NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 1733 **NQF Project:** Patient Safety Measures-Complications Project

(for Endorsement Maintenance Review)
Original Endorsement Date: **Most Recent Endorsement Date:** **Last Updated Date:** Apr 09, 2012

BRIEF MEASURE INFORMATION

De.1 **Measure Title:** Falls: Plan of Care for Falls

Co.1.1 **Measure Steward:** National Committee for Quality Assurance

De.2 **Brief Description of Measure:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

2a1.1 **Numerator Statement:** Patients at risk of future falls with a plan of care for falls document within 12 months

*Risk of future falls is defined as having had had 2 or more falls in the past year or any fall with injury in the past year.

**A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

***Plan of care is defined as consideration of appropriate assistance device AND balance, strength and gait training.

2a1.4 **Denominator Statement:** All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)seen by an eligible provider in the measurement year.

2a1.8 **Denominator Exclusions:** Patients who have documentation of medical reason (s) for not completing a risk assessment for falls (e.g. patient is not ambulatory) not considered exceptions to this measure.

1.1 **Measure Type:** Process
2a1. 25-26 **Data Source:** Administrative claims
2a1.33 **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

1.2-1.4 **Is this measure paired with another measure?** No

De.3 **If included in a composite, please identify the composite measure** (*title and NQF number if endorsed*)**:**
N/A

STAFF NOTES (*issues or questions regarding any criteria*)

Comments on Conditions for Consideration:

Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:

1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*)**:**
5. Similar/related endorsed or submitted measures (*check 5.1*)**:**
Other Criteria:

Staff Reviewer Name(s):

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.

Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I ☐

(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 **Subject/Topic Areas** *(Check all the areas that apply)*: Musculoskeletal, Musculoskeletal : Functional Status, Musculoskeletal : Hip/Pelvic Fracture, Musculoskeletal : Osteoarthritis, Musculoskeletal : Osteoporosis, Prevention, Prevention : Physical Activity, Prevention : Screening

De.5 **Cross Cutting Areas** (*Check all the areas that apply)*: Functional Status, Safety

1a.1 **Demonstrated High Impact Aspect of Healthcare:** Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1a.2 **If "Other," please describe:**

1a.3 **Summary of Evidence of High Impact** *(Provide epidemiologic or resource use data)*:

Falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert & Harmon, 2010). Older adults are five times more likely to be hospitalization for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (CDC, 2010). In those over age 80, the rate of falls increases to fifty percent (Doherty et al., 2009). Falls are also associated with substantial cost and resource use, approaching $30,000 per fall hospitalization (Woolcott, et al., 2011). Falls among elderly persons are a serious concern not simply due to the high incidence of falls but because of the susceptibility of injury and even death. Falls are the leading cause of death due to injury for the 65 and older population as well as the most common cause of nonfatal injuries and trauma related hospital admissions. In 2007, 18,000+ adults above the age of 64 died due to unintentional fall injuries. In 2008, over two million older adults required emergency care as a result of a fall, 559,000 of which needed hospitalization (CDC, 2010). A recent study calculated the number needed to treat (NNT) to prevent one fall as 32 for a single intervention compared with seven for a multidisciplinary intervention (Hanley, Silke & Murphy, 2010). With such a low NNT, this measure has the opportunity to have high impact.

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

Falls can also have serious psychological and social consequences. Developing a fear of falling is another common outcome even if no injury was sustained in the first fall. Living in fear of a fall can limit an older adult's quality of life because it causes them to limit their activities, leading to reduced mobility and loss of physical fitness, which ultimately increases their risk of falling (CDC, 2010). Recurrent falls are a common reason for long-term care admissions (Soriano et al., 2007). According a statistical brief released by the Agency for Healthcare Research and Quality, falls were a significant factor in 40.9 percent of admissions to long-term care facilities (Owens et al., 2009). Adults 75 and older are about 5 times more likely to be admitted to a long-term care facility for a year or longer than those between 65 and 74 (CDC, 2010).

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

1a.4 Citations for Evidence of High Impact cited in 1a.3: al-Aama T. (2011). Falls in the Elderly: Spectrum and Prevention. Can Fam Physician; 57(7):771-6.

Centers for Disease Control and Prevention. Injury Prevention & Control: Home and Recreational Safety. Falls Among Older Adults: An Overview. September 13, 2010.

Clyburn TA & Heydemann JA. (2011). Fall Prevention in the Elderly: Analysis and Comprehensive Review of Methods Used in the Hospital and the Home. J Am Acad Orthop Surg;19(7):402-9.

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

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

Hanley A, Silke C & Murphy J. (2010). Community-based Health Efforts for the Prevention of Falls in the Elderly. Clinical Inverventions in Aging;6:19-25.

Schneider EC, Shubert TE & Harmon KJ. (2010). Addressing the Escalating Public Health Issue of Falls Among Older Adults. North Carolina Medical Journal;71(6):547-52.

Weinberg J, PRoske D, Szerszen A, Lefkovic K, Cline C, El-Sayegh S, Jarrett M, & Weiserbs KF. (2011). An Inpatient Fall Prevention Initiative in a Tertiary Care Hospital. Jt Comm J Qual Patient Saf;37(7):317-25.

Woolcott JC, Khan KM, Mitrovic S, Anis AH, & Marra CA. (2011). The Cost of Fall Related Presentations to the ED: A Prospective, In-Person, Patient-Tracking Analysis of Health Resource Utilization. Osteporos Int;[Epub ahead of print].

Centers for Disease Control and Prevention. Injury Prevention & Control: Home and Recreational Safety. Costs of Falls Among Older Adults. September 13, 2010.

Centers for Disease Control and Prevention. Injury Prevention & Control: Home and Recreational Safety. Hip Fractures Among Older Adults. September 10, 2010.

Centers for Disease Control and Prevention. Injury Prevention & Control: Home and Recreational Safety. Falls Among Older Adults: An Overview. September 13, 2010.

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

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

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

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

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

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

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

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
Outlining a plan of care for falls prevention based on a multi-factorial risk assessment is a critical step in falls prevention. Family physicians have a pivotal role in applying preventive strategies for patients at risk (al-Aama, 2011).

al-Aama T. (2011). Falls in the Elderly: Spectrum and Prevention. Can Fam Physician; 57(7):771-6.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*: **[*For Maintenance* –** *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]**
CMS 2009 Physician Quality Reporting System:
This measure is used in the CMS Physician Quality Reporting System 2009 and 2010 Claims and Registry options. There is a gap in care as shown by this 2009 data:

Mean Performance Rate: 86.80%
Eligible Professionals Submitting: 3,257

1b.3 Citations for Data on Performance Gap: [*For Maintenance* – *Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]**
Section 1b.2 references data from 2009, most recent year available from PQRS.

2009 Physician Quality Reporting System and eRx Experience Report. Appendix B: 2009 Physician Quality Reporting System Detailed Tables

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance* –*Descriptive statistics for performance results for this measure by population group*]**
The measure is not stratified by patient groups or cohorts that could potentially be affected by disparities in care, NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, and employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden without generating meaningful results. We believe that the measure specifications should NOT require this unless absolutely necessary since the data needed to determine disparities cannot be ascertained from the currently available sources.

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance* – *Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]**
N/A

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I ☐ Quality: H☐ M☐ L☐ I ☐ Consistency: H☐ M☐ L☐ I ☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No☐

M-H	**L**	**M-H**	**Yes**☐ IF potential benefits to patients clearly outweigh potential harms: otherwise **No**☐
L-M-H	**L-M-H**	**L**	**No** ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	**Does the measure pass subcriterion1c?** **Yes**☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)***:**
Widely accepted evidenced based guidelines recommend that all older persons who are under the care of a health professional should be asked at least once a year about falls and if falls have occurred, that they receive assessment and advice on how to avoid falls. Older persons who seek medical attention directly for a fall, report multiple falls per year, or demonstrate irregularities of gait and/or balance should receive a fall evaluation. A fall evaluation identifies risk factors related to vision, muscle strength and reflexes— important information for developing a treatment plan (AGS/BGS/AAOS, 2001).

Fall risk screening (Identify population at risk; #0101) >> risk assessment for falls (multi-component assessment for fall risk-factors; #1730) >> plan of care for falls (appropriate multi-component intervention to reduce falls risk; #1733) >> reduced number of falls

The American Geriatrics Society along with the British Geriatrics Society recommends fall risk assessment based on epidemiological studies demonstrating an association between certain risk factors and falls and from experimental studies in which assessment followed by intervention demonstrated benefit. Assuming that the interventions are carried out, multifactorial falls risk assessment and management programs could be one of the most effective intervention for reducing both the risk for falling and the monthly rate of falling (Chang, 2004; Gillespie, 2010).

Individuals who have experienced two or more falls in the last year or who have gait or balance issues have an increased likelihood of falling, therefore would benefit from multifactorial falls risk assessment (AGS, 2010).

1c.2-3 Type of Evidence *(Check all that apply)***:**
Clinical Practice Guideline, Systematic review of body of evidence (other than within guideline development)

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)***:**
This measure is evaluating the prevalence of plan of care for falls risk in the elderly population. The evidence cited here is directly associated with the intent and focus of this measure.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)***:** 111

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*)**:** Good

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* The studies are all in agreement that multi-factorial interventions can significantly affect the rate of fall prevention. The USPSTF is currently evaluating the body of evidence for fall risk prevention.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:**
The evidence cited here all discuss the effectiveness of multi-factorial risk assessment paired with the appropriate intervention for reducing the incidence of falls among community-dwelling older adults.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: N/A

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: N/A

1c.13 Grade Assigned to the Body of Evidence: N/A

1c.14 Summary of Controversy/Contradictory Evidence: No controversy or contradiction.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:

Chang JT, Morton SC, Rubenstein LZ, et al. Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomized clinical trials. BMJ 2004; 328:680-3.

Gillespie LD, Robertson MC, Gillespie WJ, Lam WE, Gates S, Cumming RG, Rowe BH. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub2.

The American Geriatrics Society. AGS Clinical Practice Guideline: Prevention of Falls in Older Persons (2010). Accessed at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations

1c.16 Quote verbatim, <u>the specific guideline recommendation</u> *(Including guideline # and/or page #)*:

Two sets of guidelines/recommendations are listed below: American Geriatric Society/British Geriatric Society (AGS/BGS) and the National Institute for Clinical Excellence (NICE).

AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons summary of recommendations

INTERVENTIONS

OLDER PERSONS LIVING IN THE COMMUNITY

1. The multifactorial fall risk assessment should be followed by direct interventions tailored to the identified risk factors, coupled with an appropriate exercise program.[A]
2. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified.[A]
3. The components most commonly included in efficacious interventions were:

a. Adaptation or modification of home environment [A]
b. Withdrawal or minimization of psychoactive medications [B]
c. Withdrawal or minimization of other medications [C]
d. Management of postural hypotension [C]
e. Management of foot problems and footwear [C]
f. Exercise, particularly balance, strength, and gait training [A]

4. All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]
5. Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]
6. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]
7. Psychoactive medications (including sedative hypnotics, anxiolytics, antidepressants) and antipsychotics (including new antidepressants or antipsychotics) should be minimized or withdrawn, with appropriate tapering if indicated. [B]
8. A reduction in the total number of medications or dose of individual medications should be pursued. All medications should be reviewed, and minimized or withdrawn. [B]
9. Exercise should be included as a component of multifactorial interventions for fall prevention in community-residing older persons. [A]
10. An exercise program that targets strength, gait and balance, such as Tai Chi or physical therapy, is recommended as an

effective intervention to reduce falls [A]
11. Exercise may be performed in groups or as individual (home) exercises, as both are effective in preventing falls. [B]
12. Exercise programs should take into account the physical capabilities and health profile of the older person, (i.e., be tailored) and be prescribed by qualified health professionals or fitness instructors. [I]
13. The exercise program should include regular review, progression and adjustment of the exercise prescription as appropriate. [I]
14. In older women in whom cataract surgery is indicated, surgery should be expedited as it reduces the risk of falling. [B]
15. There is insufficient evidence to recommend for or against the inclusion of vision interventions within multifactorial fall prevention interventions. [I]
16. There is insufficient evidence to recommend vision assessment and intervention as a single intervention for the purpose of reducing falls. [D]
17. An older person should be advised not to wear multifocal lenses while walking, particularly on stairs. [C]
18. Assessment and treatment of postural hypotension should be included as components of multifactorial interventions to prevent falls in older persons. [B]
19. Dual chamber cardiac pacing should be considered for older persons with cardioinhibitory carotid sinus hypersensitivity who experience unexplained recurrent falls. [B]
20. Vitamin D supplements of at least 800 IU per day should be provided to older persons with proven vitamin D deficiency. [A]
21. Vitamin D supplements of at least 800 IU per day should be considered for people with suspected vitamin D deficiency or who are otherwise at increased risk for falls. [B]
22. Identification of foot problems and appropriate treatment should be included in multifactorial fall risk assessments and interventions for older persons living in the community. [C]
23. Older people should be advised that walking with shoes of low heel height and high surface contact area may reduce the risk of falls. [C]
24. Home environment assessment and intervention carried out by a health care professional should be included in a multifactorial assessment and intervention for older persons who have fallen or who have risk factors for falling. [A]
25. The intervention should include mitigation of identified hazards in the home, and evaluation and interventions to promote the safe performance of daily activities. [A]
26. Education and information programs should be considered part of a multifactorial intervention for older persons living in the community. [C]
27. Education should not be provided as a single intervention to reduce falls in older persons living in the community. [D]

OLDER PERSONS IN LONG-TERM CARE FACILITES

28. Multifactorial/multicomponent interventions should be considered in long-term care to reduce falls. [C]
29. Exercise programs should be considered to reduce falls in older persons living in long-term care settings with caution regarding risk of injury in frail persons. (C)
30. Vitamin D supplements of at least 800 IU per day should be provided to older persons residing in long-term care settings with proven or suspected vitamin D insufficiency. [A]
31. Vitamin D supplements of at least 800 IU per day should be considered in older persons residing in long-term care settings who have abnormal gait or balance or who are otherwise at increased risk for falls. [B]

OLDER PERSONS WITH COGNITIVE IMPAIRMENT

32. There is insufficient evidence to recommend for or against multifactorial or single interventions to prevent falls in older persons with known dementia living in the community or in long-term care facilities. [I]

NICE Clinical Guideline Recommendations

1.3 Multifactorial interventions
1.3.1 All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. [A]
In successful multifactorial intervention programmes the following specific components are common – against a background of the general diagnosis and management of causes and recognised risk factors: [A]
? strength and balance training
? home hazard assessment and intervention
? vision assessment and referral
? medication review with modification/withdrawal.
1.3.2 Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting

independence and improving physical and psychological function. [A]

1.4 Strength and balance training
1.4.1 Strength and balance training is recommended. Those most likely to benefit are older community dwelling people with a history of recurrent falls and/or balance and gait deficit.A muscle strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional. [A]
1.5 Exercise in extended care settings
1.5.1 Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling. [A]
1.6 Home hazard and safety intervention
1.6.1 Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained health care professional.Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team.
[A]
1.6.2 Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation. [A]

1c.17 **Clinical Practice Guideline Citation:** The American Geriatrics Society. AGS Clinical Practice Guideline: Prevention of Falls in Older Persons (2010).

National Institute for Clinical Excellence (NICE). (2004). Clinical practice guideline for the assessment and prevention of falls in older people. Royal College of Nursing: London.

1c.18 **National Guideline Clearinghouse or other URL:**
http://www.guideline.gov/syntheses/synthesis.aspx?id=25624&search=falls+prevention; http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations; http://guidance.nice.org.uk/nicemedia/live/10956/29585/29585.pdf

1c.19 **Grading of Strength of Guideline Recommendation.** Has the recommendation been graded? Yes

1c.20 **If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** American Geriatric Society and British Geriatric Society, expert consensus with evidence review. National Institute for Clinical Excellence, expert consensus with evidence review.

1c.21 **System Used for Grading the Strength of Guideline Recommendation:** Other

1c.22 **If other, identify and describe the grading scale with definitions:** AGS/BGS: Strength of Recommendation Rating System
[A] A strong recommendation that the clinicians provide the intervention to eligible patients.
Good evidence was found that the intervention improves health outcomes and the conclusion is that benefits substantially outweigh harm.
[B] A recommendation that clinicians provide this intervention to eligible patients.
At least fair evidence was found that the intervention improves health outcomes and the conclusion is that benefits outweigh harm.

NICE
Grade A- directly based on category 1 evidence

1c.23 **Grade Assigned to the Recommendation:** AGS/ BGS Grade A-B; NICE Grade A

1c.24 **Rationale for Using this Guideline Over Others:** An expert panel of diverse stakeholders reviewed the guidelines and evidence for supporting this measure concept. The panel determined the evidence used to support this measure was scientifically sound using after reviewing the full body of evidence and available guidelines.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: High **1c.26** Quality: High**1c.27** Consistency**:** High
1c.28 Attach evidence submission form**:**
1c.29 Attach appendix for supplemental materials**:**

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **(evaluation criteria)**
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? Yes

S.2 If yes, provide web page URL: http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)***:**
Patients at risk of future falls with a plan of care for falls document within 12 months

*Risk of future falls is defined as having had had 2 or more falls in the past year or any fall with injury in the past year.

**A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

***Plan of care is defined as consideration of appropriate assistance device AND balance, strength and gait training.

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)***:**
A twelve month measurement period.

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses***:**
All patients who have plan of care for fall risks completed in the 12 month measurement period comprised of consideration of appropriate assistance device AND balance, strength and gait training.

Consideration of appropriate assistance device: Documentation that an assistive device was provided or considered, or referral for evaluation for an appropriate assistance device
Balance, strength, and gait training: Documentation that balance, strength, and gait training/instructions were provided, or referral to an exercise program, which includes at least one of the three components: balance, strength or gait.

All components do not need to be completed during a single patient visit, but should be documented in the medical record as

having been performed within the past 12 months.

The following CPT II codes indicate numerator compliance for this measure:
CPT II 0518F: Falls plan of care documented

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)seen by an eligible provider in the measurement year.

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care, Populations at Risk

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
A twelve month measurement period.

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
Patients are included in the denominator if they have been seen by a healthcare practitioner during the measure period. Using the following CPT codes to identify that meet inclusion criteria:

CPT Code: 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Report the following CPT Category II code to confirm a history of falls:

1100F: Patient screened for future fall risk; documentation of two or more falls in the past year.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Patients who have documentation of medical reason (s) for not completing a risk assessment for falls (e.g. patient is not ambulatory) not considered exceptions to this measure.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
Patients are considered to be excluded from measurement if any of the following codes are present in the patient record:

0518F with 1P: Documentation of medical reason(s) for no plan of care for falls

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
N/A

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
N/A

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*: Better quality = Higher score

2a1.20 Calculation Algorithm/Measure Logic*(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*:
Measure Calculation
For performance purposes, this measure is calculated by creating a fraction with the following components: Denominator, Numerator, and Exceptions.

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

Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above. The denominator includes all patients 65 and up seen by a health care provider in the measurement year with documentation of two or more falls in the previous year.

Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above.. The numerator includes all patients in the denominator population
with a documented plan of care for falls within 12 months.

Step 4: Identify patients with valid exclusions. Patients with documented medical reason(s) for not having a plan of care for falls (e.g., patient is not ambulatory) are excluded from to the denominator.
Step 5: Calculate the rate by dividing the total from Step 3 by the total from Step 2 minus the total from Step 4. (e.g. Step 3/(Step 2 – Step 4))

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
N/A

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Administrative claims

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): N/A

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Urgent Care, Home Health, Hospice, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
PCPI Testing Project
Four practice sites representing various practice types, geographic locations and patient volumes were recruited to participate in testing the measure concept
- The number of geriatricians per site ranged from 1-16
- The sites were located in four different regions of the United States
- Patient visit volume per site ranged from 500 – 1,000 geriatric patients per month

Total patient population per practice varied (as indicated below). A random sample of 70 geriatric patient charts were selected from each site for abstraction. The sample included any Medicare patient who had an office visit between January 1 and December 31, 2009. One testing site extracted the information manually from paper medical records while the other three sites extracted testing data from electronic medical records. A total of 220 patient records were able to be successfully abstracted from all sites for the purposes of this study.

- Site 1 (Paper): 2,500 patients
- Site 2 (EHR): 1,800 patients
- Site 3 (EHR): 3,700 outpatients/2,000 LTC patients
- Site 4 (EHR): 2,500 patients

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
Data was abstracted from a series of randomly selected patient records and used to calculate inter-rater reliability,by comparing it to measure results derived from claims.

Data analysis included:
• Percent agreement
• Kappa statistic of reliability

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Overall, this measure is highly reliable.

(N, % Agreement, Kappa (95% Confidence Interval))
Denominator (15, 100.00%, Kappa is not calculable)
Exceptions (1, 100.00%, Kappa is not calculable)
Numerator (15, 100.00%, 1.00)
Overall (15, 100.00%, 1.00)

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* **are consistent with the evidence cited in support of the measure focus (***criterion 1c)* **and identify any differences from the evidence:**
The measure focuses on interventions to prevent future falls in the elderly population. The evidence is consistent with the focus and scope of this measure.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
An expert panel used to assess this measure consisted of 33 members representing the following areas: internal medicine, geriatrics, anesthesia, orthopedic surgery, physical medicine & rehabilitation, neurology, palliative medicine, urology, geriatric psychiatry, emergency medicine, nephrology, radiation oncology, ophthalmology, medical epidemiology, methodology, hospital medicine, family medicine, and bioethics. The list of experts is provided in section Ad.1. Workgroup/Expert Panel Involved in Measure Development.

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)***:**
All NCQA-AMA-PCPI performance measures are assessed for content validity by expert work group members during the development process. Additional input on the content validity of draft measures is obtained through a public comment period as well as direct solicitation of comments from a panel of consumer, purchaser, and patient representatives convened specifically for this purpose. All comments received are reviewed by the experts and the measure specifications are adjusted as needed. Other external review groups (i.e. focus groups) may be convened if there are any remaining concerns related to the content validity of the measures.

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)***:**
The aforementioned panel was asked to rate their agreement with the following statement:

The scores obtained from the measure as specified will accurately differentiate quality across providers.

Scale 1-5, where 1=Strongly Disagree; 3=Neither Disagree nor Agree; 5=Strongly Agree

The results of the expert panel rating of the validity statement were as follows:
N = 23 Mean rating = 4.35

Frequency Distribution of Ratings
1 - 0 (Strongly Disagree)
2 - 0
3 - 4 (Neither Disagree nor Agree)
4 - 7
5 - 12 (Strongly Agree)

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
The effect of measure exclusions was conducted on the entire sample of patients included in the field test.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)***:**
Exclusions included medical and patient reasons. Exclusions were analyzed for frequency and variability across providers.

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
The exclusion rate for this measure was 0.00%.

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
N/A

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)***:**
N/A

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)***:**
N/A

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: N/A

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
This measure is also used in the CMS 2009 Physician Quality Reporting System (PQRS):

This measure was used in the CMS Physician Quality Reporting System 2009 and 2010 Claims and Registry options. This measure was used in the CMS Physician Quality Reporting System 2009 and 2010 Claims and Registry options.

427,022 cases were reported on for the 2009 program, the most recent year for which data is available. The following information is for the 2009 program, the only year for which such data is available. Mean Performance Rate was 86.80%.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)***:**
For the CMS Physician Quality Reporting Initiative (PQRI), the mean performance rate was calculated from the number of eligible professionals submitting reports for the 2009 measurement year.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:
Clinical Condition and Measure: PQRS #155 Falls: Plan of Care
Eligible Professionals: 6,810
Professionals Reporting >1 Valid QDC: 3,183
% Professionals Reporting >1 Valid QDC: 46.74%
# Professionals Reporting Satisfactorily Reporting: 2,262
% Professionals Reporting Satisfactorily Reporting: 71.07%

Mean Performance Rate: 86.80%

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
N/A

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)***:**
N/A

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)***:**

N/A

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 **If measure is stratified for disparities, provide stratified results** *(Scores by stratified categories/cohorts)*: The measure is not stratified.

2c.2 **If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:**
N/A

2.1-2.3 **Supplemental Testing Methodology Information:**

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

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

C.1 **Intended Actual/Planned Use** *(Check all the planned uses for which the measure is intended)*: Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 **Current Use** *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Professional Certification or Recognition Program, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. **Use in Public Reporting - disclosure of performance results to the public at large** *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s))*. If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[*For Maintenance* –** *If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.***]**
This measure is currently being used in the CMS Physician Quality Reporting System for 2011. This measure was also used in the 2009 and 2010 CMS PQRI programs. The results from the 2009 and 2010 programs can be found on the CMS website: http://www.cms.gov/PQRS/01_Overview.asp#TopOfPage

3a.2.**Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting**. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results**:** The successful use in PQRI supports the feasibility and usability of the measure specification on a national scale and the results indicate that there is still room for improvement in this critical patient safety area.

3.2 **Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s)**:** This measure has been used in the CMS Physician Quality Reporting Initiative (https://www.cms.gov/PQRS/)

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐

(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance* – *If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
The measure specifications are made freely available on the PCPI website and through the implementation efforts of medical specialty societies.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
The successful use in PQRI supports the feasibility and usability of the measure specification on a national scale.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

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

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are**:**
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)***:** ALL data elements are in a combination of electronic sources

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
We are not aware of any unintended consequences related to the use of this measure.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*)**:** Proprietary measure
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)***:**
The specific costs for implementing or using this measure have not been measured, however the successful use in a national reporting program (PQRS) support the feasibility and utility of the measure concept.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.

If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

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

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:
0035 : Fall Risk Management
0101 : Falls: Screening for Future Fall Risk
0141 : Patient Fall Rate
0202 : Falls with injury
0537 : Multifactor Fall Risk Assessment Conducted in Patients 65 and Older
1730 : Falls: Risk Assessment for Falls

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:
SEE 5b1 FOR MORE INFORMATION.

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality)*; OR provide a rationale for the additive value of endorsing an additional measure. *(Provide analyses when possible)*:
RELATED MEASURES:
NQF# 0141 measures patient fall rate in the hospital setting during one month. This measure is related but not competing. The target population is different (#1733- adult in ambulatory care or home health or nursing home; #0141 – adults in the hospital setting) and the measure concept is different (#1730 – Plan of care for falls prevention documented; #0141 rate of falls outcome measure).

NQF #0202 measures patient fall with injury rate in the hospital setting. This measure is related by not competing. The target population is different (#1733- adult in ambulatory care or home health or nursing home; #0202 – adults in the hospital setting) and the measure concept is different (#1733 – Plan of care for falls prevention documented; #0202 – rate of falls with injury outcome measure).

NQF #0537 measures risk assessment for falls in the home health setting. This measure is related by not competing. The target population overlap but are different in focus (#1733-adults in all non-acute settings including home-care; #0537 – adults in the home health setting) and the measure concept is different (#1733 – plan of care for fall prevention documented; #0537 – multi-factorial risk assessment for falls)

NQF #0101 and #1730 are related by not competing. The target population is the same, however the measure concept is different (#0101 – screening for falls risk to determine if multi-factorial risk assessment is appropriate; #1730 – multi-factorial falls risk assessment; #1733 – plan of care for falls prevention).

NQF #0035 measures falls risk management for all individuals across settings. This measure is related but not competing. The target population is the same; however the measure concept is different (#1733 – Plan of care for falls prevention documented; #0035 patient report of discussing balance, walking or falls problem and receiving an intervention). NQF #0035 is a health plan level measure and uses a different data source (patient reported) from #1733 (administrative claims).

COMPETING MEASURES:
No competing measures.

CONTACT INFORMATION

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 **Point of Contact:** Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-

Co.3 **Measure Developer if different from Measure Steward:** National Committee for Quality Assurance, 1100 13th Street NW, Washington, District Of Columbia, 20005

Co.4 **Point of Contact:** Dawn, Alayon, MPH, CPH, alayon@ncqa.org, 202-955-3533-

Co.5 **Submitter:** Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-, National Committee for Quality Assurance

Co.6 **Additional organizations that sponsored/participated in measure development:**
This measure was developed with the cooperation of the American Geriatrics Society, the National Committee for Quality Assurance and the American Medical Association.

Co.7 **Public Contact:** Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-, National Committee for Quality Assurance

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

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

An expert panel was used to assess face validity of the measure. The panel consists of 33 members, whose specialties include internal medicine, geriatrics, anesthesia, orthopedic surgery, physical medicine & rehabilitation, neurology, palliative medicine, urology, geriatric psychiatry, emergency medicine, nephrology, radiation oncology, ophthalmology, medical epidemiology, methodology, hospital medicine, family medicine, and bioethics.

Caroline Blaum, MD (Work Group Co-Chair) (Geriatrics/Internal Medicine) Associate Professor of Internal Medicine, University of Michigan, Ann Arbor, MI
Carol M. Mangione, MD (Work Group Co-Chair) (Internal Medicine) Professor of Medicine, David Geffen School of Medicine at UCLA, Los Angeles, CA
Chris Alexander, III, MD, FACP (Methodology) Social Security Administration, Office of Hearings and Appeals, Earlysville, VA
Patricia P. Barry, MD, MPH (Internal Medicine) American College of Physicians, Gloucester Point, VA
Frederick W. Burgess, MD, PhD (Anesthesia) Rhode Island Hospital, Department of Anesthesia, Providence, RI
Gary S. Clark, MD, MMM, CPE (Physical Medicine & Rehabilitation) Professor and Chair, MetroHealth Medical Center, Dept. of PM&R, Cleveland, OH
Eric Coleman, MD, MPH (Geriatrics) Associate Professor, Division of Health Care Policy and Research, University of Colorado Health Services Center, Aurora, CO
Stephen R. Connor, PhD Vice President, Research and International Development, National Hospice and Palliative Care Organization, Alexandria, VA
Gail A. Cooney, MD (Neurology, Palliative Medicine) Hospice of Palm Beach County, West Palm Beach, FL
Roger Dmochowski, MD (Urology) Department of Urologic Surgery, Vanderbilt University, Nashville, TN
Catherine DuBeau, MD (Geriatrics) Associate Professor of Medicine, University of Chicago, Chicago, IL
Joyce Dubow Associate Director, AARP Policy Institute, Washington, DC
Mary Fermazin, MD, MPA (Internal Medicine) Vice President, Health Policy & Quality Measurement, Health Services Advisory Group, Inc., Phoenix, AZ
Sanford I. Finkel, MD (Geriatric Psychiatry) Professor of Clinical Psychiatry, University of Chicago Medical School, Wilmette, IL

Terry Fulmer, PhD Dean, NYU College of Nursing, New York, NY
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Flora Lum, MD American Academy of Ophthalmology, Director, Quality of Care & Knowledge Base Development, San Francisco, CA
Diane E. Meier, MD Professor, Director: Hertzberg Palliative Care Institute, Director: Center to Advance Palliative Care, Mount Sinai School of Medicine, Department of Geriatrics, New York, NY
Alvin "Woody" H. Moss, MD (Nephrology and Palliative Care) Professor of Medicine & Director, Center for Health Ethics & Law, Section of Nephrology, West Virginia University, Morgantown, WV
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Knight Steel, MD (Internal Medicine/Geriatrics) Chief, Geriatrics, Internist, Professor of Medicine Emeritus, Hackensack University Medical Center, Hackensack, NJ
Eric Tangalos, MD (Internal Medicine/Geriatrics) Co-Director, Program on Aging, Mayo Clinic, Rochester, MN
Joan M. Teno, MD, MS (Geriatrics/Palliative Care) Professor of Community Health and Medicine, Brown Medical School, Providence, RI
David J. Thurman, MD, MPH CDC, Atlanta, GA
Mary Tinetti, MD (Internal Medicine/Geriatrics) Gladys Phillips Crofoot Professor of Medicine, Epidemiology and Public Health, Yale University School of Medicine, Section of Geriatrics, New Haven, CT
Laura Tosi, MD (Orthopaedic Surgery) American Academy of Orthopaedic Surgery, Director, Bone Health Program, Washington, DC
Gregg Warshaw, MD Director, Office of Geriatric Medicine, University of Cincinnati College of Medicine, Cincinnati, OH
Neil S. Wenger, MD (Internal Medicine/Geriatrics) Professor of Medicine, UCLA, Los Angeles, CA

Ad.2 **If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:**

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 **Year the measure was first released:**
Ad.4 **Month and Year of most recent revision:**
Ad.5 **What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines have changed significantly.
Ad.6 **When is the next scheduled review/update for this measure?**

Ad.8 **Disclaimers:**

Ad.9 **Additional Information/Comments:**

Date of Submission (*MM/DD/YY*)**:** 09/14/2011