated for their clinical circumstances. This may be similar to standardization expected with use of the Patient Health Questionnaire-9 for depressive findings in the Minimum Data Set version 3.0. For example, using Pain Assessment in Advanced Dementia (PAINAD) as a tool for nonverbal residents with Dementia may help advance this challenging area. - continued in Part 2 -	CMS response: Your comment regarding the use of consistent pain scales across nursing homes is noted. Please refer to the Scientific Reliability Section of this NQF submission (measure criterion 2b) as well as the final report by RAND regarding the development of the MDS 3.0 for complete details regarding the testing of the pain items (Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.) As stated in the final report, utilizing a standard method of assessment "likely reflecting CMS national initiatives to increase pain assessment with standardized scales in NHs, most of the facilities in our sample reported that they routinely used pain severity scales to assess their residents. Eighty percent used the 0-10 scale and 25% reported using other pain scales." Dr. Debra Saliba, lead researcher for the development for the MDS 3.0, also tested inter-rater reliability as part of the nursing home validation study. This national test of the MDS 3.0 examined the agreement between assessors; both gold-standard (research nurses) to gold standard nurses as well as gold standard nurses to facility nurses. (response con't on next page)	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
196	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 1 of 2 This measure is fundamental in the quality of life of nursing home residents. Unfortunately it carries a potential for quite varied practice. The area is such a complex one and the Steering Committee touched on some aspects. But standardization of practice, which includes many specific details, should be emphasized as an expected part of these measures. It would lessen any potential for more favorable management of reported outcomes. Pain scales that are used should be consistent across nursing homes. Non-verbal residents, among the most vulnerable, should all be assessed for pain both regularly and using only a tool which is validated for their clinical circumstances. This may be similar to standardization expected with use of the Patient Health Questionnaire-9 for depressive findings in the Minimum Data Set version 3.0. For example, using Pain Assessment in Advanced Dementia (PAINAD) as a tool for nonverbal residents with Dementia may help advance this challenging area. - continued in Part 2 -	(response cont'd)For the pain items, the average kappa for the gold-standard nurse to gold-standard nurse agreement was 0.961 and the average kappa for gold-standard nurse to facility nurse was 0.967. Patient self-report of the presence and severity of pain, which is incorporated in the MDS 3.0 items supporting this proposed measure, is considered the most reliable and accurate approach to pain assessment. A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to the cited section of the NQF submission for a complete discussion and references. Your comment regarding the assessment of non-verbal residents is noted; staff observation is utilized in the MDS 3.0 for those residents who cannot complete the pain interview. Finally, your concern regarding using only a validated tool for non-verbal residents is noted and will be considered as we analyze the MDS 3.0 data as well as for further refinement of this quality measure.	

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
197	P	Simon Kassabian, MD, Jewish Home Lifecare System	Part 2 of 2 Times of pain assessment should be similarly standardized. Again this would prevent a potential for favorable management of the quality measures. In our experience the occasions of greatest pain intensity, which should be sought, are times of wound care, transferring or moving residents with activities of daily living and during rehabilitation therapy sessions. Where pre-medicated and post-medicated pain intensities are documented, selective reporting of favored data only may bias the value of the measure, as would a practice that notably fails to assess during those times of maximally expected pain. Tolerance of pain is another aspect that would enhance understanding of what could be interpreted too simplistically, if severity alone were used. Stoic residents with high intensity pain may endure or are possibly seen to make significant gains in their rehabilitation program. Conversely, individuals with moderate intensity pain and poor tolerance may have significant non-physical characteristics that are inadequately addressed. A comprehensive measure of pain, beyond an understanding of 'physical' severity, remains challenging and would be enhanced with tolerance incorporated in the characteristics of this measure, including psychological impact on those affected. Thank you for the opportunity to provide the above comments, among many complexities. Simon Kassabian, MD, Director of Palliative Care Liz Weingast,RN,MSN,NP Marie Rosenthal,RN,MSN	CMS response: Your comment regarding standardizing the times of pain assessment and the limitations of this quality measure regarding resident's pain tolerance based on the current MDS 3.0 items is noted and will be considered as part of the analysis of the MDS 3.0 data as well as for further refinement of this measure. The underlying pain items for this measure are standardized in the sense that residents are asked about their worst pain over the last five days. Therefore, residents are asked to think back to when their worse pain occurred (whether during wound care, physical therapy etc.)	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
220	P	Linda Spokane, NYAHSA	This measure does not indicate the quality of pain related care provided to residents who are not able to self-report their pain. This represents a potentially serious flaw b/c many residents who do not have the ability to self-report pain have cognitive impairment. Research has shown pain is underreported in residents with cognitive impairment. The new MDS 3.0 pain items capture non-verbal pain indicators and, thus, both a self-report and staff assessment measure for pain should be calculated. In addition, the risk adjustment for this measure does not make sense. Since this measure excludes residents that can't self-report pain, Item C1000 will not be completed for most residents included in the measure and, thus, this item should not be used for resident-level limited covariate risk adjustment. Suggestion: In addition to a measure that calculates the percent of long-stay residents who have moderate to severe pain that can self-report pain, another measure should be added that calculates the same rate for residents who cannot self-report pain. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: As stated in section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed quality, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....". A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered as we analyze this measure using the MDS 3.0 data as well as for ongoing refinement of this measure. Item C1000 refers to residents who are rarely/never understood which is not necessarily residents who cannot complete the pain interview.	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
239	P	Teresa Lewis, MN Dept of Human Services	The 'Pain' QMs (NH-010-10 and NH-011-10) only use information from the resident pain interview; they don't include a comparable calculation using the staff observation of pain within the measure or as a separate measure. While this would require some development, it is a concern that residents unable to communicate on this topic will not be accounted for.	CMS response: As stated in section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed measure, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0.." Please refer to this section of the NQF submission for a complete discussion and references. Your recommendation to include the reporting of this measure when staff assessment of pain is used is noted and will be considered as we analyze the measure using the MDS 3.0 data as well as for ongoing refinement of this measure.	NH-011-10: % of long stay residents who have moderate to severe pain
247	P	Barbara Yody, Genesis HealthCare	•Uses the old risk adjustment from 2.0 – covariate (or predictive variable) of independent or modified independent in daily decision making on prior MDS; however this has not been mathematically tested on a new pain interview – recommend not using	This measure is currently still in testing and therefore has been recommended for time-limited endorsement. It will be tested before receiving full endorsement.	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
269	M, Purchaser Council	Gaye Fortner, HC21	I support the concept of pain assessment for long-stay residents, but would like to suggest that the measure be specified to capture the extent to which nursing home staff are trained and able to assess pain for dementia patients who cannot verbally express their pain. There is ample opportunity for training staff and nursing home aids who spend significant time with dementia residents on how to understand pain based on observing the resident's behavior, and this is an important element to consider in this measure as it relates to long-stay patients, who may predominantly be diagnosed with dementia.	CMS response: Currently the MDS 3.0 does not capture information regarding nursing home staff who are specifically trained and able to assess pain for dementia patients who cannot verbally express their pain. Your comment is noted and will be considered as we further refine both the MDS 3.0 and this quality measure.	NH-011-10: % of long stay residents who have moderate to severe pain
306	M, Health Professional Council	Diane Carter, AANAC	Comment: This measure is set to show negative results in that it will not show that the nursing home has decreased pain in the facility. This does not show the public that staff are attempting to improve care. Comment: Although these are very important measures the subjectivity of the residents ability to describe pain could produce erroneous information on the MDS. This would in-turn provide incorrect information for the QI/QMs. I would recommend that this measure include other items in determining if there is a problem with pain management such as hospice disease process, cognitive abilities, etc. Comment: CMS has submitted several measures that are calculated based on a non-admission assessment (annual, quarterly, significant change, significant correction) being submitted within the quarter. These measures should document how computations will be handled in instances where multiple targeted record types (e.g. quarterly & significant change, annual and significant correction) are submitted in the same quarter. Are both records counted? Only the most recent? Etc.	CMS response: Your concern regarding the ability of this measure to capture decreased pain in the facility is noted and will be considered as we analyze the measure using MDS 3.0 data and for further refinement of the quality measure. Regarding the subjectivity of the resident's ability to describe pain, please refer to section 4.d.1 Susceptibility to Inaccuracies, Errors or Unintended Consequences- "The proposed measure, which relies on resident self-report, is based on MDS 3.0 items, which may under-report for 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 this proposed measure, is considered the most reliable and accurate approach to pain assessment....A national test of the MDS 3.0 items supporting the proposed measure found that 87% of a validation sample of residents were able to successfully complete the pain interview portion of the MDS 3.0." We refer you to this section of the NQF submission for a complete discussion and references. In the case of multiple target record types, the most recent assessment is used.	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
327	M, Consumer Council	Debra Ness, National Partnership for Women & Families	We support the concept of pain assessment for long-stay residents, but would like to suggest that the measure be specified to capture the extent to which nursing home staff are trained and able to assess pain for dementia patients who cannot verbally express their pain. There is ample opportunity for training staff and nursing home aids who spend significant time with dementia residents on how to understand pain based on observing the resident's behavior, and this is an important element to consider in this measure as it relates to long-stay patients, who may predominantly be diagnosed with dementia.	CMS response: Currently the MDS 3.0 does not capture information regarding nursing home staff who are specifically trained and able to assess pain for dementia patients who cannot verbally express their pain. Your comment is noted and will be considered as we further refine both the MDS 3.0 and this quality measure.	NH-011-10: % of long stay residents who have moderate to severe pain
361	M, Provider Council	Renee Demski, Johns Hopkins Medicine	Moderate to severe pain may occur given the illnesses of the nursing facility patients, but effective management of pain is a quality measure of care provided by the facility.	No response needed.	NH-011-10: % of long stay residents who have moderate to severe pain
365	M, Provider Council	Sandra Fitzler, American Health Care Association	Measure excludes any long stay resident who can not self report pain. AHCA recommends the title be changed to "Percent of Residents Who Self Report Moderate to Severe Pain During the 5-Day Assessment Period (long stay)."	CMS response: Your comment is noted and the quality measure title will be revised to "Percent of Residents Who Self-Report Moderate to Severe Pain (long stay)".	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
386	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	APTA agrees with the intent of this pain measure. Adequate and consistent assessment of pain signs / symptoms and the appropriate management of pain in this population are critical to the well-being of the resident as documented in the measure description. We would also comment that pain and pain management are complex issues and a variety of interventions are required to meet these complex needs. The management of pain should be a multifaceted and interprofessional process. Medications are often a first line intervention for pain management. In some instances, medications, especially multiple medications can results in various side-effects and raise a residents risk for other problems (i.e. falls). Some pain, especially pain of musculoskeletal origin can be treated effectively with various types of positioning, activity and at times modalities administered by a physical therapist. These interventions might include splinting, gentle stretching, myofascial release techniques, assisted or non assisted movement or electrical stimulation.	CMS response: Your comment is noted. This quality measure focuses on residents who self-report moderate to severe pain not the pain interventions.	NH-011-10: % of long stay residents who have moderate to severe pain

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
153	P	Loren Haynes Haynes, Harber Laman LLC	In lines 714-715, you recommend exclusion of residents admitted with stage 4 pressure ulcers from the quality measure evaluating long-term high-risk residents with pressure ulcers, because they may not heal within 100 days. Would this very same resident, admitted under Part A (and thereby included in short stay measures), count against the facility if, for instance, the resident is discharged home, showing improvement in all other areas except for the ulcers? For the short-stay, residents with ulcers are included when a new ulcer develops, or does not improve, between the 5 day and discharge assessment. The only "improvement" that can be coded, per coding instructions, would be complete healing of an ulcer as reverse staging is no longer allowed. Therefore, a facility can only avoid being penalized in the short stay quality measure if a Stage II, III, or IV pressure ulcer is totally closed upon discharge form skilled services, no matter the length of time between the 5-day and discharge assessment. Further, how does a resident admitted with SDTI/unstageable ulcers affect the QM if the ulcer is surgically debrided, cover dressing removed, or "opens up", and must then be coded at the proper stage? Does the facility now "own" this wound?	CMS response: Your concern regarding a pressure ulcer not showing improvement due to MDS 3.0 instructions not to reverse stage is noted. This quality measure reflects item M0800 indicating the pressure ulcer was either not present or at a lesser stage. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)". Regarding your comment about SDTI/unstageable pressure ulcers and debridement, please refer to the RAI Manual, Chapter 3, Section M, Coding Tips for M0800. "If a pressure ulcer is acquired during a hospital admission, it is coded as "present on admission" and not included in a count of worsening pressure ulcers." "If an ulcer was unstageable on admission, do not consider it to be worse on the first assessment. However, if it worsens after that assessment, it should be included." Also, please refer to the section "Coding Instructions" for M0300 for further instructions regarding the coding of unstageable pressure ulcers and "Coding Tips" "Once the pressure ulcer is debrided of slough and/or eschar such that the tissues involved can be determined, then code the ulcer for the reclassified stage."	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
172	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. We thank CMS for the MDS 3.0 coding instructions change for the blood filled blister from a Stage 2 to Unstageable in order to maintain the consistency of clinical practice.	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 items (M0800A, B and C) composing the quality measure are completed with a dash or left blank (if A0310E=0). The MDS 3.0 items (M0800A, B and C) composing the quality measure are skipped automatically when A310E=1, and are not considered missing data. We will evaluate any skip patterns as part of our analysis plan for the MDS 3.0 data.	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
208	P	Melody Malone, Independent Consultant	In this measure, the developers have confused two issues. 1.The pressure ulcers are new, and 2.Or fail to improve. I agree that component number 1: "The pressure ulcers are new" is a great indicator of bad nursing home care and should be a measure of quality of care. However, component number 2: (the pressure ulcers) "fail to improve prior to the discharge assessment" may not be an indicator of the quality of care delivered at the nursing home at all. This is especially true if the discharge occurs prior to a reasonable amount of time passing to allow for the healing of the pressure ulcer. Healing time for pressure ulcers vary greatly and I request that the steering committee review the literature and apply the appropriate exclusions if the discharge occurs prior to the average healing time for the pressure ulcer. For example, Bersgtrom noted for Stage 2 pressure ulcers a median time to heal was 46 days. If a resident was discharged in less than 46 days, their pressure ulcer may not have healed, but yet may have made progress. However, if this indicator stands as is, the facility will be viewed as delivering poor care, in this example. I strongly urge NQF to reconsider the parameters of this measure. Citation: Bergstrom N, Smout R, Horn S, Spector W, Hartz A, Limcangco MR. Stage 2 pressure ulcer healing in nursing homes. J Am Geriatr Soc. 2008 Jul;56(7):1252-8. Epub 2008 May 14.□	CMS response: We note the issue raised by the commenter, however, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
221	P	Linda Spokane, NYAHSA	The numerator states that this measure compares stage 2-4 pressure ulcers on discharge assessment (A0310F=10, 11) to the prior OBRA admission (A0310A=01) or the 5-day PPS assessment (A0310B=1). One of the conditions for a resident to be included in the numerator is if items M0800A>0 or M0800B>0 or M0800C>0 on discharge assessment. These items indicate the number of pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA, PPS, or Discharge). In this case, prior assessment to the discharge assessment (included in this measure) is not necessarily an admission assessment or a 5-day PPS assessment, which is inconsistent with the first statement above. Also, on the risk adjustment, it states that covariates for the risk adjustment are based on the 5-day PPS assessment. Why does this not also include the OBRA admission assessment? This is inconsistent with the denominator definition, which includes the OBRA admission assessment as a baseline. Is this a typo? Suggestion: Be consistent with the measure definitions. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: Your comment is noted, the specification should be compared to the latest assessment, not only an admission OBRA or 5-day PPS assessment. Also, on the risk-adjustment covariate, it was an omission not to include the OBRA admission assessment.	NH-012-10: % of short stay residents with new or not improved pressure ulcers
229	P	Tammy Barker, HCR ManorCare	3.NH-012-10 relating to short stay pressure ulcers is in conflict with the coding of the MDS 3.0. If the MDS 3.0 is coded correctly then a wound would have to completely heal in order to show any improvement as the MDS 3.0 does not allow for reverse staging and the measure will trigger if the value remains constant or worsens. Therefore if a patient improved from a Stage III to a Stage II the MDS 3.0 will not allow this to be coded and no improvement noted as it would have been in MDS 2.0.	CMS response: We note the issue raised by the commenter, however, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
248	P	Barbara Yody, Genesis HealthCare	•QM only includes short stay population with a discharge (assume Discharge Return Unanticipated? Need clarification) •BIG Problem – MDS 3.0 does NOT back stage so no way to measure "have not improved" QM uses 2 areas of MDS to measure: M0800 indicates a worsening by stage and M0300 counts # wounds by stage (B1,C1,D1). If count of wounds or equal or greater indicates a worsening – recommendation to use language "new or worsened" rather than failed to improve •If admission and discharge ARDs are only days apart, can a stage 2 ulcer be removed from the MDS? – perhaps recommend that QM target only new wounds, seems more reasonable •Uses unproven risk adjustment : covariates of residents who have healed ulcers & BMI which were not included before. Not verified with new MDS	CMS response: The measure includes both discharge assessments, return not anticipated and return anticipated. We note the issue raised by the commenter, however, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)". The covariates of residents who have healed ulcers and BMI were included for the current quality measure based on MDS 2.0 data. We will analyze the impact of the covariates on the performance of this quality measure using the MDS 3.0 data.	NH-012-10: % of short stay residents with new or not improved pressure ulcers
256	P	Jeanine Maguire, Genesis	the amount of days between assessments is unreasonable to measure 'improvement'. It would be more reasonable to measure new pressure ulcers; or worsening pressure ulcers. Additionally, if 'improvement' is measured by lenght, width, and tissue type of the 'worse' wound- each assessment could use a different pressure ulcer depending on rate of healing. Given that, it would not be reasonable to assume that those measures would reflect improvement or decline.	CMS response: Your comment concerning lack of ability to measure improvement is noted. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
307	M, Health Professional Council	Diane Carter, AANAC	1 of 2 Comment: Using the 14-day PPS assessment (or discharge assessment if discharged prior to the completion of the 14-day MDS) and comparing it to the answers on the 5-day PPS assessment for improvement of pressure ulcers does not seem realistic. I agree that new pressure ulcers identified on the 14-day assessment is a good measure. However, residents admitted with a stage 2, 3 or 4 pressure ulcer will not likely have the ulcer completely heal prior to the lookback window for the 14-day MDS. The ARD for the 14-day PPS assessment is usually set on day 11, so the lookback window includes days 5-11. Pressure ulcers would not likely heal within that short of a time. Any ulcer present anytime during the lookback window would be included on the MDS. Although the measure discusses short stay as less than 100 days, the measure is said to use the 14 day PPS assessment or the discharge assessment –whichever comes first. It is unrealistic to expect that pressure ulcers would heal in that short of a time. Since there is no back staging of Pressure ulcers on MDS 3.0, it will not be possible for the QMs to note if the ulcers are actually improving or not.	CMS response: We note the issue raised by the commenter, however, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers
308	M, Health Professional Council	Diane Carter, AANAC	2 of 2 Comment: The time frames for showing change are not consistent with other comparable time frames (i.e. pain). That being said comparing a 5 day assessment with the discharge assessment could be 2 days to never. The comparison needs to be set between points in time such as the 5 day and the 30 day etc. The wording of this measure also will include pressure ulcers that were admitted with vs. acquired, which will give a false impression of the care provided by staff in the building.	CMS response: We note the issue raised by the commenter, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
315	M, Health Professional Council	Jacqueline Vance, AMDA	AMDA would like some clarification. Does this measure only occur if the resident was present for an entire quarter? If not, a pressure ulcer may not likely heal (dependant on its stage) in a short time frame). AMDA members also expressed the same concerns for many of the same reasons as indicated in the draft report raised by members of the review committee.	CMS response: The measure includes residents with a discharge assessment and prior OBRA or PPS admission assessment. We note the issue raised by the commenter, however, the items used for the quality measure (M0800A, B, or C) specifically focus on new or worsening pressure ulcers. We will revise the title to make this clarification, "Percent of Residents with Pressure Ulcers that are New or Worsened (Short-stay)".	NH-012-10: % of short stay residents with new or not improved pressure ulcers
341	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-012-10: LOS assessments need to be consistent across measures. As a short stay measure, this should apply to patients in facilities <100 days. Need to have reproducible and valid assessment tools for the pressure ulcers. Those should be specified and included in the measure. Easily extractable information for an automated report from the EHR.	CMS response: Short Stay residents are defined as those whose length of stay in a facility is less than or equal to 100 days. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-012-10: % of short stay residents with new or not improved pressure ulcers
366	M, Provider Council	Sandra Fitzler, American Health Care Association	"Missing data" for each of the data items (a dash, blank or code 9) needs to be defined. Blanks and dashes do not always mean the information is "missing." For example, I12300 is left blank if no UTI present or a dash can mean "not assessed". Skip patterns need to be evaluated to make sure they don't remove the ability to answer a MDS question that triggers a QM data element. AHCA appreciates the MDS 3.0 coding instructions change for the blood-filled blister from a Stage 2 to Unstageable.	CMS response: For this quality measure, missing data is noted when the items (M0800A, B and C) composing the quality measure are completed with a dash or left blank when A0310E=0. We will evaluate missing data and associated skip patterns as part of our analysis plan for the MDS 3.0 data.	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
387	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	Physical therapy is extremely important for short stay residents with pressure ulcers that are new or have not improved. Interventions involve the application of therapeutic procedures and modalities that are intended to enhance wound perfusion, manage scar, promote an optimal wound environment, remove excess exudate from a wound complex, and eliminate nonviable tissue from a wound bed. Procedures and modalities may include debridement; dressings; orthotic, prosthetic, and supportive devices; physical agents and mechanical and electrotherapeutic modalities; and topical agents. Additionally, interventions to protect the skin and vulnerable areas for pressure ulcer development include positioning, and protective devices such as pressure relief cushions, and seating systems. Physical therapists also utilize a variety of treatment options to assist in wound closure.	CMS response: We appreciate the comment and acknowledge the importance of physical therapy as a critical component of the interdisciplinary care for residents in a nursing facility setting.	NH-012-10: % of short stay residents with new or not improved pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
173	P	Darlene Thompson, Kindred Healthcare	In the coding for high risk, the measure no longer recognizes other ICD diagnoses for malnutrition that may be coded in Section I8000. Although the MDS 3.0 has a specific item I5600 for malnutrition, it should be considered to also accept an ICD code under I8000. We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. We thank CMS for the MDS 3.0 coding instructions change for the blood filled blister from a Stage 2 to Unstageable in order to maintain the consistency of clinical practice.	CMS response: The comment regarding the inclusion of an ICD-9-CM code for malnutrition under I8000 is noted. This ICD-9-CM code, as well as any skip patterns will be examined during the analysis of the MDS 3.0 data. For this quality measure, data is considered missing when M0300B C, D, G0110A, B, or B0100 are missing or completed by a dash.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
178	P	Jane Pederson, Stratis Health	The changes in MDS 3.0 should improve the accuracy with which pressure ulcer status is reflected in the data for each resident and nursing home. The proposed measure will look at any stage 2-4 pressure ulcers (without back-staging) present at the time of the assessment. It appears that this measure represents ulcers that may have been present upon resident admission to the facility as well as ulcers that developed or worsened during the stay. From a quality improvement standpoint it would be most helpful to be able to determine ulcers that are developing during the stay as opposed to those that were present upon admission. It is the facilities ability to prevent new ulcers and heal or improve already developed ulcers that is a better measure of quality of care. May be suggestions for future consideration since it does appear this type of analysis could be possible given the changes in MDS 3.0.	CMS response: We appreciate your comments and will consider your recommendations as we continue to refine the quality measure.	NH-013-10: % of high-risk long stay residents with pressure ulcers
182	P	Elaine Brewer, BLTC	I would like to know if low risk pressure ulcers are being eliminated from the measures or are they be rolled up into 1 measure? As a clinican I needed to know 2 things: Were the residents with pressure ulcers healing and why, if any resident, developed a pressure ulcer who was not defined by the high risk criteria. To me both measured quality care. It is just as important to know which processes required intervention.	CMS response: The public reporting of the percentage of the low-risk population with pressure ulcers was eliminated due to very low prevalence as well as poor performance of the quality measure according to the NQF criteria for scientific acceptability. Although the percentage of low risk residents with Stage 2-4 pressure ulcers may no longer be reported, as stated in the RAI Manual, Chapter 3, Section M, "It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program."	NH-013-10: % of high-risk long stay residents with pressure ulcers
202	P	Erica Koser, PANPHA	A PANPHA member commented that, "We are requesting exclusion criteria of hospice residents, deep tissue injuries, and unstageable wounds (which most likely will not heal within 100 days)."	CMS response: Your comment regarding the exclusion of residents receiving hospice care is noted. This topic was discussed in detail during a technical expert panel and the decision was made continue to include residents on hospice. However, your comment in noted and will be considered as we analyze the MDS 3.0 data. Deep tissue injuries and unstageable wounds are not included in this quality measure.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
209	P	Melody Malone, Independent Consultant	I recommend the steering committee reconsider the issue of "High Risk" pressure ulcers and begin to measure "Facility Acquired" pressure ulcers. While the NPUAP recently published their version of an unavoidable pressure ulcer and the federal tag, F 314 has it as well; the Facility Acquired pressure ulcer is what the facility has some control over and therefore is a better measure of quality care in the nursing home. For many nursing homes, this measure will be, and has been, a measure of the development of pressure ulcers in their community that are the admitted to the nursing home. Therefore it is not measuring the quality of nursing care in the nursing home. However, to measure Facility Acquired pressure ulcers comes much closer to measuring the quality of nursing care. This measure can be easily calculated by comparing each stage's number of total pressure ulcers in section M, item 1, to the number of those pressure ulcers present on admission, item 2. For example, in a stage 2, it would be item M0300.B1 minus item M0300.B2. That would give the number of pressure ulcers that are facility acquired. I strongly urge NQF to reconsider the parameters of this measure since it is measuring the quality of care not only in the nursing home but what is on in the community.	NH care includes interventions to prevent and treat pressure ulcers. It also may be difficult to delineate when a pressure ulcer began. NQF did not receive any measures related to facility-acquired pressure ulcers, so the Committee was unable to recommend any measures in this area.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
222	P	Linda Spokane, NYAHSA	This measure includes only high-risk residents in the calculation; there is no measure for low-risk residents. Based on NY State 2009 MDS 2.0 data, the correlation coefficient between PU rate in high-risk residents and PU rate in low-risk residents is low (about 0.25) implying that it is not uncommon for a facility to have a very low rate of pressure ulcers among high-risk residents but to have a high rate of PU among low-risk residents. In this case, to measure how well a facility is providing PU-related care, one needs to review the rate in high-risk residents together with the rate in low-risk residents. In addition, we feel better risk-adjustment is necessary for this measure to include other key risk factors that significantly increase the likelihood of developing a pressure ulcer (i.e. history of pressure ulcers, diabetes, PVD, CVA, hip fracture, bowel incontinence). Suggestion: Calculate the rate of pressure ulcers among low-risk residents in addition to the rate among high risk-residents. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: The public reporting of the percentage of the low-risk population with pressure ulcers was eliminated due to very low prevalence as well as poor performance of the quality measure according to the criteria for scientific acceptability. Although the percentage of low risk residents with Stage 2-4 pressure ulcers may no longer be reported, as stated in the RAI Manual, Chapter 3, Section M, "It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program." We will take your comment regarding risk adjustment, as well as low-risk population, under consideration as we analyze this measure using the MDS 3.0 data.	NH-013-10: % of high-risk long stay residents with pressure ulcers
232	P	Tammy Barker, HCR ManorCare	6.There is agreement with the committee's recommendation for NH-013-10 related to long stay pressure ulcers. Patients who are admitted with Stage IV pressure ulcers should be excluded as many of these patients are in centers that specialize in complex wound care and the measure shouldn't be triggered for review due to a specialty area.	CMS response: Your comment concerning the exclusion of residents with Stage 4 ulcers is noted and will be considered as we analyze the MDS 3.0 data.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
249	P	Heidi Turpin, TMF Health Quality Institute	For some time, nursing homes, Quality Improvement Organizations, and the public in general have been looking forward to being able to evaluate nursing homes utilizing a stratified approach by separating facility and community-acquired pressure ulcers. While there is some attempt to separate this information in the measure for short stay residents, long stay resident data is not reflecting this stratification. Research reflects an average healing time of 46 days for a Stage II pressure ulcer. Healing times for Stage III and Stage IV can be much longer than that. Facilities who accept patients with more complex wounds will face the same problem that they faced with MDS 2.0. When looking at the data for nursing homes, we still will not be able to tell how many of the pressure ulcers in the rates are facility-acquired vs. community-acquired. It is unfortunate that nursing homes will be providing a great deal of specific data in the 3.0 which would afford adequate stratification, yet the measures still do not reflect this level of detail.	CMS response: Your comment concerning the stratification of facility and community acquired pressure ulcers is noted; we will consider stratification as we analyze the MDS 3.0 data as well as for the ongoing refinement of the quality measure.	NH-013-10: % of high-risk long stay residents with pressure ulcers
250	P	Barbara Yody, Genesis HealthCare	•High risk is defined same as MDS 2.0 •Possible that long-stay resident with a 90 assessment will not be included as they have not been in the center for 100 days •Does exclude stage 1 ulcers which is good and will reduce numerator, however excluding residents in the center <100 days may also decrease denominator; not comparable to current QM	CMS response: Your comment concerning the definition of high-risk population and the possibility of the inclusion of a long-stay resident with a 90-day assessment but may not have been in the facility for 100 days is noted and will be considered as we analyze the MDS 3.0 data as well as for the ongoing refinement of the quality measure.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
309	M, Health Professional Council	Diane Carter, AANAC	1 of 2 Comment: I am concerned that this measure would count against a facility who has a strong wound care program and admits residents specifically for wound care. The measure shows that it counts against the facility if any pressure ulcers are present at stage 2-4 on the MDS. Since there is no longer backstaging of pressure ulcers with MDS 3.0, it is not possible to determine if ulcers are actually improving from the MDS coding. Once a stage 3 always a stage 3 until completely healed. I believe it would be a much better criteria to include only ulcers that were NOT present on admission. This way, ulcers that deteriorated during a hospitalization would not count against a good performing facility. And, likewise, pressure ulcers that were present on admission and being correctly treated would not count against a facility. If using the "present on admission " criteria, ulcers that develop in the facility would count against the facility. Comment: This measure as it is currently, is going to show the care of both admitted vs. acquired. It will give a false negative impression for those facilities that admit a large number of residents with wounds as part of the resident baseline with wounds. Those residents admitted with ulcers needs to be subtracted from the numerator.	CMS response: Your comment concerning including only pressure ulcers not present on admission is noted and will be considered as we analyze the MDS 3.0 data as well as for the ongoing refinement of the quality measure. This quality measure excludes OBRA or 5 day PPS assessment. The focus of this long-stay measure is on residents who are in a facility greater than 100 days.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
310	M, Health Professional Council	Diane Carter, AANAC	2 of 2 Comment: Residents come from home with Stage IVs and there is no way to heal these wounds prior to the first quarter. The case for new or have not improved might not provide enough information on the ability of the residents metabolism/body to heal or the treatments and interventions completed in the facility. Not improving does not necessarily mean the resident does not have the ability to heal or that the nurses are not providing adequate treatments to help with the healing process. Perhaps the wound is stagnant due to the severity of the wound and will not improve for long periods of time. Comment: 1. The "Time Window" under the Numerator for this measure states: Time Window: The data are collected quarterly. The term "annual" in this sentence refers to one of the various MDS 3.0 assessments utilized to calculate the measure (which may be an admission, annual, quarterly, significant change or correction assessment). "Admission" seems to be an inappropriate assessment type to be included in this statement. While this may be a reference to the exclusion of admission or Medicare 5-day assessments, the statement could benefit from clarification.	CMS response: this comment refers to NH-012-10: % of short stay residents with new or not improved pressure ulcers? This quality measure refers to the prevalence of Stage 2-4 pressure ulcers. In the NQF submission, 2a.2, numerator time window, stated "each quarter CMS selects the MDS 3.0 annual, quarterly, significant change or significant correction assessment for each nursing facility." An admission assessment is not included in this statement.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
316	M, Health Professional Council	Jacqueline Vance, AMDA	Just to note, pressure ulcers are not always related to unrelieved pressure and do not necessarily reflect poor care. There are other non-modifiable intrinsic risk factors that contribute significantly to risks for PU that despite the best of care, may still have the resident "break down". We can understand the wisdom of a measure reflecting a % of low risk residents with PU but question high risk. This should not be endorsed.	In their discussion, the Committee recognized the issue of other factors aside from poor care contributing to the development of pressure ulcers, and questioned the developer on why the measure was limited to high-risk patients. The developer explained that they had tried to develop a measure for low-risk patients, but found that the measure was not usable. The Committee also discussed the need for further research into how to define high-risk in the nursing home population. As the measure is untested, the developer agreed to consider these issues during testing. The Committee felt that there is a great deal of opportunity for improvement in this area and that the measure met the NQF criteria for endorsement.	NH-013-10: % of high-risk long stay residents with pressure ulcers
342	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-013-10: Same comments and concerns as for NH-012-10.	Please see response to comment 341.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
367	M, Provider Council	Sandra Fitzler, American Health Care Association	In the coding for high risk, the measure no longer recognizes other ICD diagnoses for malnutrition that may be coded in Section I8000. Although the MDS 3.0 has a specific item I5600 for malnutrition, it should be considered to also accept an ICD code under I8000. "Missing data" for each of the data items (a dash, blank or code 9) needs to be defined. Blanks and dashes do not always mean the information is "missing." For example, I12300 is left blank if no UTI present or a dash can mean "not assessed". Skip patterns need to be evaluated to make sure they don't remove the ability to answer a MDS question that triggers a QM data element. AHCA appreciates the MDS 3.0 coding instructions change for the blood-filled blister from a Stage 2 to Unstageable.	CMS response: The comment regarding the inclusion of an ICD-9-CM code for malnutrition under I8000 is noted. This ICD-9-CM code, as well as any skip patterns will be examined during analysis of the MDS 3.0 data. For this quality measure, missing data determination is made when items M0300B C, D, G0110A, B, or B0100 are missing or completed by a dash.	NH-013-10: % of high-risk long stay residents with pressure ulcers
388	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	APTA applauds this measure as it addresses a significant quality issue for nursing home residents. Residents with limited mobility are at high risk for the development of pressure ulcers, particularly those individuals with additional co-morbidities such as spinal cord injury or other mobility limiting diagnoses, and/or advanced dementia. Pressure ulcers can cause residents to have pain, limited functional recovery, and are prone to infections. Physical therapist's scope of practice includes interventions that help to prevent pressure ulcers as well as provide interventions that assist in wound healing, pressure relief, and protection of vulnerable sites for pressure ulcer development.	No response needed.	NH-013-10: % of high-risk long stay residents with pressure ulcers

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
394	M, Health Professional Council	Susan Sherman, American Geriatrics Society	We do not endorse this measure. We would endorse a measure regarding acquired stage 2-4 pressure ulcers. We believe there needs to be better evidence supporting the healing of pressure ulcers as a quality measure, especially with respect to treating stages 2-4 as being sufficiently related to be pooled.	In a long-term care situation the healing for stages 2-4 will equalize over time. However, the Committee recommends that the developer should further examine this during implementation.	NH-013-10: % of high-risk long stay residents with pressure ulcers
157	P	Darlene Thompson, Kindred Healthcare	We appreciate recognition in the measure for those residents who refused the vaccination or have medical contradictions. Adding these residents to the numerator and denominator will basically equate to the same percentage as the current QM which excludes the resident from the measure. The MDS answer O250B=6 (inability to receive vaccine due to a declared shortage) should be considered to be included in the numerator in the event that there is a national shortage that extends over time in order to more accurately reflect the vaccine percentages. Title suggests the posted percentage is of resident who were given the vaccine. Since the percentage also includes those who do not receive it for specific reasons, should title be changed in order to be clearer to the consumer?	**NQF response:** Although the developer agreed to examine this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; should a shortage occur, it affects all providers and the measure should not be reported or the shortage noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages due to lack of vaccine programs, inadequate planning, or inadequate ordering of vaccine, which are quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed. **CMS response:** Your comment concerning including O250B=6 (inability to receive vaccine due to a declared shortage) in the numerator in the event that there is a national shortage is noted and will be considered when we analyze the MDS 3.0 data and for the ongoing refinement of the quality measure. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents" which does not exclude the response "inability to obtain the vaccine". Your comment is noted regarding the accuracy of the measure title and will be revised to 'Percent of Short Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine'	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
188	P	Simon Kassabian, MD, Jewish Home Lifecare System	This appropriately omits location where vaccine administration was provided, particularly for short stay residents who may have received it elsewhere. In addition the measure supports relevant details, for example a numerator which includes those with contraindications and those who were offered and declined vaccination. - Thank you for a thorough, detailed support of an essential standard of care. Liz Weingast, RN, MSN, GNP, Corp Director of Clinical Excellence Simon Kassabian, MD, FACP Marie Rosenthal, RN, MSN	No response needed.	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...
198	P	Erica Koser, PANPHA	A PANPHA member commented that, "We are recommending using the same criteria as the pneumococcal vaccine (i.e. page 15 offered/declined, vaccine status, ect.)"	CMS response: Your comment is noted. While the current seasonal flu vaccine measure does include residents who were offered and declined the vaccine (item O0250C=3) and residents who are ineligible due to contraindications (item O0250C=4) it differs from the pneumococcal vaccine measure in the additional categories "Did the resident receive the influenza vaccine in this facility" (item O0250A=1), whether the resident was not in the facility during this year's flu season (item O250C=1), and whether the resident received the influenza vaccine outside the facility (O0250C=2). Given that the influenza season is a specific time frame during the year while the pneumococcal vaccine measures focuses on the vaccine status, without a fixed time frame each year, the two measures could not have a same criteria.	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...
242	P	Barbara Yody, Genesis HealthCare	This is an important measure but the definition indicates an admission assessment can be used however unclear how when the sample requires a LOS of 100 days or less. You would have an additional assessment post admission. Main issue is metric does not exclude the answer “inability to obtain vaccine” which woudl reduce the vaccination rate due to something beyond the centers control.	CMS response: Your comment concerning including an admission assessment when the sample requires a LOS of 100 days or less and the exclusion of the category "inability to obtain vaccine" is noted and will be considered when we analyze the MDS 3.0 data. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents" which does not exclude the response "inability to obtain the vaccine".	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
257	M, Health Professional Council	Shannon Oriola, APIC	It would be helpful if the measure included direction for the MDS coordinator regarding action to be taken when the immunization status of the resident is unknown. If the influenza vaccine status is unknown the resident should receive the influenza vaccine.	CMS response: Please refer to the RAI Manual for the MDS 3.0, Chapter 3, Section O, "Steps for Assessment" for details regarding facility guidance for vaccines.	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...
290	M, Health Professional Council	Diane Carter, AANAC	Comment: Percentage of short-stay nursing home/skilled nursing facility residents who are given the seasonal influenza vaccination during the influenza season. The dates for this measure, since it is a short stay measure, should only be addressed from this date to another date (flu season). Comment: The flu season is now dependent on varying months based on how early the flu season may start as well as how soon the vaccine is available. The flu season needs to be defined as August thru July or something fixed to incorporate variation but be explicit enough to insure that the measure is consistent from year to year.	CMS response: Your comment regarding the need for the flu season to be defined as August thru July or another fixed timeframe is noted and will be considered when we analyze the MDS 3.0 data and ongoing refinement of the measure. The proposed quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents".	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...
329	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-014-10 and NH-015-10: Both of these should be easily extractable from the EHR, for both LOS and immunization, as a report to be submitted for compliance.	No response needed.	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
368	M, Provider Council	Sandra Fitzler, American Health Care Association	The MDS answer O250B=6 (inability to receive vaccine due to a declared shortage) should be considered to be included in the numerator in the event that there is a national shortage that extends over time. The measure title suggests the posted percentage pertains to patients who were given the vaccine. Since the percentage also includes those who are offered but do not receive the vaccine for specific reasons, the title needs be changed in order to be clearer to the consumer. AHCA recommends changing the title to "Percent of residents who were assessed and offered the seasonal influenza vaccine during the flu season (short stay)."	**NQF response:** Although the developer agreed to examine this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; should a shortage occur, it affects all providers and the measure should not be reported or the shortage noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages due to lack of vaccine programs, inadequate planning, or inadequate ordering of vaccine, which are quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed. **CMS response:** Your comment concerning the exclusion of the category "inability to obtain vaccine" is noted and will be considered when we analyze the MDS 3.0 data. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents" which does not exclude the response "inability to obtain the vaccine". Your comment is noted regarding the accuracy of the measure title and will be revised to 'Percent of Short Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine'	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...
399	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	The American Nurses Association (ANA) wishes to offer specific comments on the following measure: •NH-014-10: Percent of nursing home residents who were assessed and given the seasonal influenza vaccine (short stay) (CMS) and NH-015-10: Percent of long-stay nursing home residents who were assessed and given the seasonal influenza vaccine (CMS) ~ ANA has concerns regarding the potential unintended consequences of a facility's desire to achieve a high rate of vaccination which may raise ethical questions around consent.	All interventions require patient consent including administering medications, therapy, etc. all of which are the focus of measurement. The measure allows for tracking patients who were offered but refused the vaccine.	NH-014-10: % of short stay residents assessed & given seasonal flu vaccine...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
158	P	Darlene Thompson, Kindred Healthcare	We appreciate recognition in the measure for those residents who refused the vaccination or have medical contradictions. Adding these residents to the numerator and denominator will basically equate to the same percentage as the current QM which excludes the resident from the measure. The MDS answer O250B=6 (inability to receive vaccine due to a declared shortage) should be considered to be included in the numerator in the event that there is a national shortage that extends over time in order to more accurately reflect the vaccine percentages. Title suggests the posted percentage is of resident who were given the vaccine. Since the percentage also includes those who do not receive it for specific reasons, should title be changed in order to be clearer to the consumer?	**NQF response:** Although the developer agreed to examine this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; should a shortage occur, it affects all providers and the measure should not be reported or the shortage noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages due to lack of vaccine programs, inadequate planning, or inadequate ordering of vaccine, which are quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed. **CMS response:** Your comment concerning including O250B=6 (inability to receive vaccine due to a declared shortage) in the numerator in the event that there is a national shortage is noted and will be considered when we analyze the MDS 3.0 data and for the ongoing refinement of the quality measure. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents". Your comment is regarding the accuracy of the title noted and the title will be revised to: 'Percent of Long Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine'	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine
189	P	Simon Kassabian, MD, Jewish Home Lifecare System	This appropriately omits location where vaccine administration was provided, particularly for residents who may have received it elsewhere. In addition the measure supports relevant details, for example a numerator which includes those with contraindications and those who were offered and declined vaccination. - Thank you for a thorough, detailed support of an essential standard of care. Liz Weingast, RN, MSN, GNP, Corp Director of Clinical Excellence Simon Kassabian, MD, FACP Marie Rosenthal, RN, MSN	No response needed.	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
243	P	Barbara Yody, Genesis HealthCare	Main issue is metric does not exclude the answer "inability to obtain vaccine" which woudl reduce the vaccination rate due to something beyond the centers control.	**NQF response:** Although the developer agreed to examine this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; should a shortage occur, it affects all providers and the measure should not be reported or the shortage noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages due to lack of vaccine programs, inadequate planning, or inadequate ordering of vaccine, which are quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed. **CMS response:** Your comment concerning the exclusion of the category "inability to obtain vaccine" is noted and will be considered when we analyze the MDS 3.0 data. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents" which does not exclude the response "inability to obtain the vaccine".	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine
291	M, Health Professional Council	Diane Carter, AANAC	1 of 3 Comment: The flu season is now dependent on varying months based on how early the flu season may start as well as how soon the vaccine is available. The flu season needs to be defined as August thru July or something fixed to incorporate variation but be explicit enough to insure that the measure is consistent from year to year.	CMS response: Your comment regarding the need for the flu season to be defined as August thru July or something fixed is noted and will be considered when we analyze the MDS 3.0 data and ongoing refinement of the measure. The proposed quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents".	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
292	M, Health Professional Council	Diane Carter, AANAC	2 of 3 Comment: 1. The "Description" states in line #2:"The measure reports on the percentage of residents who were assessed and received the seasonal influenza vaccine (MDS items O0250A and O250C) on the target MDS assessment (which may be an annual, quarterly or significant change or correction assessment)." This statement is inconsistent with the descriptions of the numerator and denominator as "admission" assessments are included in both calculations. Recommend revising the statement to include admission assessments. 2.The "Denominator Details" start off by stating that this measure is for long-stay residents (i.e. those with stays greater than 100 days), however some of the following sample criteria seems contradictory to the stated intent: "The long-stay influenza vaccination sample includes residents meeting any of the following three conditions during the influenza season: (1) the resident has an MDS 3.0 OBRA assessment (A0310.A=01,02,03,04,05,06) with assessment reference date (item A2300) during the influenza season; or (2) the resident has a discharge assessment (A0310.F=10,11) with discharge date (item A2000) during the influenza season.	CMS response: 1. Your comment regarding the omission of the OBRA admission in the general description is noted and will be added. 2. Your comment regarding criteria 2 and 3 being included in the short stay versus long stay sample is noted and will be analyzed with the MDS 3.0 data.	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
293	M, Health Professional Council	Diane Carter, AANAC	3 of 3 The preceding MDS assessment is a OBRA assessment (A0310.A= 01,02,03,04,05,06) with assessment reference date (item A2300) before October 1 and the discharge date (item A2000) minus the assessment reference date (item A2300) is 100 days or less; or (3) the resident has a discharge assessment "prior to completing the initial assessment" (item A0310.A=99). The start of this stay is the later of the admission date (item A1600) from the discharge tracking form or the 13th day prior to the discharge date (item A2000 date minus 13 days). Either the start date or the discharge date (item A2300) is within the influenza season. It seems that criteria #2 and #3 will pick up short-stay residents in the denominator. •With criteria #2 it appears that a resident with an October 15 Discharge date and an Admission Assessment ARD of 9/15 would meet the stated criteria. •With criteria #3, a resident who has an assessment type "discharged prior to completing initial assessment" is clearly NOT a long-stay resident.	CMS response: Please refer to response listed in the cell above (comment 292).	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
369	M, Provider Council	Sandra Fitzler, American Health Care Association	The MDS answer O250B=6 (inability to receive vaccine due to a declared shortage) should be considered to be included in the numerator in the event that there is a national shortage that extends over time. The measure title suggests the posted percentage pertains to patients who were given the vaccine. Since the percentage also includes those who are offered but do not receive the vaccine for specific reasons, the title needs be changed in order to be clearer to the consumer. AHCA recommends changing the title to "Percent of residents who were assessed and offered the seasonal influenza vaccine during the flu season (long stay)."	**NQF response:** Although the developer agreed to examine this issue as they review MDS 3.0 data for future refinement of these measures, the standard specifications endorsed in the prior immunization project do not have an exclusion for a vaccine shortage. A shortage is not a patient-level exclusion; should a shortage occur, it affects all providers and the measure should not be reported or the shortage noted in conjunction with any reporting. Otherwise, it is difficult to distinguish facility shortages due to lack of vaccine programs, inadequate planning, or inadequate ordering of vaccine, which are quality problems. This issue can be addressed in the upcoming prevention topic area in which immunization measures will be reviewed.**CMS response:** Your comment concerning the exclusion of the category "inability to obtain vaccine" is noted and will be considered when we analyze the MDS 3.0 data. This quality measure is harmonized with the current NQF quality measure 0432 "Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents" which does not exclude the response "inability to obtain the vaccine". Your comment is noted regarding the accuracy of the measure title and the title will be revised to: 'Percent of Long Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine'	NH-015-10: % of long stay residents assessed & given seasonal influenza vaccine
159	P	Darlene Thompson, Kindred Healthcare	We appreciate the measure being harmonized with NQF-endorsed measure and presented as separate components based upon the MDS answer. Title suggests the posted percentage is residents who were given the vaccine. Since the percentages will be posted for ineligible and declined, should title be changed in order to be clearer to the consumer?	CMS response: Your comment is noted regarding the accuracy of the measure title and will be revised to: 'Percent of Short Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine'	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
190	P	Simon Kassabian, MD, Jewish Home Lifecare System	This appropriately omits location where vaccine administration was provided, particularly for short stay residents who may have received it elsewhere. In addition the measure supports relevant details, for example numerator computation which includes those with contraindications and those who were offered and declined vaccination, with separate reporting. - Thank you for a thorough, detailed support of an essential standard of care. Liz Weingast, RN, MSN, GNP, Corp Director of Clinical Excellence Simon Kassabian, MD, FACP Marie Rosenthal, RN, MSN	No response needed.	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine
258	M, Health Professional Council	Shannon Oriola, APIC	It would be helpful if the measure included direction for the MDS coordinator regarding action to be taken when the immunization status of the resident is unknown. If the influenza vaccine status is unknown the resident should receive the influenza vaccine.	CMS response: Please refer to the RAI Manual for the MDS 3.0, Chapter 3, Section O, "Steps for Assessment" for details regarding facility guidance for vaccines.	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine
273	M, Provider Council	Sandra Fitzler, AHCA	The title suggests the posted percentage is patients who were given the vaccine. Since the percentages will be posted for ineligible and declined, the title needs to be changed to be clearer to the consumer. AHCA recommends the title be changed to "Percent of residents who were assessed and offered the pneumococcal vaccine (short stay)."	CMS response: Your comment is noted regarding the accuracy of the measure title and will be revised to 'Percent of Short Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine'	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine
294	M, Health Professional Council	Diane Carter, AANAC	Comment: Percentage of short-stay nursing home/skilled nursing facility residents whose PPV status is up to date during the 12-month reporting period. Comment: "PPV status up to date" is open to variation. Similar to comments on the flu season, the definition of "up to date" should be refined to give a specific range of dates so that the measure is consistently interpreted.	CMS response: Your comment is noted and will be considered when we analyze the MDS 3.0 data and for the ongoing refinement of the quality measure.	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
330	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-016-10 and NH-017-10: Same comments as for influenza....easily extractable from the EHR as an automated report for submission to reporting agency.	CMS response: We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-016-10: % of short stay residents assessed & given the pneumococcal vaccine
160	P	Darlene Thompson, Kindred Healthcare	We appreciate the measure being harmonized with NQF-endorsed measure and presented as separate components based upon the MDS answer. Title suggests the posted percentage is residents who were given the vaccine. Since the percentages will be posted for ineligible and declined, should title be changed in order to be clearer to the consumer?	CMS response: Your comment is noted regarding the accuracy of the measure title and the title will be revised to 'Percent of Long Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine'	NH-017-10: % of long stay residents assessed & given the pneumococcal vaccine
191	P	Simon Kassabian, MD, Jewish Home Lifecare System	This appropriately omits location where vaccine administration was provided, particularly for residents who may have received it elsewhere. In addition the measure supports relevant details, for example numerator computation which includes those with contraindications and those who were offered and declined vaccination, with separate reporting. - Thank you for a thorough, detailed support of an essential standard of care. Liz Weingast, RN, MSN, GNP, Corp Director of Clinical Excellence Simon Kassabian, MD, FACP Marie Rosenthal, RN, MSN	No response needed.	NH-017-10: % of long stay residents assessed & given the pneumococcal vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
274	M, Provider Council	Sandra Fitzler, AHCA	A short stay patient can be offered and received the vaccine. This same patient can become a long stay patient within the 12-month reporting period. Given this, is this patient counted again in the long stay measure? The title suggests the posted percentage is patients who were given the vaccine. Since the percentages will be posted for ineligible and declined, the title needs to be changed in order to be clearer to the consumer. AHCA recommends the title be changed to "percent of residents who were assessed and offered the pneumococcal vaccine (long stay)."	CMS response: A short stay patient who becomes a long-stay resident would be counted again in the long stay measure. Your comment is noted regarding the accuracy of the measure title and will be revised to 'Percent of Long Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine'	NH-017-10: % of long stay residents assessed & given the pneumococcal vaccine
295	M, Health Professional Council	Diane Carter, AANAC	Comment: Percentage of long-stay residents whose PPV status is up to date during the 12-month reporting period.	Not enough information to respond	NH-017-10: % of long stay residents assessed & given the pneumococcal vaccine

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
161	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as exclusion in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. The MDS 3.0 manual change for the coding of the UTI from November 2009 posted definition (DX of UTI – OR - signs & symptoms AND Significant lab findings OR Treatment) and May 2010 posted definition clarifies that the UTI must now meet all of the conditions listed (DX of UTI, signs & symptoms, Significant lab findings and Treatment) should help in maintaining the consistency and accuracy of this measure.	CMS response: The MDS 3.0 item I2300 which composes the quality measure is completed with a check in the item box if applicable. Therefore, there is no listing of missing data in the specifications and there is no skip pattern.	NH-018-10: % of long stay residents with a urinary tract infection
199	P	Erica Koser, PANPHA	A PANPHA member commented that, "The CDC definition is for acute care not Long Term Care. We recommend adopting the McGeer definition which is specific for Long Term Care and also used by PA-PSRS."	CMS response: Your comment is noted, we will consider your recommendation during the ongoing refinement of the quality measure. In the RAI Manual, Section I, Coding Tips the reference to the CDC is as follows: "In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information" The criteria utilized in the RAI manual refers to current clinical practice in nursing facilities and not specifically the CDC definition for UTI.	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
223	P	Linda Spokane, NYAHSA	On page 63 of the Draft Technical Report, it states there are 2 exclusions for this measure but only 1 is noted. Is this a typo? Also, seasonal variation can not be eliminated by computing the rate over 2 quarters. For example, the rate for October-March is affected by winter season and the rate for April-September is affected by summer season. Suggestion: To adjust for seasonal variation, it is better to compute the rate over 4 quarters rather than only over 2 quarters OR the rate is calculated only for 1 quarter and then adjusted with state/national seasonal factor calculated based on MDS data from previous year. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: Thank you for your comment, that is a typo, there is one exclusion for this quality measure. Your comment regarding seasonal variation is noted will be considered as we analyze the MDS 3.0 data.	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
259	M, Health Professional Council	Shannon Oriola, APIC	The measure submitted uses the Minimum Data Set (MDS) definition/reporting. This measure does not accurately reflect the incidence of urinary tract infections in long-stay residents because "UTI" may be entered into the system when a prescription for antibiotics is written rather that when the clinical MDS definition is applied. Calculating a rate per 1000 resident days using a more robust definition (e.g., the McGeer longterm care definition) would be a more meaningful way to assess the incidence of UTIs, although it is recognized that it might not be possible for all facilities to track this information.	CMS response: Although a UTI may be listed in the medical record by a practitioner when a prescription is written, in order to code a UTI on the MDS 3.0, all four criteria listed in the RAI Manual, Chapter 3, Section I, Coding Tips must be met. They are as follows: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days, 2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria), 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 4. Current medication or treatment for a UTI in the last 30 days. You comment regarding using the McGeer definition and calculating a rate per 1,000 resident days is noted and will be considered as we analyze the MDS 3.0 data and for ongoing refinement of the quality measure.	NH-018-10: % of long stay residents with a urinary tract infection
260	M, Health Professional Council	Shannon Oriola, APIC	The measure submitted uses the Minimum Data Set (MDS) definition/reporting. This measure does not accurately reflect the incidence of urinary tract infections in long-stay residents because "UTI" may be entered into the system when a prescription for antibiotics is written rather that when the clinical MDS definition is applied. Calculating a rate per 1000 resident days using a more robust definition (e.g., the McGeer longterm care definition) would be a more meaningful way to assess the incidence of UTIs, although it is recognized that it might not be possible for all facilities to track this information.	CMS response: Duplicate comment - see above response (comment 259).	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
275	M, Provider Council	Sandra Fitzler, AHCA	The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. The proposed measure is to be computed over two quarters to reduce the effect of seasonal variation. Since utilizing MDS data to report QMs, CMS has reported the QM on a quarterly basis. The quarterly QMs have a very prominent seasonal component with clear patterns from year to year. AHCA along with other organizations have made this an issue of concern to CMS and since January 2010, CMS has begun to calculate the QM average score using the most recent three quarters of QM data available. While this does begin to smooth out the seasonal (quarterly) variability in data, it does not fully remove the seasonality issue. AHCA recommends that CMS move toward a 4-quarter average.	CMS response: The MDS 3.0 item I2300 composing the quality measure is completed with a check in the box if applicable. Therefore, there is no listing of missing data in the specifications and there are no skip patterns. Your comment regarding seasonal variation will be considered as we analyze the MDS 3.0 data and for ongoing refinement of the quality measure. We will specifically examine the impact of a 2 quarter versus 4 quarter facility average on the quality measure outcome.	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
296	M, Health Professional Council	Diane Carter, AANAC	Comment: In the discussion of exclusions it refers to admission assessment as an exclusion since the UTI could have originated in the hospital. The resident who went to the hospital and returned and had a significant change could also have a UTI that originated in the hospital and will falsely show up on the QI. Exclusion needs to be put in place for a reentry/significant change UTI. Comment: This measure should address acute versus chronic. Many residents have a long-standing history of and continue to have a UTI (if not using the Beers criteria for infections). If one is using the Beers criteria for infections then long-stay residents with UTI can be quantified. **The criteria for determining a UTI must be the same in the RAI manual and standards of care which are the Beers criteria for infections**	CMS response: Your example regarding the resident returning from the hospital with a UTI and their reentry requires completion of a significant change assessment is noted and will be considered as we analyze the MDS 3.0 data and for the ongoing refinement of the quality measure.	NH-018-10: % of long stay residents with a urinary tract infection
317	M, Health Professional Council	Jacqueline Vance, AMDA	Percent of patients with UTIs-the most common infection in the nursing home is a UTI. Why should a facility be penalized for patients developing UTIs when it is secondary to altered immune defenses with aging (reflex past the sphincter, for example)? There may also be other pathological reasons-Neurogenic bladder with incomplete emptying (DM, Nephropathy, B12 for instance), strictures, BPH, etc. Ref: Clinical Practice Guideline for UI by AMDA. In addition, many residents return from an acute care stay after bring catheterized at the acute care setting and don't manifest the UTI till after their readmission at the NH. It is not a reflection of care. This should not be endorsed.	The Committee discussed this issue in depth and decided that excluding patients from this measure will mean that it will miss capturing patients who should have been captured. This measure has been paired with measure NH-020-10, percent of long-stay residents who have/had a catheter inserted and left in their bladder, in order to address the catheterization issue.	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
331	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-018-10: This appears to use a different definition of "long stay" than the immunization parameters. Should be consistent. Both LOS and UTI diagnosis can be easily extracted from the EHR via automated reports (for UTI, want both C&S and ICD for validity) for submission to reporting agency.	CMS response: Long Stay residents are defined as those whose length of stay in a facility is greater than 100 days. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-018-10: % of long stay residents with a urinary tract infection
390	M, Health Professional Council	Susan Sherman, American Geriatrics Society	AGS does not endorse this measure. The goal to reduce the spurious labeling of bacteriuria as an infection is laudable. However, the public would be unlikely to understand the measure as such. While good nursing care and perineal hygiene are important, the link to UTI prevention is not established. The primary intervention to reduce UTI is addressed in the measure for indwelling catheter use.	Preventing UTIs is difficult, and the Committee agrees with the issues raised, but voted to recommend the measure despite these concerns. The purpose of the measure is to measure how many there are. The measure is currently in use using the MDS 2.0 data. Dissenting Committee members strongly agreed with the commenter and were concerned with possible unintended adverse consequences. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls.	NH-018-10: % of long stay residents with a urinary tract infection

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
162	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. One of the denominator exclusion criteria [page 7] for severe cognitive impairment is C0500 = greater than or equal to 5. This is the BIMS score. The MDS 3.0 manual posting of May 2010 lists severe impairment as 0-7, moderately impaired as 8-12 and cognitively intact as 13-15. If the denominator exclusion as listed is retained, the measure will be excluding all moderate and intact residents verses excluding severely impaired. This criteria element needs to be changed to 0-7 to match the BIMs scoring. The developer also needs to know what to do with a score of 99 (unable to complete the interview).	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 items composing the quality measure (H0300 and H0400) are completed with a dash or left blank or the items regarding exclusions and based on the following skip patterns (C1000 or C0700 if C0600=1 and B0100 =0), (C0500 if C0100=1 and B0100 =0), (G0110A.1, B.1, E.1, B0100) are completed by a dash or left blank. Your comment is noted regarding the coding of severe cognitive impairment and the specifications will be revised to reflect a BIMS score of less than or equal to 7.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
224	P	Linda Spokane, NYAHSA	What is the definition of "severe cognitive impairment" as indicated in the exclusions? Also, the MDS 2.0 similar quality measure excluded residents with ostomy. What is the rationale for not excluding them in this measure? In addition, including both bladder and bowel incontinence in one measure can mask potential quality problems. If a resident is incontinent of both bowel and bladder, and one is found to be remediable and is treated successfully, the resident is still defined as incontinent by the current measure definition. Suggestion: To evaluate bowel and bladder incontinence separately. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: Residents with an ostomy are excluded (see 2a.10 Denominator exclusion details). Your comment regarding having bladder and bowel incontinence as separate measures is noted and will be considered when we analyze the MDS 3.0 data for this quality measure as well as for ongoing refinement of this measure.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder
254	P	Barbara Yody, Genesis HealthCare	2.0 version of the QM excluded resident of ostomies, would keep that exclusion.	CMS response: Residents with an ostomy are excluded (see 2a.10 Denominator exclusion details).	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
276	M, Provider Council	Sandra Fitzler, AHCA	The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. One of the denominator exclusion criteria [page 7] for severe cognitive impairment C0500 = greater than or equal to 5. This is the BIMS score. The MDS 3.0 manual posting of May 2010 lists severe impairment as 0-7, moderately impaired as 8-12 and cognitively intact as 13-15. If the denominator exclusion as listed is retained, the measure will be excluding all moderate and intact patients' verses excluding those who are severely impaired. This criteria element needs to be changed to 0-7 to match the BIMs scoring. The developer also needs to know what to do with a score of 99 (unable to complete the interview). In addition, if the measure focuses on low risk patients, then the measure exclusion should include I1399 Colitis and Inflammatory Bowel Disease.	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 items composing the quality measure (H0300 and H0400) are completed with a dash or left blank or the items regarding exclusions and based on the following skip patterns (C1000 or C0700 if C0600=1 and B0100 =0), (C0500 if C0100=1 and B0100 =0), (G0110A.1, B.1, E.1, B0100) are completed by a dash or left blank. Your comment is noted regarding the coding of severe cognitive impairment and the specifications will be revised to reflect a BIMS score of less than or equal to 7.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder
297	M, Health Professional Council	Diane Carter, AANAC	Comment: Due to the definition of incontinence the information is not an appropriate reflection of the care given by the nursing home. Residents with stress incontinence for which it may not be possible to control controlled will be included in this QI and this is not a reflection of the care.	Patients at low risk of incontinence often experience events due to care practices from availability of staff to assist, interventions to maintain mobility, to proper diet and fluid intake.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
332	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-019-10 and NH-020-10: Again, LOS definitions need to be consistent across measures or confusion and possible data quality issues can arise. Again, all of these measures should be extractable from the EHR using ICD or CPT codes or orders via automated reports and submitted to the reporting agency.	CMS response: Long Stay residents are defined as those whose length of stay in a facility is greater than 100 days. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder
382	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	This measure seems to only address functional incontinence and ignores the numerous other risk factors for developing incontinence. Further, we contend that there is research which suggests a difference in incontinence rates with regards to race and this should be noted. However, accounting for differences in incontinence rates with regards to race would not require major modifications to this measure. We would like to note that physical therapists can provide both assessment and interventions for individuals with incontinence. Physical therapist can provide behavioral education and training, bladder retraining exercises and other therapeutic exercises. There is growing evidence to support this non-pharmacological intervention.	CMS response: In the RAI Manual, Chapter 3, Section H, Intent states "The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." We note your comment regarding racial disparities and would appreciate the citation. We will examine the use of catheters by race when analyzing the MDS 3.0 data.	NH-019-10: % of low-risk long stay residents who lose control of bowels or bladder

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
154	P	Loren Haynes Haynes, Harber Laman LLC	In relation NH-020-10 (catheters), changing the look-back period from 14 days to 5 days is a great improvement, however it still poses a problem for facilities when an OBRA assessment happens to fall in the same time frame as a 5-day PPS assessment. Situations occur when long-term residents return from the hospital with catheters in place, for whatever reason, and even if the facility immediately removes the catheter it is captured on the MDS, and consequently captured on the quality measure when the OBRA and PPS fall in the same time frame. This situation does not happen frequently, and a facility might not have to combine the two assessments and could hold off on the OBRA until the 5-day look-back has passed, but it does happen more times than one might expect when the two have to be combined due to time constraints.	CMS response: The look back period for this item (H0100A) is 7 days and the assessments used for the calculation of this measure include an annual, quarterly, significant change or significant correction assessment, not an admission assessment.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...
163	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure as well as the additional exclusions for neurogenic bladder and obstructive uropathy. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 item H0100A, composing the quality measure, is completed with a dash or left blank. There is no skip pattern for this quality measure.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
204	P	Erica Koser, PANPHA	A PANPHA member commented that, "It would be best if when looking at a catheter, that we consider the details of an appropriate diagnosis and review of follow up for history of why a catheter is needed."	CMS response: The comment is noted by the developers. The RAI Manual, Chapter 3, Section H, Health Related Quality of Life states: "It is important to know what appliances are in use and the history and rationale for such use. Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter."	NH-020-10: % of long stay residents who have/had a catheter inserted and left...
277	M, Provider Council	Sandra Fitzler, AHCA	AHCA appreciate the measure exclusions for neurogenic bladder and obstructive uropathy. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.	CMS response: For this quality measure, a determination of missing data occurs when the MDS 3.0 item H0100A, composing the quality measure, is completed with a dash or left blank. There is no skip pattern for this quality measure.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
298	M, Health Professional Council	Diane Carter, AANAC	Comment: The target population as described for the numerator will include those long term residents that have had a significant change upon return to the hospital. How will that be addressed? Will the system look to see if there was a "reentry" completed prior to the significant change? Without this being addressed catheters used in the hospital could be captured on the significant change MDS upon return. Comment: Percentage of long-stay residents who have had an indwelling catheter in the last five days noted on an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (three-month period). This should read since readmission due to many significant changes being done because of a hospitalization/readmissions and the resident having a catheter prior to coming back to the facility. ***Also although the measure has been adopted the measure needs further information such as if a medical condition has caused the resident to have a long-term catheter placement, the resident has a surgically implanted tube, etc these should be excluded from the measure***	CMS response: When a resident returns from a hospital stay, it is possible that an assessment will be performed within a few days of the entry date. Often, this assessment will be a significant change assessment, but depending upon the resident's OBRA or PPS schedule, it could be an assessment of another type as well (for example, a quarterly could be due within a few days of return from the hospital). Regardless of the type of assessment, we will compare the ARD of the assessment against the entry date (A1600) that is reported on that assessment. If the ARD is before Day 7 of the stay, then it is possible that reported catheter use could have occurred outside of the nursing facility (i.e., in the hospital). Therefore we can exclude assessment where the ARD minus the entry date is less than or equal to 5 days (i.e., the ARD is on or before Day 6). If the difference between these dates is 6 or greater (i.e., if the ARD is on or after Day 7), then the 7-day look back period for catheter use will include only days in the facility and the assessment can be used for the measure. Also, the comment "the measure needs further information such as if a medical condition has caused the resident to have a long-term catheter placement, the resident has a surgically implanted tube, etc these should be excluded from the measure" will be explored as we further refine the quality measure.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...
311	M, Health Professional Council	Diane Carter, AANAC	Comment: The measure discusses how many residents have had catheters inserted in the last 5 days. The look back window for MDS 3.0 is 7 days. I believe the measure is reporting how the item performed on the MDS 3.0 validation testing tool which only had a 5-day assessment window. Language should be updated to show the correct (7-day) MDS look-back window.	CMS response: Your comment is noted and the language will be updated to reflect a 7 day look-back period.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
318	M, Health Professional Council	Jacqueline Vance, AMDA	There may just be a situation that is unavoidable after attempts to remove the catheter with recurrent elevated bladder residuals that may increase the risk of UTIs since the bladder is not emptying (eg: Diabetic Uropathy, B12, Multiple Sclerosis, BPH with obstruction where the patient is inoperable, stricture that is recurrent and so on). Please add language that there is documentation that removal has been attempted but is unsuccessful due to the following conditions.	CMS response: The comment is noted. We will analyze the MDS 3.0 data for this quality measure and examine catheter use in relation to diabetic uropathy (item I2900), and BPH (item I1400), multiple sclerosis (I5200) and B12 (when listed in item I8000). We appreciate your comment regarding adding language that there is documentation that removal has been attempted but is unsuccessful due to the conditions noted and will consider it further when refining this quality measure.	NH-020-10: % of long stay residents who have/had a catheter inserted and left...
164	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.□ We do not understand the exclusion in the numerator of residents who have the MDS coding answer for P0100H (Other) = 2, since this is a valid data item on the MDS.□	CMS response: For this quality measure, a missing data designation is made when the MDS 3.0 items (PO100b,c, e, f, or g) composing the quality measure are completed with a dash or left blank. A skip pattern is not applicable to this quality measure. Adding the 'other' response to the measure numerator would have introduced an undefined element with an unknown impact. The Technical Expert Panel convened to review the quality measures discussed this point and concern was raised regarding the interpretation of this category; their recommendation was to exclude the 'other' category until further analysis using the MDS 3.0 data.	NH-021-10: % of long stay residents who were physically restrained

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
177	P	Jane Pederson, Stratis Health	This does not represent a marked change from the current QM. MDS 3.0 does indicate where the restraint is used (bed or chair) but this change should not impact this measures usefulness in quality improvement. Restraint use is an important clinical issue and the lack of restraints has been shown to be increase safety and promote better resident outcomes. Thus, this measure does appear useful as a way to assess quality of care over time. It will be important to consider how this measure may relate to the proposed QM's addressing falls. While it is not currently part of the restraint QM, the inclusion of chemical and psychological restraints would be a worthwhile consideration for future measure development. It would be helpful to understand whether in an attempt to decrease falls and fall risk there was a increase in the use of interventions such as bed alarms and other non-mechanical restraints.	The Steering Committee recommended future development of measures regarding non-mechanical restraints. The relationship of falls to specific types of interventions would need to be the subject of research and/or QI studies.	NH-021-10: % of long stay residents who were physically restrained
225	P	Linda Spokane, NYAHSA	We agree with the committee recommendation to consider chemical restraints in future measure development. The rates of off-label use of antipsychotic medications to address behavior issues in residents with dementia have not decreased significantly in spite of the increasing evidence of the harmful adverse side effects and increased risk of death, as well as the impact on quality of life. The existence of a public quality measure reporting on physical restraint use may make the use of chemical restraints as an alternative treatment approach more prevalent. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN Christie Teigland, PhD	No response needed.	NH-021-10: % of long stay residents who were physically restrained

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
261	M, Provider Council	Nansi Greger-Holt, Duke Geriatric Psychiatry	I am writing a comment due to my concern with limitations in SNF and AL to use certain equipment, as they are limited by avoidance of a restraint. Recently I have recommended the use of the merrywalker for some patients, but have been told this is a restraint and therefore the facility will not allow it. Often people with advanced dementia are fall risks, impulsive, have gait instability and do not remember they need to use their walker, or only walk when they have assistance. People with advanced dementia often cannot learn new things. When a person with advanced dementia has a fractured hip and their strength, gait and balance change and are limited, often they cannot remember this, so they try to walk unaided. They often are restless and 'need' to walk and move about. Occasionally these patients are assigned a CNA to supervise them one on one, whose job is to keep the patient safe, by reminding them to sit down, or to assist them if they stand up and try to walk. This is an enormous expense for the facility or for their family, if this cost is passed on to them. An alternative would be to use a Merry Walker, which helps provide safety, but also allows freedom of movement. However, some believe the Merry walker is a restraint because the patient might not be able to unbuckle or unlatch. Actually the use of the merry walker is less restricting to personal freedom,as it allows the patient to walk freely Please revisit this policy	CMS response: Enclosed-frame wheeled walkers, with or without a posterior seat, and other similar devices should not automatically be classified as a restraint. As stated in the RAI manual, Chapter 3, Section P, these types of walkers are only classified as a restraint if the resident cannot exit the gate. Please refer to the RAI manual Chapter 3, Section P, "Steps for Assessment" in order to make a determination regarding what is considered a physical restraint.	NH-021-10: % of long stay residents who were physically restrained

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
278	M, Provider Council	Sandra Fitzler, AHCA	The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. We do not understand the exclusion in the numerator of residents who have the MDS coding answer for P0100H (Other) = 2, since this is a valid data item on the MDS.	CMS response: For this quality measure, a missing data designation is made when the MDS 3.0 items (PO100b,c, e, f, or g) composing the quality measure are completed with a dash or left blank. A skip pattern is not applicable to this quality measure. Adding the 'other' response to the measure numerator would have introduced an undefined element with an unknown impact. The Technical Expert Panel convened to review the quality measures discussed this point and concern was raised regarding the interpretation of this category; their recommendation was to exclude the 'other' category until further analysis using the MDS 3.0 data.	NH-021-10: % of long stay residents who were physically restrained
333	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-021-10: LOS definitions need to be consistent across measures. Unclear what is being used here. Easily extracted from the EHR using orders, ICD or CPT codes for automated reporting.	CMS response: Long Stay residents are defined as those whose length of stay in a facility is greater than 100 days. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development. At this time, the quality measure utilizes data from the MDS 3.0.	NH-021-10: % of long stay residents who were physically restrained
391	M, Health Professional Council	Susan Sherman, American Geriatrics Society	AGS supports endorsement. However, this is an example of the importance of MDS instructions and survey guidance to reduce the incorrect exclusion or inclusion of devices (e.g. enabling devices) as restraints.	CMS response: Your concern regarding the importance of the MDS instructions and survey guidance is noted. In the RAI manual Chapter 3, Section P, "Steps for Assessment" provides instruction to determine what is considered a physical restraint. Additionally, further details in are provided in "Clarifications", "Coding Tips and Special Populations", and "Additional Information" within this section.	NH-021-10: % of long stay residents who were physically restrained

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
151	P	Loren Haynes Haynes, Harber Laman LLC	I believe the intent behind the development of this measure is well and good. Facilities have a responsibility to help their residents maintain the highest practicable level of physical functioning. However, it concerns me that the committee feels that the large list of concerns with this measure are "trumped" by the need to have the measure. First, there is no available research-based target percentage for facilities to use as a goal,simply a comparison of the mathematical average of all facilities, which in and of itself doesn't really mean anything, it is just an average. The data that is used to calculate decline for a resident is inherently unreliable as the ADL section (G) of the MDS (at least MDS 2.0) is the most incorrectly coded section of the assessment. There are too many variables that can affect this section, from a resident simply being too tired to do much for a few days of the look-back period, to more severe illness, to medication changes, to improper coding, etc. etc. In addition, most long term residents are admitted to nursing facilities because they have declined physically on some level, and simply assigning all responsibility for any further ADL decline squarely on the facility seems unfair in most situations. Bottom line, too many variables that are unaccounted for affect this quality measure. That does not mean it is not important, but it's importance should not "trump" a laundry list of concerns. Now is the time to make it right.	The MDS 3.0 has been tested much more extensively than MDS 2.0, it requires direct observation of the resident to rate physical functioning, and the look-back period for the questions has been tightened, leaving less room for error. The Committee agrees that this is a population at a high risk for functional decline, and that it is not inherent that any decline is bad.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
152	P	Loren Haynes Haynes, Harber Laman LLC	In line 420, you suggest that hospice residents should not be excluded from the ADL decline quality measure because "loss of function in this population should not be viewed as acceptable". Yet in lines 448-450, you recommend further research to determine if Hospice residents should be excluded from the weight loss quality measure because asking them to be weighed on a scale could cause discomfort. How would weighing a resident cause more discomfort than intervening daily with restorative nursing or physical/occupational therapy in order to prevent ADL decline? The determining factor in delivering treatment to this population is: does the Hospice resident, or their family, want you to intervene with weights, or therapy, or anything else treatment related? However, this resident/family wish is not on the MDS, and therefore not a factor in the data. Holding a facility responsible for a physical decline in a resident where typically the decision has been made to allow for a comfortable death, and consequently the cessation of most treatment interventions other than comfort medications, once again seems unfair.	Hospice patients and those with a prognosis of 6 months or less are excluded because ADL decline is expected. The Committee discussed whether or not hospice patients should be excluded, but ultimately decided that they should be. If a patient chooses rehabilitation, than the nursing home should be held accountable, but patients should not be pushed into rehab against their wishes. Dissenting Committee members agreed with the commenter and were concerned with possible unintended adverse consequences of not risk adjusting the measure. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
165	P	Darlene Thompson, Kindred Healthcare	The denominator exclusions include the admission assessment. There is no indication in the measure if the discharge assessment is included or excluded in this measure. We also appreciate recognition of the ADL Self-Performance score of a 7 equating to total dependence so that a resident score shifting from a 4 to a 7 would not equate to a decline. We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.	CMS response: Thank you for your comment, we will add the discharge assessment to the denominator exclusions. For this quality measure, a determination of missing data occurs when the MDS 3.0 items G0110A1, G0110B1, G0110H1, and G0110I1, composing the quality measure, are completed with a dash or left blank. There is no skip pattern for this quality measure.	NH-022-10: % of long stay residents with increased need for help with daily...
180	P	Jane Pederson, Stratis Health	In reading the measure specifications, it is not clear how the measure accounts for changes in condition such as stroke or other acute illnesses that could greatly impact a residents function and be out of the control of the nursing home.	CMS response: We appreciate your comment. We will analyze the impact of active diagnoses in Section I for the most recent MDS assessment on the quality measure results as part of our analysis plan for the MDS 3.0 data and consider ways to improve the measure.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
185	P	Simon Kassabian, MD, Jewish Home Lifecare System	Percentage of all long-stay residents in a nursing home whose need for help with late-loss Activities of Daily Living [ADLs] increased since the previous quarter (three-month period). The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. Increased need for help with daily activities is a fundamental standard in nursing home care. The Steering Committee's review of avoidable and unavoidable aspects in this regard appropriately upheld its importance. But as with comments submitted about #NH-024-10 on weight loss, hospice exclusion provides a relevance that might not be fully appreciated by the committee. Caregivers commonly involved with the terminally ill are quite familiar with their functional limitations, but more importantly of inappropriate functional expectations on those dying. Hospice care may require physician certification of six months or less in life expectancy, but typically the time frame is far shorter. It is hoped that the committee in its future examination of hospice role with this measure will support insightful consideration of these circumstances. Thank you for the opportunity to present the above comments. It is hoped they will provide a valued contribution for further consideration of this NQF measure. Yours most sincerely, Simon Kassabian, MD, Director of Palliative Care Marie Rosenthal, RN, MSN Liz Weingast, RN, MSN, GNP	Hospice patients and those with a prognosis of 6 months or less are excluded because ADL decline is expected.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
186	P	Simon Kassabian, MD, Jewish Home Lifecare System	Percentage of all long-stay residents in a nursing home whose need for help with late-loss Activities of Daily Living [ADLs] increased since the previous quarter (three-month period). The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. Increased need for help with daily activities is a fundamental standard in nursing home care. The Steering Committee's review of avoidable and unavoidable aspects in this regard appropriately upheld its importance. But as with comments submitted about #NH-024-10 on weight loss, hospice exclusion provides a relevance that might not be fully appreciated by the committee. Caregivers commonly involved with the terminally ill are quite familiar with their functional limitations, but more importantly of inappropriate functional expectations on those dying. Hospice care may require physician certification of six months or less in life expectancy, but typically the time frame is far shorter. It is hoped that the committee in its future examination of hospice role with this measure will support insightful consideration of these circumstances. Thank you for the opportunity to present the above comments. It is hoped they will provide a valued contribution for further consideration of this NQF measure. Yours most sincerely, Simon Kassabian, MD, Director of Palliative Care Marie Rosenthal, RN, MSN Liz Weingast, RN, MSN, GNP	Duplicate of comment # 185	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
226	P	Linda Spokane, NYAHSA	Residents with total dependence in ADLs are excluded from the calculation. Total dependence could be attributed to poor quality of care. In this case, poor quality of care affects the speed of deteriorating in ADL. The rate of ADL decline varies across the level of ADL itself. Residents with mild or moderate ADL dependence are more likely to have ADL decline than those who are almost totally dependent. This implies that facilities with a high proportion of mild or moderate ADL dependent residents are expected to have a higher rate compared to other facilities. Suggestion: This measure should be used together with a new measure, percent of residents with total dependence in ADLs, and needs to be risk adjusted. Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: Your comment is noted and will be considered as we analyze the MDS 3.0 data and consider ways to improve the measure.	NH-022-10: % of long stay residents with increased need for help with daily...
236	P	Teresa Lewis, MN Dept of Human Services	We would recommend considering changing the 'Need for help with daily activities has increased' QM (NH-022-10) to 'increased or stayed at the maximum'. That is, the numerator should trigger if a resident gets worse OR stays at maximum dependence on the included items, and the denominator should *not* exclude those at maximum dependence. (If this change was made, the denominator would likely require some number of additional clinical exclusions, such as quadriplegia.) There are two reasons: 1) excluding residents who are fully dependent based on facility (in)action leads to a QM score that is misleadingly positive; and 2) there are unclear complications for tracking facility performance over time when residents who hit the maximum score are no longer included in the calculation.	CMS response: Your comment is noted; we will consider your recommendations as we analyze the function data from the MDS 3.0.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
253	P	Barbara Yody, Genesis HealthCare	Measure is the same definition as MDS 2.0 and this is always problemmatic. The measurement of retaining function is worthwhile, however it is clear this metric is strongly influenced by the state payment systems, thus not a true measure of quality. Previous TEP had recommended discontinuing this measure. Finally, the scale of the ADL dependence is not sensitive to changes.	CMS response: Your comment is noted; we will continue to examine the sensitivity of the scale to changes using data from the MDS 3.0.	NH-022-10: % of long stay residents with increased need for help with daily...
264	M, Purchaser Council	Gaye Fortner, HC21	I support this measure, but suggest that it be specified to allow for nursing homes to risk adjust for residents with dementia, whose need for help with daily activities may increase due to their condition, and not necessarily due to the quality of care provided. Granted, the quality of care can improve or exacerbate the rate at which help is needed, so I urge the measure developer to assure that there is a way to account for nursing home quality of care, and make the distinction between performance and the natural progression of dementia.	CMS response: Your concern is noted; we will analyze the impact of the diagnosis of dementia (Section I, item I4800) on the quality measure as we analyze the MDS 3.0 data	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
279	M, Provider Council	Sandra Fitzler, AHCA	The measure reports the percentage of long stay patients whose need for help with late-loss ADLs increases when compared to the previous assessment. According to Katz, late-loss ADLs are functions (like bed mobility, transferring, eating & toileting) that are lost in the opposite order from which they are acquired from infancy. Late-loss functional decline is considered a component of the geriatric aging syndrome. There is no evidence that late-loss ADLs can be prevented. Considering that the purpose of the measure is to measure decline in a population where decline is expected (long stay), the intent of the measure is not clear as well as the measure's value to providers and consumers. AHCA recommends that the measure developers reframe the measure to focus on activities proven to be effective in slowing/forestalling the rate of decline. The measure does not exclude individuals with severe cognitive impairment. Research shows that individuals with severe cognitive impairment will have a greater deterioration in late-loss ADL - eating. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4. Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable.	CMS response: Your comments are noted; we will examine the proportion of patients in a facility with dementia when we further analyze this measure using MDS 3.0 data. For this quality measure, a determination of missing data occurs when the MDS 3.0 items G0110A1, G0110B1, G0110H1, and G0110I1, composing the quality measure, are completed with a dash or left blank. There is no skip pattern for this quality measure.	NH-022-10: % of long stay residents with increased need for help with daily...
299	M, Health Professional Council	Diane Carter, AANAC	Comment: The discussion on not using the 5 day PPS assessment is unnecessary. The assessments should be stated as all OBRA assessments with the exception of the admission assessment.	CMS response: Your comment is noted, we will make the revision.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
319	M, Health Professional Council	Jacqueline Vance, AMDA	There are many patients in NHs in whom a decline is expected and non preventable. Many are at the end of life but not on "hospice care". The plurality of patients in LTC have an expectation of progressive ADL decline, thus, a quality measure is proposed that would penalize facilities for the expected outcomes of residents they would be expected to care for. This is particularly unenlightened and is surprising. It is disheartening to imagine that we would be penalized for caring for patients who were declining, when they were expected to decline. There needs to have exceptions in the measure to pull those residents out of the numerator.	CMS response: Your comment is appreciated and noted. While decline can be expected in some circumstances, the trajectory of decline can be mitigated and slowed. We will continue to consider comments such as yours as we work to improve this measure.	NH-022-10: % of long stay residents with increased need for help with daily...
324	M, Consumer Council	Debra Ness, National Partnership for Women & Families	We support this measure, but suggest that it be specified to allow for nursing homes to risk adjust for residents with dementia, whose need for help with daily activities may increase due to their condition, and not necessarily due to the quality of care provided. Granted, the quality of care can improve or exacerbate the rate at which help is needed, so we urge the measure developer to assure that there is a way to account for nursing home quality of care, and make the distinction between performance and the natural progression of dementia.	CMS response: Your comment is appreciated and noted. We will examine the relationship between dementia and this measure as we analyze data from the MDS 3.0.	NH-022-10: % of long stay residents with increased need for help with daily...
334	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-022-10: This is a weak measure. The ability to ascertain avoidable versus unavoidable ADL decline may be beyond the usual NF staff skill set, including the medical director (unless he/she is a neurologist). This may either get ignored, reported incorrectly or result in many unnecessary referrals for neurology evaluation. Unless there is a relatively reliable and easy to perform test to determine if ADL decline is avoidable or unavoidable, would not support this measure.	Decline is measured by the change in ADL function as measured by an MDS assessment requiring direct observation (which may be an annual, quarterly, significant change, or significant correction assessment). The Committee decided the importance and the strengths of the measure override the limitations, which included concerns about exclusion criteria, sensitivity to Medicaid payment policies, and the challenges of risk adjustment for this measure. Dissenting Committee members were concerned with the lack of risk adjustment. For full details of the Committee's discussion, please see the project report and the notes from the Committee's meeting and conference calls.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
383	M, Health Professional Council	Sarah Nichols, American Physical Therapy Association	We commend the inclusion of this measure on residents in need for help with daily activities. While there may at times be a functional decline in residents with a long term stay, any decline should be addressed for causal factors. Furthermore, with any functional decline, habilitation and rehabilitation interventions should be employed to ensure a resident is participating at their optimal level of self and/or assisted care. The benefits to residents to remain active and participate to their greatest abilities in all activities of daily living are well expressed in the measure description. While there may some intention to limit participation in activities of daily living for safety reasons, current guidelines in the care of older adults, even older adults with dementia do not support this behavior. Physical therapists play a crucial role in assisting patients who need help with activities of daily living (ADLs) including bed mobility, transferring, eating, and toileting. Physical therapists are trained to assess these factors and make recommendations regarding necessary assistive devices or technologies the patient might need in order to undertake activities of daily living.	No response needed.	NH-022-10: % of long stay residents with increased need for help with daily...

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
166	P	Darlene Thompson, Kindred Healthcare	The denominator exclusions include the admission assessment. There is no indication in the measure if the discharge assessment is included or excluded in this measure. We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4". Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. Although our goal for residents who are end of life and/or hospice is not to lose weight – it is an outcome of many end of life and hospice residents and should be considered for exclusion. Since this is for long stay residents, many may be at the end of their hospice or end of life cycle at the time they are counted as a long stay resident for this measure. Definition of "physician-prescribed" weight loss program in the MDS 3.0 manual may need further refinement as the providers become more educated on the MDS 3.0 and outliers begin to be recognized.	CMS response: Thank you for your comment regarding the discharge assessment, this was an omission and will be added to the list of MDS 3.0 assessments included in the quality measure. For this measure, a missing data designation is made when the MDS 3.0 item K0300, composing the quality measure, is completed with a dash or left blank. There is no skip pattern for this quality measure. Your comment regarding end of life and/or hospice residents is noted. This concern was discussed in detail by our Technical Expert Panel. The current prognosis item J1400 of having less than 6 months to live is likely subject to substantial measurement error given that it is very difficult to predict when someone will die. Also, substantial weight loss is not necessarily associated with the last 6 months of life. However, we do plan to analyze the MDS 3.0 data regarding refinements related to this quality measure, and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live. Your comment that the definition of "physician-prescribed weight loss program in the MDS 3.0 manual may need further refinement as the providers become more educated" is noted and we will revise the RAI MDS 3.0 manual as needed.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
184	P	Simon Kassabian, MD, Jewish Home Lifecare System	The weight loss parameters would be better if appropriately qualified beyond just percentage criteria. Failure to account for the expected course of many conditions, like terminal cancer, advanced and progressive dementia, or refractory psychiatric disorders, could potentially provide an incentive to inappropriately counter weight loss despite optimal management in a care plan. Hospice enrolment alone would not provide an adequate exclusion, for example in cases that may decline enrolment or might not be eligible possibly. The ideal criteria may be more effective and specific beyond 'weight loss that is physician prescribed', in a two-quarter period. If there was physician documentation affirming it as 'expected weight loss in a disease course, despite optimized caloric intake and therapeutic interventions', this would substantiate appropriate care. It is suggested to add this physician affirmation as an exclusionary criterion, with hospice enrollment as another. To depend on peer comparison, for example using national or regional benchmarks of percent-based weight loss only, would uphold a clinically inappropriate standard. Thank you for the opportunity to present the above comments. Yours sincerely, Simon Kassabian, MD, FACP Marie Rosenthal, RN, MSN Liz Weingast, RN, MSN, GNP	CMS response: Your concern regarding accounting for the expected course of many conditions, such as terminal cancer, advanced and progressive dementia, or refractory psychiatric disorders, is noted as well as your recommendation that physician documentation affirming weight loss as "expected weight loss in a disease course" be included as an exclusion criteria. This will be considered in future refinement of the quality measure. Regarding hospice enrollment, this concern was discussed in detail by our Technical Expert Panel. The majority of TEP members did not want to exclude the hospice population and/or population having a prognosis of less than 6 months to live because it is likely subject to substantial measurement error given it is very difficult to predict when someone will die. In addition, it was felt that substantial weight loss is not necessarily associated with the last 6 months of life nor with residents receiving hospice care.	NH-024-10: % of long stay residents who lose too much weight
200	P	Erica Koser, PANPHA	A PANPHA member commented that, "We recommend exclusion based on advanced directives."	CMS response: Your comment regarding exclusion based on advanced directives is noted. Currently the MDS 3.0 does not collect data on advanced directives. This will be considered in future refinement of the quality measure.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
227	P	Linda Spokane, NYAHSA	We are unclear why this quality measure is being adjusted for seasonal variation but, in any case, seasonal variation can not be eliminated by computing the rate over 2 quarters. For example, the rate for October-March is affected by winter season and the rate for April-September is affected by summer season. Suggestion: To adjust for seasonal variation, it is better to compute the rate over 4 quarters rather than only over 2 quarters OR the rate is calculated only for 1 quarter and then adjusted with state/national seasonal factor calculated based MDS data from previous year Linda Spokane, MS Zulkarnain Pulungan, PhD Kathleen Pellatt, RN	CMS response: The comment is noted; we will consider your recommendation as we further analyze this measure for seasonal variation using the MDS 3.0 data. The issue of seasonal variation for this quality measure was discussed during the technical expert panel and it was anticipated that utilizing 6 months of data would address this concern.	NH-024-10: % of long stay residents who lose too much weight
255	P	Barbara Yody, Genesis HealthCare	This measure has improved by capturing and removing those individuals on a physician-prescribed weight loss program. However, in nursing homes there are numerous cases of expected weight loss. A QM that measures unexpected or avoidable weight loss would have so much meaning to the clinicians with whom I work.	Additional recommendations for measure development will be added to the revised draft report.	NH-024-10: % of long stay residents who lose too much weight
265	M, Purchaser Council	Gaye Fortner, HC21	This is a measure that may lead to unintended adverse consequences for dementia patients. While I understand the importance of monitoring nursing home residents' weight during a long-stay, the palliative care evidence base indicates that dementia patients tend to lose weight when they are ready to die. There is concern that nursing homes may try to counteract this natural process by imposing feeding upon these residents. Therefore, I suggest that this measure be specified in such a way to account for dementia patients through risk adjustment.	CMS response: Your comment is noted and will be considered as we analyze the MDS 3.0 data (item I4800) related to weight loss among patients diagnosed with dementia for further refinement of this quality measure including potential risk adjustment.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
280	M, Provider Council	Sandra Fitzler, AHCA	The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4. Also a skip pattern may remove the ability to answer a question that triggers a QM data element so specifications need to include the look back to the last assessment that contains that question if this is applicable. AHCA recommends that hospice patients be excluded from the measure since weight loss is anticipated and forced nutrition can cause severe discomfort and pain. Patient comfort is the goal of care.	CMS response: For this measure, a missing data designation is made when the MDS 3.0 item, K0300, composing the quality measure is completed with a dash or left blank. A skip pattern is not associated with this quality measure. Your comment and concern regarding excluding hospice residents is noted. We will analyze the MDS 3.0 data for this quality measure specifically pertaining to residents receiving hospice care, item O0100K, and consider further refinement of this quality measure.	NH-024-10: % of long stay residents who lose too much weight
282	M, Health Professional Council	Lea Anne Gardner RN, PhD (on behalf of the Performance Measurement Committee), American College of Physicians	The ACP Performance Measurement Committee (PMC) noted the Nursing Home Committees statement that "this measure highlighted its strong supporting evidence and prior use, as well as its importance. Concerns focused on the inclusion and exclusion criteria pertaining to missing data and patients near the end of life. The steward clarified that missing data for this measure requires several missed weigh- in opportunities." The PMC can not identify any reference for the "strong supporting evidence". Where is the evidence to support the validity of the measure as a quality indicator or evidence that the measurement improves quality?	CMS response: Please refer to the NQF submission, Section 1a.3, Summary of High Impact. The submission form is available on NQF's site: http://www.qualityforum.org/Projects/Nursing_Homes.aspx#t=2&p=4|5|&s=	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
300	M, Health Professional Council	Diane Carter, AANAC	Comment: Percentage of long-stay residents who had a weight loss of 5 percent or more in the last month or 10 percent or more in the last 6 months who were not on a physician-prescribed weight-loss regimen noted on an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period). To address seasonal variation, the proposed measure uses a 2-quarter average for the facility. Residents on hospice or some other type of end-of-life program should not be included in this measure.	CMS response: This concern was discussed in detail by our Technical Expert Panel. Substantial weight loss is not necessarily associated with residents on hospice. However, we do plan to analyze the MDS 3.0 data regarding refinements related to this quality measure, and in particular, for residents receiving hospice care and those with a prognosis of less than 6 months to live.	NH-024-10: % of long stay residents who lose too much weight
320	M, Health Professional Council	Jacqueline Vance, AMDA	There are instances in the nursing home where weight loss is unavoidable (per Clinical Practice Guideline-Altered Nutritional Status by AMDA) and a key indicator of end-of-life status. The key is that a Tier 1 and Tier II work up has been performed and the Care Plan has been revised in each case and with no result and weight loss is secondary to Cancer, Chronic Inflammation, severe Dementia, etc.It does not appear that approroiate exlusions have been applied. This should not be endorsed.	The Committee discussed the issue of unavoidable weight loss, but voted to recommend the measure despite these concerns. Dissenting Committee members strongly agreed with the commenter and were concerned with possible unintended adverse consequences. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls. The Committee recommended further research to examine issues including patients in palliative care. NQF is beginning a palliative care project that may provide an opportunity to review measures for weight loss in the hospice and palliative care populations.	NH-024-10: % of long stay residents who lose too much weight
325	M, Consumer Council	Debra Ness, National Partnership for Women & Families	As noted in our general comments, this is a measure that may lead to unintended adverse consequences for dementia patients. While we understand the importance of monitoring nursing home residents' weight during a long-stay, the palliative care evidence base indicates that dementia patients tend to lose weight when they are ready to die. There is concern that nursing homes may try to counteract this natural process by imposing undesired feeding upon these residents. Therefore, we suggest that this measure be specified in such a way to account for dementia patients through risk adjustment.	CMS response: Your comment and concern regarding excluding residents with dementia at their end of life is noted. The current prognosis item J1400 of having less than 6 months to live is likely subject to substantial measurement error given that it is very difficult to predict when someone will die. However, we do plan to analyze the MDS 3.0 data regarding refinements related to this quality measure, and in particular, for residents with dementia.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
335	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-024-10: Similar to the ADL measure, this one could be due to cognitive decline independent of any other factors. Echo the Committee's concerns about addressing weight loss with feeding tubes or other invasive measures that could result in increased morbidity or mortality. This measure needs an algorithm for the investigation of and interventions for (including doing nothing) weight loss. The LOS issue is germane here as well. Easily reportable via EHR extracts using ICD, CPT and orders.	CMS response: Your concern regarding residents with cognitive decline as well as the risk of addressing weight loss with feeding tubes and other invasive measures is noted. We will analyze the MDS 3.0 data for this quality measure keeping in mind the issues you raise and will consider further refinement as appropriate. We appreciate the suggestion that this quality measure can be automated using data from EHRs and we will take this into consideration in future development, however, at this time, the quality measure utilizes data from the MDS 3.0.	NH-024-10: % of long stay residents who lose too much weight
359	M, Provider Council	Renee Demski, Johns Hopkins Medicine	Weight loss is also possible as illness progresses in the nursing facility. This measure is concerning as it may promote placement of percutaneous gastrostomy feeding tubes, a burden for frail older adults who are approaching end of life.	The Committee discussed the possible unintended consequence of an increased use of feeding tubes, but voted to recommend the measure despite these concerns. Dissenting Committee members agreed with the commenter and were concerned about possible unintended consequences of this measure. For a full summary of the discussion, please see the project report and the notes from the Committee's meeting and conference calls. The Committee recommended further research to examine issues including patients in palliative care. NQF is beginning a palliative care project that may provide an opportunity to review measures for weight loss in the hospice and palliative care populations.	NH-024-10: % of long stay residents who lose too much weight
392	M, Health Professional Council	Susan Sherman, American Geriatrics Society	AGS does not endorse this measure. We support proper attention to the nutritional and feeding needs of residents, but do not believe that the measure adequately addresses differentiation between unavoidable weight loss and that due to lower quality of care. We are particularly concerned about expected weight loss for residents who, while long-term, are predominantly receiving palliative care.	The Steering Committee discussed the issue of unavoidable weight loss, but voted to recommend the measure despite concerns. Dissenting Committee members strongly agreed with the commenter and were concerned with possible unintended adverse consequences. For full details of this discussion, please see the project report and the notes from the Committee's meeting and conference calls. The Committee recommended further research to examine issues including patients in palliative care. NQF is beginning a palliative care project that may provide an opportunity to review measures for weight loss in the hospice and palliative care populations.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
400	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	The American Nurses Association (ANA) wishes to offer specific comments on the following measure: •NH-024-10: Percent of residents who lose too much weight (long stay) (CMS) ~ background is 17 years in home care which includes hospice. ANA understands that the elderly do need to be monitored for weight loss. Causative factors of the change should be explored including physical, social, psychological and environmental. As is verbalized in the draft report, ANA is concerned that individuals will be treated unnecessarily for normal weight loss that is seen at end of life. As individuals age, their caloric needs decrease. Appetite normally decreases, and hunger as the healthy individual defines it will be nonexistent. It would be disrespectful of individual rights to push food and fluids where they are not wanted.	CMS response: Your concerns are noted regarding residents at the end of life as well as the risk of addressing weight loss with feeding tubes and other invasive measures. We will analyze the MDS 3.0 data for this quality measure taking your concerns into consideration and consider further measure refinement as appropriate. Your comment regarding the need for causative factors being explored in noted and the MDS 3.0 RAI Manual, Chapter 3, Section K, Planning for Care "Weight loss may be an important indicator of a change in the resident's health status or environment. If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status."	NH-024-10: % of long stay residents who lose too much weight
401	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	Recognizing that weight loss is impacted by several variables; ANA suggests albumin levels may be a better indicator of nutritional health and have the potential to offer additional insight into the overall health of the individual. This measure may be costly for the organizations to manage and needs to be considered carefully within the constraints of reimbursement. Certain considerations need to be made when individuals are in the end stages of life. Research highlights the risks and benefits of tube feeding and oral feeding when swallowing difficulties arise. Certain concessions should be made so that facilities are not penalized for weight loss associated with individuals in the late stages of their disease. Further research to provide better stratification of data for LTC residents with weight-loss concerns should be encouraged.	CMS response: At this time, the MDS 3.0 does not collect data regarding albumin levels unless a diagnosis is made and an ICD-9-CM code is entered in I8000. Your concerns are noted regarding residents at the end of life as well as the risk of addressing weight less with feeding tubes and other invasive measures. We will analyze the MDS 3.0 data for this quality measure keeping in mind the issues you raise and will consider further refinement as appropriate.	NH-024-10: % of long stay residents who lose too much weight

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
150	P	Roberta Maruschock, Vincentian Regency	Assessing depression is very difficult. No one wants to be in a Nursing Home. Many elderly have symptoms that seem like depression but is it that the elderly have different moods than younger people? Are we making judgements based on what someone younger would do, think, say or how a younger person acts; but that is not what someone 88 would do or say or how they would act? Many of our residents trigger for depression, but when I walk the building, I don't see "depressed" people. The questions on the MDS currently make it look as though folks are depressed, but looking around, I don't see this to be the case. Because the elderly don't want to continue doing some activities, that may not mean depression.	CMS response: Your concern regarding the assessment of depression among residents of a nursing facility is noted. A systematic review of the PHQ-9 concluded that it is a brief, well-validated measure for detecting and monitoring depression (Kroenke, K., Spitzer, R.L., Williams, J.B.W., and Lowe, B.: The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: A Systematic Review. General Hospital Psychiatry. DOI 10.1016/j.genhosppsych. 2010.03.006). Research and information regarding depression in the elderly can be found in the NQF submission, in the section 1a.3. Summary of Evidence of High Impact. Additionally Dr. Debra Saliba, lead researcher in the development of the MDS 3.0, provides background information regarding depression in the Final Report to CMS - Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf. Based on these studies, we feel confident that the PHQ-9 can provide valid information regarding depression in this population.	NH-025-10: % of residents who have symptoms of major depression
174	P	Darlene Thompson, Kindred Healthcare	We appreciate the developer's understanding of the use of missing data in the MDS and retaining this answer as part of the exclusion coding in the measure. The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing", (ex: I12300 is blank if no UTI present), a dash can mean "not assessed". See Chapter 3-4".	CMS response: For this measure, a missing data designation is made when item B0100 is missing or left blank, fD0100 is missing or left blank, the resident interview - if three or more D0200 sub-items are missing or left blank, or for the staff assessment - if three of more D0500 sub-items are left blank. The skip pattern for this quality measure is B0100 (comatose) and D0100 (should resident mood interview be conducted?)	NH-025-10: % of residents who have symptoms of major depression

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
203	P	Erica Koser, PANPHA	A PANPHA member commented that, "We are recommending a one-time trigger for this area not be counted as part of the numerator due to possible grief reactions (death of a spouse, new diagnosis, change in discharge plans, ect). Normal grief reactions are self-limiting and should not be considered a diagnosable depressive episode. Should the resident trigger a second time then perhaps this is indeed a true measure of depression. The literature used in this section (as well as other sections throughout the document) are quite old. A more recent literature search would have revealed more supportive findings that would validate our position." Another PANPHA member commented that, "When looking at major depression,it should also include a review of treatment provided since medications are listed on the 3.0."	CMS response: The PHQ-9 is a screening tool for depression. As noted in the RAI Manual, Chapter 3, Section D Mood - Intent "It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D, they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan." The measure title will be revised to 'Percent of Residents Who have Depressive Symptoms ' (long stay)	NH-025-10: % of residents who have symptoms of major depression
281	M, Provider Council	Sandra Fitzler, AHCA	The developer did not identify what would constitute "missing data" for each of the data items (a dash, blank or code 9). Depending upon the MDS item, this data answer does not always equate to "missing," (ex: I12300 is blank if no UTI present), a dash can mean "not assessed." See Chapter 3-4.	CMS response: For this measure, a missing data designation is made when item B0100 is missing or left blank, fD0100 is missing or left blank, the resident interview - if three or more D0200 sub-items are missing or left blank, or for the staff assessment - if three of more D0500 sub-items are left blank. The skip pattern for this quality measure is B0100 (comatose) and D0100 (should resident mood interview be conducted?)	NH-025-10: % of residents who have symptoms of major depression

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
283	M, Health Professional Council	Lea Anne Gardner RN, PhD (on behalf of the Performance Measurement Committee), American College of Physicians	The ACP Performance Measurement Committee has the same concerns for this measure as the concerns expressed in our comments on measure NH-024-10: % of long stay residents who lose too much weight.	CMS response: Please refer to the NQF submission, Section 1a.3, Summary of High Impact. The submission form is available on NQF's site: http://www.qualityforum.org/Projects/Nursing_Homes.aspx#t=2&p=4|5|&s=	NH-025-10: % of residents who have symptoms of major depression
343	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-025-10: The LOS definition issue is germane here as well. The PHQ-9 is a validated tool for assessing depression. There are also other geriatric depression assessments that could be considered. The Committee needs to decide which one offers the best assessment that is reproducible and valid in the population being assessed. Just as important is the percentage who are offered or receive treatment for the depression that is diagnosed. Other factors include cognitive status and situational components.	**NQF response:** the Committee is limited to reviewing measures that are submitted. **CMS response:** Long Stay residents are defined as those whose length of stay in a facility is greater than 100 days. Regarding your comment concerning other geriatric assessments, other depression screening tools were considered by the developers of the MDS 3.0. Dr. Debra Saliba, lead researcher in the development of the MDS 3.0, provides background information regarding the depression items in the Final Report to CMS - Saliba D, Buchanan J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf. The current MDS 3.0 only collects data for the treatment of depression with medication (item N0400) but your comment is noted and will be considered as we analyze the MDS 3.0 data and for further refinement of the MDS 3.0 and quality measure. (response con't on next page)	NH-025-10: % of residents who have symptoms of major depression

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
343	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-025-10: The LOS definition issue is germane here as well. The PHQ-9 is a validated tool for assessing depression. There are also other geriatric depression assessments that could be considered. The Committee needs to decide which one offers the best assessment that is reproducible and valid in the population being assessed. Just as important is the percentage who are offered or receive treatment for the depression that is diagnosed. Other factors include cognitive status and situational components.	(response cont'd) Finally, in the RAI MDS 3.0 Manual, as stated in Chapter 3, Section D, Intent: Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan. • Depression can be associated with: psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain), decreased participation in therapy and activities (e.g., caused by isolation),□ decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and poorer outcomes (e.g., decreased appetite, decreased cognitive status). Findings suggesting mood distress should lead to: identifying causes and contributing factors for symptoms,□ identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and ensuring resident safety.	NH-025-10: % of residents who have symptoms of major depression

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
175	P	Darlene Thompson, Kindred Healthcare	We recognize the value in obtaining data from our discharged residents as part of our service excellence initiatives and currently many providers are already gathering this data using industry-recognized survey tools and vendors. Although the survey includes the main categories of care and services the questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. Mood related questions like "how often did you feel worried"; "how often did you feel happy" would make answers appear to be related to stay at the center and not personal or family issues or life changes. Question "Think about how you felt about your life when you were in the nursing home. Use any number from 0 to 10 where 0 is the worst possible and 10 is the best possible. What number would you use to rate your life then?" needs to be removed as answer is not specific to the care and services in the center. Denominator is total number of surveys with at least 50% of key items answered. Developer needs to identify what the key items are. Denominator exclusions in the detailed document include those under 18, those in nursing center less than 5 days or more than 90 days, those discharged to another care facility and not discharged home and those who are deceased. Need clarification of which MDS A2100 answers are included in exclusions. These exclusions are not all present on the NQF Measure Evaluation form on page 6.	AHRQ Response: Question: The questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. AHRQ Response: See CAHPS Frequently Asked Question (FAQ) area of CAHPS website (at https://www.cahps.ahrq.gov/content/cahpsOverview/faq.asp?p=101&s=17), Topic of Survey Instruments; subtopic of General Design Decisions. This is the same rationale for the 0 -10 response option starting with the worst on the top. Question: Why does CAHPS order response options or questions in such a way that the negative wording comes first? Answer: CAHPS surveys present the never-to-always response options in the order from "never" to "always,". Studies have shown that respondents tend to be reluctant to use negative response options. Putting the negative responses first yields a better distribution of responses. Citations:• Kalton G, Collins M, Brook C. Experiments in wording opinion questions. Appl Stat. 1978:27,149-161. • Krosnick JA, Alwin DF. An evaluation of a cognitive theory of response-order effects. Public Opinion Q. 1987:51,201-219. • Dillman DA, Brown TL, Carlson JE, Carpenter EH, Lorenz FO, Mason R, Saltiel J, Sangster RL. Effects of category order on answers to mail and telephone surveys. Rural Sociology 1995 60(4):674-687 (response cont'd on next page)	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
175	P	Darlene Thompson, Kindred Healthcare	We recognize the value in obtaining data from our discharged residents as part of our service excellence initiatives and currently many providers are already gathering this data using industry-recognized survey tools and vendors. Although the survey includes the main categories of care and services the questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. Mood related questions like "how often did you feel worried"; "how often did you feel happy" would make answers appear to be related to stay at the center and not personal or family issues or life changes. Question "Think about how you felt about your life when you were in the nursing home. Use any number from 0 to 10 where 0 is the worst possible and 10 is the best possible. What number would you use to rate your life then?" needs to be removed as answer is not specific to the care and services in the center. Denominator is total number of surveys with at least 50% of key items answered. Developer needs to identify what the key items are. Denominator exclusions in the detailed document include those under 18, those in nursing center less than 5 days or more than 90 days, those discharged to another care facility and not discharged home and those who are deceased. Need clarification of which MDS A2100 answers are included in exclusions. These exclusions are not all present on the NQF Measure Evaluation form on page 6.	(comment cont'd) Question: Mood related questions like "how often did you feel worried"; "how often did you feel happy" would make answers appear to be related to stay at the center and not personal or family issues or life changes. Question "Think about how you felt about your life when you were in the nursing home. Use any number from 0 to 10 where 0 is the worst possible and 10 is the best possible. What number would you use to rate your life then?" needs to be removed as answer is not specific to the care and services in the center. AHRQ Response: These questions were added as potential case mix adjusters (based on CMS sponsored research by Dr. Rosalie Kane) and are being analyzed for that purpose. They are placed at the end of the core set of questions so as not to influence a resident's response to the core set of questions. Question: Denominator is total number of surveys with at least 50% of key items answered. Developer needs to identify what the key items are. AHRQ Response: Please contact developer for a list of current key items. AHRQ is analyzing data from 2009 Maryland based on a larger sample and the key items may be revised. Question: Denominator exclusions in the detailed document include those under 18, those in nursing center less than 5 days or more than 90 days, those discharged to another care facility and not discharged home and those who are deceased. Need clarification of which MDS A2100 answers are included in exclusions. These exclusions are not all present on the NQF Measure Evaluation form on page 6 AHRQ Response: AHRQ is working with CMS to update the specifications from MDS 2.0 to MDS 3.0.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
176	P	Darlene Thompson, Kindred Healthcare	CMS updated MDS 3.0 manual no longer mandates a Discharge Return Not Anticipated if resident who is Discharged Return Anticipated does not return to center in 30 days. Depending upon what that Discharge Return Anticipated MDS was coded – the resident may or may not correctly fall into the exclusions for this measure. Need to provide an example of how scores are going to be reported and published.	AHRQ Response: AHRQ is working with CMS to update the specifications from MDS 2.0 to MDS 3.0. Please contact developer for example of how scores could be reported for provider feedback.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument
201	P	Erica Koser, PANPHA	A PANPHA member commented that, "With shrinking reimbursement from both Medicare and Medicaid, to mandate these surveys could pose a financial hardship. The reliability and validity of the instruments were not provided and difficult to find on the website. Would it be possible to add a short list of satisfaction questions as an addendum to the MDS 3.0? There was no mention of who would score these measures. We understand that the expectation for administering the surveys would be a third party, but scoring was not mentioned and where/how to submit results was not clarified. This is true for all three of the surveys."	With shrinking reimbursement from both Medicare and Medicaid, to mandate these surveys could pose a financial hardship. AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone who desires to use them. AHRQ does not have legal authority to mandate these surveys. The Centers for Medicare & Medicaid Services has no current plan to implement these surveys. **The reliability and validity of the instruments were not provided and difficult to find on the website. AHRQ Response:** AHRQ provided information on reliability and validity from the 2005 pilot study as part of the NQF submission. In addition, AHRQ is analyzing data from 2009 Maryland survey to obtain additional estimates based on a larger sample. **Would it be possible to add a short list of satisfaction questions as an addendum to the MDS 3.0? AHRQ Response:**	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
201	P	Erica Koser, PANPHA	A PANPHA member commented that, "With shrinking reimbursement from both Medicare and Medicaid, to mandate these surveys could pose a financial hardship. The reliability and validity of the instruments were not provided and difficult to find on the website. Would it be possible to add a short list of satisfaction questions as an addendum to the MDS 3.0? There was no mention of who would score these measures. We understand that the expectation for administering the surveys would be a third party, but scoring was not mentioned and where/how to submit results was not clarified. This is true for all three of the surveys."	**(response cont'd)** The MDS 3.0 is designed to be administered by nursing home staff. AHRQ recommends that the resident survey only be administered by a third party because of concern based on previous research that staff administration biases the results (see Hodlewsky, R. and Decker, F. "The Problem of Bias When Nursing Facility Staff Administer Customer Satisfaction Surveys" Journal on Quality Improvement 2002:546-554) There was no mention of who would score these measures. We understand that the expectation for administering the surveys would be a third party, but scoring was not mentioned and where/how to submit results was not clarified. This is true for all three of the surveys." AHRQ Response: AHRQ will provide information on how to score composites once these are finalized. AHRQ developed these patient experience surveys and puts them in the public domain free for anyone who desires to use them. AHRQ recommends that the resident survey only be administered by a third party because of concern based on previous research that staff administration biases the results (see AHRQ response to #201 -9). It depends on the survey sponsor how they stipulate submission of results.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument
266	M, Purchaser Council	Gaye Fortner, HC21	I support the addition of the nursing home CAHPS tools for endorsement and implementation in Nursing Home Compare. I appreciate the separate modules for long-stay, family member, and discharged resident, given that each will have different perspectives on their experience of care, all of which can make a critically important contribution to improving quality of care in the nursing home setting.	No response needed.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
370	M, Provider Council	Sandra Fitzler, American Health Care Association	We recognize the value in obtaining data from our discharged residents as part of our service excellence initiatives and currently many providers are already gathering this data using industry-recognized survey tools and vendors. However, AHCA has the following concerns with the CAHPS tool. The survey questions often list first the "worse" choices and thus may inadvertently lead the response. Mood related questions like "how often did you feel worried," or "how often did you feel happy" would make answers appear to be related to stay at the center and not personal or family issues or life changes. Question "Think about how you felt about your life when you were in the nursing home. Use any number from 0 to 10 where 0 is the worst possible and 10 is the best possible. What number would you use to rate your life then?" needs to be removed as answer is not specific to the care and services in the center. It is not known if the survey questions related to mood are consistent with the evidence-based assessment used in MDS 3.0. Are the results consistent or related?	AHRQ Response: see response to Comment # 175 (1), (2) It is not known if the survey questions related to mood are consistent with the evidence-based assessment used in MDS 3.0. Are the results consistent or related? AHRQ Response: There is no MDS 3.0 data available yet to examine this question.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
371	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) The survey is designed for discharged patients who were in the facility for 5 to 90 days. Responses from this patients population can differ based upon discharge expectations, treatment goals and medical conditions like mild to moderate cognitive impairment. It is not clear that the CAHPS survey adequately researched responses by patient length of stay and cognitive decline to validly determine experience of care. It is important to note that MDS 3, Section Q – Return to the Community is designed to identify patients with the potential for discharge and to find community-based settings where care can be received. In following the goal of Section Q, individuals that previously stayed in the facility will be discharged. Thus, it is likely that more and more individuals with cognitive decline and once considered long-stay will be discharged by day 100. Denominator exclusions in the detailed document include those under 18, those in nursing center less than 5 days or more than 90 days, those discharged to another care facility and not discharged home and those who are deceased. Need clarification of which MDS A2100 answers are included in exclusions. The survey excludes any questions related to rehabilitation – a common care regimen for short-stay patients. Denominator is total number of surveys with at least 50% of key items answered. The measure developer needs to identify the key items.	AHRQ Response: Please contact the developer for a copy of the 2005 Resident Field Test Report which provides analyses of response by cognitive status and type of resident (long stay versus discharged). AHRQ is working with CMS to update the specifications from MDS 2.0 to MDS 3.0. It should be noted that residents staying more than 100 days will be excluded instead of 90 days (as noted in earlier AHRQ response to NQF) **Denominator exclusions in the detailed document include those under 18, those in nursing center less than 5 days or more than 90 days, those discharged to another care facility and not discharged home and those who are deceased. Need clarification of which MDS A2100 answers are included in exclusions. AHRQ Response:** AHRQ is working with CMS to update the specifications from MDS 2.0 to MDS 3.0. It should be noted that residents staying more than 100 days will be excluded instead of 90 days (as noted in earlier AHRQ response to NQF) **The survey excludes any questions related to rehabilitation – a common care regimen for short-stay patients. AHRQ Response:** The survey contains a screening question to determine if the person did receive therapy services and, if yes, the resident is asked to give an overall rating of therapy services on a 0 to 10 scale. **Denominator is total number of surveys with at least 50% of key items answered. The measure developer needs to identify the key items. AHRQ Response:** Please contact developer for list of key items for current survey version. This version may change once additional testing and analysis are complete.	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
372	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) These exclusions are not all present on the NQF Measure Evaluation form on page 6. The updated MDS 3.RAI Manual no longer mandates a Discharge Return Not Anticipated if the patient who is Discharged Return Anticipated does not return to the center in 30 days. Depending upon what that Discharge Return Anticipated MDS was coded, the patient may or may not correctly fall into the exclusions for this measure. Need to provide an example of how scores are going to be reported and published. (line 770) There is a lag time between when someone is discharged and when they receive the survey which could undermine the feedback because the experience becomes more remote. The one year trail for this measure should provide information to be evaluated. (line 760) There is discussion about the lack of culture change oriented questions. It was suggested that the CTM-3 questions could be added or that a separate survey could be developed. We recommend that ample consideration be give to length and number of surveys that are been sent to the same person. It is not clear whether NQF is endorsing a measure on patient experience or the use of the CAHPS tool. Were other surveys tools evaluate for potential use?	1. Need to provide an example of how scores are going to be reported and published. AHRQ Response: Please contact developer for example of how scores could be reported for provider feedback. 2. (line 770) There is a lag time between when someone is discharged and when they receive the survey which could undermine the feedback because the experience becomes more remote. The one year trail for this measure should provide information to be evaluated. AHRQ Response: AHRQ recommends that residents be sampled only if they have been discharged within the past 2 months to prevent problems with patient's memory of the nursing home experience. 3. (line 760) There is discussion about the lack of culture change oriented questions. It was suggested that the CTM-3 questions could be added or that a separate survey could be developed. We recommend that ample consideration be give to length and number of surveys that are been sent to the same person. AHRQ Response: The common name given to the national movement for the transformation of older adult services, based on person-directed values and practices, where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living. (response cont'd on next page)	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
372	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) These exclusions are not all present on the NQF Measure Evaluation form on page 6. The updated MDS 3.RAI Manual no longer mandates a Discharge Return Not Anticipated if the patient who is Discharged Return Anticipated does not return to the center in 30 days. Depending upon what that Discharge Return Anticipated MDS was coded, the patient may or may not correctly fall into the exclusions for this measure. Need to provide an example of how scores are going to be reported and published. (line 770) There is a lag time between when someone is discharged and when they receive the survey which could undermine the feedback because the experience becomes more remote. The one year trail for this measure should provide information to be evaluated. (line 760) There is discussion about the lack of culture change oriented questions. It was suggested that the CTM-3 questions could be added or that a separate survey could be developed. We recommend that ample consideration be give to length and number of surveys that are been sent to the same person. It is not clear whether NQF is endorsing a measure on patient experience or the use of the CAHPS tool. Were other surveys tools evaluate for potential use?	(response cont'd) The following items in the long stay resident survey address person-centered care: . What number would you use to rate how respectful the nursing home staff were to you? (this question relates to person-directed values of dignity and respect) . What number would you use to rate how well the nursing home staff listened to you? (this question relates to person-directed values of dignity and respect) . When you were in the nursing home, could you choose what time you went to bed? (this question relates to person-directed values of choice) . When you were in the nursing home, could you choose what clothes you wore? (this question relates to person-directed values of choice) . When you were in the nursing home, could you choose what activities you did there? (this question relates to person-directed values of choice) . What number would you use to rate how quickly the nursing home staff came when you called for help? (if it was truly person-centered, the resident would receive help quickly). AHRQ, in collaboration with MHCC, plans to test several discharge planning questions, modified from HCAHPS and CTM3 to reflect the nursing home setting. 4. It is not clear whether NQF is endorsing a measure on patient experience or the use of the CAHPS tool. Were other surveys tools evaluate for potential use? E233AHRQ Response: NQF should respond to this question about its intent	NH-026-10: CAHPS Nursing Home Survey: Discharged Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
251	P	Barbara Yody, Genesis HealthCare	•45 questions too long for long stay residents to tolerate •Scale of 0-10 too difficult for residents to answer, unreliable •Not funded; in-person survey conducted by external parties •Rolling sample of 85 to 90 may be difficult to obtain •Tool not validated in nursing home environment •Tool does not ask questions that measure patient & family engagement •Does not coordinate with new QIS process •Multiple states requiring patient & family surveys •In appendix, CAHPS describes long stay as 30+ days •Exclusions eliminate residents (severely impaired in cognition for daily d-making, comatose, and unable to speak English and <100 day stay)	1. 45 questions too long for long stay residents to tolerate AHRQ Response: In the pilot study, about 83% of residents took 20 minutes or less to complete. There were only 15 of the 424 interviews that took more than 30 minutes to complete and most of these took that long because the residents liked to talk and it was sometimes hard to keep them focused on the interview. 2. Scale of 0-10 too difficult for residents to answer, unreliable AHRQ Response: AHRQ tested a range of response options for both quality of care and quality of life items in several rounds of cognitive testing. This is described in article Sangl J., Buchanan J., Cosenza C., Bernard S., Keller S., Mitchell N., Brown J., Castle N., Sekscenski E., & Larwood D. (2007). The Development of a CAHPS Instrument for Nursing Home Residents (NHCAHPS). Journal of Aging and Social Policy, 19(2): 63-82. It is also described in NQF submission in Usability 3.a.6. 3. Not funded; in-person survey conducted by external parties AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone (such as states) who desires to use them. AHRQ does not have legal authority to mandate these surveys. 4. Rolling sample of 85 to 90 may be difficult to obtain AHRQ Response: AHRQ calculated the number of residents needed for each composite to reach a reliability of 0.70, assuming the goal is public reporting for reliable comparison purposes. A sponsor will usually suppress reporting of survey results if sample size is considered too small. If the goal is to use survey data only for quality improvement purposes, a smaller number of completes may be used. See section 2a.23 of NQF submission for more detail. (response cont'd on next page)	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
251	P	Barbara Yody, Genesis HealthCare	•45 questions too long for long stay residents to tolerate •Scale of 0-10 too difficult for residents to answer, unreliable •Not funded; in-person survey conducted by external parties •Rolling sample of 85 to 90 may be difficult to obtain •Tool not validated in nursing home environment •Tool does not ask questions that measure patient & family engagement •Does not coordinate with new QIS process •Multiple states requiring patient & family surveys •In appendix, CAHPS describes long stay as 30+ days •Exclusions eliminate residents (severely impaired in cognition for daily d-making, comatose, and unable to speak English and <100 day stay)	(response con'td) 5. Tool not validated in nursing home environment AHRQ Response: The pilot study was conducted in 13 nursing homes in the New England area. 6. Tool does not ask questions that measure patient & family engagement AHRQ Response: CAHPS is currently testing patient engagement questions as part of its person-centered medical homes instrument. In the future, these questions may be able to be included as supplemental items it appropriately modified for nursing home residents. 7. Does not coordinate with new QIS process AHRQ Response: First, the QIS survey process has not been implemented in every state. For those states that have implemented it, a survey sponsor (such as a State Department of Aging or Health) might consider using information from the QIS survey process as an additional quality measure. 8. Multiple states requiring patient & family surveys AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone (such as states) who desires to use them. AHRQ does not have legal authority to mandate these surveys. 9. In appendix, CAHPS describes long stay as 30+ days AHRQ Response: Our intent was to include residents who had been in a nursing home for at least 30 days and with no planned discharge, that is, for a long stay population. 10. Exclusions eliminate residents (severely impaired in cognition for daily d-making, comatose, and unable to speak English and <100 day stay) AHRQ Response: By definition, comatose residents are not able to be interviewed. In the field test, AHRQ excluded residents who had CPS of 5 or 6 but included those with CPS levels 1-4 and recommends using a 3 questions in a row approach to determine if a person can be interviewed. At the current time, the instrument is only available in English although AHRQ anticipates that a Spanish translation will be available by the end of 2011.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
267	M, Purchaser Council	Gaye Fortner, HC21	I support the addition of the nursing home CAHPS tools for endorsement and implementation in Nursing Home Compare. I appreciate the separate modules for long-stay, family member, and discharged resident, given that each will have different perspectives on their experience of care, all of which can make a critically important contribution to improving quality of care in the nursing home setting.	No response needed.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument
301	M, Health Professional Council	Diane Carter, AANAC	Comment: Even if the facility is not doing the survey it is still an added responsibility. If this measure is to be done it should simply be done by a third party based on sampling MDS discharge data. Leave the facility staff out of it and let them take care of residents.	Endorsing the measure does not include how it is implemented. If it is mandated by states or the Medicare program, they will issue the requirements. However, the validity of the results requires that it not be administered by NH personnel.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument
326	M, Consumer Council	Debra Ness, National Partnership for Women & Families	We strongly support the addition of the nursing home CAHPS tools for endorsement and implementation in Nursing Home Compare. This comment covers measures 026, 027, and 028. We particularly appreciate the separate modules for long-stay, family member, and discharged resident, given that each will have different perspectives on their experience of care, all of which can make a critically important contribution to improving quality of care in the nursing home setting.	No response needed.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
336	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	NH-027-10: CAHPS is a standardized and validated assessment. The only question is one of LOS definition...again. Should be available for patients to complete online or by giving answers to staff who can directly document for them in full view of the patient.	1. CAHPS is a standardized and validated assessment. The only question is one of LOS definition...again. AHRQ Response: Per our earlier agreement with NQF, AHRQ will exclude residents who have stayed for less than 100 days in nursing home. 2. Should be available for patients to complete online or by giving answers to staff who can directly document for them in full view of the patient. AHRQ Response: AHRQ recommends that the long stay resident survey only be administered by a third party because of concern based on previous research that staff administration biases the results (see Hodlewsky, R. and Decker, F. "The Problem of Bias When Nursing Facility Staff Administer Customer Satisfaction Surveys" Journal on Quality Improvement 2002:546-554). An online survey may not be feasible in many nursing homes because of the health and cognitive status of many long stay residents as well as lack of computer availability. Further research would need to be done to demonstrate the feasibility of online surveys.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
373	M, Provider Council	Sandra Fitzler, American Health Care Association	Denominator exclusions on page 6 are still listed as MDS 2.0 data elements and needs to be updated for MDS 3.0. Although the survey includes the main categories of care and services the questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. Since this is an interview with trained screeners, there is concern over continuity of interviews and potential interviewer influence on answers. Need to provide information on how continuity will be maintained and monitored for the screeners. Cost is a concern since funding for this is unknown and the current burden for state and federal budgets is alarming. There is concern that funding for this may become an additional burden of the providers. Need to provide an example of how scores are going to be reported and published The interview tool has 50 questions. Consideration should be focused to the areas that are the key drivers for resident satisfaction. This will help to ensure that the information gained is of value across stakeholders –current and prospective residents, families, nursing home leaders and their staff, and researchers. Research should be done to determine what the key factors are – care and concern of staff, competency of staff, Nursing Care, choices/preference, and respect. Cited in the 2009, My InnerView Workforce and Customer satisfaction Surveys.	1. Denominator exclusions on page 6 are still listed as MDS 2.0 data elements and needs to be updated for MDS 3.0. AHRQ Response: AHRQ is working with CMS to update the specifications from MDS 2.0 to MDS 3.0. 2. Although the survey includes the main categories of care and services the questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. AHRQ Response: see response to #175 – 1 3. Since this is an interview with trained screeners, there is concern over continuity of interviews and potential interviewer influence on answers. Need to provide information on how continuity will be maintained and monitored for the screeners. AHRQ Response: Proper training of interviewers eliminates or minimizes any individual interviewer influence on answers. Training should be considered in selection of survey vendor. Each sponsor is responsible for selecting their own vendor. 4. Cost is a concern since funding for this is unknown and the current burden for state and federal budgets is alarming. There is concern that funding for this may become an additional burden of the providers. AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone (such as states) who desires to use them. AHRQ does not have legal authority to mandate these surveys. (response cont'd on next page)	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
373	M, Provider Council	Sandra Fitzler, American Health Care Association	Denominator exclusions on page 6 are still listed as MDS 2.0 data elements and needs to be updated for MDS 3.0. Although the survey includes the main categories of care and services the questions are presented with the 0-10 score starting with the "worst" choices on the top – which may appear leading. Since this is an interview with trained screeners, there is concern over continuity of interviews and potential interviewer influence on answers. Need to provide information on how continuity will be maintained and monitored for the screeners. Cost is a concern since funding for this is unknown and the current burden for state and federal budgets is alarming. There is concern that funding for this may become an additional burden of the providers. Need to provide an example of how scores are going to be reported and published The interview tool has 50 questions. Consideration should be focused to the areas that are the key drivers for resident satisfaction. This will help to ensure that the information gained is of value across stakeholders –current and prospective residents, families, nursing home leaders and their staff, and researchers. Research should be done to determine what the key factors are – care and concern of staff, competency of staff, Nursing Care, choices/preference, and respect. Cited in the 2009, My InnerView Workforce and Customer satisfaction Surveys.	(response cont'd) 5. Need to provide an example of how scores are going to be reported and publishedAHRQ Response: Please contact developer for example of how scores could be reported for provider feedback. 6. The interview tool has 50 questions. Consideration should be focused to the areas that are the key drivers for resident satisfaction. This will help to ensure that the information gained is of value across stakeholders –current and prospective residents, families, nursing home leaders and their staff, and researchers. Research should be done to determine what the key factors are – care and concern of staff, competency of staff, Nursing Care, choices/preference, and respect. Cited in the 2009, My InnerView Workforce and Customer satisfaction Surveys. AHRQ Response: As part of survey development, AHRQ conducted focus groups with residents and family members to find the areas that were the most important to them, and performed literature search of other research.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
374	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) (Line 482) -- Resident surveys conducted via a personal interview could be looked at as the "gold standard," however an assessment of the implementation must be undertaken to inform the feasibility of such an undertaking. It is recommended that these costs be evaluated in terms of the current market for third party vendors certified to provide similar services for Home Health and Hospital CAHPs services. The summary for this measure cites the costs to the developer ranging from $32 - $51. This is likely on the modest side as costs for this service would likely increase with the costs of living over several years. In addition these costs do not include the expense to the third party for preparing the data for submission and records management at the facility which should not be done by nursing home caregivers. Another factor to consider for implementation is the needs and challenges for rural providers – estimated at more than 40% of nursing homes.	AHRQ Response: AHRQ has obtained updated costs from Ohio based on their 2009 in-person survey (using a similar survey). Their per-person cost for completed interview is $29.52. Ohio balances the cost of in-person resident interviews by alternating them every other year with a mail survey of family members of residents. AHRQ would be interested in learning more about how the survey implementation needs of rural providers may differ from urban ones. CMS has not provided a response for this comment.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
375	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) Training is another important factor that needs to be examined. Third party vendors will need to ensure that they hire and retain a competent workforce. This workforce will need to be oriented and trained to interview residents without adding bias. The need for this is exemplified in the implementation of the MDS 3.0 interview questions. It was found that special training was to support even the most seasoned nurses and clinical researchers. Training will need to be on going so that new interviewers can be trained and so that refinements can be made to the process as they are evidenced particularly early on. It would be valuable to know about the training provided by the developer. □ The costs for implementation are an important factor to be considered. Based on the costs provided by the developer, if you extrapolate to these costs for all residents the financial impact is quite significant. We estimate the number of residents to be approximately 1.3 million – if we subtract for sub acute patients (20%) and those residents that are cognitively impaired (20%), we have a pool of approximately 750,000 residents. Multiply this by $51.00 and the costs would be $45,750,000. Again, the costs need to be updated to reflect today's service costs and additional costs for submitting data.	AHRQ Response: The CAHPS website (https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Long-Stay_Prelim_Guidelines.htm#_Toc162868085) has preliminary recommendations for fielding the CAHPS Nursing Home Survey-Long Stay Resident Instrument. These recommendations state that the Long-Stay Resident Instrument must be administered in person by a trained interviewer. Sponsors should retain a third-party vendor with experience in in-person interviewing and interviewing an elderly/nursing home population. The CAHPS Consortium recommends using professional interviewers to conduct the in-person interviews; AHRQ used professional interviewers for its 2005 resident field test. Some studies have used graduate students, ombudsmen, or volunteers to conduct the interviews. These individuals should receive training in standardized interviewing techniques, particularly with an elderly/nursing home population. A survey sponsor should consider the type and extent of interviewer training and their experience as one criterion in selection of a vendor.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
376	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) Training is another important factor that needs to be examined. Third party vendors will need to ensure that they hire and retain a competent workforce. This workforce will need to be oriented and trained to interview residents without adding bias. The need for this is exemplified in the implementation of the MDS 3.0 interview questions. It was found that special training was to support even the most seasoned nurses and clinical researchers. Training will need to be on going so that new interviewers can be trained and so that refinements can be made to the process as they are evidenced particularly early on. It would be valuable to know about the training provided by the developer. The costs for implementation are an important factor to be considered. Based on the costs provided by the developer, if you extrapolate to these costs for all residents the financial impact is quite significant. We estimate the number of residents to be approximately 1.3 million – if we subtract for sub acute patients (20%) and those residents that are cognitively impaired (20%), we have a pool of approximately 750,000 residents. Multiply this by $51.00 and the costs would be $45,750,000. Again, the costs need to be updated to reflect today's service costs and additional costs for submitting data.	1. The costs for implementation are an important factor to be considered. AHRQ Response: see response to #374 -9. Because less than 100% of the long stay population is able to complete an interview, one should not multiply cost of interview by 80 percent of the nursing home population . 2. Training is another important factor that needs to be examined. AHRQ Response: see response to #375 -10	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument
393	M, Health Professional Council	Susan Sherman, American Geriatrics Society	We do not support use of a staff member obtaining satisfaction information. Such information should be collected confidentially ideally. Until the potential for staff guiding answers or the resident feeling coercion can be eliminated, we believe that on-site survey interviews and other CAHPS measures will need to suffice.	The Committee and developer agree with this concern. Nursing home staff members do not administer the survey. It is intended to be administered by external third parties.	NH-027-10: CAHPS Nursing Home Survey: Long-Stay Resident Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
252	P	Barbara Yody, Genesis HealthCare	•Tool not validated in nursing home environment •Tool does not ask questions that measure patient & family engagement •Does not coordinate with new QIS process •Multiple states requiring patient & family surveys •In appendix, CAHPS describes long stay as 30+ days •Exclusions eliminate families not 18, did not visit NH at least once in 6 months, those who residents have discharged •Four items to case-mix adjust the data – most likely unproven risk-adjustment in LTC	1. Tool not validated in nursing home environment AHRQ Response: This survey was pilot tested in 15 nursing homes between October 2006 and February 2007. 2. Tool does not ask questions that measure patient & family engagement AHRQ Response: The survey has family engagement related question about whether the family member has been involved in decisions about the resident's care and, if yes, how often they were involved as much as they wanted to be. AHRQ also tested the following patient and family engagement questions. The singular problem with measuring patient engagement is patient capability and proxy response. • How often did you see the nursing home staff encourage your family member to participate in decisions about their own care? In cognitive testing we found that participants would say "never" because although he knew it happened, he never saw it. Another participant said "always" because she "knew they were doing it all the time (thus it was a proxy response). • How often did you see the nursing home staff encourage your family member to be as independent as possible in his or her daily routine? In cognitive testing we found that "For those who have FM with Dementia or Alzheimer's, any independence may be impossible as they are incapable of making decisions or perhaps even moving. One respondent said, "Not applicable since she is totally helpless." • Since the date on the label, how often did nursing home staff consult with you about your family member's care? Respondents include people who are not guardians/POAs/HC-POAs for the NH resident. In cognitive testing we found that these respondents do not necessarily want nor expect to be involved in making care planning decisions for the resident. (response cont'd on next page)	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
252	P	Barbara Yody, Genesis HealthCare	•Tool not validated in nursing home environment •Tool does not ask questions that measure patient & family engagement •Does not coordinate with new QIS process •Multiple states requiring patient & family surveys •In appendix, CAHPS describes long stay as 30+ days •Exclusions eliminate families not 18, did not visit NH at least once in 6 months, those who residents have discharged •Four items to case-mix adjust the data – most likely unproven risk-adjustment in LTC	(response cont'd) A care conference is a formal meeting about care planning and health progress between a care team and a resident and his or her family. Did you participate in a care conference in the last 6 months? In cognitive testing we found that respondents include people who are not guardians/POAs/HC-POAs for the NH resident. These respondents do not necessarily want nor expect to be involved in making care planning decisions for the resident. 3. Does not coordinate with new QIS process AHRQ Response: First, the QIS survey process has not been implemented in every state. For those states that have implemented it, a survey sponsor (such as a State Department of Aging or Health)might consider using information from the QIS survey process as an additional quality measure . 4. Multiple states requiring patient & family surveys AHRQ Response: AHRQ develops these patient experience surveys and puts them in the public domain free for anyone (such as states) who desires to use them. AHRQ does not have legal authority to mandate these surveys. (response cont'd on next page)	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
252	P	Barbara Yody, Genesis HealthCare	•Tool not validated in nursing home environment •Tool does not ask questions that measure patient & family engagement •Does not coordinate with new QIS process •Multiple states requiring patient & family surveys •In appendix, CAHPS describes long stay as 30+ days •Exclusions eliminate families not 18, did not visit NH at least once in 6 months, those who residents have discharged •Four items to case-mix adjust the data – most likely unproven risk-adjustment in LTC	(response cont'd) 5. In appendix, CAHPS describes long stay as 30+ days AHRQ Response: Our intent was to include family members of residents who had been in a nursing home for at least 30 days and with no planned discharge, that is, for a long stay population. 6. Exclusions eliminate families not 18, did not visit NH at least once in 6 months, those who residents have discharged AHRQ Response: AHRQ wants to exclude family members who are not adults (less than age 18), who have not visited at least twice (i.e., would have limited experience) and those whose family members have been discharged from the nursing home. 7. Four items to case-mix adjust the data – most likely unproven risk-adjustment in LTC AHRQ Response: The 2008 Final Report on the family member survey submitted to AHRQ recommends four variables as the case-mix adjusters for the family member survey: respondent age, respondent perception whether resident was permanently in nursing home, and respondent perception whether resident was capable of making decisions. AHRQ can provide additional details on case mix adjustment analysis.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument
268	M, Purchaser Council	Gaye Fortner, HC21	I support the addition of the nursing home CAHPS tools for endorsement and implementation in Nursing Home Compare. I appreciate the separate modules for long-stay, family member, and discharged resident, given that each will have different perspectives on their experience of care, all of which can make a critically important contribution to improving quality of care in the nursing home setting.	No response needed.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument
302	M, Health Professional Council	Diane Carter, AANAC	Comment: Even if the facility is not doing the survey it is still an added responsibility. If this measure is to be done it should simply be done by a third party based on sampling MDS discharge data. Leave the facility staff out of it and let them take care of residents.	Duplicate comment, see response to comment 301.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
337	M, Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	Agree with measure. No comment.	No response needed.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
377	M, Provider Council	Sandra Fitzler, American Health Care Association	It is recognized that obtaining the demographic information for the sample respondents was difficult and there is no one uniform electronic location where this is housed. Centers being required to maintain this data in a format usable for this survey are an added administrative burden. The survey allows a family member to respond after only one visit in a 6 month period so reliability based upon one visit that may be close to 6 months old is questionable. Survey questions are leading when asking for further information [ex: In the last six months, during any of your visits, did you help your family member with drinking? Y/N. If yes – was it because the nurses or aides either didn't help or made him or her wait too long? Y/N]. The only choice if the answer is Yes is worded in a negative manner. One survey question is geared toward asking the family member's opinion of care of others and what is appropriate [ex: In the last 6 months, did you see any resident, including your family member, behave in a way that made it hard for nurses or aides to provide care? Y/N. If Yes – In the last six months, how often did the nurses and aides handle the situation in a way you felt was appropriate? The survey is asking the respondent to assess the plan of care interventions for other patients who are not the respondent's family member and of whom they do not have detailed diagnosis or care plan knowledge.	1. Centers being required to maintain this data in a format usable for this survey are an added administrative burden. AHRQ Response: The pilot study found a range of capabilities among nursing homes to provide information for sampling family members. A survey vendor hired by a sponsor should work with the nursing home providers to minimize data collection burden. 2. The survey allows a family member to respond after only one visit in a 6 month period so reliability based upon one visit that may be close to 6 months old is questionable. AHRQ Response: Based on the field test results, very few (only 3%) of family members visited 0 to 1 times in the past 6 months. During the field test AHRQ excluded those participants who had 0-1 visits. AHRQ recommends these persons be excluded from analysis. 3. Survey questions are leading when asking for further information AHRQ Response: Because of the significant issue of staff failing to respond to requests for assistance in nursing homes (2008 National Ombudsmen Reporting System), the CAHPS team developed items that would explore the issue of staff responsiveness on the most essential ADLs – eating, drinking fluids and toileting. For example, the survey asks a screener question, "In the last 6 months, during any of your visits, did you help your family member with eating?" and if yes, the survey then asks, "Was it because the nurses or aides either didn't help or made him or her wait too long?" Two similar items to this on drinking and toileting are also asked. These questions help distinguish family members who want to help a resident because they simply want to from those family members who help a resident because a staff person was not available. In our pilot study, three quarters of respondents (of those screened in) answered they helped the resident with eating or drinking (and more than half of respondents for toileting) because they wanted to; these percentage do not suggest that this series is "leading". (response cont'd on next page)	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
377	M, Provider Council	Sandra Fitzler, American Health Care Association	It is recognized that obtaining the demographic information for the sample respondents was difficult and there is no one uniform electronic location where this is housed. Centers being required to maintain this data in a format usable for this survey are an added administrative burden. The survey allows a family member to respond after only one visit in a 6 month period so reliability based upon one visit that may be close to 6 months old is questionable. Survey questions are leading when asking for further information [ex: In the last six months, during any of your visits, did you help your family member with drinking? Y/N. If yes – was it because the nurses or aides either didn't help or made him or her wait too long? Y/N]. The only choice if the answer is Yes is worded in a negative manner. One survey question is geared toward asking the family member's opinion of care of others and what is appropriate [ex: In the last 6 months, did you see any resident, including your family member, behave in a way that made it hard for nurses or aides to provide care? Y/N. If Yes – In the last six months, how often did the nurses and aides handle the situation in a way you felt was appropriate? The survey is asking the respondent to assess the plan of care interventions for other patients who are not the respondent's family member and of whom they do not have detailed diagnosis or care plan knowledge.	(response cont'd) By definition, a "leading question" are those that suggest an answer. These initial questions are "screening questions" that is, they are used to determine whether something occurred or not and if so, then an additional question is asked. In addition we cognitively tested two items: "how often did you see nursing home staff check on residents to see if they were comfortable or needed something" and "how often did you see the nursing home staff help your family member when needed?" but these were ultimately removed in cognitive testing because the respondents were answered as proxies or because respondents included assistance that was not solicited (for the latter question). 4. The survey is asking the respondent to assess the plan of care interventions for other patients who are not the respondent's family member and of whom they do not have detailed diagnosis or care plan knowledge. AHRQ Response: AHRQ included this screener question to get at the issue of residents with Alzheimer's Disease and related dementias (a very common condition in nursing homes) and their sometimes difficult behaviors. We had a screener question and approximately 75% of persons said they did not witness this type of behavior. Only the remaining 25 % were asked the followup item. In addition, the intent of this item is to ask about respondents perceptions, not assess the plan of care.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
378	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) The questions on the family CAHPs survey are outdated. In the last five years there has been great emphasis on person-centered care promoted by the culture change movement. The questions in the current instrument need to be updated to provide a better measure of what is important to today's residents and families. Need to provide an example of how scores are going to be reported and published.	1. The questions on the family CAHPs survey are outdated. AHRQ Response: The common name given to the national movement for the transformation of older adult services, based on person-directed values and practices, where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living. Culture change transformation supports the creation of both long- and short-term living environments as well as community-based settings where both older adults and their caregivers are able to express choice and practice self-determination in meaningful ways at every level of daily life. Culture change transformation may require changes in organization practices, physical environments, relationships at all levels and workforce models—leading to better outcomes for consumers and direct care workers without being costly for providers (source: http://www.pioneernetwork.net/Consumers/PickerGlossary/). The following items in the family member survey address person-centered care: 1. In the last 6 months, how often did the nurses and aides treat your family member with courtesy and respect? (this question relates to person-directed values of dignity and respect) 2. In the last 6 months, how often did you see the nurses and aides treat your family member with kindness? (this question relates to person-directed values of dignity and respect) 3. In the last 6 months, how often did you feel that the nurses and aides really cared about your family member? (this question relates to person-directed values of dignity and respect) 4. Did you help your family with eating, drinking, toileting? [if yes] Was it because the nurses or aides either didn't help or made him or her wait too long? (if it was truly person-centered, the resident would receive help quickly). (response cont'd on next page)	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
378	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) The questions on the family CAHPs survey are outdated. In the last five years there has been great emphasis on person-centered care promoted by the culture change movement. The questions in the current instrument need to be updated to provide a better measure of what is important to today's residents and families. Need to provide an example of how scores are going to be reported and published.	(response cont'd) • Using any number from 0-10 where 0 is least "homelike" and 10 is most "homelike," what number would you use to rate how "homelike" the public areas of the nursing home were? In cognitive testing we found that "The term 'homelike' resulted in confusion by some respondents, and the others requested a more precise definition as they indicated they did not know what this term meant. Others viewed "homelike" as a home which they clearly felt that the NH could never be. More seriously, respondents had difficulty with trying to assess how "homelike" are public areas that cannot be 'homelike.'" (response cont'd on next cell)	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument
378	M, Provider Council	Sandra Fitzler, American Health Care Association	(continued) The questions on the family CAHPs survey are outdated. In the last five years there has been great emphasis on person-centered care promoted by the culture change movement. The questions in the current instrument need to be updated to provide a better measure of what is important to today's residents and families. Need to provide an example of how scores are going to be reported and published.	(response cont'd) In addition we tested the following items that were later dropped, mainly because there were problems with respondents being able to assess the room or because the items were proxy responses. • How often did you see the nursing home staff encourage your family member to participate in decisions about their own care? In cognitive testing we found that participants would say "never" because although he knew it happened, he never saw it. Another participant said "always" because she "knew they were doing it all the time (thus it was a proxy response). • How often did you see the nursing home staff encourage your family member to be as independent as possible in his or her daily routine? In cognitive testing we found that "For those who have FM with Dementia or Alzheimer's, any independence may be impossible as they are incapable of making decisions or perhaps even moving. One respondent said, "Not applicable since she is totally helpless." • How often did you see the same nursing home staff care for your family member? This was highly dependent on when a respondent would visit and not an accurate reflection of coordination of care, thus we dropped it. 2. Need to provide an example of how scores are going to be reported and published. AHRQ Response: Please contact developer for example of how scores could be reported for provider feedback.	NH-028-10: CAHPS Nursing Home Survey: Family Member Instrument

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
187	P	Simon Kassabian, MD, Jewish Home Lifecare System	The measures #NH-006-10 (Nsg Skill mix) and #NH-007-10 (Nsg care hrs/day) may provide significant details about nursing care, but with valid concerns by the Steering Committee (SC). Difficulty with appropriate data collection on staffing levels may be a reasonable concern for the SC but the absence of any equivalent by NQF, since these are not recommended for endorsement, may be regarded as a notable omission. Another measure addressing this issue is found at the Nursing Home Compare website by CMS providing substantial value as an indicator on the extent of personalized care. Most importantly, it acts as a surrogate marker for many non-measured outcomes beyond, for example, weight loss, pressure ulcers or other specific findings. The importance is especially heightened with CMS assigning their measure an entire domain, resulting in profound input for the star-rating system of nursing homes. It appears the outcome of the SC's vote may have superseded broader consideration in NH care. It is suggested the measure by CMS be used instead, to counteract possibly narrowed scope of quality regard. This may have its own data collection concerns though quite different to the candidate standards - and is currently in effect. Even on a time-limited basis pending further improvement for this key area, it would help to address a significant absence in the list of QMs. Marie Rosenthal, RN, MSN, Asst Admin for Clinical Svcs Simon Kassabian, MD Liz Weingast, RN, MSN, GNP	NQF can only consider measures that are submitted. The skill mix and nursing care hours measures that were submitted were not specified for implementation in the NH setting or tested there. It is our understanding that CMS is developing such measures and they as well as the ANA may submit more developed measures in the future.	not recommended

Cmnt ID#	Member Council/ Public	Organization Contact	Comment	Response	
321	M, Health Professional Council	Jacqueline Vance, AMDA	Measure #NH-001-10: Assessment of dementia on admission to long term care facility. AMDA feels very strongly that the measure is an important component to providing quality dementia care in nursing homes and requests to have it reconsidered as part of the allowable measure determination process. We request another review and would like to be assured that the main reviewer has no conflict of interest with AMDA. See letter sent to NOF plus supporting letter from the Alzheimer's Association	The Committee agrees regarding the importance of the topic. However, the Committee voted that the measure did not meet the NQF evaluation criteria of scientific acceptability and usability. All committee members are required to disclose interests both publically and in a review with NQF's General Counsel. The primary and secondary reviewers, as well as the rest of the Committee, had no conflict of interest with this measure. The Committee's discussion of this issue is summarized in the project report and detailed in the meeting and conference call notes posted online.	not recommended
396	M, Health Professional Council	Susan Sherman, American Geriatrics Society	We would like to acknowledge the need for a more diverse measurement set addressing such important aspects of care such as care transitions, end of life decision-making and palliative care. We acknowledge the need for improved evidence of the importance of these measures and of care processes in improving outcomes. We look forward to working with NQF in the future as we jointly advance the field of quality measurement, and more importantly, the quality of care in nursing homes.	NQF is beginning a Palliative Care project that will address palliative and hospice measures. Additional recommendations for measure development will be added to the revised draft report.	not recommended
402	M, Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	In regards to measures which were not recommended, while the American Nurses Association (ANA) appreciates the Steering Committee's perspective regarding the feasibility of accurate data capture by the field, the importance of falls and those with injury cannot be denied. Also, the correlation between staffing (skill mix and hours of care) and outcomes is well documented. The literature points out that RN to total nurse staffing ratio is negatively related to serious deficiencies in nursing homes. As the RN to licensed vocational nurse ratios increases, total deficiencies and serious deficiencies also decreases. These four measures (NH-004-10 through NH-007-10) should be reconsidered.	The SC agrees with the importance of the topics of the proposed measures; however, the measures were not specified for implementation in the NH setting or tested there. The Committee's discussion of this issue is summarized in the project report and detailed in the meeting and conference call notes posted online.	not recommended