Person and Family Centered Care 2015-2016

DRAFT REPORT FOR COMMENT

July 14, 2016

NATIONAL QUALITY FORUM

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Person and Family Centered Care

DRAFT REPORT

Executive Summary

There are various definitions of what comprises person and family centered care (PFCC) but all illuminate the need for higher quality care that is organized around the needs of individuals and their families. Often, healthcare is received in a manner that does not account for the preferences and goals of individuals and their families. Over the past decade, efforts have been underway to shift the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers persons to participate actively in their own care. The National Quality Strategy (NQS) priority of "*Ensuring that each person and family is engaged as partners in their care"* emphasizes this approach. Emerging evidence points to the positive impact of collaborative partnerships between persons, families, and their healthcare providers on outcomes and cost.

The National Quality Forum's (NQF) definition of person and family centered care is:

> *An approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values.*

The definition is consistent with definitions used by the Institute for Patient- and Family-Centered Care and the Institute of Medicine (IOM).[1] Over the past 5 years, NQF has engaged in various projects highlighting the importance of PFCC and promoting progress in measure prioritization, measure implementation, and the closure of gaps across the healthcare delivery system. The projects have included multiple phases of consensus development process (CDP) work where a number of new measures have been reviewed and endorsed. Additionally, the Measures Application Partnership (MAP) makes recommendations on families of measures in order to promote the alignment of performance measurement across federal programs and private-sector initiatives. MAP identified priority areas for measuring PFCC, which include: interpersonal relationships, patient and family engagement, care planning and delivery, access to support, and quality of life, including measures of physical and cognitive functioning, symptom and symptom burden (e.g., pain, fatigue), and treatment burden (on patients, families, caregivers, siblings).

NQF's PFCC portfolio includes measures focused on quality of life, functional status, experience of care, shared decision making, symptom/symptom burden and communication.

In this third phase of PFCC CDP work, the Standing Committee evaluated 12 newly-submitted measures and 1 measure undergoing maintenance review against NQF's standard evaluation criteria. Of the 13 measures, 8 were recommended for endorsement, and the Committee did not recommend or did not

reach consensus on 5 measures. The 8 measures that were recommended by the Standing Committee are:

- 0420 Pain Assessment and Follow Up, Centers for Medicare & Medicaid Services (CMS)
- 2614 CoreQ: Short Stay Discharge Measure, American Health Care Association
- 2615 CoreQ: Long-Stay Resident Measure, American Health Care Association
- 2616 CoreQ: Long-Stay Family Measure, American Health Care Association
- 2769 Functional Change: Change in Self Care Score for Skilled Nursing Facilities, Uniform Data System for Medical Rehabilitation (UDSMR)
- 2774 Functional Change: Change in Mobility Score for Skilled Nursing Facilities, UDSMR
- 2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities, UDSMR
- 2962 Shared Decision Making, Healthwise

The Committee did not reach consensus on the following measures:

- 2776 Functional Change: Change in Motor Score for Long Term Acute Care Facilities, UDSMR
- 2777 Functional Change: Change in Self Care Score for Long Term Acute Care Facilities, UDSMR
- 2958 Informed, Patient Centered Hip and Knee Replacement Surgery, Massachusetts General Hospital

The Committee did not recommend the following measures:

- 2778 Functional Change: Change in Mobility Score for Long Term Acute Care Facilities, UDSMR
- 2967 Home and Community Based Services Experience of Care Measures, CMS

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

In addition to the measures evaluated for maintenance or new endorsement, the Committee had an opportunity to provide feedback on an additional 7 measures that will be evaluated in the future for maintenance endorsement. These measures, based on the Communication Climate Assessment Toolkit (C-CAT), were originally reviewed by NQF's Disparities Steering Committee. While due for maintenance review, they have been in a transition process between stewards and thus a request for delay was granted. A brief overview of the Committee discussion is included in the body of the report.

Introduction

One of the priorities of the NQS[2], first published in 2011, is ensuring that each person and family is engaged as partners in their care. As such, the healthcare community has the opportunity to build upon the concept of person and family centeredness to guide efforts to improve health and healthcare quality. NQF has multiple projects underway related to patient centeredness, and, over the past few years, has seen an increasing number of new measures submitted for endorsement consideration that reflect the interest in this area. As with measurement in other priority areas, the expansion of measurement to be inclusive of the issues of importance and value to patients and caregivers has started to show results.

A study published in 2015 in the *Journal of General Internal Medicine* examined the implementation of a patient-centered medical home (PCMH) pilot program in 15 small and medium primary care practices in Colorado. Over a 3-year period, the study found that the patient-centered primary care delivered in the PCMH model led to sustained decreases in the number of annual emergency department visits and primary care visits, as well as increased screening for some types of cancer.[3]

Person centered care also needs to be integrated outside of medical homes in the fee-for-service settings where most patients receive care. As outlined in the NQS, successful person-centered care entails more than just the successful completion of clinical care; it also means that patients achieve their own desired outcomes.

According to the 5th anniversary update on the NQS, person centered care improved quickly, but person centered care disparities were common, especially for Hispanics and poor people. As is true for access, disparities by income are larger than disparities by race/ethnicity. Effective and respectful provider-patient communication is at the core of person-centered care. The 2013 enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care[4] provides a framework to help organizations deliver services that are responsive to patients' diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.[5]

In addition, the report indicates that such efforts have led to widespread improvements in person-centered care; 80% of measures tracked showed improvement. However, many disparities exist and only about 30% of the disparities are getting smaller over time. An additional decrease in disparities is expected, in part, because of enforcement of Section 1557 of the Affordable Care Act, which prohibits organizations from discriminating on the grounds of race, color, national origin, age, disability or sex, under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by HHS, including the Health Insurance Marketplaces.[2]

As developers have been exploring new measurement approaches to assess person and family centeredness, which, in turn, has led NQF to review those measures for endorsement, challenges in meeting the evaluation criteria are being identified. This is especially true for measures derived from surveys, instruments and other tools. In previous phases of PFCC work, the Committee has assessed measures based on patient reported outcome measures (e.g. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys) and clinician assessment tools (e.g. functional status

instruments). As the complexity of performance measures has increased, NQF criteria continue to evolve to overcome challenges in interpretation. In this project, the Committee urged NQF to provide additional guidance on scientific acceptability criteria to ensure enough information, specifically data, is provided to ensure the ability to compare measure performance and evaluate entities at the level of accountability or analysis. The Committee was especially interested in the availability of data to assess variation and reliability between reporting entities which extends beyond within entity or unit testing.

Communication Climate Assessment Toolkit

The C-CAT was originally developed at the American Medical Association (AMA), and is the basis of 7 currently endorsed measures. These measures are due for endorsement review; however, upon submission to this project it was recognized that due to a dormant period when the measure stewardship transitioned from the AMA to the University of Colorado, the measures were not ready for maintenance review. NQF staff worked with the University of Colorado and has approved rescheduling their maintenance review. Because these measures will come to the PFCC Standing Committee, Matt Wynia, the Principal Investigator and developer of the C-CAT measures, was invited to the in-person meeting to discuss the measures and obtain feedback from the Committee to facilitate their resubmission.

Dr. Wynia provided an overview of the toolkit and indicated the original development team included the American Hospital Association, the Nurses Association, the Joint Commission, National Committee for Quality Assurance, CMS, Agency for Healthcare Research and Quality, and patient organizations, including most notably the National Health Council. Based on the original measure exploration, the team wanted to measure whether organizations were doing a good job of creating an environment in which minority patients, people with limited English proficiency, and people with low literacy were getting excellent care. To assess these issues, the C-CAT team recognized the need to look at the communication climate, so they developed a toolkit assessing 9 domains of communication. Seven of those domains were endorsed: performance evaluation, literacy, language services, cross cultural communication, patient engagement, and shared decisions, work force development, and leadership commitment. The 2 domains that were not endorsed were community engagement and data collection. The measures are based on both a patient and staff survey that can be considered a 360 evaluation of the organization.

Dr. Wynia indicated the team is struggling with the need for risk-adjustment and indicated the results are currently stratified by race, ethnicity, and other variables. The Committee provided feedback including:

- Recommendation not to risk adjust, as the issues are important to highlight and there is a lot of variation around the country
- Request to demonstrate how the toolkit and measures are associated with improvements in care
- Consideration for the “game-ability” of the metrics, and, if found, how they would be addressed
- If this is really a set of measures, or a set of services

Based on the discussion at the meeting, the developers and NQF will develop a re-submission timeline and the measures will be returned to the PFCC Committee for consideration of maintenance endorsement.

NQF Portfolio of Performance Measures for Person and Family Centered Care

The PFCC Standing Committee (see Appendix D) oversees NQF's portfolio of PFCC measures that includes measures for symptom/symptom burden, experience of care, functional status, health-related quality of life (HRQoL), patient activation, and communication (see Appendix B). This portfolio contains 62 measures: 7 process measures, 54 outcome measures, and 1 structure measure (see table below).

Table 1. NQF Person and Family Centered Care Portfolio of Measures

	Process	Outcome	Structure	Composite
Symptom/Symptom Burden	1	1	0	0
Experience of Care	0	14	0	0
Functional Status	3	30	0	0
Health-Related Quality of Life	1	1	0	0
Patient Activation	0	1	0	0
Communication	2	7	1	0
Total	7	54	1	0

Additional measures related to PFCC are assigned to other projects. These include measuring the experience of hospice patients and pain assessments (Palliative and End of Life Care project) and HRQoL assessments in dialysis patients (Renal project).

Use of Measures in the Portfolio

Many of the measures in the PFCC portfolio are in use in at least 1 federal program, such as Home Health Quality Reporting, Hospital Compare, Hospital Inpatient Quality Reporting, Nursing Home Compare, or the Physician Quality Reporting System. In addition, some of these measures have been used as part of state, regional, and community measurement initiatives, such as Aligning Forces for Quality (AF4Q) community alliances. A number of the measures in use in federal programs were submitted and endorsed in response to the government charge in the IMPACT Act; in addition, many have been included in the MAP Family of Measures. See Appendix C for details of federal program use for the measures in the portfolio. Only one measure in this current project is currently in use in a federal program: #0420: Pain Assessment and Follow-Up.

Improving NQF's Person and Family Centered Care Portfolio

Although the number of new measures submitted for endorsement has continued to grow, there remain gaps in measures for specific focus areas that could be of value to individuals, families and the broader

healthcare community. During their discussions the Committee identified numerous areas where additional measure development is needed, including:

- Pediatric measures, especially for shared decision making
- Measures derived from shorter version of the CAHPS surveys
- The next level of functional measures: measures not tied to traditional inpatient settings, and that focus on functional restoration, becoming independent and non-medical outcomes (e.g. return to employment)
- Setting-specific measures that ensure issues and outcomes specific to that site are measured (for example, measures for ventilator care, which would only happen in Long Term Acute Care (LTAC)Facilities and would not be applicable to Skilled Nursing Facilities (SNF) or Inpatient Rehabilitation Facilities (IRFs)
- Measures for partnerships between large health systems and community-based agencies, to help health systems partner with high-quality community agencies
- More measures of informed and shared decision making, to ensure people are effective consumers of healthcare, including: how to choose and change a provider; how to use the healthcare system to your best advantage; how to use technology to benefit the patient; how to interpret quality data
- Measures across the continuum of care, starting in primary care or Emergency Departments, through the completion of all services for the patient
- The medical neighborhood extending past the medical home and into other areas of the community where care is received

Due to the cross-cutting nature of the topic, gaps in PFCC portfolio have been identified in other projects. In addition to the gaps identified by the PFCC Committee, the MAP Dual Eligible Beneficiaries workgroup has recently noted gaps in both their family of measures and the NQF portfolio in the following areas:

- Goal-directed, person-centered care planning and implementation
- Shared decision-making
- Systems to coordinate acute care, long-term services and supports and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning
- Home- and community-based services
- Patient engagement and activation in healthcare

Person and Family Centered Care Measure Evaluation

The PFCC Standing Committee (see Appendix D) oversees NQF's portfolio of measures for PFCC. On June 6-7, 2016 the PFCC Standing Committee evaluated 12 new measures and 1 measure undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Person and Family Centered Care Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	1	12	13
Measures recommended for endorsement	1	7	8
Measures where consensus is not yet reached	-	3	3
Measures not recommended for endorsement	-	2	2
Reasons for not recommending	-	Scientific Acceptability – 1 Overall – 1	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from April 27-May 10, 2016 for the 13 measures under review. A total of 5 pre-evaluation comments were received (Appendix G).

All submitted comments were provided to the Committee prior to its initial deliberations during the in-person meeting.

Overarching Issues

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

Jimmo v. Sebelius

Six measures considered in Phase 3 assess improvement in functional status for patients in Skilled Nursing Facilities and Long Term Acute Care Facilities. Consistent with conversations during Phase 2 of the project, the Committee urged developers to consider the implications of the settlement in Jimmo v. Sebelius and how to recognize that improvement is not the only goal with these populations. This is a particularly important consideration for the LTAC population where patients tend to require more intensive care and their longer-term goals may differ. The Committee suggested that in some cases facilities should be focused on assessing the maintenance of function or slowing of further deterioration in patients who require skilled services regardless of the underlying illness, disability of injury.

In Jimmo v. Sebelius,[6] the Center for Medicare Advocacy (CMA) alleged that Medicare claims involving skilled care were being inappropriately denied by contractors based on a rule-of-thumb "Improvement Standard"—under which a claim would be summarily denied due to a beneficiary's lack of restoration potential, even though the beneficiary did require a covered level of skilled care in order to prevent or

slow further deterioration in his or her clinical condition. The settlement agreement is intended to clarify that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. The settlement applies to Medicare coverage for home healthcare, skilled nursing facility services, outpatient therapies, and to some extent, care provided by inpatient rehabilitation facilities. The Jimmo settlement is intended to ensure that Medicare claims will be adjudicated consistently and appropriately.

Issues with Testing & Scientific Acceptability Criteria

As the PFCC portfolio has grown and the complexity of measures has increased, NQF staff and Committees are identifying areas where the existing endorsement criteria may need refinements. Tool-based measures, or those measures whose data are derived from surveys, assessments, and other instruments require reliability and validity testing results be evaluated at the performance measurement level. The concept behind this is ensuring variability in performance and the ability to differentiate between the facilities whose performance is being assessed. Although measure developers have made great strides in submitting data to support the reliability and validity of their measures under consideration, the Committee has encouraged NQF and the developer community to consider additional testing approaches to ensure scientifically acceptability criteria is met. In addition, the Committee identified an interest in seeing results of cognitive testing to further support the validly of proposed measures that are based on patient reports. The Committee's expectation is this will lead to measures that include a patient's perspective on the design and selection of questions to make sure that the questions are understood, meaningful and impactful.

Measures of Shared Decision Making and Patient Engagement

As the awareness and importance of patient engagement becomes more widespread among healthcare providers, it is imperative that providers and developers take the steps necessary to ensure that patients are engaged as decision-makers in their care. The Committee agreed that involving patients in their care is critical in building high-quality care systems and encouraged developers to continue to consider outcome measures that drive improvement in this area. The Committee also acknowledged challenges faced by developers in acquiring data to satisfy the scientific acceptability criteria for these novel measures.

Summary of Measure Evaluation

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

Recommended Measures

0420: Pain Assessment and Follow-Up (CMS) Recommended

Description: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient; **Data Source**: Administrative claims, Paper Medical Records

This process measure was first endorsed in 2008 and is used in Physician Quality Reporting System (PQRS). Committee members noted that assessing pain is crucial in order to treat it, but the literature that supports better outcomes after assessment is limited, in part because it is very difficult to do a controlled study on pain management without violating ethical guidelines. However, there was also acknowledgement that additional evidence exists supporting assessment of symptoms more globally and the benefits to patients. NQF staff reported other pain assessment measures have met the evidence criteria by using the insufficient evidence with exception option. In the vote on evidence, the Committee did not reach consensus. However, the Committee did reach consensus on allowing the evidence exception. Performance gaps were noted, especially by race/ethnicity, with a high of 84.2% for white patients and a low of 68.2% for black patients. The Committee noted some concerns with the testing results given that 90% of providers reporting are in the 25th percentile, yet the mean score is 82%. However, this is a voluntary measure and only 10% of eligible providers are reporting, which tends to skew results. As the measure is based on administrative data and has been in use for several years, the Committee had no concerns with the feasibility. They did note potential unintended consequences of narcotics overuse, but agreed this issue did not outweigh the importance of the measure. Ultimately, the Committee recommended 0420 for continued endorsement.

2614: CoreQ: Short Stay Discharge Measure (American Health Care Association) Recommended

Description: The measure calculates the percentage of individuals discharged in a six month time period from a SNF, within 100 days of admission, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items; **Measure Type**: PRO; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Patient Reported Data/Survey

This new Patient Reported Outcome Performance Measure (PRO-PM) assesses patient satisfaction of SNF patients who have been discharged within 100 days of admission and is derived from data collected via the CoreQ Short Stay Discharge questionnaire. The Committee agreed that measuring and reporting satisfaction with care helps patients and their families choose and trust a healthcare facility and can help facilities improve the quality of the care they provide. The Committee raised concerns about whether the exclusions might limit the generalizability to a small proportion of nursing home patients in a single facility, around the consistency of implementation across facilities, and the possibility that scores could be compromised by the low response rate, but all of these were adequately addressed by the developer. The major concern with validity was around cognitive impairment and the effect this has on overall responses. The developer agreed that cognitive impairment does have an effect in this setting and that by having everyone use the Brief Interview for Mental Status (BIMs) score, which is used to get a

snapshot of how well someone is functioning cognitively at a given moment, allows for a more consistent approach across all nursing home residents. Committee members agreed with the decision not to risk adjust as it is inappropriate to control out differences based on sociodemographic factors. There were no concerns around use and usability and many appreciated that this tool is concise as staffing in this area tends to be sparse. Ultimately, this measure was recommended for endorsement. This measure was identified as related to #2615: CoreQ: Long-Stay Resident Measure and #2616: CoreQ: Long-Stay Family Measure, submitted by the same developer.

2615: CoreQ: Long-Stay Resident Measure (American Health Care Association) Recommended

Description: The measure calculates the percentage of long-stay residents, those living in the facility for 100 days or more, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Long-Stay Resident questionnaire that is a three item questionnaire; **Measure Type**: PRO; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Patient Reported Data/Survey

This new PRO-PM is very similar to #2614: CoreQ: Short Stay Discharge Measure and #2616: CoreQ: Long-Stay Family Measure. The Committee had questions about validity and whether staff members were allowed to fill out the surveys on the behalf of patients. The developer responded that while there is no way to stop them from filling it out on the patient's behalf, if they do indicate as such, their data will be excluded. The Committee agreed the measure was very similar to #2614 and did not require additional discussion or voting. Ultimately, the Committee recommended this measure for endorsement.

2616: CoreQ: Long-Stay Family Measure (American Health Care Association) Recommended

Description: The measure calculates the percentage of family or designated responsible party for long stay residents (i.e., residents living in the facility for 100 days or more), who are satisfied (see: S.5 for details of the timeframe). This consumer reported outcome measure is based on the CoreQ: Long-Stay Family questionnaire that has three items; **Measure Type**: PRO; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Patient Reported Data/Survey

This new PRO-PM is very similar to #2614: CoreQ: Short Stay Discharge Measure and #2615: CoreQ: Long-Stay Resident Measure. One Committee member had a question about other languages that this survey was available in and the developer responded that it is currently only available in English but they are exploring other options for the future. The Committee agreed the measure was very similar to #2614 and did not require additional discussion or voting. Ultimately, the Committee recommended this measure for endorsement.

2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities (UDSMR) Recommended

Description: Change in rasch derived values of self-care function from admission to discharge among adult patients treated as short term rehabilitation patients in a skilled nursing facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This new outcome measure is similar to a set of measures for inpatient rehabilitation facilities endorsed in Phase 2 of this work. Based in the Functional Independence Measure (FIM) tool, this measure is for skilled nursing facility patients and focuses on restoration and improvement of function during the course of treatment. The Committee discussed this measure in relation to Jimmo v. Sebelius and was reassured by the developer's statement that it looks at change in function (not just improvement), and also is intended to flag patients who may need a change in care plan based on their functional assessment. The Committee was concerned about the overlap and potential burden of data collection between this measure and those being explored for implementation based on the Continuity Assessment Record and Evaluation (CARE) tool developed by CMS in response to the IMPACT Act. This is one of the measures where the Committee expressed interest in additional reliability testing that would demonstrate variation between facilities (versus within) and the ability to distinguish between facilities. The major concern around usability focused on the need and burden of training for staff to administer the tool, since it is not as widely implemented in SNFs as compared to IRFs. However, the Committee agreed that training to ensure accurate data collection is especially important for measures that may be used for payment. Committee members returned to Jimmo v. Sebelius for a discussion of potential unintended consequences, noting the potential for patients who cannot improve becoming "less desirable" but agreed that was not a reason not to endorse. Committee members also warned that this measure should not be used to make comparisons to other levels of care (IRF vs. SNF for example) as they are not comparable (in terms of patient complexity, levels of care, etc.), even though the measures are very similar. Ultimately, the Committee recommended this measure for endorsement. This measure was identified as competing with measure #2613: CARE: Improvement in Self Care. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.

2774: Functional Change: Change in Mobility Shore for Skilled Nursing Facilities (UDSMR) Recommended

Description: Change in rasch derived values of mobility function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This new outcome measure is very similar to #2769: Functional Change in Self Care. The Committee questioned why there is also a Functional Change in Motor Skills measure, which includes both the self-care and mobility domains. The developer explained that there are patients who may have restricted mobility, but still be able to do self-care; the different measures are intended to provide different levels of functional measurement for different types of facilities. It was further clarified that the composite score would not require duplicate data collection since it is the same data. The Committee agreed the measure was very similar to #2769 and did not require additional discussion. Ultimately, the Committee recommended this measure for endorsement. This measure was identified as competing with measure #2612: CARE: Improvement in Mobility. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.

2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities (UDSMR) Recommended

Description: Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This new outcome measure is very similar to #2769: Functional Change in Self Care. The Committee agreed the measure did not require additional discussion. Ultimately, the Committee recommended this measure for endorsement. This measure is the "parent" to the mobility and self-care measures that have been identified as competing with measures: #2612: CARE Improvement in Mobility and #2613: Care Improvement in Self-Care. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.

2962: Shared Decision Making (Healthwise) Recommended

Description: This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. **Measure Type**: PRO; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Ambulatory Care: Clinician Office/Clinic; **Data Source**: Patient Reported Data/Survey.

This new patient-reported outcome performance measure (PRO-PM) assesses the extent to which health care providers involve patients in a decision-making process when there is more than one reasonable option. The Committee agreed that this measure demonstrated the value of the shared decision making approach and the 4 items within the tool adequately address the 3 essential concepts, as it was designed. The developer noted that this measure works best when applied to a specific kind of clinical decision (e.g. decision to have surgery for herniated disc).

One of the greatest challenges in this type of measure is that it is restricted to patients who have had the treatment or procedure, meaning that patients who have been faced with the same decision and chose not to have the specific treatment are not included. While it would be desirable to include them, the data are not available. The Committee raised concerns with the small, non-diverse sample of patients included in testing, but the developer responded by suggesting there would be more variability with lager numbers. The Committee voiced their concerns about the importance of health literacy for patients and how improving the delivery of adequate information to patients could greatly impact participation in the decision making process. The Committee also discussed a need for engaging the participation of various demographics, including all ethnicities and ages. The general consensus was that shared decision making is appropriate for all patients. Although this measure is not currently in use, the committee noted that Accountable Care Organization evaluations could find shared decision making useful within quality improvement efforts. The Committee agreed that this measure met the criteria and voted to recommend it for endorsement.

Measures Where Consensus is Not Yet Reached

2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities (UDSMR)
Consensus Not Reached

Description: Change in rasch derived values of motor function from admission to discharge among adult long term acute care facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Long Term Acute Care Hospital; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

This is a new outcome measure. The Committee agreed that many of the issues discussed for #2769 would be similar as the main difference for this measure is the setting: LTAC instead of SNF. However, Committee members pointed out that LTACs are a new setting for the FIM tool, and the data on their use is limited thus far. The developer noted that the same drastic level of functional improvement is not expected or seen in LTACs, but that a slight improvement can be possible, and the measure can also be used to both find patients that may be declining and to assess the level of care a patient needs. The Committee had some concerns with the limited performance gap; while the developer indicated this may be an artifact of the small sample size, the Committee was unable to reach consensus on the performance gap criterion. The Committee agreed that aside from the new setting and limited data, the issues for this measure were very similar to #2769, specifically that the data provided did not demonstrate variation in performance across facilities nor the reliability of performance between facilities. However, because the setting for these measures is newer and number of facilities represented in the testing data was limited in comparison to the SNF measures, the Committee did not reach consensus on reliability or validity. There were no concerns raised for feasibility, but the Committee was unable to come to consensus on usability. Ultimately, the Committee did not reach consensus on an endorsement decision. The developer agreed to bring back additional testing data

after the comment period. The Committee is specifically seeking comments on this measure and will revote after the Comment period.

2777: Functional Change: Change in Self Care Score for Long Term Acute Care Facilities (UDSMR) Consensus Not Reached

Description: Change in rasch derived values of self-care function from admission to discharge among adult patients treated in a long term acute care facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Long Term Acute Care Hospital; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

The Committee agreed this new outcome measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the criteria over from that measure. They did not reach consensus on performance gap, reliability, validity, usability, and an overall recommendation for endorsement. The developer agreed to bring back additional testing data after the comment period. The Committee is specifically seeking comments on this measure and will revote after the Comment period.

2958: Informed, Patient Centered Hip and Knee Replacement Surgery (Massachusetts General Hospital) Consensus Not Reached

Description: The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of osteoarthritis; **Measure Type**: PRO; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Ambulatory Care: Clinician Office/Clinic; **Data Source**: Patient Reported Data/Survey

This new PRO-PM assesses the extent to which patients who had elective surgery were well informed and had a clear preference for surgery beforehand. The survey instrument is based on 6 items: 5 knowledge questions and 1 question that elicits a patient's preference and focuses on the surgical benefits, harms, and recovery time. Hip and knee replacements are very common, and the Committee agreed that simply being clinically eligible for one of these procedures does not mean it is the best choice of treatment. Concerns were raised around the measure's reliability testing i.e., how the developer found the sample of patients and the length of the post-operative timeline for giving the instrument to patients. The developer noted that ideally the instrument would be collected close to the time of the surgery, but in order to obtain a large enough sample to improve the validity and reliability of performance results a clinic may need up to 2 years to collect data. Since this measure deals with both hip and knee replacement surgeries, there were concerns from the Committee about why the correct answer to recovery time was the same for both procedures. The developer indicated that experts in both surgical procedures were involved in the development of the instruments and that the

measure was not seeking a precise answer, just acknowledgement that recovery times can vary. Committee members asked about the burden of collecting the data and how much time is required in collecting the responses. The developer explained the patient burden is very limited as it only takes a few minutes to complete the questions. In terms of burden on the provider, the developer thought it depended on the practice as some likely already have resources in place to assess patient-reported outcomes. The measure is currently used in a quality recognition program but is not publically reported or used in an accountability program. The Committee did not reach consensus on this measure and is specifically seeking comments; they will revote after the Comment period.

Measures Not Recommended

2778: Functional Change: Change in Mobility Score for Long Term Acute Care Facilities (UDSMR) Not Recommended

Description: Change in rasch derived values of mobility function from admission to discharge among adult LTAC patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post Acute/Long Term Care Facility: Long Term Acute Care Hospital; **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records

The Committee agreed this new outcome measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the criteria over from that measure. They did not reach consensus on performance gap, reliability, validity, and usability. Ultimately, the Committee voted not to recommend this measure for endorsement. The developer agreed to bring back additional testing data after the comment period.

2967: Home and Community Based Services (CMS) Not Recommended

Description: Home and Community Based Services (HCBS) Experience of Care (EoC) measures derive from a cross disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS) about the quality of the long-term services and supports they receive in the community. The measures consist of seven scale measures, 6 global rating and recommendation measures and 6 individual measures:

Scale Measures
1. Staff are reliable and helpful – average of applicable beneficiary scores on 6 survey items
2. Staff listen and communicate well – average of applicable beneficiary scores on 11 survey items
3. Case manager is helpful - average of applicable beneficiary scores on 3 survey items
4. Choosing the services that matter to you - average of applicable beneficiary scores on 2 survey items
5. Transportation to medical appointments - average of applicable beneficiary scores on 3 survey items
6. Personal safety and respect - average of applicable beneficiary scores on 3 survey items
7. Planning your time and activities - average of applicable beneficiary scores on 6 survey items

Global Ratings Measures
8. Global rating of personal assistance and behavioral health staff- average score on a 0-10 scale
9. Global rating of homemaker- average score on a 0-10 scale

10. Global rating of case manager- average score on a 0-10 scale
Recommendations Measures
11. Would recommend personal assistance/behavioral health staff to family and friends – average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)
12. Would recommend homemaker to family and friends –– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)
13. Would recommend case manager to family and friends– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)
Unmet Needs Measures
14. Unmet need in dressing/bathing due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)
15. Unmet need in meal preparation/eating due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)
16. Unmet need in medication administration due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)
17. Unmet need in toileting due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)
18. Unmet need with household tasks due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)
Physical Safety Measure
19. Hit or hurt by staff –average score on a 1-4 scale (Never, Sometimes, Usually, Always);
Measure Type: PRO; **Level of Analysis**: Population: State; **Setting of Care**: Other; **Data Source**: Patient Reported Data/Survey

This new PRO-PM is a package of 19 different measures calculated from data from a newly developed experience of care survey focusing on HCBS programs. Numerous challenges were identified with this measure submission including level of accountability and variation in the types of programs and services offered both across and between states. The developer noted the survey and reporting of the measures are being introduced for voluntary use by states and relevant programs and would help programs in identifying areas for quality improvement interventions. Committee members with experience in this area noted what matters to consumers is that their needs are met, not who is meeting them. The Committee decided to vote on evidence all together, and then split the measure set into 5 measure batches and vote on each of the domains separately for performance gap and the remaining criteria. The performance and testing data submitted for these measures was limited due to the pilot testing of the survey, so the Committee found it challenging to understand the opportunity for improvement (performance gap) and reliability of some of the domain results. The Committee provided recommendations to the developer on opportunities to address some of the data challenges; however, they ultimately voted two of the measure sets down at performance gap and the remaining measures at reliability. The Committee encouraged the developers to determine if alternate testing procedures might better differentiate programs and better support the reliability of the metrics.

The recommendation, unmet needs, and global measures moved forward to the reliability discussion. Committee members continued to raise concerns with the specifications and testing and requested additional testing. The 3 remaining measure sets did not pass the reliability criteria.

Committee members were supportive of the idea of these measures, noting their importance to the disability community, yet they had a number of concerns and ultimately did not think the measures were ready for endorsement at this time. They urged the developers to use their feedback to improve the measures and to resubmit at a later date. The measures will be included in the public comment period to elicit additional feedback.

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[3] Rosenthal M, Alidina S, Friedberg M, et al. (2016). A difference-in-difference analysis of changes in quality, utilization, and cost following the Colorado Multi-Payer Patient-Centered Medical Home Pilot. J Gen Intern Med 2016 Mar;31(3):289-96. PMID:26450279.

[4] National Standards for Culturally and Linguistically Appropriate Services in Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practices. April 2013. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf. Last accessed June 2016.

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[6] Centers for Medicare & Medicaid Services (CMS). Jimmo v. Sibelius Settlement Agreement Fact Sheet. Baltimore, MD: CMS; 2013. Available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf. Last accessed June 2016.

Appendix A: Details of Measure Evaluation

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

Measures Recommended

0420 Pain Assessment and Follow-Up

Submission | Specifications

Description: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

Numerator Statement: 2013 Specification Numerator Statement (used in Registry Data Testing):

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present (Testing completed on Registry Data)

2014 and 2016 Numerator Statement (used in Claims Data Testing):

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

Denominator Statement: All visits for patients aged 18 years and older

Exclusions: Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Adjustment/Stratification: No risk adjustment or risk stratification

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

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Outpatient Rehabilitation

Type of Measure: Process

Data Source: Administrative claims, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **H-0**; **M-7**; **L-5**; **I-9**; 1b. Performance Gap: **H-9**; **M-12**; **L-0**; **I-0; ;** Evidence Exception: **Y-19; N-2**

Rationale:

- Committee members noted that assessing pain is crucial in order to treat it, but the literature that demonstrates better outcomes after such assessment is limited. The developer agreed that all of the published studies that look at the effectiveness of pain assessment are low quality, both those reporting a difference and those reporting no difference; the developer recommends further study.
- Committee members with expertise in palliative care also noted limitations of the current pain scales used to do these assessments, both in terms of providing meaningful data (particularly since the FACES scale was designed for children and the evidence for it was on low back pain) and because the assessments are relatively easy to game; patients who report higher numbers get stronger medications. The developer noted the measure does not require any particular pain assessment tool.
- Patient advocates on the Committee strongly supported the need for pain assessment.
- The measure was originally developed for use by physical and occupational therapists.
- This is a process measure, but the Committee agreed it is one step closer to an outcome measure since it

includes both the assessment of pain and the development of a plan to address it. In response to questions, the developer noted that the intent of the measure is not to specify treatment, but to create a care plan, which could include non-pharmacological interventions.
- The Committee discussed concerns around over-prescription of opioids and the opioid epidemic, noting that much research still needs to be done on how to best manage pain, and that providers are currently being encouraged to limit opioid prescriptions.
- The developer clarified that pain needed to be assessed by a valid pain tool, not just a simple question or two.
- The Committee struggled with the lack of direct evidence linking better outcomes to pain assessment. The developer noted part of the reason there is a lack of data are because it is very difficult to do a controlled study on this particular topic since obtaining a patient history and developing a treatment plan is the standard of care; therefore, to not do an assessment in order to study outcomes would be unethical. Committee members noted there is general evidence supporting the practice of monitoring symptoms and then altering practice based on that monitoring.
- NQF staff noted, in response to questions, that other endorsed pain measures have passed the evidence criteria by using insufficient evidence with exception option. In the vote on evidence, the Committee did not reach consensus. However, the Committee did reach consensus on the evidence exception, and the measure moved forward.
- There are differences in assessment and treatment rates by race/ethnicity (Asian 76.2%, Black 68.2%, Hispanic 79.1%, Native 73.6%, White 84.2%, Other 79.6%, Unknown 86.1%), and this was highlighted as a gap area demonstrating the need for continuing endorsement of this measure.

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

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

2a. Reliability: **H-5**; **M-14**; **L-1**; **I-1** 2b. Validity: **H-2**; **M-11**; **L-6**; **I-2**

<u>Rationale</u>:

- Committee members requested information on why patients under 18 were excluded, given that there are good tools for measuring pain in children. The developer explained that the measure was developed for use in adults and hasn't been updated, and agreed that was a concern.
- One Committee member had questions about the reliability testing at the provider level and how well the measure demonstrates variability between providers; another noted that 90% of the providers reporting are in the 25th percentile. The developer responded that only 10% of eligible providers are reporting and so they believe the scores are skewed towards high performance, especially since this is typical of voluntary measures; however, they cannot confirm this.
- During the validity discussion, the Committee noted that while most providers (over 90%) are reporting very high scores, the mean is 82%; this means a small group of providers are reporting very poor scores. The measure also passed the validity criteria.

3. Feasibility: H-14; M-6; L-1; I-0

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

<u>Rationale</u>:

- The measure uses administrative data and has been in use for several years, so the Committee had no concerns with the feasibility.

4. Usability and Use: H-10; M-11; L-0; I-0

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

<u>Rationale</u>:

- The measure has been in use for several years and the Committee did not have major concerns with the usability. However, they did note the potential unintended consequence of narcotics overuse.
- Committee members noted that patients with chronic complex conditions are actually more likely to under report pain. Ultimately the Committee agreed that the potential unintended consequences did not outweigh the importance of the measure.

5. Related and Competing Measures

This measure is related, but not competing, with a number of NQF-endorsed measures:

- 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
- 0676: Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)
- 0677: Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)
- 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
- 1634: Hospice and Palliative Care -- Pain Screening
- 1637: Hospice and Palliative Care -- Pain Assessment

Standing Committee Recommendation for Endorsement: **Y-20**; **N-1**

Rationale

- This measure did not pass Evidence but moved forward on the Evidence Exception.

6. Public and Member Comment

-

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2614 CoreQ: Short Stay Discharge Measure

Submission | Specifications

Description: The measure calculates the percentage of individuals discharged in a six month time period from a SNF, within 100 days of admission, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items.

Numerator Statement: The measure assesses the number of patients who are discharged from a SNF, within 100 days of admission, who are satisfied. The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the four questions on the CoreQ: Short Stay Discharge questionnaire.

Denominator Statement: The denominator includes all of the patients that are admitted to the SNF, regardless of payor source, for post-acute care, that are discharged within 100 days; who receive the survey (e.g. people meeting exclusions do not receive a questionnaire) and who respond to the CoreQ: Short Stay Discharge questionnaire within the time window (See: S.5).

Exclusions: Exclusions used are made at the time of sample selection and include:

(1) Patients who died during their SNF stay;

(2) Patients discharged to a hospital, another SNF, psychiatric facility, inpatient rehabilitation facility or long term care hospital;

(3) Patients with court appointed legal guardian for all decisions;

(4) Patients discharged on hospice;

(5) Patients who left the nursing facility against medical advice (AMA);

(6) Patients who have dementia impairing their ability to answer the questionnaire defined as having a BIMS score on the MDS as 7 or lower. [Note: we understand that some SNCCs may not have information on cognitive function available to help with sample selection. In that case, we suggest administering the survey to all residents and assume that those with cognitive impairment will not complete the survey or have someone else complete on their behalf which in either case will exclude them from the analysis.]

(7) Patients who responded after the two month response period; and

(8) Patients whose responses were filled out by someone else.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: PRO

Data Source: Healthcare Provider Survey

Measure Steward: American Health Care Association

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **Y-17; N-1**; 1b. Performance Gap: **H-7**; **M-10**; **L-1**; **I-0**

<u>Rationale</u>:

- Committee members noted that this is a very significant measure for those who go into a nursing home or a SNF who will not stay indefinitely or for a long period of time. Measuring patient satisfaction and the rate of discharges back into the community is very important to measurement as including the patient and their preferences is becoming an integral part of healthcare's changing landscape. Additionally, measuring and reporting satisfaction with care helps patients and their families choose and trust a healthcare facility and can help facilities improve the quality of the care they provide.
- One Committee member had a question about the scale being used for this measure and felt that the choice of the response scale (poor, average, good, very good, and excellent) seemed heavily weighted towards positive responses. The developer explained that they did focus groups and cognitive testing of different response scales from ten points down to four point Likert scales and found that no matter how they captured responses, they had different satisfaction scores but the relative ranking remained the same.
- Overall, Committee members liked that there was a conceptual framework at the beginning of the measure submission form that linked the measure with information on additional improvement programs, organizational change initiatives, and policies that are going on both at the federal level and the facility level.

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

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

2a. Reliability: **H-6**; **M-8**; **L-4**; **I-0** 2b. Validity: **H-6**; **M-9**; **L-3**; **I-0**

<u>Rationale</u>:

- One Committee member felt that the exclusions may limit the generalizability to a small proportion of facility nursing home patients.
- There was additional concern around the consistency of implementation across facilities and the possibility that scores could be compromised by the low response rate.
- Committee members also questioned the test/retest reliability at the patient level and sample size. The developer explained that the data elements were tested using a test-retest methodology: the survey was sent out and responses received from 853 patients; 100 were re-surveyed one month later. The developer responded to these concerns by saying that while morbidity does occur, and may affect the data, there is an emphasis on making sure that both the voice of the patient and the voice of the family are heard.
- There was also discussion around cognitive impairment and the effect this has on the survey's overall responses. The developer agreed that cognitive impairment does have an effect in this setting and that by having everyone use the BIMs score, which is used to get a snapshot of how well someone is functioning cognitively at a given moment, allows for a more consistent approach across all nursing home residents. A standardized approach helps reduce the incidence of gaming.
- One Committee member had a question on the methodology used to reduce the number of items in the tool and how they got from 22 to 4 items without losing some precision. The developer responded that the process was extremely iterative and was done hundreds of times. The purpose of this was to try and get to the items that were capturing the most satisfaction information that did not overlap with other items and if two items correlated very highly, it made sense to drop one of them.
- All members agreed with the decision not to risk adjust as it is inappropriate to control out differences based on sociodemographic factors.

- Cognitive testing was done with family members, residents, and with short stay residents. The developers collected more than 100 responses from each population at facilities in Pittsburgh. This testing was conducted by reading questions and having the testing groups respond back based on what they thought was being asked and if they felt it could be asked differently. The Committee indicated providing the results of this testing, although supplemental, would have been useful information.

3. Feasibility: H-5; M-13; L-0; I-0

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

Rationale:

- The Committee agreed that this tool is timely as there is currently no required experience of care reporting or measurement in the SNF population.
- Members appreciated that this tool is brief especially since the staffing in this area tends to be very sparse.

4. Usability and Use: H-5; M-11; L-2; I-0

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

Rationale:

- The Committee did not have any concerns or questions about the use and usability.

5. Related and Competing Measures

- This measure was identified as related with #2615: CoreQ: Long-Stay Resident Measure and #2616: CoreQ: Long-Stay Family Measure, submitted by the same developer.

Standing Committee Recommendation for Endorsement: **Y-16**; **N-1**

6. Public and Member Comment

-

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2615 CoreQ: Long-Stay Resident Measure

Submission | Specifications

Description: The measure calculates the percentage of long-stay residents, those living in the facility for 100 days or more, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Long-Stay Resident questionnaire that is a three item questionnaire.

Numerator Statement: The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the three questions on the CoreQ: Long -Stay Resident questionnaire.

Denominator Statement: The denominator includes all of the residents that have been in the SNF for 100 days or more regardless of payer status; who received the CoreQ: Long-Stay Resident questionnaire (e.g. people meeting exclusions do not receive the questionnaire), who responded to the questionnaire within the two month time window, who did not have the questionnaire completed by somebody other than the resident, and who did not have more than one item missing.

Exclusions: Exclusions made at the time of sample selection are the following: (1) Residents who have poor cognition defined by the BIMS score; (2) residents receiving hospice; (3) residents with a legal court appointed guardian; and (4) residents who have lived in the SNF for less than 100 days.

Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) b) surveys that have more than one questionnaire

item missing c) surveys from residents who indicate that someone else answered the questions for the resident. (Note this does not include cases where the resident solely had help such as reading the questions or writing down their responses.)

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: PRO

Data Source: Healthcare Provider Survey

Measure Steward: American Health Care Association

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **Y-17; N-1**; 1b. Performance Gap: **H-7**; **M-10**; **L-1**; **I-0**

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on evidence and gap from the previous measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-6**; **M-8**; **L-4**; **I-0** 2b. Validity: **H-6**; **M-9**; **L-3**; **I-0**

Rationale:

- One Committee member had questions around validity and whether staff members were allowed to fill out the surveys on patients' behalf. The developer responded that while there is no way to stop them from filling it out on the patient's behalf, if they do indicate as such, their data will be excluded.
- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on reliability and validity from the previous measure.

3. Feasibility: H-5; M-13; L-0; I-0

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

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on feasibility from the previous measure.

4. Usability and Use: H-5; M-11; L-2; I-0

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

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on usability and use from the previous measure.

5. Related and Competing Measures

- This measure was identified as related with #2614: CoreQ: Short-Stay Discharge Measure and #2616: CoreQ: Long-Stay Family Measure, submitted by the same developer.

Standing Committee Recommendation for Endorsement: **Y-17**; **N-1**

- Although the Committee carried the discussions and votes through to each of these SNF experience of care measures, they voted separately for Recommendation for Endorsement.

6. Public and Member Comment

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2616 CoreQ: Long-Stay Family Measure

Submission | Specifications

Description: The measure calculates the percentage of family or designated responsible party for long stay residents (i.e., residents living in the facility for 100 days or more), who are satisfied (see: S.5 for details of the timeframe). This consumer reported outcome measure is based on the CoreQ: Long-Stay Family questionnaire that has three items.

Numerator Statement: The numerator assesses the number of family or designated responsible party for long stay residents that are satisfied. Specifically, the numerator is the sum of the family or designated responsible party members for long stay residents that have an average satisfaction score of =>3 for the three questions on the CoreQ: Long-Stay Family questionnaire.

Denominator Statement: The target population is family or designated responsible party members of a resident residing in a SNF for at least 100 days. The denominator includes all of the individuals in the target population who respond to the CoreQ: Long-Stay Family questionnaire within the two month time window (see S.5) who do not meet the exclusion criteria (see S.10).

Exclusions: Please note, the resident representative for each current resident is initially eligible regardless of their being a family member or not. Only one primary contact per resident should be selected.

Exclusions made at the time of sample selection include: (1) family or designated responsible party for residents with hospice; (2) family or designated responsible party for residents with a legal court appointed guardian; (3) representatives of residents who have lived in the SNF for less than 100 days; and (4) representatives who reside in another country.

Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (more than two months after the administration date) and b) surveys that have more than one questionnaire item missing.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: PRO

Data Source: Healthcare Provider Survey

Measure Steward: American Health Care Association

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **Y-17; N-1**; 1b. Performance Gap: **H-7**; **M-10**; **L-1**; **I-0;**

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on evidence and gap from the previous measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-6**; **M-8**; **L-4**; **I-0** 2b. Validity: **H-6**; **M-9**; **L-3**; **I-0**

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on reliability and validity from the previous measure.

3. Feasibility: H-5; M-13; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/

unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on feasibility from the previous measure.

4. Usability and Use: H-5; M-11; L-2; I-0

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

Rationale:

- One Committee member had a question about other languages that this survey was available in. The developer responded and said that it is currently only available in English but they are exploring other options for the future.
- The Committee agreed that this measure was very similar to #2614 and did not require additional discussion or voting. They agreed to carry the votes on usability and use from the previous measure.

5. Related and Competing Measures

- This measure was identified as related with #2614: CoreQ: Short-Stay Discharge Measure and #2615: CoreQ: Long-Stay Resident Measure, submitted by the same developer.

Standing Committee Recommendation for Endorsement: **Y-17**; **N-1**

- Although the Committee carried the discussions and votes through to each of these SNF experience of care measures, they voted separately for Recommendation for Endorsement.

6. Public and Member Comment

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2769 Functional Change: Change in Self Care Score for Skilled Nursing Facilities

Submission | Specifications

Description: Change in rasch derived values of self-care function from admission to discharge among adult patients treated as short term rehabilitation patients in a skilled nursing facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.

Numerator Statement: Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.

Denominator Statement: Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age

Exclusions: Excluded in the measure are patients who died in the SNF or patients less than 18 years old.

Adjustment/Stratification: Stratification by risk category/subgroup

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records

Measure Steward: Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **Y-19; N-0**; 1b. Performance Gap: **H-3**; **M-13**; **L-1**; **I-2**

<u>Rationale</u>:

- This measure uses the FIM tool, and is similar to measures endorsed in the PFCC Phase 2 project; those measures were for inpatient rehabilitation facilities while this measure is set in SNFs.
- The Committee was concerned about the overlap and potential burden of data collection between this measure, which uses the FIM tool, and the mobility and self-care functional status changes measures that are derived from the CARE tool as well as data collected through the Minimum Data Set (MDS). The developer explained this measure includes self-care items of both cognitive and physical function, while the CARE measure for self-care only covers physical function. They also noted that data shows a change over time when using the FIM-based measures but the change is not shown for reports using the MDS, which leads the developer to conclude they are measuring different functional domains.
- The submission form for this measure focuses on restoration and improvement of function as a goal of rehabilitation, which is a component of skilled nursing. Committee members expressed concern about this, noting that for some patients, the goal may be to maintain function and thus facilities would be able to use these measures to potentially "cherry pick" patients and only choose those that have the opportunity to improve. They also brought up Jimmo v. Sebelius, the Medicare law requiring SNFs to provide services to maintain or slow deterioration of function, even for patients that cannot improve. The developer agreed their measure submission placed a heavy emphasis on improvement, but they are amenable to adding language that clarified the measures can not only identify improvement, but those patients who are maintaining or declining in function. They also indicated the performance measure is an aggregated population measure, and thus was looking more globally at performance of a facility versus singling out individuals.
- The developer explained how the expected performance range was developed; since as the Committee noted, almost half of the facilities reporting were below expectations in 2014. Using rasch modeling, the developer calculated the average patient's function for each measure and compared each facility to that number; expected performance therefore is a statistical value rather than a benchmark.
- The Committee requested a distribution of the facility level scores to better assess the performance gaps. Committee members also requested information on whether functional performance has changed over time in response to the efforts made to improve quality in this area. The developer noted that differences are clear when the data are stratified.

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

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

2a. Reliability: **H-3**; **M-9**; **L-2**; **I-5** 2b. Validity: **H-4**; **M-13**; **L-1**; **I-1**

<u>Rationale</u>:

- In response to questions on the exclusions, the developer explained they have another tool, the WeeFIM, for children under 18 that accounts for differences between adults and children; the developer thought it would make the measure simpler to exclude children from this measure. Patients who died in care are excluded due to the lack of discharge scores, which would make it impossible to measure change.
- The developer also noted that missing data are not an issue because their system requires all the information needed to calculate the measure. However, they are not able to track the percentage of patients that data was not collected on.
- The Committee had questions about the 12-month window, since stays at SNFs are less than 12 months, and the developer explained that it was intended to allow smaller facilities to collect enough data (at least 30 cases). They also explained that facilities receive internal quarterly reports.
- After the submission, NQF suggested that the developer perform inter-class correlation testing at the facility level to provide additional reliability data. The results from this testing were submitted prior to the Committee meeting. The intra-class correlation (ICC) between facilities was -0.03 with a P value of 0.59; according to the developer this is a poor score which demonstrates a good amount of variability between facilities. The within-facility ICC was 0.87 with a P value of less than 0.001, demonstrating consistency in ratings within a particular facility.

- Committee members questioned this interpretation and indicated the results demonstrate a lot variation within a single facility but not a lot of variation between facilities; lots of difference at the patient level makes it challenging to understand whether there are facility variations. It was noted by the Committee that while this type of testing is important for identifying variation within a facility and reliability, understanding the reliability of the performance measure *between* facilities requires different testing. The Committee was asked to vote and make their recommendations with the data provided, and the developers are being provided the opportunity to assess if they have data to support the additional analyses for consideration. The Committee specifically suggested the developers could do generalized estimation equations; and then perform the ICC.
- During the validity discussion, Committee members asked about the response rate. The measure is currently voluntary, and the developers do not know the exact response rate but they believe it is the majority of patients.

3. Feasibility: H-5; M-11; L-3; I-0

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

Rationale:

- The Committee had no major concerns with the feasibility of the measure.

4. Usability and Use: H-3; M-11; L-2; I-3

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

Rationale:

- The developer clarified that the FIM tool is free to use, but is not in the public domain, as the developer wants to maintain the integrity of the instrument through uniform use. Use of the tool requires training, and the developer does offer certification training to subscribers. Committee members noted concerns around burden for facilities that have not trained their staff. They noted that several groups of providers will need to be involved and there will need to be periodic retraining in response to staff turnover. The developer responded that there is free training available, and that it is important that the staff collecting the data understand what they are measuring to ensure the data are good. The Committee agreed that training to ensure accurate data collection is especially important for measures that may be used for payment.
- Non-subscriber facilities have access to the instrument and the published training guide, but not the data repository. The developer clarified that if the measures are endorsed and adopted for use in federal programs, CMS will be able to use them royalty-free in any venue they choose.
- Committee members reiterated the potential unintended consequences of this measure in relation to Jimmo vs. Sebelius, with the possibility of making patients who cannot improve “less desirable”, but they noted this could be an issue for many measures and was not enough of a reason to not endorse this measure.
- Committee members also warned that this measure should not be used to make comparisons to other levels of care (IRF vs. SNF for example) as they are not comparable (in terms of patient complexity, levels of care, etc.), even though the measures are very similar. The developer stated that they agree, but others do not, and that collecting the same data across venues will provide data to prove that point.
- The developer also noted the IMPACT Act requires common measures that can be used across settings of care.
- Committee members who use the FIM-based measures in the IRF setting noted that they receive results at a facility, regional, and national level, so that they can compare themselves to other providers. The developer added that they provide reports for facilities that take into account the average patient’s change as well as the discharge dispositions, adjusting for case mix.
- In response to questions about potential manipulation of data, the developer added that they do not usually see major drastic changes in performance over short times without other significant changes at the facility such as a change in administration.

5. Related and Competing Measures

- This measure was identified as competing with measure #2613: CARE: Improvement in Self Care. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.

Standing Committee Recommendation for Endorsement: **Y-16**; **N-3**

6. Public and Member Comment

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2774 Functional Change: Change in Mobility Score for Skilled Nursing Facilities

Submission | Specifications

Description: Change in rasch derived values of mobility function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items:Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.

Numerator Statement: Average change in rasch derived mobility functional score (Items Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) from admission to discharge at the facility level. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the facility or patients who died within the facility are excluded.

Denominator Statement: Facility adjusted adjusted expected change in rasch derived values, adjusted at the Skilled Nursing Facility Case Mix Group level.

Exclusions: Excluded in the measure are patients who died in the SNF or patients less than 18 years old.

Adjustment/Stratification: Stratification by risk category/subgroup

Level of Analysis: Facility

Setting of Care: Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

Type of Measure: Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

Measure Steward: Uniform Data System for Medical Rehabilitation

STANDING COMMITTEE MEETING [06/06/2016]

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

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

1a. Evidence: **Y-19; N-0**; 1b. Performance Gap: **H-3**; **M-13**; **L-1**; **I-2**

Rationale:

- This measure is very similar to #2769: Functional Change in Self Care. The Committee questioned why there is also a Functional Change in Motor Skills measure, which includes both the self-care and mobility domains. The developer explained that there are patients who may have restricted mobility, but still be able to do self-care; the different measures are intended to provide different levels of functional measurement for different facilities and different patients. It was further clarified that the composite score would not require duplicate data collection since it is the same data.
- The developer reported that they did not see differences in performance by sociodemographic factors.
- The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the votes on evidence and gap from the previous measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-3**; **M-9**; **L-2**; **I-5** 2b. Validity: **H-4**; **M-13**; **L-1**; **I-1**

Rationale:

- The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the votes on reliability and validity from the previous measure.

3. Feasibility: H-5; M-11; L-3; I-0

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

Rationale:

- The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the vote on feasibility from the previous measure.

4. Usability and Use: H-3; M-11; L-2; I-3

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

Rationale:

- The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the vote on usability from the previous measure.

5. Related and Competing Measures

- This measure was identified as competing with measure #2612: CARE: Improvement in Mobility. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.

Standing Committee Recommendation for Endorsement: **Y-15**; **N-4**

Rationale

- Although the committee decided to carry both the discussions and voting across the UDSMR SNF measures, they voted on overall recommendation for endorsement for each individually.

6. Public and Member Comment

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

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities

Submission | Specifications

Description: Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.

Numerator Statement: Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the SNF or patients who died within the SNF are excluded.

Denominator Statement: Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age.

Exclusions: Patients age at admission less than 18 years old

Patients who died in the SNF.

2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities
Adjustment/Stratification: Stratification by risk category/subgroup **Level of Analysis:** Facility **Setting of Care:** Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility **Type of Measure**: Outcome **Data Source**: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records **Measure Steward**: Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
STANDING COMMITTEE MEETING [06/06/2016] **1. Importance to Measure and Report: The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **Y-19; N-0**; 1b. Performance Gap: **H-3**; **M-13**; **L-1**; **I-2** Rationale: • The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the votes on evidence and gap from the previous measure.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-3**; **M-9**; **L-2**; **I-5** 2b. Validity: **H-4**; **M-13**; **L-1**; **I-1** Rationale: • The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the votes on reliability and validity from the previous measure.
3. Feasibility: H-5; M-11; L-3; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the vote on feasibility from the previous measure.
4. Usability and Use: H-3; M-11; L-2; I-3 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The Committee agreed that this measure was very similar to #2769 and did not require additional discussion or voting. They agreed to carry the vote on usability from the previous measure.
5. Related and Competing Measures • This measure is the "parent" to the mobility and self-care measures that have been identified as competing with measures #2612: CARE Improvement in Mobility and #2613: Care Improvement in Self-Care. A discussion on harmonization and best in class will occur after the NQF Member and Public Comment period.
Standing Committee Recommendation for Endorsement: **Y-15**; **N-4** Rationale • Although the committee decided to carry both the discussions and voting across the UDSMR SNF measures, they voted on overall recommendation for endorsement for each individually.
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X

2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities
9. Appeals

2962 Shared Decision Making Process
Submission | Specifications
Description: This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of 7 common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure. **Numerator Statement**: Patient answers to four questions about whether not 4 essential elements of shared decision making (laying out options, discussing the reasons to have the intervention and not to have the intervention, and asking for patient input) were part of the interactions with providers when the decision was made to have the procedure. **Denominator Statement**: All responding patients who have undergone one of the following 7 surgical procedures: back surgery for a herniated disc; back surgery for spinal stenosis; knee replacement for osteoarthritis of the knee; hip replacement for osteoarthritis of the hip; radical prostatectomy for prostate cancer; percutaneous coronary intervention (PCI) for stable angina, and mastectomy for early stage breast cancer. **Exclusions**: For back, hip, knee, and prostate surgery patients, there are no exclusions, so long as the surgery is for the designated condition. PCI patients who had a heart attack within 4 weeks of the PCI procedure are excluded, as are those who have had previous coronary artery procedures (either PCI or CABG). For patients who have mastectomy, patients who had had a prior lumpectomy for breast cancer in the same breast and patients who have not been diagnosed with breast cancer (who are having prophylactic mastectomies) are excluded. **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Clinician : Group/Practice **Setting of Care:** Ambulatory Care : Clinician Office/Clinic **Type of Measure**: PRO **Data Source**: Patient Reported Data/Survey **Measure Steward**: Informed Medical Decisions Foundation, a division of Healthwise
STANDING COMMITTEE MEETING [06/07/2016] **1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **Y-19; N-0**; 1b. Performance Gap: **H-10**; **M-8**; **L-1**; **I-0** <u>Rationale</u>: • The Committee agreed that this PRO-PM demonstrated the value of the shared decision making approach and the 4 items within the questionnaire are based on the 3 essential concepts it was designed to address (ensuring that patients were informed and understood their issues; ensuring there was meaningful interaction between provider and patient to provide the opportunity for the patient's voice to be heard during the decision making process; and aligning the patient's goals, concerns and priorities by the end of the process). • The developer noted that this measure works best when applied to a specific kind of decision (e.g. decision to have surgery for herniated disc).

2962 Shared Decision Making Process

- The Committee voted to pass the evidence criteria for this measure.
- The Committee noted a lack of diversity in the testing population and voiced their concerns about whether the developer had looked at health literacy and how that was accounted for in the tool, as health literacy level has been shown to impact people's ability to participate in the decision making process.
- The developer agreed the testing population was less heterogeneous than they would have liked, but said they reviewed the research carefully and were unable to find evidence that any groups (i.e., older or low educated patients) are resistant to being involved in decision making.
- Committee members noted the gap was smaller for back surgery patients. The developer explained they thought it was that back pain is often not fixable by surgery so back surgeons work particularly hard to ensure patients are aware of the pros and cons.
- Committee members wanted to know if there were some procedures not included because there is less of a choice in whether to have the procedure. The developer noted that shared decision making is appropriate for all medical care, but the procedures in the measure were selected because they thought they could both reliably sample the people who had made a decision at a given point, and they had the data.
- In response to Committee questions, the developer noted that discussing the patient's goals and concerns is an essential part of real shared decision making, but they wanted to keep the questionnaire as short as they could. They hope to expand it in the future.
- The measure passed performance gap.

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

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

2a. Reliability: **H-2**; **M-14**; **L-3**; **I-0** 2b. Validity: **H-2**; **M-15**; **L-2**; **I-0**

<u>Rationale</u>:

- The Committee discussed the challenge of reliably identifying people who are faced with a decision and decided not to do something (i.e., surgery), and agreed that there needs to be a reliable way of getting the same population of patients who have had the same experiences. They also understood the limitations the lack of such data places on measurement.
- The developer addressed this concern by stating the goals of the measure are to be able to identify a set of people that should actually have had a choice and to ensure that the same kind of patients can reliably be identified and compared across multiple clinical sites.
- The Committee agreed that although the numbers in the testing population were small, there would likely be more variability with larger numbers and hospitals involved in the shared decision making process.
- Committee members requested more information about response rates, particularly the rate needed to ensure a valid sample (and whether that was feasible), and whether the homogeneity of the sample impacted the response rate. The developer noted that the way the survey is presented affects response rates, particularly when the clinical site follows up to ensure it is returned. The developer noted they are working on shared decision making on pregnancy and childbirth related care, but didn't currently have the data to include them. Their research thus far indicates the questions would not only apply to white men or to orthopedic decisions.
- The developer provided additional information on the cognitive testing performed.
- In response to questions, the developer explained they had randomized practices (not within practices) to ensure the samples were not contaminated.
- General consensus was reached that this measure met the reliability and validity criteria.

3. Feasibility: H-0; M-12; L-7; I-0

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

<u>Rationale</u>:

- The Committee noted that mailed surveys and follow up calls are expensive and asked if there were IT ways to make gathering data easier. The developer explained that currently, the response rates were much lower with online surveys but it might be more feasible in other populations.

2962 Shared Decision Making Process
• The developer also noted this would not be performed all the time, but might be collected on back patients one year and hip patients the next, reducing the burden on any particular group. • Despite some concerns, the measure did pass feasibility.
4. Usability and Use: H-6; M-11; L-2; I-0 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • In response to questions, the developer noted that getting shared decision making right involves more providers than just physicians, and there are training programs available to teach providers how to incorporate shared decision making into their care. • Although this measure is not currently in use for public reporting (and the developer indicated that while they support public reporting, they cannot have a direct role in implementing it), the Committee noted that accountable care organization evaluations could find shared decision making useful within quality improvement.
5. Related and Competing Measures • The developer identified measure #1741: Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey, as a related measure and stated that the approved PCMH and ACO CAHPS measures of shared decision making were adaptations of the measures they developed and are proposing. The Committee agreed they are similar but not competing. • The developer mentioned that the measures were used for respondents who reported they had discussed starting or stopping a prescription medication (for PCMH) and for patients who reported discussion a prescription medication or a procedure with a provider (ACO). The shared decision making measure focuses measuring the process of patient and provider interaction and the extent it meets the process of shared-decision making.
Standing Committee Recommendation for Endorsement: **Y-19**; **N-0**
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

Measures Where Consensus Is Not Yet Reached

2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities
Submission | Specifications
Description: Change in rasch derived values of motor function from admission to discharge among adult long term acute care facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. **Numerator Statement**: Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the LTAC or patients who died within the LTAC are excluded. **Denominator Statement**: Facility adjusted expected change in rasch derived values, adjusted for CMG (Case Mix

2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities
Group), based on impairment type, admission functional status, and age. **Exclusions**: Patients age at admission less than 18 years old Patients who died in the LTAC. **Adjustment/Stratification**: Stratification by risk category/subgroup **Level of Analysis:** Facility **Setting of Care:** Post Acute/Long Term Care Facility: Long Term Acute Care Hospital **Type of Measure**: Outcome **Data Source**: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records **Measure Steward**: Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
STANDING COMMITTEE MEETING [06/06/2016] **1. Importance to Measure and Report: <u>The measure did not reach consensus on the Importance criteria</u>** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **Y-18; N-1**; 1b. Performance Gap: **H-2**; **M-7**; **L-4**; **I-6** <u>Rationale</u>: • The Committee agreed that many of the issues discussed for measure #2769 would be applicable, as the main difference for this measure is the setting: LTAC instead of SNF. However, Committee members pointed out that LTACs are a new setting for the FIM tool, and the data on their use are limited thus far: the reliability testing was performed using data from 6 facilities and ICC testing was performed using 16 LTAC facilities, as compared to almost 200 SNFs and more than 800 IRFs using the measure. Similar to SNFs, this measure is voluntary for LTACs. • The developer noted that the same drastic level of functional improvement is not expected or seen in LTACs, but that a slight improvement can be possible. The measure can be used to find patients who are starting to decline and need readmission to acute or intensive care. Patients at the lowest level – complete dependence – are also captured. In addition, the developer said that LTACs have not traditionally measured function, and they believe that asking questions about function can improve the quality of care by reminding providers of the importance of mobility and overall function. • The measure also assesses the burden of care a patient needs by quantifying the help needed, therefore providing information needed by providers and families if patients are projected to go home. • In response to questions, Committee members explained that patients in LTACs are medically debilitated and require serious care such intravenous or respiratory therapy, or are dependent on ventilators; patients may have spinal cord or traumatic brain injuries. • The data presented only reflect through 2011, but Committee members noted a shrinking gap in care; the developer indicated they believe it is an artifact of the small sample size. Committee members noted that some premiere LTACs are providing significant rehabilitation services, but were uncomfortable with agreeing there was a gap based on testing in 6 facilities, especially since 3 were in 1 state (Massachusetts). The developer explained they now had more data on more facilities and could provide it if requested. • The measure passed evidence but did not reach consensus on performance gap.
2. Scientific Acceptability of Measure Properties: <u>The measure did not reach consensus on the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-2**; **M-8**; **L-3**; **I-6** 2b. Validity: **H-1**; **M-10**; **L-4**; **I-4** <u>Rationale</u>: • The Committee agreed that aside from the new setting and limited data, the issues for this measure were very similar to #2769 and did not require additional discussion on the reliability and validity. The Committee did not reach consensus on reliability or validity.

2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities
3. Feasibility: H-4; M-11; L-3; I-1 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee had no major concerns around the feasibility for this measure.
4. Usability and Use: H-2; M-9; L-3; I-5 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The Committee agreed that the issues for this measure were very similar to #2769 and did not require additional discussion on the usability. The Committee did not reach consensus on usability.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-11**; **N-8** Rationale • The Committee did not reach consensus on a recommendation for endorsement.
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2777 Functional Change: Change in Self Care Score for Long Term Acute Care Facilities
Submission | Specifications
Description: Change in rasch derived values of self-care function from admission to discharge among adult patients treated in a long term acute care facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. **Numerator Statement**: Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. **Denominator Statement**: Facility adjusted expected change in rasch derived values, adjusted for CMG (Case Mix Group), based on impairment type, admission functional status, and age **Exclusions**: Excluded in the measure are patients who died in the LTAC or patients less than 18 years old. **Adjustment/Stratification**: Stratification by risk category/subgroup **Level of Analysis:** Facility **Setting of Care:** Post Acute/Long Term Care Facility: Long Term Acute Care Hospital **Type of Measure**: Outcome **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records **Measure Steward**: Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
STANDING COMMITTEE MEETING [06/06/2016] **1. Importance to Measure and Report: The measure did not reach consensus on the Importance criteria**

2777 Functional Change: Change in Self Care Score for Long Term Acute Care Facilities
(1a. Evidence, 1b. Performance Gap) 1a. Evidence: **Y-18; N-1**; 1b. Performance Gap: **H-2**; **M-7**; **L-4**; **I-6** Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the criteria over from that measure. They did not reach consensus on performance gap.
2. Scientific Acceptability of Measure Properties: The measure did not reach consensus on the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-2**; **M-8**; **L-3**; **I-6** 2b. Validity: **H-1**; **M-10**; **L-4**; **I-4** Rationale: • The developer noted they had provided both concurrent and predictive validity testing. They also explained they had attempted to have consistent sample sizes across facility types, which means they could show more variability in IRFs. However, they offered to provide more data on LTACs for the Committee to review. • The Committee explained that LTACs are a new setting for both the tool and the measures, and that was why they wanted more data for this set of measures. Specifically, they requested information on the facility level distribution of results, and the ICC coefficients at the facility level. • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the votes on the criteria over from that measure. They did not reach consensus on either reliability or validity.
3. Feasibility: H-4; M-11; L-3; I-1 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the criteria over from that measure.
4. Usability and Use: H-2; M-9; L-3; I-5 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the criteria over from that measure. The Committee did not reach consensus on usability.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-9**; **N-10** Rationale • While the votes on the individual criteria were carried over from #2776, the Committee voted separately on the recommendation to endorse. The Committee did not reach consensus on this measure.
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery

Submission | Specifications

Description: The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision.

The target population is adult patients who had a primary hip or knee replacement surgery for treatment of osteoarthritis.

Numerator Statement: The numerator is the number of respondents who have an adequate knowledge score (60% or greater) and a clear preference for surgery.

Denominator Statement: The denominator includes the number of surveys of patients who have undergone primary knee or hip replacement surgery for osteoarthritis. Participants who answer at least 3 of the 5 knowledge items and the preference item will be counted in the denominator.

Exclusions: Respondents who are missing 3 or more knowledge items do not get a total knowledge score and are not able to be assessed for the measure. Similarly, respondents who do not indicate a preferred treatment do not get counted in the denominator.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician: Group/Practice

Setting of Care: Ambulatory Care: Clinician Office/Clinic

Type of Measure: PRO

Data Source: Patient Reported Data/Survey

Measure Steward: Massachusetts General Hospital

STANDING COMMITTEE MEETING [06/07/2016]

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

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

1a. Evidence: **Y-18; N-1**; 1b. Performance Gap: **H-1**; **M-14**; **L-4**; **I-0**

Rationale:

- This measure assesses the extent to which patients who had elective surgery for hip or knee replacement were well informed and had a clear preference for surgery beforehand. The survey instrument is based on 6 items: 5 knowledge questions and 1 that elicits a patient's preference. These questions focus on the surgical benefits, harms, recovery time, etc. The developer received input from both patients and providers when developing the questions.
- The Committee agreed that asking a patient simple questions such as which treatment do they prefer, do they prefer to have surgery/non-surgical options, etc. should be standard for someone who is actually going to have surgery and if they are not given those options, then they should not be operated on.
- Hip and knee replacements are very common, and the Committee agreed that just because a patient is clinically eligible for one of these procedures, does not mean it is the best choice of treatment. Thus, patients who elect to have one of these procedures should be well informed about the risks and benefits and have a clear preference.
- Additional questions were raised regarding how the questions in the instrument were derived and whether they are meant to be used in conjunction with Healthwise measure #2962: Shared Decision Making. The developer explained that while measuring the quality of the decision and the idea that someone is meaningfully involved in the decision making process is important; this measure is less generic and aims to ensure that a patient is more focused on knowledge.
- During their research, the developer found that there was no correlation between a patient's perception of feeling informed and their ability to answer knowledge-specific questions.
- The measure was tested at 3 different hospitals in the same geographic region in Massachusetts and therefore is not a nationally-representative sample.

- This instrument has a Spanish version available but has not been widely used.

2. Scientific Acceptability of Measure Properties: <u>The measure did not reach consensus on the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-0**; **M-11**; **L-7**; **I-1** 2b. Validity: **H-0**; **M-13**; **L-5**; **I-1**

<u>Rationale</u>:

- One Committee member questioned whether the developer did not or could not compare people with high scores to low scores. The developer responded that in order to test for discriminant validity, they split patients into 2 groups and gave only 1 of the groups decision aids. When comparing the 2 groups, they found significant differences on the knowledge questions, with the decision aids group scoring much higher.
- As with other measures considered during this phase of work, the Committee suggested additional reliability testing, specifically testing at the practice level. It was suggested the developer should perform tests to assess between versus within practice variation.
- The Committee questioned how the developer found the sample of patients and the post-operative timeline for giving the instrument given to patients. The developer noted that in order to get a reliable sample size, they had to survey patients who had received a hip or knee replacement within the last 2 years. The developer agreed that ideally, patients would be surveyed the week after surgery, but in order to collect enough data to calculate the measure, they recommended allowing a look back period of up to 2 years. The Committee questioned the ability of patients to reliably and validly recollect conversations over that length of time.
- There were additional questions around what is considered to be a passing score when completing this instrument. The developer explained that they had set the criteria and in order to be considered well-informed, a patient must answer 3 or more of the 6 questions correctly.
- Since this measure deals with both hip and knee replacement surgeries, there were concerns about why the correct answer to recovery time was the same for both when those recovering from hip surgery are functional more quickly than those recovering from knee surgery. The developer responded to these concerns by saying that the instrument was not developed to assess actual precision, but more of the general realization that recovery takes a couple of months rather than a few days or a few years. To ensure that these questions and answers remain current, a multi-stakeholder expert panel reviews them every 2 years to ensure that the answers remain accurate and are updated if needed.
- An additional comment was raised around exclusions and looking at non-elective surgeries in addition to primary surgeries. The developer agreed to look into this but also noted that the most evidence supports the importance of shared decision making for elective or preference sensitive surgeries and procedures. It was also noted that non-elective surgeries are not considered exclusions.
- A number of Committee members raised concerns with the instrument being given out up to 2 years after a surgery since so much can change in that time period; they argued that even those with a great memory would have a difficult time remembering such specific details about their surgery. In addition, they noted that patients could have done additional research after the surgery, thus giving them more knowledge than what was provided by their doctor. The developer agreed that it is important to have their knowledge assessed earlier, but explained that they have data on a study they did among breast cancer patients where they surveyed patients right after their surgery and then a year later. While they had predicted the numbers would drop, after data analysis they did not find a big difference in knowledge scores.
- Due to the testing concerns, the Committee did not reach consensus on reliability. The measure passed validity.

3. Feasibility: H-0; M-15; L-3; I-1

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

<u>Rationale</u>:

- Some Committee members wanted information about the burden of collecting the data and how much

2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
time is required in collecting the responses. The developer explained the patient burden is very limited as it only takes a few minutes to complete the questions. In terms of burden on the provider, the developer thought it depended on the practice as some likely already have resources in place to assess patient-reported outcomes.
4. Usability and Use: H-0; M-9; L-6; I-3 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The measure is currently used in a quality recognition program but is not publically reported or used in an accountability program. The developer stated they would like to see this incorporated into programs that are assessing the quality of the surgical process of care, including whether the right patient was in the operating room, whether patients were well informed, and whether they had a clear preference for surgical treatments prior to surgery. • A Committee member was concerned that if endorsed, this measure could be used for both evaluating quality improvement and for holding providers accountable, but the Committee member did not think the measure was ready to be used for payment programs.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-10**; **N-8** Rationale • The Committee did not reach consensus on this measure. The Committee is specifically seeking comments on this measure and will revote after the Comment period.
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

Measures Not Recommended

2778 Functional Change: Change in Mobility Score for Long Term Acute Care Facilities
Submission
Description: Change in rasch derived values of mobility function from admission to discharge among adult LTAC patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items:Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. **Numerator Statement**: Average change in rasch derived mobility functional score (Items Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) from admission to discharge at the facility level. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the facility or patients who died within the facility are excluded. **Denominator Statement**: Facility adjusted adjusted expected change in rasch derived values, adjusted at the Case Mix Group level. **Exclusions**: Excluded in the measure are patients who died in the LTAC or patients less than 18 years old. **Adjustment/Stratification**: Stratification by risk category/subgroup **Level of Analysis:** Facility

2778 Functional Change: Change in Mobility Score for Long Term Acute Care Facilities
Setting of Care: Post Acute/Long Term Care Facility: Long Term Acute Care Hospital **Type of Measure**: Outcome **Data Source**: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records **Measure Steward**: Uniform Data System for Medical Rehabilitation
STANDING COMMITTEE MEETING [06/06/2016] **1. Importance to Measure and Report: The measure did not reach consensus on the Importance criteria** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **Y-18; N-1**; 1b. Performance Gap: **H-2**; **M-7**; **L-4**; **I-6** Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on evidence and performance gap over from that measure. The Committee did not reach consensus on performance gap.
2. Scientific Acceptability of Measure Properties: The measure did not reach consensus on the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-2**; **M-8**; **L-3**; **I-6** 2b. Validity: **H-1**; **M-10**; **L-4**; **I-4** Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on the reliability and validity over from that measure. The Committee did not reach consensus on either reliability or validity.
3. Feasibility: H-4; M-11; L-3; I-1 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on feasibility over from that measure.
4. Usability and Use: H-2; M-9; L-3; I-5 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The Committee agreed this measure is very similar to #2776: Functional Change: Change in Motor Score in Long Term Acute Care Facilities, and elected to carry the discussion and votes on usability over from that measure. They did not reach consensus on usability.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-7**; **N-11** Rationale • Although the discussion and votes were carried forward to this measure from the other similar measures, the Overall Recommendation for Endorsement vote was taken separately on each measure. At the time of the Overall Recommendation vote for this measure, the number of Committee members participating in the vote had changed, thus this measure failed.
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

2778 Functional Change: Change in Mobility Score for Long Term Acute Care Facilities
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2967 Home and Community Based Services (HCBS) Experience of Care (EoC) Measures
Submission
Description: Home and Community Based Services (HCBS) Experience of Care (EoC) measures derive from a cross disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS) about the quality of the long-term services and supports they receive in the community. The measures consist of seven scale measures, 6 global rating and recommendation measures and 6 individual measures: Scale Measures 1. Staff are reliable and helpful – average of applicable beneficiary scores on 6 survey items 2. Staff listen and communicate well – average of applicable beneficiary scores on 11 survey items 3. Case manager is helpful - average of applicable beneficiary scores on 3 survey items 4. Choosing the services that matter to you - average of applicable beneficiary scores on 2 survey items 5. Transportation to medical appointments - average of applicable beneficiary scores on 3 survey items 6. Personal safety and respect - average of applicable beneficiary scores on 3 survey items 7. Planning your time and activities - average of applicable beneficiary scores on 6 survey items Global Ratings Measures 8. Global rating of personal assistance and behavioral health staff- average score on a 0-10 scale 9. Global rating of homemaker- average score on a 0-10 scale 10. Global rating of case manager- average score on a 0-10 scale Recommendations Measures 11. Would recommend personal assistance/behavioral health staff to family and friends – average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 12. Would recommend homemaker to family and friends –– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 13. Would recommend case manager to family and friends– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) Unmet Needs Measures 14. Unmet need in dressing/bathing due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always) 15. Unmet need in meal preparation/eating due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always) 16. Unmet need in medication administration due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always) 17. Unmet need in toileting due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always) 18. Unmet need with household tasks due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always) Physical Safety Measure 19. Hit or hurt by staff –average score on a 1-4 scale (Never, Sometimes, Usually, Always) **Numerator Statement**: HCBS service experience is measured in the following areas. Attached Excel Table S.2b includes the specific item wording for each measure and the response options that go into the numerator. Scale Measures

2967 Home and Community Based Services (HCBS) Experience of Care (EoC) Measures

1. Staff are reliable and helpful – average of applicable beneficiary scores on 6 survey items

2. Staff listen and communicate well – average of applicable beneficiary scores on 11 survey items

3. Case manager is helpful - average of applicable beneficiary scores on 3 survey items

4. Choosing the services that matter to you - average of applicable beneficiary scores on 2 survey items

5. Transportation to medical appointments - average of applicable beneficiary scores on 3 survey items

6. Personal safety and respect - average of applicable beneficiary scores on 3 survey items

7. Planning your time and activities - average of applicable beneficiary scores on 6 survey items

Global Rating Measures

8. Global rating of personal assistance and behavioral health staff- average score on a 0-10 scale

9. Global rating of homemaker- average score on a 0-10 scale

10. Global rating of case manager- average score on a 0-10 scale

Recommendation Measures

11. Would recommend personal assistance/behavioral health staff to family and friends – average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)

12. Would recommend homemaker to family and friends –– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)

13. Would recommend case manager to family and friends– average score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)

Unmet Needs Measures

14. Unmet need in dressing/bathing due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)

15. Unmet need in meal preparation/eating due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)

16. Unmet need in medication administration due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)

17. Unmet need in toileting due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)

18. Unmet need with household tasks due to lack of help–average score on a 1-4 scale (Never, Sometimes, Usually, Always)

Physical Safety Measure

19. Hit or hurt by staff –average score on a 1-4 scale (Never, Sometimes, Usually, Always)

Denominator Statement: The denominator for all measures is the number of survey respondents. Individuals eligible for the HCBS survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and have received HCBS services for 3 months or longer. Eligibility is further determined using three cognitive screening items, administered during the interview:

Q1. Does someone come into your home to help you? (Yes, No)

Q2. How do they help you?

Q3. What do you call them?

Individuals who are unable to answer these cognitive screening items are excluded. Some measures also have topic-specific screening items as well. Additional detail is provided in S.9.

Exclusions: Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months should be excluded. During survey administration, additional exclusions include individuals that failed any of the cognitive screening items mentioned in the denominator statement below.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Population: State

Setting of Care: Other: Home and Community-Based Services Program

Type of Measure: PRO

2967 Home and Community Based Services (HCBS) Experience of Care (EoC) Measures

Data Source: Patient Reported Data/Survey

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING [06/06/2016]

1. Importance to Measure and Report: Some components of this measure met the Importance criteria

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

1a. Evidence: **Y-17; N-1**;

1b. Performance Gap: **Split by domain**

Scale: **H-1**; **M-2**; **L-13**; **I-2 – Did not meet the Importance Criteria**

Global Ratings**: H-0**; **M-10**; **L-7**; **I-1 – Did not reach consensus on the Importance Criteria**

Recommendations**: H-0**; **M-12**; **L-5**; **I-1 – Met the Importance Criteria**

Unmet Needs: **H-9**; **M-7**; **L-2**; **I-0 – Met the Importance Criteria**

Physical Safety: **H-0**; **M-4**; **L-7**; **I-7 – Did not meet the Importance Criteria**

Rationale:

- This is a package of 19 different measures, split into 5 domains: scale, global ratings, recommendations, unmet needs, and physical safety. The measures assess experience of care for long term home and community based service programs.
- The measures are scored at the state program level (Medicaid programs including both fee-for-service and Managed Long Term Services and Supports programs), and the developer noted there are 3-11 programs per state. The programs serve groups including frail elderly; people with physical, intellectual and developmental disabilities; and people with brain injuries. The data for the measures is collected via a 95 question survey (the developer noted there are many skip patterns so not all items are asked).
- Some of the Committee had serious concerns with the level of accountability for this measure. Since there are multiple agencies providing many staff members, the Committee was concerned it would be difficult to make the measures actionable for improvement. Committee members with experience in this area noted that while the services are provided via "a hodgepodge of a lot of different programs" what matters to consumers is that their needs are met, not who is meeting them. Therefore, an overall assessment of whether care is being provided and the quality at the aggregate level is also important, not just the quality of any individual provider.
- It was also noted that these services are vital for many people to be able to live in the community with minimal support, and are particularly important to allow young people to live on their own, away from their parents. However, people who rely on these services may not be able to follow up on care issues independently, so being asked is important.
- After an overview discussion, Committee members turned to the specific measures within the submission. They requested clarification that the endorsement would be of the measure, not the experience of care survey, and of how many measures are potentially being endorsed. In addition, they wanted more information on whether all or some components would be used. It was clarified that states could select to only report on some of the measures. Committee members noted this could affect the reliability.
- Committee members asked the developer to explain why there are both a global ratings set and a recommendations set, given that they are assessing something very similar (patient satisfaction) using a different approach. The developer indicated that consistent with CAHPS surveys, the general overall ratings and recommendations are considered behavioral intentions and the global ratings are used a validation items for those subscales. Thus you want to keep that subscale structure because it tells a program where to focus improvement.
- It was noted that some HCBS programs also provide employment services. In response, the developer noted there was a supplement regarding employment, but because so few of the people in the testing population answered in a way that would trigger the appropriate series of questions, it was not adequately tested and therefore not included for potential endorsement.

2967 Home and Community Based Services (HCBS) Experience of Care (EoC) Measures

- Committee members noted that the quality of these services is tremendously important to the disability community, and that the measures could be very useful for states as they assess whether their programs are meeting goals and are effective.
- Committee members discussed the possibility of deferring the measures, noting that while they agreed they address an important area they are still very new and that questions remain about the limited amount of testing conducted thus far. NQF staff provided information on deferral and the processes around it.
- The Committee decided to vote on evidence all together, and then split the measure set into 5 measure batches and vote on each of the domains separately for performance gap and the remaining criteria. They agreed that they were not comfortable voting on it as a single measure, but also did not think 19 separate votes was appropriate. The domains are: scale measures, global measures, recommend measures, unmet needs measures, and physical safety.
- Committee members noted that some of the questions on the scale measure are similar to other surveys that patients may be receiving, and wanted to know if this would be duplicative. The developer explained that an HCBS program would likely field this survey at most once a year, and that while individuals may receive services and surveys from other providers, these will be administered either face to face or over the phone, making it a different kind of survey. They also noted that it would be conducted on a sample, not a full population, and states would likely be careful about burden for their participants.
- Each of the items in the measures are on a "never, sometimes, usually, always" scale which is then transformed to a 0 to 100 scale to make it easier to understand. After some discussion of this scale, Committee members reviewed the data provided and were concerned about the lack of room for improvement on some of the measures. They requested information on whether the sampling or something about how the survey was administered may have led to much higher scores than might be expected based on the literature. The developer agreed the scores were high. They noted it was a random sample but only respondents who passed the cognitive screening were included, and that the modes of survey administration were appropriate for the population.
- Committee members discussed the potential for both “ceiling effect” and “floor effect” problems with the scores, given that some have very small standard deviations and some are very large, and also noted that since this is voluntary, they may only be getting high performers to participate.
- However, the Committee noted that what both HCBS providers and patients really care about is whether people are doing well, and the details are less important to measure, except to the level that the details are needed to discover whether the reason people are not doing well is due to their needs not being met. They also noted this is a patient-reported outcome measure, and the data are reported by the people receiving the services. Committee members sought and were reassured that part of the consent process of the survey made it clear that this is a care optimizing tool and that patients were not at risk of losing care based on their answers.
- While the gap on most of the measures was small, it was very high on the unmet needs category; however, the Committee was concerned that not all of this was under control of the program as the decision of what services to provide may be under the control of a state budget office.
- In a single vote, all of the measure domains passed evidence.
- The recommendation and unmet needs measures passed performance gap. The global measure did not achieve consensus on gap. The scale and physical safety measures did not pass performance gap and did not move forward in the discussion.

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

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

2a. Reliability: **Split by domain**

<u>Scale:</u> **H-X**; **M-X**; **L-X**; **I-X**

<u>Global Ratings</u>**: H-0**; **M-7**; **L-8**; **I-3**

<u>Recommendations</u>**: H-0**; **M-4**; **L-12**; **I-2**

<u>Unmet Needs:</u> **H-1**; **M-2**; **L-12**; **I-3**

Physical Safety: **H-X**; **M-X**; **L-X**; **I-X**

Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- Committee members were concerned about the exclusion of people with cognitive limitations from the measure, as this group represents a substantial part of the population receiving these services, and reiterated the need for proxy reporters. However, they noted there are typically a lot of disagreements between proxy reporters and people reporting on their own behalf. They suggested that the proxy and self-reported scores be reported separately since they may not be comparable.
- Given that some states have one program and other states have multiple programs, Committee members were concerned about being able to distinguish state variation from program variation as well as the within versus the between program variation within and across states. The developer explained that these will be administered by the states, so they might be administered differently within each state. The measures are not intended to be used to compare states to each other at this point, only to compare performance within a state. It will also be a voluntary measure.
- Committee members noted that people who cannot pass a cognitive screening would be excluded, which would include a lot of frail elderly who are receiving in-home services, and wondered whether the developer would consider including caregivers or family members. The developer explained that they had to exclude these patients for testing as they hoped for a CAHPS trademark, and CAHPS surveys do not allow proxies. However, as the testing progressed, they realized that they were receiving proxy responses so the testing pool was expanded to allow them after a period of time. In the Testing Experience and Functional Tools (TEFT) demonstration for round 2 of data collection, TEFT state grantees are including proxies since it became clear they were necessary. However, the measure testing submitted to NQF did not include this data because at the time it had not been consistently administered to proxies.
- In response to questions, the developer confirmed that three rounds of cognitive testing had been performed in both English and Spanish. The Committee requested more information about the results of this testing and the developer agreed to provide it at a later date.
- Committee members wanted to know if the measures performed differently based on whether the survey was admitted by phone or in-person. The developer said the differences were significant on some but not all of the measures and said they recommending adjusting for survey mode to account for this.
- The Committee noted the measures were tested in 26 different programs and the total responses were 2,300; they were concerned this sample was too small. The developer explained that going forward they recommend a larger sample size (400) in order to get a reliability score of 0.7. In addition, they noted in 2012, 25% of programs have less than 400 enrollees, 30% have between 400-3,000, and 41% have 3,000-50,000 enrollees. They noted that after the 2014 HCBS rule, waiver programs are expected to consolidate and grow over time. However, other Committee members were concerned a larger sample might affect the validity as some programs will be assessed with half their population and others with a very small portion. They also noted potentially underrepresented samples such as traumatic brain injury patients.
- Committee members wanted to see additional testing, such as Spearman-Brown prophecy formula, to discover whether a larger sample or more items are needed to better distinguish between facility variation. They also requested ICC coefficients to better assess within versus between program comparisons.
- None of the measures passed the reliability criteria, but the Committee offered some additional feedback to the developers to assist them in continuing to refine the measures.

3. Feasibility: H-X; M-X; L-X; I-X

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

Rationale:

- During the feedback portion of the discussion, the Committee requested more information on the feasibility of getting the optimal sample size of 400.
- The Committee also requested information on how long the survey takes to complete and the burden on

2967 Home and Community Based Services (HCBS) Experience of Care (EoC) Measures
individual patients/caregivers.
4. Usability and Use: H-X; M-X; L-X; I-X *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • During the Importance section, the Committee did discuss the intended use of this set of measures and wanted to know if this would be publically reported. Given that for some patients, the only way to receive improved care would be to move to a different state with a better program, Committee members questioned how public reporting could be useful. The developer reiterated that the measures are still voluntary and that states could decide how to use it or report on it. Round 1 data were not reported publically, but was given to the states in individual reports, and the states wanted to keep the results internal.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

Appendix B: NQF Person and Family Centered Care Portfolio and Related Measures

Endorsed Measures

Measure Number	Measure Title	Measure Steward
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Agency for Healthcare Research and Quality
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Agency for Healthcare Research and Quality
0166	Adult Hospital CAHPS	Centers for Medicare & Medicaid Services
0167	Improvement in Ambulation/locomotion	Centers for Medicare & Medicaid Services
0174	Improvement in bathing	Centers for Medicare & Medicaid Services
0175	Improvement in bed transferring	Centers for Medicare & Medicaid Services
0176	Improvement in management of oral medications	Centers for Medicare & Medicaid Services
0177	Improvement in pain interfering with activity	Centers for Medicare & Medicaid Services
0208	Family Evaluation of Hospice Care	National Hospice and Palliative Care Organization
0228	3-Item Care Transition Measure (3-CTM)	University of Colorado
0258	CAHPS In-Center Hemodialysis Survey	Centers for Medicare & Medicaid Services
0420	Pain Assessment and Follow-Up	Centers for Medicare & Medicaid Services
0422	Functional status change for patients with Knee impairments	Focus on Therapeutic Outcomes, Inc
0423	Functional status change for patients with Hip impairments	Focus On Therapeutic Outcomes, Inc
0424	Functional status change for patients with Foot and Ankle impairments	Focus on Therapeutic Outcomes, Inc
0425	Functional status change for patients with lumbar impairments	Focus on Therapeutic Outcomes, Inc
0426	Functional status change for patients with Shoulder impairments	Focus on Therapeutic Outcomes, Inc
0427	Functional status change for patients with elbow, wrist and hand impairments	Focus on Therapeutic Outcomes, Inc
0428	Functional status change for patients with General orthopaedic impairments	Focus on Therapeutic Outcomes, Inc
0517	CAHPS® Home Health Care Survey (experience with	Centers for Medicare & Medicaid

Measure Number	Measure Title	Measure Steward
	care)	Services
0688	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (long stay)	Centers for Medicare & Medicaid Services
0701	Functional Capacity in COPD patients before and after Pulmonary Rehabilitation	American Association of Cardiovascular and Pulmonary Rehabilitation
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	National Assoc. of State Mental Health Program Directors Research Institute, Inc. (NRI)
1623	Bereaved Family Survey	Department of Veterans Affairs / Hospice and Palliative Care
2286	Functional Change: Change in Self Care Score, Uniform Data System for Medical Rehabilitation (new)	Uniform Data System for Medical Rehabilitation
2287	Functional Change: Change in Motor Score, Uniform Data System for Medical Rehabilitation (new)	Uniform Data System for Medical Rehabilitation
2321	Functional Change: Change in Mobility Score, Uniform Data System for Medical Rehabilitation (new)	Uniform Data System for Medical Rehabilitation
2483	Patient Activation Measure	Insignia
2548	Child Hospital CAHPS (HCAHPS)	Agency for Healthcare Research and Quality
2612	The measure calculates a skilled nursing facility's (SNFs) average change in mobility for patients admitted from a hospital who are receiving therapy.	American Health Care Association
2613	CARE: Improvement in Self Care	American Health Care Association
2624	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
2631	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Centers for Medicare & Medicaid Services
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Centers for Medicare & Medicaid Services
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Centers for Medicare & Medicaid Services
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Centers for Medicare & Medicaid Services

Measure Number	Measure Title	Measure Steward
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Centers for Medicare & Medicaid Services
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Centers for Medicare & Medicaid Services
2643	Average Change in Functional Status Following Lumbar Spine Fusion Surgery	Minnesota Community Measurement
2653	Average Change in Functional Status Following Total Knee Replacement Surgery	Minnesota Community Measurement

Outstanding Measures

Measure Number	Measure Title	Measure Steward
0010	Young Adult Health Care Survey (YAHCS)	Oregon Health & Science University
0011	Promoting Healthy Development Survey (PHDS)	Oregon Health & Science University
0429	Change in Basic Mobility as Measured by the AM-PAC:	CREcare
0430	Change in Daily Activity Function as Measured by the AM-PAC:	CREcare
0673	Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem	RAND Corporation
0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	Centers for Medicare & Medicaid Services
0677	Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	Centers for Medicare & Medicaid Services
0700	Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation	American Association of Cardiovascular and Pulmonary Rehabilitation
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	American College of Surgeons
1821	L2: Patients receiving language services supported by qualified language servcies providers	Department of Health Policy, The George Washington University
1824	L1A: Screening for preferred spoken language for health care	Department of Health Policy, The George Washington University
1888	Workforce development measure derived from workforce development domain of the C-CAT	University of Colorado
1892	Individual engagement measure derived from the individual engagement domain of the C-CAT	University of Colorado
1894	Cross-cultural communication measure derived	University of Colorado

Measure Number	Measure Title	Measure Steward
	from the cross-cultural communication domain of the C-CAT	
1896	Language services measure derived from language services domain of the C-CAT	University of Colorado
1898	Health literacy measure derived from the health literacy domain of the C-CAT	University of Colorado
1901	Performance evaluation measure derived from performance evaluation domain of the C-CAT	University of Colorado
1905	Leadership commitment measure derived from the leadership commitment domain of the C-CAT	University of Colorado
1919	Cultural Competency Implementation Measure	RAND Corporation

Measures Assigned to Other Committees

Measure Number	Measure Title	Measure Steward
0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	National Hospice and Palliative Care Organization
0260	Assessment of Health-related Quality of Life in Dialysis Patients	Beth Witten, LLC
2651	CAHPS® Hospice Survey (experience with care)	Centers for Medicare & Medicaid Services

Appendix C: Person and Family Centered Care Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of December 31, 2015
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	Medicare Shared Savings Program;#Physician Compare; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Display Measure;#Medicare Part C Plan Rating; Medicare
0166	HCAHPS	Hospital Compare; Hospital Inpatient Quality Reporting; Hospital Value-Based Purchasing; PPS-Exempt Cancer Hospital Quality Reporting
0167	Improvement in Ambulation/locomotion	Home Health Compare; Home Health Quality Reporting
0174	Improvement in bathing	Home Health Compare; Home Health Quality Reporting
0175	Improvement in bed transferring	Home Health Compare; Home Health Quality Reporting
0176	Improvement in management of oral medications	Home Health Compare; Home Health Quality Reporting
0177	Improvement in pain interfering with activity	Home Health Compare; Home Health Quality Reporting
0228	3-Item Care Transition Measure (3-CTM)	Hospital Inpatient Quality Reporting
0258	CAHPS In-Center Hemodialysis Survey	End-Stage Renal Disease Quality Incentive Program
0420	Pain assessment and follow up	Physician Quality Reporting System (PQRS)
0422	Functional status change for patients with knee impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0423	Functional status change for patients with hip impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0424	Functional status change for patients with foot/ankle impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0425	Functional status change for patients with	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program

NQF #	Title	Federal Programs: Finalized as of December 31, 2015
	lumbar spine impairments	
0426	Functional status change for patients with shoulder impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0427	Functional status change for patients with elbow, wrist or hand impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0428	Functional status change for patients with general orthopedic impairments	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0517	CAHPS Home Health Care Survey (experience with care)	Home Health Compare; Home Health Quality Reporting
0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	Nursing Home Compare; Nursing Home Quality Initiative and Nursing Home Compare
0677	Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	Nursing Home Compare; Nursing Home Quality Initiative and Nursing Home Compare
0688	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay)	Nursing Home Compare; Nursing Home Quality Initiative and Nursing Home Compare

Appendix D: Project Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix E: Measure Specifications

	0420 Pain Assessment and Follow-Up
Status	Submitted
Steward	Centers for Medicare & Medicaid Services
Description	NOTE: Specification information in this section is from the 2016 Physician Quality Reporting System Manual. Testing Information is based on the specification in the 2013 (Registry Data) and specification in the 2014 (Claims Data) Physician Quality Reporting System Manual. Specifications from 2013, 2014 and 2016 are included in the attached "NQF Endorsement Measurement Submission Summary Materials" 2014-2016 Specification Description: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present 2013 Specification Description (used in Registry Data Testing): Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present
Type	Process
Data Source	Administrative claims, Paper Medical Records The data source is the patient medical record. Medicare Part B claims data and registry data is provided for test purposes. No data collection instrument provided Attachment Data_Dictionary_033016.xlsx
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Outpatient Rehabilitation
Numerator Statement	2013 Specification Numerator Statement (used in Registry Data Testing): Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present (Testing completed on Registry Data) 2014 and 2016 Numerator Statement (used in Claims Data Testing): Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
Numerator Details	2016 Numerator Details (Note: 2013 and 2014 Numerator Details are similar with minor language edits): Definitions: Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration. Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS). Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This

	0420 Pain Assessment and Follow-Up
	must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions. Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented: • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status NUMERATOR NOTE: The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity). G-codes are defined as Quality Data Codes (QDCs), which are subset of HCPCs II codes. QDCs are non-billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are 6 G-code options for this measure. Numerator Quality-Data Coding Options for Reporting Satisfactorily: Pain Assessment Documented as Positive AND Follow-Up Plan Documented (One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option) Performance Met: G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented OR Pain Assessment Documented as Negative, No Follow-Up Plan Required Performance Met: G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required OR Pain Assessment not Documented Patient not Eligible (One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option) Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible OR Pain Assessment not Documented, Reason not Given (One quality-data code [G8732 or G8509] is required on the claim form to submit this numerator option) Performance Not Met: G8732: No documentation of pain assessment, reason not given OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given Performance Not Met: G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not.
Denominator	All visits for patients aged 18 years and older

	0420 Pain Assessment and Follow-Up
Statement	
Denominator Details	Lists of individual codes with descriptors for the 2013, 2014, and 2016 measure specifications are provided in an Excel file at S.2b 2013 Specification (used in Registry Data Testing): Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92507, 92508, 92526, 96116, 96150, 97001, 97003, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439 2014 Specification (used in Claims Data Testing): Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439 (Denominator codes for ophthalmological, physical therapy, occupational therapy, dental and neuropsychological testing were added: CPT codes 92002, 92004, 92012, 92014, D7140, D7210, 97002, 97004 and 96118) 2016 Specification: Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439
Exclusions	Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented: Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
Exclusion details	Pain Assessment not Documented Patient not Eligible (One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option) Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	All eligible patients are subject to the same numerator criteria
Type Score	Rate/proportion better quality = higher score
Algorithm	Satisfactory reporting criteria are met by valid submission of one of six G codes on claims that meet denominator criteria. A rate of quality performance is calculated by dividing the number of records with G codes indicating that the quality actions were performed or that the patient was not eligible by total number of valid G code submissions.

	0420 Pain Assessment and Follow-Up
	THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION. NUMERATOR (A): HCPCS Clinical Quality Codes G8730, G8731 TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8730, G8731, G8442, G8939, G8732, G8509 DENONINATOR EXCLUSION (B): HCPCS Clinical Quality Code G8442, G8939 DENOMINATOR EXCLUSION CALCULATION: Denominator Exclusion (B): # of patients with valid exclusions # G8442+G8939 / # TDP PERFORMANCE DENOMINATOR CALCULATION: Performance Denominator (B): Patients meeting criteria for performance denominator calculation # A / (# TDP - # B) (Refer to section V. Measure Logic Flow Diagram for Performance Rate Calculation in attached "NQF Endorsement Measurement Submission Summary Materials" Document) Available in attached appendix at A.1
Copyright / Disclaimer	5.1 Identified measures: 0676 : Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) 0677 : Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) 0383 : Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384) 1628 : Patients with Advanced Cancer Screened for Pain at Outpatient Visits 1634 : Hospice and Palliative Care -- Pain Screening 1637 : Hospice and Palliative Care -- Pain Assessment 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Six related measures were identified that are not harmonized with NQF# 0420. The differences between these related measures and the submitted measure NQF# 0420 are listed below: 0383 - Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384 which is unrelated to and non-competing with 0420) - target population is specific to patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain; 0383 does not include the use of a standardized pain assessment tool. Both measures are process measures. Both measures have outpatient care setting. 0676 - Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) – target population is specific to short - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0676 does not include the use of a standardized pain assessment tool; 0676 does not include documentation of a follow-up plan if pain is present; 0676 is an outcome measure whereas 0420 is a process measure. Care setting for 0676 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 0677 - Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) – target population is specific to long - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0677 does not include the use of a standardized pain assessment tool; 0677 does not include documentation of a follow-up plan if pain is present; 0677 is an outcome measure whereas 0420 is a process measure. Care setting for 0677 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 1628 - Patients with Advanced Cancer Screened for Pain

	0420 Pain Assessment and Follow-Up
	at Outpatient Visits - target population is specific to patients with a diagnosis of advanced cancer; 1628 does not include a follow-up plan if pain is present; Both 1628 and 0420 are process measures; Both measures have outpatient care setting. 1634 - Hospice and Palliative Care -- Pain Screening: target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1634 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1634 does not include documentation of a follow-up plan if pain is present; Both 1634 and 0420 are process measures; Care setting for 1634 is restricted to Hospice/Hospital/Acute Care Facility, whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 1637 – Hospice and Palliative Care—Pain Assessment- target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1637 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1637 measure focus is clinical assessment within 24hrs of positive screening for pain; 0420 measure focus is performing a screening and a documented follow-up plan not just limited to a clinical assessment; Both are process measures; Care setting for 1637 is restricted to Hospice/Hospital/Acute Care Facility; whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

	2614 CoreQ: Short Stay Discharge Measure
Status	Submitted
Steward	American Health Care Association
Description	The measure calculates the percentage of individuals discharged in a six month time period from a SNF, within 100 days of admission, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items.
Type	PRO
Data Source	Healthcare Provider Survey The collection instrument is the CoreQ: Short Stay Discharge questionnaire and Resident Assessment Instrument Minimum Data Set (MDS) version 3.0. Available in attached appendix at A.1 No data dictionary
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	The measure assesses the number of patients who are discharged from a SNF, within 100 days of admission, who are satisfied. The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the four questions on the CoreQ: Short Stay Discharge questionnaire.
Numerator Details	The numerator includes all of the patients who were discharged within 100 days of admission and had an average response =>3 on the CoreQ: Short Stay Discharge questionnaire. The calculation of the individual patient's average satisfaction score is done in the following manner: -A numeric score is associated with each response scale option on the CoreQ: Short Stay Discharge questionnaire (that is, Poor=1, Average=2, Good=3, Very Good=4, and Excellent=5). -The following formula is utilized to calculate the individual's average satisfaction score: [Numeric Score Question 1 + Numeric Score Question 2 + Numeric Score Question 3 + Numeric Score Question 4]/4 -The number of respondents whose average satisfaction score >=3 are summed together and function as the numerator. For patients with one missing data point (from the four items included in the questionnaire) imputation is used (representing the average value from the other three available responses). Patients with more than one missing data point, are excluded from the analyses (i.e., no imputation will be used for these patients). Imputation details are described further below (S.22). No risk-adjustment is used (See S.18).
Denominator Statement	The denominator includes all of the patients that are admitted to the SNF, regardless of payor source, for post-acute care, that are discharged within 100 days; who receive the survey (e.g. people meeting exclusions do not receive a questionnaire) and who respond to the CoreQ: Short Stay Discharge questionnaire within the time window (See: S.5).
Denominator Details	The target population includes all of the individuals who respond to the CoreQ: Short Stay Discharge questionnaire within the time window (See: S.5). The data is collected over a maximum 6 month time window. A shorter period can be used if the sample size (125) meets the specifications described below. The questionnaire is administered to discharged patients within 2 weeks of their discharge date. The discharge date is identified from nursing facility records (e.g., MDS, wherein a discharge MDS record is created that includes a discharge date). Note, the questionnaire must be administered after the patient is discharged and not on the day of the discharge. Patients must respond to the CoreQ: Short Stay Discharge questionnaire within 2 months of receiving the questionnaire.

	2614 CoreQ: Short Stay Discharge Measure
Exclusions	Exclusions used are made at the time of sample selection and include: (1) Patients who died during their SNF stay; (2) Patients discharged to a hospital, another SNF, psychiatric facility, inpatient rehabilitation facility or long term care hospital; (3) Patients with court appointed legal guardian for all decisions; (4) Patients discharged on hospice; (5) Patients who left the nursing facility against medical advice (AMA); (6) Patients who have dementia impairing their ability to answer the questionnaire defined as having a BIMS score on the MDS as 7 or lower. [Note: we understand that some SNCCs may not have information on cognitive function available to help with sample selection. In that case, we suggest administering the survey to all residents and assume that those with cognitive impairment will not complete the survey or have someone else complete on their behalf which in either case will exclude them from the analysis.] (7) Patients who responded after the two month response period; and (8) Patients whose responses were filled out by someone else.
Exclusion details	Individuals are excluded based on information from the admission Minimum Data Set (MDS) 3.0 assessment. (1) Patients who die: This is recorded in the MDS as Deceased (A2100 = 08). (2) Patients who were discharged to a hospital, another SNCC, psychiatric facility, Inpatient Rehabilitation Facilities (IRF), or MR/DD facility: This is recorded in the MDS as Discharge to hospital (A2100 = 03); another SNCC (A2100 = 02); psychiatric facility (A2100 = 04); Inpatient Rehabilitation Facilities (A2100 = 05); ID/DD facility (A2100 = 06). (3) Patients with Court appointed legal guardian for all decisions as identified from the nursing facility health information system. (4) Patients on hospice: This is recorded in the MDS as Hospice O0100K1 = 1 (“the patient was on hospice in the last 14 days while not a resident”), O0100K2 = 1 (“the patient was on hospice in the last 14 days while a resident”), A1800=07 (“entered from hospice”), or A2100=07 (“discharged to hospice”). (5) Patients who left the nursing facility against medical advice (AMA) as identified from nursing facility health information systems. (6) Patients with a BIMS score on the MDS as 7 or lower. This is recorded in the MDS as C0500 <= 7. (7) Patients who respond after the two month response period. (8) Patients whose responses were filled out by somebody other than him/herself, as identified by the additional questions on the questionnaire. Surveys returned as undeliverable are also excluded from the denominator.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	No stratification is used (see below).
Type Score	Other (specify): Non-weighted score. Score is a percentage. better quality = higher score
Algorithm	1.Identify SNF patients that are discharged within 100 days after admission a.Calculate the duration of the SNF stay [MDS discharge date (A2000) - MDS admission date (A1900)] to determine if it is = 100 days. 2.Take the patients that have a SNF stay of = 100 days and exclude the following:

	2614 CoreQ: Short Stay Discharge Measure
	a.Patients who died; patients discharged to a hospital; patients with Court appointed legal guardian for all decisions; patients with hospice; patients who left the nursing facility against medical advice (AMA), and patients with a BIMS score of less than 7 do not receive that survey as a result of the exclusions (described in detail above). i.Patients who die: This is recorded in the MDS as Die during stay (A2100 = 08) ii.Patients who were discharged to a hospital, another SNCC, psychiatric facility, Inpatient Rehabilitation Facility, or MR/DD facility (A2100 = 06): This is recorded in the MDS as Discharge to hospital (A2100 = 03); another SNCC (A2100 = 02); psychiatric facility (A2100 = 04); Inpatient Rehabilitation Facility (A2100 = 05); MR/DD facility (A2100 = 06). iii.Patients with Court appointed legal guardian for all decisions will be identified from nursing facility health information system. iv.Patients on hospice: This is recorded in the MDS as Hospice O0100K1 = 1 ("the patient was on hospice in the last 14 days while not a resident"), O0100K2 = 1 ("the patient was on hospice in the last 14 days while a resident"), A1800=07 ("entered from hospice"), or A2100=07 ("discharged to hospice"). v.Patients who left the nursing facility against medical advice (AMA) will be identified from nursing facility health information systems. vi.Patients with a BIMS score of 7 or less. This is recorded in the MDS as C0500 <= 7. 3.Administer the CoreQ: Short Stay Discharge questionnaire (See S.25) to these individuals. The questionnaire should be administered to patients discharged within 2 weeks of discharge. Provide individuals 2 months to respond to the survey. a.Create a tracking sheet with the following columns: i.Data Administered ii.Data Response Received iii.Time to Receive Response ([Date Response Received – Date Administered]) b.Exclude any surveys where Time to Receive Response >2 Months 4.Collect data over a maximum 6 month time window or until 125 consecutive usable surveys are received (See S.21). 5.Exclude responses not completed by the intended recipient (e.g. questions were answered by a friend or family members. It is important to note that cases in which the residents had help with reading the questions, or writing down their responses, are included in the measure, because in these cases the residents answer the questions themselves). 6.Exclude surveys that are returned after two months 7.Combine the CoreQ: Short Stay Discharge questionnaire items to calculate a patient level score. Responses for each item should be given the following scores: a.Poor = 1, b.Average = 2, c.Good = 3, d.Very good =4 and e.Excellent = 5. 8.Impute missing data if only one of the four questions are missing data by taking the average of the other questions responses. 9.Exclude any survey with 2 or more survey questions that have missing data. 10.Calculated patient score from usable surveys. Patient score= (Score for Item 1 + Score for Item 2 + Score for Item 3 + Score for Item 4) / 4. a.For example, a patient rates their satisfaction on the CoreQ questions as excellent = 5, very good = 4, very good = 4, and good = 3. The resident's total score will be 5 + 4 + 4 + 3 for a total

	2614 CoreQ: Short Stay Discharge Measure
	of 16. The patient's total score (16) will then be divided by the number of questions (4), which equals 4. Thus the patients average satisfaction rating is 4.0. This individual would be counted in the numerator since their average score is >3.0. 11.Flag those patients with an average score equal to or greater than 3.0 12.Calculate the CoreQ: Short Stay Discharge measure which represents the percent of patients with average scores of 3.0 or above. CoreQ: Short Stay Measure= ([number of valid responses with an average score of =3.0] / [total number of valid responses])*100 13.No risk-adjustment is used. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not Applicable

	2615 CoreQ: Long-Stay Resident Measure
Status	Submitted
Steward	American Health Care Association
Description	The measure calculates the percentage of long-stay residents, those living in the facility for 100 days or more, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Long-Stay Resident questionnaire that is a three item questionnaire.
Type	PRO
Data Source	Healthcare Provider Survey The collection instrument is the CoreQ: Long-Stay Resident questionnaire and exclusions are from the Resident Assessment Instrument Minimum Data Set (MDS) version 3.0. Available in attached appendix at A.1 No data dictionary
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	The numerator is the sum of the individuals in the facility that have an average satisfaction score of =>3 for the three questions on the CoreQ: Long -Stay Resident questionnaire.
Numerator Details	The numerator includes all of the long-stay residents that had an average response =>3 on the CoreQ: Long Stay Resident questionnaire that do not meet any of the exclusions (see exclusions). The calculation of an individual patient's average satisfaction score is done in the following manner: -Respondents within the appropriate time window (see: S.5) and who do not meet the exclusions (See: S.11) are identified. - A numeric score is associated with each response scale option on the CoreQ: Long-Stay Resident questionnaire (that is, Poor=1, Average=2, Good=3, Very Good=4, and Excellent=5). - The following formula is utilized to calculate the individual's average satisfaction score. [Numeric Score Question 1 + Numeric Score Question 2 + Numeric Score Question 3]/3 -The number of respondents whose average satisfaction score >=3 are summed together and function as the numerator. For residents with one missing data point (from the 3 items included in the questionnaire) imputation is used (representing the average value from the other two available questions). Residents with more than one missing data point, are not counted in the measure (i.e., no imputation is used for these residents since their responses are excluded). Imputation details are described in Section S.22. No risk-adjustment is used (see S.13).
Denominator Statement	The denominator includes all of the residents that have been in the SNF for 100 days or more regardless of payer status; who received the CoreQ: Long-Stay Resident questionnaire (e.g. people meeting exclusions do not receive the questionnaire), who responded to the questionnaire within the two month time window, who did not have the questionnaire completed by somebody other than the resident, and who did not have more than one item missing.
Denominator Details	The target population includes all current individuals in the SNF on a given day who have been in the SNF for 100 days or more and respond to the CoreQ: Long-Stay Resident questionnaire and completed the survey within the two month time window (See: S.5). Residents have up to 2 months to complete and return the survey. The length-of-stay is identified from nursing facility records (MDS item A1600 "Entry Date").
Exclusions	Exclusions made at the time of sample selection are the following: (1) Residents who have poor cognition defined by the BIMS score; (2) residents receiving hospice; (3) residents with a

	2615 CoreQ: Long-Stay Resident Measure
	legal court appointed guardian; and (4) residents who have lived in the SNF for less than 100 days. Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (two months after the administration date) b) surveys that have more than one questionnaire item missing c) surveys from residents who indicate that someone else answered the questions for the resident. (Note this does not include cases where the resident solely had help such as reading the questions or writing down their responses.)
Exclusion details	Individuals are excluded based on information from the Minimum Data Set (MDS) 3.0 assessment. (1) Residents who have poor cognition: Then the Brief Interview for Mental Status (BIMS), a well validated dementia assessment tool is used. BIMS ranges are 0-7 (lowest); 8-12; and 13-15 (highest). Residents with BIMS scores of equal or less than 7 are excluded. (MDS Section C0200-C0500 items are used) (Saliba, et al., 2012). (2) Patients receiving or having received any hospice. This is recorded in the MDS as Hospice O0100K1 = 1 ("the patient was on hospice in the last 14 days while not a resident"), O0100K2 = 1 ("the patient was on hospice in the last 14 days while a resident"), A1800=07 ("entered from hospice"), or A2100=07 ("discharged to hospice"). (3) Patients with court appointed legal guardian for all decisions will be identified from nursing facility health information system. (4) Residents who have lived in the SNF for less than 100 days will be identified from the MDS. This is recorded in the MDS (Section A1600, Entry Date). (5) Residents that respond after the 2 month response period (see S.18, section 3.a on how this is determined). (6) Residents whose responses were completed by someone other than the resident will be excluded. Identified from an additional question on the CoreQ: Long-Stay Resident questionnaire. (7) Residents without usable data (defined as missing data for 2 or 3 of the survey questions). Saliba D, Buchanan J, Edelen MO, Streim J, Ouslander J, Berlowitz D, Chodosh J. J Am Med Dir Assoc. 2012 Sep;13(7):611-7. doi: 10.1016/j.jamda.2012.06.004. Epub 2012 Jul 15.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable
Stratification	No stratification is used (see below).
Type Score	Other (specify): Non-weighted score. Score is a percent. better quality = higher score
Algorithm	1.Identify the residents that have been residing in the SNF for 100 days or more. Length of stay so far is the MDS target date (TRGT_DT) - MDS admission date (A1900). 2. Take the residents that have been residing in the SNF for >=100 days and exclude the following: a. Residents who have poor cognition defined as any residents with BIMS scores of 7 or lower. (MDS Section C0200-C0500 used) (Saliba, et al., 2012). b. Patients receiving or having received any hospice. This is recorded in the MDS as Hospice O0100K1 = 1 ("the patient was on hospice in the last 14 days while not a resident"), O0100K2 = 1 ("the patient was on hospice in the last 14 days while a resident"), A1800=07 ("entered from hospice"), or A2100=07 ("discharged to hospice"). c. Residents with Court appointed legal guardian for all decisions will be identified from nursing facility health information system. 3. Administer the CoreQ: Long-stay Resident questionnaire (See S.25) to these individuals. The

	2615 CoreQ: Long-Stay Resident Measure
	questionnaire should be administered to all residents in the SNF after exclusions in step 2 above. Communicate that residents have four weeks to respond to the survey. Note, we will include surveys received up to two months from administration but specify four weeks to help increase response rate and completion within a timely manner. This also allows providers to use follow-up strategy at 4 weeks to get responses by the 8 week cut off. 4.Create a tracking sheet with the following columns: i. Data Administered ii. Data Response Received iii. Time to Receive Response ([Date Response Received – Date Administered]) 5.Exclude any surveys received after 2 months from administration. 6.Exclude responses not completed by the intended recipient (e.g. questions were answered by a friend or family members (Note: this does not include cases where the resident solely had help such as reading the questions or writing down their responses). 7.Exclude responses that are missing data for 2 or 3 of the CoreQ questions. 8.All of the remaining surveys are totaled and become the denominator. 9.Combine the CoreQ: Long-Stay Resident questionnaire items to calculate a resident level score. Responses for each item should be given the following scores: a.Poor = 1, b.Average = 2, c.Good = 3, d.Very Good =4 and e.Excellent = 5. 10.Impute missing data if only one of the three questions are missing data. 11.Calculate resident score from usable surveys. a.Patient score= (Score for Item 1 + Score for Item 2 + Score for Item 3) / 3. i.For example, a resident rates their satisfaction on the three CoreQ questions as excellent = 5, very good = 4, and good = 3. The resident's total score will be 5 + 4 + 3 for a total of 12. The resident total score (12) will then be divided by the number of questions (3), which equals 4.0. Thus the residents average satisfaction rating is 4.0. Since the resident's score is >3.0, this resident will be counted in the numerator. b.Flag those patients with a score equal to or greater than 3.0. These residents will be included in the numerator. 12. Calculate the CoreQ: Long-Stay Resident Measure which represents the percent of residents with average scores of 3.0 or above. CoreQ: Long-Stay Resident Measure= ([number of respondents with an average score of =3.0] / [total number of respondents])*100. 13.No risk-adjustment is used. Saliba, D., Buchanan, J., Edelen, M.O., Streim, J., Ouslander, J., Berlowitz, D, & Chodosh J. (2012). MDS 3.0: brief interview for mental status. Journal of the American Medical Directors Association, 13(7): 611-617. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0692 : Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The CoreQ: Long-Stay Resident measure does not conceptually address the same measure focus as any other NQF-endorsed measures, however it does conceptually address the same target population as

	2615 CoreQ: Long-Stay Resident Measure
	another NQF-endorsed measure. The Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument (NQF #0692) presented by the Agency for Healthcare Research and Quality received NQF approval over 4 years ago in Jan 24, 2012. This instrument is endorsed to collect resident satisfaction information and consists of a 50 item questionnaire. Our application also uses nursing home residents (The CoreQ: Long-Stay Resident measure) but consists of three items. No analyses have been conducted with CAHPS® such that a score representing satisfaction can be calculated. Whereas the CoreQ items are used to calculate this satisfaction score. Thus, the score from these items is used to provide standardized information on the overall resident satisfaction of the facility. The current CAHPS survey is not used in this way. 5b.1 If competing, why superior or rationale for additive value: Not Applicable

	2616 CoreQ: Long-Stay Family Measure
Status	Submitted
Steward	American Health Care Association
Description	The measure calculates the percentage of family or designated responsible party for long stay residents (i.e., residents living in the facility for 100 days or more), who are satisfied (see: S.5 for details of the timeframe). This consumer reported outcome measure is based on the CoreQ: Long-Stay Family questionnaire that has three items.
Type	PRO
Data Source	Healthcare Provider Survey The collection instrument is the CoreQ: Long-Stay Family questionnaire and for exclusions the Resident Assessment Instrument Minimum Data Set (MDS) version 3.0 is used Available in attached appendix at A.1 No data dictionary
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	The numerator assesses the number of family or designated responsible party for long stay residents that are satisfied. Specifically, the numerator is the sum of the family or designated responsible party members for long stay residents that have an average satisfaction score of =>3 for the three questions on the CoreQ: Long-Stay Family questionnaire.
Numerator Details	The numerator includes all of the family or designated responsible party members for long stay residents that had an average response =>3 on the CoreQ: Long-Stay Family questionnaire. We calculate the average satisfaction score for the individual family or designated responsible party member for long stay residents in the following manner: - Respondents within the appropriate time window (see S.5) and who do not meet the exclusions (see S.11) are identified. - A numeric score is associated with each response scale option on the CoreQ: Long-Stay Family questionnaire (that is, Poor=1, Average=2, Good=3, Very Good=4, and Excellent=5). - The following formula is utilized to calculate the individual's average satisfaction score: [Numeric Score Question 1 + Numeric Score Question 2 + Numeric Score Question 3]/3 - The number of respondents whose average satisfaction score >=3 are summed together and function as the numerator. For respondents with one missing data point (from the 3 items included in the questionnaire) imputation will be used (representing the average value from the other two available questions). For respondents with more than one missing data point, they will be excluded from the analyses (i.e., no imputation will be used for these family members). Imputation details are described further below (S.18). No risk-adjustment is used (see S.13).
Denominator Statement	The target population is family or designated responsible party members of a resident residing in a SNF for at least 100 days. The denominator includes all of the individuals in the target population who respond to the CoreQ: Long-Stay Family questionnaire within the two month time window (see S.5) who do not meet the exclusion criteria (see S.10).
Denominator Details	The denominator includes all of the family or the designated responsible party members for residents that have been in the SNF for 100 days or more regardless of payer status; who received the CoreQ: Long-Stay Family questionnaire (e.g. people meeting exclusions do not receive the questionnaire), and who responded to the questionnaire within the two month time window. The length-of-stay (of the resident of the family member or designated responsible party) will be identified from MDS nursing facility records (MDS item A1600 "Entry Date").

	2616 CoreQ: Long-Stay Family Measure
Exclusions	Please note, the resident representative for each current resident is initially eligible regardless of their being a family member or not. Only one primary contact per resident should be selected. Exclusions made at the time of sample selection include: (1) family or designated responsible party for residents with hospice; (2) family or designated responsible party for residents with a legal court appointed guardian; (3) representatives of residents who have lived in the SNF for less than 100 days; and (4) representatives who reside in another country. Additionally, once the survey is administered, the following exclusions are applied: a) surveys received outside of the time window (more than two months after the administration date) and b) surveys that have more than one questionnaire item missing.
Exclusion details	Exclusions will be based on information from the Minimum Data Set (MDS) 3.0 assessment. Representatives of residents with the following criteria will be excluded: (1) Residents on hospice. This is recorded in the MDS as Hospice O0100K1 = 1 ("the patient was on hospice in the last 14 days while not a resident"), O0100K2 = 1 ("the patient was on hospice in the last 14 days while a resident"), A1800=07 ("entered from hospice"), or A2100=07 ("discharged to hospice"). (2) Residents with court appointed legal guardian for all decisions will be identified from nursing facility health information system. (3) Residents who have lived in the SNF for less than 100 days will be identified from the MDS. This is recorded in the MDS (item A1600 "Entry Date"). (4) Respondents who reside in another country, to be identified from nursing facility health information system. (5) Respondents who have two or more missing data point are excluded from the analysis. (6) Respondents that respond after the two month response period will be excluded.
Risk Adjustment	No risk adjustment or risk stratification Not Applicable.
Stratification	No stratification is used.
Type Score	Other (specify): Non-weighted score. Score is a percent. better quality = higher score
Algorithm	1. Identify the representatives of residents that have been residing in the SNF for 100 days or more. Length of stay so far is the MDS target date (TRGT_DT) - MDS admission date (A1900). 2. Take the representatives of residents that have been residing in the SNF for >=100 days and exclude the following: a. Representatives of residents on hospice. This is recorded in the MDS as Hospice O0100K1 = 1 ("the patient was on hospice in the last 14 days while not a resident"), O0100K2 = 1 ("the patient was on hospice in the last 14 days while a resident"), A1800=07 ("entered from hospice"), or A2100=07 ("discharged to hospice"). b. Residents with Court appointed legal guardian for all decisions as identified from nursing facility health information system. 3. Exclude representatives of residents who reside in another country. 4. Administer the CoreQ: Long-Stay Family questionnaire (See S.25) to the representatives that do not meet these exclusion criteria. Provide the family or designated responsible party member for the resident two months to respond to the survey. a. Create a tracking sheet with the following columns: i. Date Administered ii. Date Response Received iii. Time to Receive Response: ([Date Response Received – Date Administered]) b. Exclude any surveys where Time to Receive Response >60 days (2 months)

	2616 CoreQ: Long-Stay Family Measure
	5.Combine the CoreQ: Long-Stay Family questionnaire items to calculate a resident' representative satisfaction score. Responses for each item should be given the following scores: a.Poor = 1, b.Average = 2, c.Good = 3, d.Very good =4 and e.Excellent = 5. 6.Impute missing data if only one of the three questions are missing data. Drop all survey response if 2 or more survey questions have missing data. 7.Calculate resident's representative score from usable surveys. a.Representative average score = (Score for Item 1 + Score for Item 2 + Score for Item 3) / 3. b.Flag those representatives with a score equal to or greater than 3.0 i.For example, a representative of a resident rates their satisfaction on the three CoreQ questions as excellent = 5, very good = 4, and good = 3. The family member's total score will be 5 + 4 + 3 for a total of 12. The representative of the long-stay resident total score (12) will then be divided by the number of questions (3), which equals 4.0. Thus the representative's average satisfaction rating is 4.0. Since this person's average response is >3.0 they would be counted in the numerator. If it was <3.0 they would not be counted. 8.Calculate the facility's CoreQ: Long-Stay Family Measure which represents the percent of respondents with average scores of 3.0 or above. a.CoreQ: Long-Stay Family Measure = ([number of respondents with an average score of =3.0] / [total number of valid responses])*100 9.No risk-adjustment is used. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0693 : Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The CoreQ: Long-Stay Family measure does not conceptually address the same measure focus as any other NQF-endorsed measures, however it does conceptually address the same target population as another NQF-endorsed satisfaction measure. The Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Family Member Survey Instrument (NQF #0693) presented by the Agency for Healthcare Research and Quality received NQF approval over five years ago in March, 2011. This instrument is endorsed to collect family member satisfaction information and consists of a 50 item questionnaire. Our application also uses nursing home residents (The CoreQ: Long-Stay Family measure) but consists of three items that are aggregated into a single measure. The score from these items is used to provide standardized information on the overall family satisfaction of the facility. The current CAHPS survey is not used in this way. 5b.1 If competing, why superior or rationale for additive value: Not Applicable

	2769 Functional Change: Change in Self Care Score for Skilled Nursing Facilities
Status	Submitted
Steward	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	Change in rasch derived values of self-care function from admission to discharge among adult patients treated as short term rehabilitation patients in a skilled nursing facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission_Self_Care_SNF.xlsx
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Numerator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived self-care functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) / total number of patients).
Denominator Statement	Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age
Denominator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum of 8 items ((Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Excluded in the measure are patients who died in the SNF or patients less than 18 years old.
Exclusion details	Living at discharge and age at admission are collected through the MDS.
Risk Adjustment	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average self-care functional change score. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of SNF-CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b

	2769 Functional Change: Change in Self Care Score for Skilled Nursing Facilities
Stratification	See definition of the SNF-CMGs in the appendix.
Type Score	Ratio better quality = higher score
Algorithm	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total self-care change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in attached excel file). 5. Calculate the average rasch derived self-care change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average self-care change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average self-care change score/facility's national expected self-care change score. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 2613 : CARE: Improvement in Self Care 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While the CARE items and the self-care measure the same construct of functional (in)dependence, there are some key differences key differences included in the measures, and in the measurement of the items. The self-care measure submitted by UDS includes the following items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. The CARE items included in the measure submitted by AHCA include: Eating, Oral hygiene, Toilet hygiene, Shower/bathe self, Upper body dressing, Lower body dressing, Putting on/taking off footwear. Once again there is great overlap in the items, particularly for feeding, grooming, and toileting. However, where the AHCA measure does not contain any cognitive items in their measure, our measure contains two cognitive items when determining a patient's ability to care for one's self especially for discharge planning, cognitive ability play a key role, thus we maintain our measure is best in class considering it is more robust, has greater sensitivity in measurement (our measure uses a seven level rating scale whereas the CARE measure uses a six level, thus our rating scale offers greater refinement in measurement). Finally, the UDSMS change in self-care measure is the exact same measure (same items, same rating scale, same adjustment) used in SNF, IRF and LTAC, offering consistency in measuring patient function across PAC venues, which has been an interest for PAC and is a current objective of the IMPACT ACT. 5b.1 If competing, why superior or rationale for additive value: The functional items in our proposed measure have been collected in SNFs for over 20 years. This allows for a historical perspective of function in the SNFs that the CARE items do not allow. In addition, the functional items in our proposed measure have been used in inpatient rehabilitation facilities for over 30 years, and therefore, a comparison in functional gains between IRFs and SNFs can be easily made should this measure be utilized in both venues of care.

	2774 : Functional Change: Change in Mobility Score for Skilled Nursing Facilities
Status	Submitted
Steward	Uniform Data System for Medical Rehabilitation
Description	Change in rasch derived values of mobility function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items:Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission_Mobility-635749898391586121.xlsx
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Average change in rasch derived mobility functional score (Items Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) from admission to discharge at the facility level. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the facility or patients who died within the facility are excluded.
Numerator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived mobility functional score from admission to discharge for each patient at the facility level, including items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).
Denominator Statement	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Skilled Nursing Facility Case Mix Group level.
Denominator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 4 items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected Mobility functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission,and age at admission). This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average).
Exclusions	Excluded in the measure are patients who died in the SNF or patients less than 18 years old.
Exclusion details	Living at discharge and age at admission are collected through the MDS.
Risk Adjustment	Stratification by risk category/subgroup This adjustment procedure is an indirect standardization procedure (observed facility

	2774 : Functional Change: Change in Mobility Score for Skilled Nursing Facilities
	average/expected facility average). The numerator is the facility´s average mobility functional change score. The denominator is meant to reflect the expected Mobility functional change score at the facility, if the facility had the same distribution of SNF-CMGs(impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	See definition of the SNF-CMGs in the excel file provided.
Type Score	Ratio better quality = higher score
Algorithm	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total mobility change score for each of the remaining patients (sum of change at the patient level for all items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in the excel file). 5. Calculate the average rasch derived mobility change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility´s expected rasch derived average mobility change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average mobility change score/facility´s national expected mobility change score.
Copyright / Disclaimer	5.1 Identified measures: 2612 : CARE: Improvement in Mobility 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While the CARE items and the change in mobility items measure the same construct of functional (in)dependence, there are some key differences included in the measures, and in the measurement of the items. The mobility measure, submitted by UDS includes the following items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. The CARE items included in the measure submitted by AHCA include: : Roll left and right, Sit to lying, Lying to sitting on side of bed, Sit to stand, Chair/bed-to-chair transfer, Toilet transfer, Car transfer, Walk 10 feet, Walk 50 feet with 2 turns, Walk 150 feet, Walking 10 feet on uneven surfaces, 1 step, 4 steps, 12 steps, Pick up object. Once again there is great overlap in the items, There is great overlap between the items in the two measures, particularly in the transfer items, locomotion, and stairs. However while our measure contains only four items, the CMS measure contains 14 items. While our measure has the one locomotion item, for instance, the ACHA measure has four. Similarly, our measure contains one item for stairs, while the CMS measure contains three. This becomes burdensome on the provider to have to collect an additional 10 items and it hasn't been proven that there is additional value or specificity in the measure. Rasch analysis shows us that more items do not always mean better measurement. Finally, the UDSMS change in mobility measure is the exact same measure (same items, same rating scale, same adjustment) used in SNF, IRF and LTAC, offering consistency in measuring patient function across PAC venues, which has been an interest for PAC and is a current objective of the IMPACT ACT. 5b.1 If competing, why superior or rationale for additive value: The functional items have been

	2774 : Functional Change: Change in Mobility Score for Skilled Nursing Facilities
	collected in SNFs for over 20 years. This allows for a historical perspective of function in the SNFs that the CARE items do not allow. In addition, the these items have been used in inpatient rehabilitation facilities for over 30 years, and therefore, a comparison in functional gains between IRFs and SNFs can be easily made should this measure be utilized in both venues of care.

	2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities
Status	Submitted
Steward	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items:Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission-635749892715380581.xlsx
Level	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the SNF or patients who died within the SNF are excluded.
Numerator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived motor functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).
Denominator Statement	Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age.
Denominator Details	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 12 items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Patients age at admission less than 18 years old Patients who died in the SNF.
Exclusion details	Living at discharge and age at admission are collected through the MDS.
Risk Adjustment	Stratification by risk category/subgroup

	2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities
	This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average motor functional change score. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same distribution of SNF-CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	See definition of the SNF-CMGs in the excel file provided.
Type Score	Ratio better quality = higher score
Algorithm	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total motor change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in the attached excel file). 5. Calculate the average rasch derived motor change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average motor change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average motor change score/facility's national expected motor change score. Available in attached appendix at A.1
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	2962 Shared Decision Making Process
Status	Submitted
Steward	Informed Medical Decisions Foundation, a division of Healthwise
Description	This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of 7 common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.
Type	PRO
Data Source	Patient Reported Data/Survey We have used these questions in mail surveys most often, but we have also use them on the Internet and in a national telephone survey using telephone interviewers. We have used these questions in English and Spanish. No data collection instrument provided Attachment ICD_Codes.xlsx
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Patient answers to four questions about whether not 4 essential elements of shared decision making (laying out options, discussing the reasons to have the intervention and not to have the intervention, and asking for patient input) were part of the interactions with providers when the decision was made to have the procedure.
Numerator Details	All responding patients will answer four questions about their pre-surgical interactions with their providers: 1. How much did a doctor (or health care provider) talk with you about the reasons you might want to (HAVE INTERVENTION)—a lot, some, a little, or not at all? 2. How much did a doctor (or other health care provider) talk with you about reasons you might not want to (HAVE INTERVENTION)—a lot, some, a little or not at all? 3. Did any of your doctors ask you if you wanted to (HAVE INTERVENTION)? (YES/NO) 4. Did any of your doctors (or health care providers) explain that you could choose whether or not to (HAVE INTERVENTION)? (YES/NO) OR: “Did any of your doctors (or health care providers) explain that there were choices in what you could do to treat your [condition]? (YES/NO) SCORING: 1 POINT EACH FOR ANSWERING “A LOT” OR “SOME” TO QUESTIONS 1 AND 2; 1 POINT EACH FOR ANSWERING “YES” TO QUESTIONS 3 AND 4. TOTAL SCORE = 0 TO 4. Score for a provider or provider group is simply the average score for their responding patients. This will be a continuous number from 0 to 4.
Denominator Statement	All responding patients who have undergone one of the following 7 surgical procedures: back surgery for a herniated disc; back surgery for spinal stenosis; knee replacement for osteoarthritis of the knee; hip replacement for osteoarthritis of the hip; radical prostatectomy for prostate cancer; percutaneous coronary intervention (PCI) for stable angina, and mastectomy for early stage breast cancer.
Denominator Details	See S2. There is an attached sheet with ICD 10 and CPT codes needed to identify eligible patients.
Exclusions	For back, hip, knee, and prostate surgery patients, there are no exclusions, so long as the surgery is for the designated condition.

	2962 Shared Decision Making Process
	PCI patients who had a heart attack within 4 weeks of the PCI procedure are excluded, as are those who have had previous coronary artery procedures (either PCI or CABG). For patients who have mastectomy, patients who had had a prior lumpectomy for breast cancer in the same breast and patients who have not been diagnosed with breast cancer (who are having prophylactic mastectomies) are excluded.
Exclusion details	Included in attached file
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	none
Type Score	Continuous variable, e.g. average better quality = higher score
Algorithm	All responding patients will answer four questions about their pre-surgical interactions with their providers: 1. How much did a doctor (or health care provider) talk with you about the reasons you might want to (HAVE INTERVENTION)—a lot, some, a little, or not at all? 2. How much did a doctor (or other health care provider) talk with you about reasons you might not want to (HAVE INTERVENTION)—a lot, some, a little or not at all? 3. Did any of your doctors ask you if you wanted to (HAVE INTERVENTION)? (YES/NO) Did any of your doctors (or health care providers) explain that you could choose whether or not to (HAVE INTERVENTION)? (YES/NO) OR: "Did any of your doctors (or health care providers) explain that there were choices in what you could do to treat your [condition]? (YES/NO) SCORING: 1 POINT EACH FOR ANSWERING "A LOT" OR "SOME" TO QUESTIONS 1 AND 2; 1 POINT EACH FOR ANSWERING "YES" TO QUESTIONS 3 AND 4. TOTAL SCORE = 0 TO 4. Score for a provider or provider group is simply the average score for their responding patients. This will be a continuous number from 0 to 4. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 1741 : Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The approved PCMH and ACO CAHPS measures of shared decision making were adaptations of the measures we developed and are proposing. Those measures were used for respondents who reported they had discussed starting or stopping a prescription medication (for PCMH) and for patients who reported discussion a prescription medication or a procedure with a provider (ACO). The problem with integrating this measure into the CAHPS protocols includes both sample sizes and sample designs. This measure works best when applied to a specific kind of decision (eg. Decision to take medication for high blood pressure or decision to have surgery for herniated disc.) CAHPS samples relatively small numbers of ambulatory patients from a clinician's practice or a clinical site. Those samples do not include enough encounters at which decisions are made about specific medications or specific tests or surgical procedures to provide reliable data. Hence, they had to ask about any decisions about starting or stopping medications or surgical procedures and combine the answers for each type of decision. The numbers of such decisions tend to be very small, even when all medications or procedures are combined. Moreover, we have abundant data showing that the Shared Decision Making Process Score varies widely from medication to medication and procedure to procedure. (Zikmund=Fisher et al, 2010; Fowler et al, 2012; Fowler et al, 2014). The approach we are proposing, sampling patients who have undergone a procedure, provides the ability to control the sample sizes of

	2962 Shared Decision Making Process
	respondents and provides for collecting data about the same decision when using the data to compare clinical sites—which is essential in order to meaningfully interpret the results as measures of quality of care. 5b.1 If competing, why superior or rationale for additive value: There is no other measure that we have identified of the shared decision process that has NQF endorsement. There was a shared decision making measure for back pain that consisted of whether or not physicians recorded in the medical record that they had reviewed various aspects of risks and benefits of back surgery prior to surgery. This measure is no longer endorsed. In addition, obviously patient reports of their discussions with physicians are very different from physician reports of their own perceptions of their discussions. We certainly think that patient reports are a more credible measure of what transpired.

	2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities
Status	Submitted
Steward	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	Change in rasch derived values of motor function from admission to discharge among adult long term acute care facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 12 items:Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission-635749865761904393.xlsx
Level	Facility
Setting	Post Acute/Long Term Care Facility : Long Term Acute Care Hospital
Numerator Statement	Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the LTAC or patients who died within the LTAC are excluded.
Numerator Details	The target population is all LTAC patients, at least 18 years old, who did not die in the LTAC. The numerator is the average change in rasch derived motor functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).
Denominator Statement	Facility adjusted expected change in rasch derived values, adjusted for CMG (Case Mix Group), based on impairment type, admission functional status, and age.
Denominator Details	The target population is all LTAC patients, at least 18 years old, who did not die in the LTAC. Impairment type is defined as the primary medical reason for the LTAC stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 12 items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the LTAC. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same distribution of CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Patients age at admission less than 18 years old Patients who died in the LTAC.
Exclusion details	Living at discharge and age at admission are collected through OASIS.
Risk Adjustment	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average motor functional change score. The denominator is meant to reflect the expected motor functional change

	2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities
	score at the facility, if the facility had the same distribution of CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	See definition of the CMGs in the excel file provided.
Type Score	Ratio better quality = higher score
Algorithm	1. Identify all patients during the assessment time frame (12 months). 2. Exclude any patients who died in the LTAC. 3. Exclude any patients who are less than 18 at the time of admission to the LTAC. 3. Calculate the total motor change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in excel file). 5. Calculate the average rasch derived motor change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average motor change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average motor change score/facility's national expected motor change score. Available in attached appendix at A.1
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	2777 Functional Change: Change in Self Care Score for Long Term Acute Care Facilities
Status	Submitted
Steward	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	Change in rasch derived values of self-care function from admission to discharge among adult patients treated in a long term acute care facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission_Self_Care-635749886179500305.xlsx
Level	Facility
Setting	Post Acute/Long Term Care Facility : Long Term Acute Care Hospital
Numerator Statement	Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Numerator Details	The target population is all LTAC patients, at least 18 years old, who did not die in the LTAC. The numerator is the average change in rasch derived self-care functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) / total number of patients).
Denominator Statement	Facility adjusted expected change in rasch derived values, adjusted for CMG (Case Mix Group), based on impairment type, admission functional status, and age
Denominator Details	The target population is all LTAC patients, at least 18 years old, who did not die in the LTAC. Impairment type is defined as the primary medical reason for the LTAC stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 8 self-care items ((Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) at the facility level. Age is the age of the patient at the time of admission to the LTAC. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Excluded in the measure are patients who died in the LTAC or patients less than 18 years old.
Exclusion details	Living at discharge and age at admission are collected through OASIS.
Risk Adjustment	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average self-care functional change score. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of CMGs(impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	See definition of the CMGs in the excel file provided.

	2777 Functional Change: Change in Self Care Score for Long Term Acute Care Facilities
Type Score	Ratio better quality = higher score
Algorithm	1. Identify all patients during the assessment time frame (12 months). 2. Exclude any patients who died in the LTAC. 3. Exclude any patients who are less than 18 at the time of admission to the LTAC. 3. Calculate the total self-care change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in excel file). 5. Calculate the average rasch derived self-care change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average self-care change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average self-care change score/facility's national expected self-care change score. Available in attached appendix at A.1
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
Status	Submitted
Steward	Massachusetts General Hospital
Description	The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of osteoarthritis.
Type	PRO
Data Source	Patient Reported Data/Survey The measure is derived from responses to the Hip and Knee Decision Quality Instruments. These patient reported surveys have been administered by mail, phone, and online for patients. The method we have used most often is mail with a postage paid return envelope. A combination of mail, email, and phone reminders are often needed to achieve adequate response rates. A third party vendor may also be used to administer the survey. We have used these questions in English and Spanish. Available in attached appendix at A.1 Attachment NQF_IPC_Hip_Knee_Replacement_Measure_ICD10CPTcodes.xlsx
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	The numerator is the number of respondents who have an adequate knowledge score (60% or greater) and a clear preference for surgery.
Numerator Details	The numerator is the number of respondents who have a positive decision quality assessment. The numerator is calculated based on patient responses to 6 questions from the Hip or Knee Decision Quality Instruments (these items are listed below in S.18 and included as an appendix): five multiple choice knowledge items and one preference item. One point is awarded for each correct knowledge item and then a total knowledge score is calculated and scaled from (0-100%). Respondents who score 60% or higher on knowledge and who indicate a clear preference for surgery have a positive decision quality assessment and are counted in the numerator. Those who score less than 60% and/or who are either unclear or prefer nonsurgical options have a negative decision quality assessment, and are not counted in the numerator.
Denominator Statement	The denominator includes the number of surveys of patients who have undergone primary knee or hip replacement surgery for osteoarthritis. Participants who answer at least 3 of the 5 knowledge items and the preference item will be counted in the denominator.
Denominator Details	The denominator is all adult patients who had a hip or knee replacement surgery for treatment of osteoarthritis and responded to the Hip or Knee Decision Quality Instrument.
Exclusions	Respondents who are missing 3 or more knowledge items do not get a total knowledge score and are not able to be assessed for the measure. Similarly, respondents who do not indicate a preferred treatment do not get counted in the denominator.
Exclusion details	There is an attached sheet with ICD 10 and CPT codes needed to identify eligible patients to be surveyed for inclusion in the measure.
Risk Adjustment	No risk adjustment or risk stratification No risk stratification used.
Stratification	N/A

	2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
Type Score	Categorical, e.g., yes/no passing score defines better quality
Algorithm	The following steps need to be taken to calculate the measure: (1) identify eligible patients (2) administer the Hip or Knee Decision Quality Instrument (3) collect and code responses (4) calculate total knowledge scores and exclude those with 3 or more knowledge items missing (5) calculate the numerator (informed and clear preference for surgery or not) for each individual, excluding those with no knowledge score and/or no preference item and (6) aggregate the measure into a rate over the center or practice. Responses to five knowledge questions and one preference item from the Hip or Knee Decision Quality Instrument are needed to calculate the Informed, Patient Centered (IPC) surgery measure and are coded and scored as indicated below. Scoring of Knee Items used to generate the measure 1. Which treatment is most likely to provide relief from knee pain caused by osteoarthritis? Surgery (Coded- 1) Non-surgical treatments (coded =0) Both are about the same (coded= 0) Multiple responses = 0 Missing response = 0.33 2. After knee replacement surgery, about how many months does it take most people to get back to doing their usual activities? Less than 2 months (coded= 0) 2 to 6 months (coded = 1) 7 to 12 months (coded= 0) More than 12 months (coded= 0) Multiple responses = 0 Missing response = 0.25 3.If 100 people have knee replacement surgery, about how many will have less knee pain after the surgery? 20 (coded= 0) 40 (coded= 0) 60 (coded= 0) 80 (coded = 1) Multiple response = 0 Missing response = 0.25 4.If 100 people have knee replacement surgery, about how many will have a serious complication within 3 months after surgery? 4 (Coded=1) 10 (coded= 0) 14 (coded= 0) 20 (coded= 0) Multiple responses = 0 Missing response = 0.25 5. If 100 people have knee replacement surgery, about how many will need to have the same knee replaced again in less than 15 years? More than half (coded= 0) About half (coded= 0)

	2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
	Less than half (coded =1) Multiple responses = 0 Missing = 0.33 Scoring of Preference Item for Knee: 6. Which treatment did you want to have to treat your knee osteoarthritis? Surgery (coded=1) Non-surgical treatments (coded= 0) Not sure (coded= 0) Multiple responses (coded=0) Scoring of Hip Items used to generate the measure: 1. Which treatment is most likely to provide relief from hip pain caused by osteoarthritis? Surgery (Coded- 1) Non-surgical treatments (coded =0) Both are about the same (coded= 0) Multiple responses = 0 Missing response = 0.33 2. After hip replacement surgery, about how many months does it take most people to get back to doing their usual activities? Less than 2 months (coded= 0) 2 to 6 months (coded = 1) 7 to 12 months (coded= 0) More than 12 months (coded= 0) Multiple responses = 0 Missing response = 0.25 3. If 100 people have hip replacement surgery, about how many will have less hip pain after the surgery? 30 (coded= 0) 50 (coded= 0) 70 (coded= 0) 90 (coded = 1) Multiple response = 0 Missing response = 0.25 4. If 100 people have hip replacement surgery, about how many will have a serious complication within 3 months after surgery? 4 (Coded=1) 10 (coded= 0) 14 (coded= 0) 20 (coded= 0) Multiple responses = 0 Missing response = 0.25 5. If 100 people have hip replacement surgery, about how many will need to have the same hip replaced again in less than 20 years? More than half (coded= 0) About half (coded= 0) Less than half (coded =1)

	2958 Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery
	Multiple responses = 0 Missing = 0.33 Scoring of Preference Item for Hip: 6. Which treatment did you want to have to treat your hip osteoarthritis? Surgery (coded=1) Non-surgical treatments (coded= 0) Not sure (coded= 0) Multiple responses (coded=0) Knowledge: The responses are coded as indicated above. A total knowledge score is calculated by summing the five items, dividing by 5 and converting to percentage to get scores 0-100%. Missing answers are imputed with 1/k where k is the number of possible responses (essentially equivalent to guessing). Multiple responses (e.g. on paper survey) are considered incorrect and coded as 0. A total knowledge score is calculated for all surveys that have three or more knowledge items completed. Preference item: Respondents who mark surgery are considered to indicate a clear preference for surgery. Respondents that mark either non surgical treatments or not sure, are not considered to have a clear preference for surgery. Missing responses are not counted. Multiple responses (e.g. on a paper survey) are considered "not sure" and coded as 0. A positive assessment "yes" for decision quality requires a knowledge score of 60% or higher and a clear preference for surgery. Otherwise, decision quality is "no." No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

Appendix F: Related and Competing Measures

Comparison of NQF #2613 and NQF #2769

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
Steward	American Health Care Association	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	The measure calculates a skilled nursing facility's (SNFs) average change in self care for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in self care score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status. This is a risk adjusted outcome measure, based on the self care subscale of the Continuity Assessment and Record Evaluation (CARE) Tool and information from the admission MDS 3.0 assessment. The measure is calculated on a rolling 12 month, average updated quarterly.	Change in rasch derived values of self-care function from admission to discharge among adult patients treated as short term rehabilitation patients in a skilled nursing facility who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 8 items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Type	Outcome	Outcome
Data Source	Electronic Clinical Data, Other Resident Assessment Instrument Minimum Data Set (MDS) version 3.0 Continuity Assessment and Record Evaluation (CARE) tool; Self Care subscale Available in attached appendix at A.1 No data dictionary	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission_Self_Care_SNF.xlsx
Level	Facility	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	This outcome measure assesses the change in self-care. The numerator is the risk adjusted sum of the change in the CARE Tool self care subscale items between admission and discharge for each individual admitted from a hospital or another post-acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.	Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Numerator Details	The numerator includes all residents admitted from a hospital or another post-acute care setting that receive any PT or OT therapy for any reason in a SNF that have a completed CARE Tool self care subscale assessment at admission and discharge (see denominator definition below). The self care items used from the CARE	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived self-care functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming,

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	tool are listed below and rated on a 1-6 scale (see Appendix for CARE Tool). The items included in the CARE Tool self care subscale include: • A1. Eating • A3. Oral Hygiene • A4. Toilet Hygiene • A5. Upper Body Dressing • A6. Lower Body Dressing • C1. Wash Upper Body • C2. Shower / Bathe • C6. Putting on / taking off footwear The numerator is facility's average risk adjusted change score on the self care subscale of the CARE tool. The risk adjusted average change score is calculated in several steps: Step 1: Each individual's admission and discharge self care subscale score is calculated. Items rated as S. Not attempted due to safety concerns, A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to one on a six point rating scale (e.g. dependent). For each individual, the ratings for all the self care items on the CARE tool at admission are summed and transformed to a 0-100 scale. The same is done for the discharge assessment. Step 2: Each individual's unadjusted change score is calculated by taking the admission score minus the discharge score. Step 3: The individual's unadjusted change score is risk adjusted (see S.14) Step 4: The facility's risk adjusted change score is the sum of all the individual's risk adjusted change scores divided by the denominator.	Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) / total number of patients).
Denominator Statement	The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed self care subscale of the CARE Tool at admission and discharge and do not meet any of the exclusion criteria and do not have missing data. The self care items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for CARE Tool). The items included in the CARE Tool self care subscale include:	Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	• A1. Eating • A3. Oral Hygiene • A4. Toilet Hygiene • A5. Upper Body Dressing • A6. Lower Body Dressing • C1. Wash Upper Body • C2. Shower / Bathe • C6. Putting on / taking off footwear	
Denominator Details	The denominator includes all residents admitted to a SNF who are receiving any PT or OT therapy for any reason. The denominator is based on admission from any hospital or post-acute care setting and is determined using information from MDS item “A1800 Entered From” coded as “03 Acute Care Hospital” or “02 Another nursing home or swing bed” or “05 inpatient rehabilitation facility” or "09 Long Term Care Hospital (LTCH)", regardless of payor status. They must receive either PT or OT therapy during their stay. A resident’s stay is defined as an episode of care from admissions to discharge from the facility or discharge from therapy services (defined as completing a discharge CARE Tool assessment).	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum of 8 items ((Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Individual patients are excluded for two broad reasons: 1. if they have conditions where improvement in self-care is very unlikely, OR 2. have missing data necessary to calculate the measure Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting of their data.	Excluded in the measure are patients who died in the SNF or patients less than 18 years old.
Exclusion Details	Individuals with conditions where improvement in self care (as determined by a panel of expert therapists) is very unlikely were excluded based on information from the admission MDS 3.0 assessment. Individuals with one of the following MDS 3.0 items marked as yes were excluded: • Ventilator (O0100F1 =1 or O0100F2 =1) • Coma (B0100 =1)	Living at discharge and age at admission are collected through the MDS.

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	• Quadriplegic (I5100=1) • Hospice (O0100K1 = 1) In addition, we also excluded individuals whose age is less than 18 years. Overall, these exclusions resulted in 1.1% of all admissions being excluded. Missing data also resulted in individuals being excluded, details are as follows: • Missing a discharge CARE Tool assessment (this resulted when individuals died or were hospitalized during their SNF stay) resulted in patients being excluded since one could not calculate a change from admission. Nationally approximately 21.6% of admissions to a SNF will be hospitalized during their therapy stay and 4.5% will die (based on analysis of SNF part A claims from 2009-2011). • Missing data on individual items on either the admission or discharge CARE Tool assessment resulted in the individual being excluded from calculation. For self care items, this occurred 4.4% of the time. We did not impute any missing data for self care items.	
Risk Adjustment	Statistical risk model Each individual's change score was risk adjusted based on the following formula: Risk Adjusted Score for individual = (National Average Change Score – Predicted Change Score) + Actual Change Score. The National Average Change Score was calculated as a population average change score for all patients in all SNFs who had a CARE Tool self care subscale assessment completed at admission and discharge. The change score is the difference in the aggregate of each individuals scale score from admission to discharge transformed to 0 to 100 scale. The Predicted Change Score is calculated based on logistic regression using the process outlined in 2b4. The Actual Change Score is the difference between the individual person's admission self care score transformed to 0 to 100 scale and their discharge self care score transformed to a 0 to 100 scale. Provided in response box S.15a	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average self-care functional change score. The denominator is meant to reflect the expected Self-Care functional change score at the facility, if the facility had the same distribution of SNF-CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	Not Applicable	See definition of the SNF-CMGs in the appendix.
Type Score	Continuous variable, e.g. average better	Ratio better quality = higher score

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	quality = higher score	
Algorithm	The facility-level self care improvement scores are calculated using the following 14 steps. Step 1. Choose the 12 month window for which we will select episodes. This is the four consecutive calendar quarters ending with the most recent calendar quarter for which both MDS data and CARE tool data are available for use in the measure. Step 2. Identify all MDS discharge assessments (in which we understand the CARE tool items will be embedded) with a discharge date that fell within the 12 month window identified in Step 1. Step 3. For each MDS tool discharge assessment identified in Step 2, identify the corresponding MDS admission assessment (in which we understand the CARE tool items will be embedded). An MDS assessment is identified as an admission assessment if A0310F == “01” (entry record). Note that the admission date may lie before the 12 month window defined in Step 1. The period of time from the admission date (corresponding with the MDS admission assessment) through to the discharge date (corresponding with the MDS discharge assessment) is called an “episode”. If no MDS admission assessment was found, discard the discharge assessment from all subsequent steps. Step 4. Identify all MDS admission assessments that indicate the admission to the SNF was from the hospital, another SNF or IRF. An MDS admission assessment indicates that the SNF admission was from a hospital when MDS item “A1800 Entered From” coded as “03 Acute Care Hospital” or “02 Another nursing home or swing bed” or “05 inpatient rehabilitation facility” of "09 Long Term Care Hospital". The MDS item A1600 indicates the date of entry to the SNF. Step 5. For any admission or discharge CARE tool item (that enters the calculation of the self-care improvement scores) with letter code “S” (activity not attempted due to safety concerns), A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to “1” on a six point rating scale (indicating full functional dependence). Step 6. Apply the self care improvement measure’s exclusions (see s.11), and exclude any episode that did not involve either physical or occupational therapy. The clinical measure	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total self-care change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in attached excel file). 5. Calculate the average rasch derived self-care change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average self-care change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average self-care change score/facility's national expected self-care change score. No diagram provided

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	exclusions are detailed in S.11 (Denominator exclusion details and codes). The exclusion of episodes not involving either occupational or physical therapy is as follows: We identify the patient as having received occupational therapy if on the MDS discharge assessment: The total number of minutes of occupational therapy in the last 7 days (O0400B1) is greater than zero; or The most recent occupational therapy regimen (starting on the date recorded in O0400B5, and ending on the date recorded in O0400B6) intersects the episode (beginning with the CARE admission assessment's date and ending with the CARE discharge assessment's date). We identify the patient as having received physical therapy if on the MDS discharge assessment: The total number of minutes of physical therapy in the last 7 days (O0400C1) is greater than zero; or The most recent physical therapy regimen (starting on the date recorded in O0400C5, and ending on the date recorded in O0400C6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date). If the episode involves neither occupational nor physical therapy, as identified above, then exclude it from all subsequent steps in the calculation. Step 7. For each episode remaining after Step 6, calculate a preliminary admission score and a discharge score as the sum of the values for the following CARE tool self care items A1 (Eating), A3 (Oral Hygiene), A4 (Toilet Hygiene), A5 (Upper Body Dressing), A6 (Lower Body Dressing), C1 (Wash Upper Body), C2 (Shower/Bath Self), C6 (Putting on/Taking off Footwear). Each of those 8 CARE tool items takes an integer value of 1, 2, 3, 4, 5 or 6, and so the preliminary admission score will be an integer between 8 and 48, and the preliminary discharge score will be an integer between 8 and 48. Step 8. For each episode, linearly transform the	

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
	preliminary admission score and preliminary discharge score so that it lies in the range 1-100 using the following equation: ["transformed self-care admission score"]=2.475×["preliminary self-care admission score"]-18.8 ["transformed self-care discharge score"]=2.475×["preliminary self-care discharge score"]-18.8 Step 9. For each episode, calculate the episode-level change score by subtracting the transformed discharge score from the transformed admission score. Each score will lie between -99 and 99. Step 10. Calculate the national average change score as the simple mean of all episode-level change scores calculated in Step 9. Step 11. For each episode, calculate the predicted change score using the risk adjustment methodology detailed in S.15a. That is, having prepared the risk adjustment variables in the way described in S.15a, apply the equation: [predicted change score] = 25.98 - 0.28×[patient is 85 years or older] -4.43×[dialysis while a patient] -3.83×[entered from SNF] -2.37×[oxygen while a patient] -1.06×[catheterization/ostomy] -2.87×[unhealed pressure ulcers] -7.12×[mental status] -3.33×[resident mood] -8.11×[psychiatric conditions] -4.05×[feeding tube or IV feeding] -5.43×[suctioning or tracheotomy] -2.76×[infections of the foot]. Step 12. For each episode, calculate the risk adjusted change score using the actual change score calculated in Step 9, the national average change score calculated in Step 10, and the predicted change score calculated in Step 11. The risk adjusted change score is: ["risk adjusted change score"]=(["national average change score"]-["predicted change score"])+["actual change score"] Step 13. Exclude any facility that has fewer than 30 episodes for which we could calculate a risk adjusted change score. Step 14. For each facility remaining after Step 13, calculate its self care improvement score as the simple mean of the risk adjusted change scores calculated in Step 12. No diagram provided	

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not Applicable	5.1 Identified measures: 2613 : CARE: Improvement in Self Care 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While the CARE items and the self-care measure the same construct of functional (in)dependence, there are some key differences key differences included in the measures, and in the measurement of the items. The self-care measure submitted by UDS includes the following items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. The CARE items included in the measure submitted by AHCA include: Eating, Oral hygiene, Toilet hygiene, Shower/bathe self, Upper body dressing, Lower body dressing, Putting on/taking off footwear. Once again there is great overlap in the items, particularly for feeding, grooming, and toileting. However, where the AHCA measure does not contain any cognitive items in their measure, our measure contains two cognitive items when determining a patient's ability to care for one's self especially for discharge planning, cognitive ability play a key role, thus we maintain our measure is best in class considering it is more robust, has greater sensitivity in measurement (our measure uses a seven level rating scale whereas the CARE measure uses a six level, thus our rating scale offers greater refinement in measurement). Finally, the UDSMS change in self-care measure is the exact same measure (same items, same rating scale, same adjustment) used in SNF, IRF and LTAC, offering consistency in measuring patient function across PAC venues, which has been an interest for PAC and is a current objective of the IMPACT ACT. 5b.1 If competing, why superior or rationale for additive value: The functional items in our proposed measure have been collected in SNFs for over 20 years. This allows for a historical perspective of function in the SNFs that the CARE items do not allow. In addition, the functional items in our proposed measure have been used in inpatient rehabilitation facilities for over 30 years, and therefore, a comparison in

	2613: CARE: Improvement in Self Care	2769: Functional Change: Change in Self Care Score for Skilled Nursing Facilities
		functional gains between IRFs and SNFs can be easily made should this measure be utilized in both venues of care.

Comparison of NQF #2612 and NQF #2774

	2612: CARE: Improvement in Mobility	2774: : Functional Change: Change in Mobility Score for Skilled Nursing Facilities
Steward	American Health Care Association	Uniform Data System for Medical Rehabilitation, a
Description	The measure calculates a skilled nursing facility's (SNFs) average change in mobility for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in mobility score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status. This is a risk adjusted outcome measure, based on the mobility subscale of the Continuity Assessment and Record Evaluation (CARE) Tool and information from the admission MDS 3.0 assessment. The measure is calculated on a rolling 12 month, average updated quarterly.	Change in rasch derived values of mobility function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 4 mobility items:Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome	Outcome
Data Source	Electronic Clinical Data, Other Resident Assessment Instrument Minimum Data Set (MDS) version 3.0 Continuity Assessment and Record Evaluation (CARE) Tool; Mobility subscale Available in attached appendix at A.1 No data dictionary	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission_Mobility-635749898391586121.xlsx
Level	Facility	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	The measure assesses the change in mobility. The numerator is the risk adjusted sum of the change in the CARE Tool mobility subscale items between admission and discharge for each individual admitted from a hospital or another post acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.	Average change in rasch derived mobility functional score (Items Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) from admission to discharge at the facility level. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the facility or patients who died within the facility are excluded.

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Numerator Details	The numerator includes all residents admitted from a hospital or another post acute care setting that receive any PT or OT therapy for any reason in a SNF that have a completed mobility CARE tool assessment at admission and discharge (see denominator definition below). The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the CARE Tool assessment). The items included in the CARE Tool Mobility subscale include: • B1. Lying to Sitting on Side of Bed • B2. Sit to Stand • B3. Chair/Bed to Chair Transfer • B4. Toilet Transfer • B5a & B5b. Walking or Wheelchair Mobility • C3. Roll left / right • C4. Sit to Lying • C5. Picking up object • C7a. One Step Curb • C7b. Walk 50 ft. with Two Turns • C7c. Walk 12 Steps. • C7d. Walk Four Steps • C7e. Walking 10 ft. on Uneven Surface • C7f. Car Transfer The numerator is a facility's average risk adjusted change score on the mobility component of the CARE tool. The risk adjusted average change score is calculated in several steps: Step 1: Each individual's admission and discharge mobility scale score is calculated. Items rated as S. Not attempted due to safety concerns, A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to one. For each individual, the ratings for all the mobility items on the CARE tool at admission are summed and transformed to a 0-100 scale. The same is done for the discharge assessment. Step 2: Each individual's unadjusted change score is calculated by taking the admission score minus the discharge score. Step 3: The individual's unadjusted change score is risk adjusted (see risk adjustment section) Step 4: The facilities risk adjusted change score is the sum of all the individual's risk adjusted	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived mobility functional score from admission to discharge for each patient at the facility level, including items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).

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	change scores divided by the denominator.	
Denominator Statement	The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed mobility CARE tool assessment at admission and discharge and do not meet any of the exclusion criteria. The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the mobility CARE tool assessment). The items included in the CARE Tool Mobility subscale include: • B1. Lying to Sitting on Side of Bed • B2. Sit to Stand • B3. Chair/Bed to Chair Transfer • B4. Toilet Transfer • B5a & B5b. Walking or Wheelchair Mobility • C3. Roll left / right • C4. Sit to Lying • C5. Picking up object • C7a. One Step Curb • C7b. Walk 50 ft. with Two Turns • C7c. Walk 12 Steps. • C7d. Walk Four Steps • C7e. Walking 10 ft. on Uneven Surface • C7f. Car Transfer	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Skilled Nursing Facility Case Mix Group level.
Denominator Details	The denominator includes all residents admitted to a SNF who are receiving any PT or OT therapy for any reason. The denominator is based on admission from any hospital or post-acute care setting and is determined using information from MDS item "A1800 Entered From" coded as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" or "09 Long Term Care Hospital" regardless of payor status. They must receive either PT or OT therapy during their stay. A resident's stay is defined as an episode of care from admissions to discharge from the facility or discharge from therapy services (defined as completing a discharge CARE tool assessment). Overall, approximately 85% of all admissions from a hospital receive either PT or OT therapy based	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 4 items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected Mobility functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission,and age at

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	on SNF Part A claims (or MDS 3.0 data).	admission). This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average).
Exclusions	Patients are excluded for two broad reasons: 1. if they have conditions where improvement in mobility is very unlikely, OR 2. have missing data necessary to calculate the measure Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting their data.	Excluded in the measure are patients who died in the SNF or patients less than 18 years old.
Exclusion Details	Individuals with conditions where improvement in mobility (as determined by a panel of expert therapists) is very unlikely were excluded based on information from the admission MDS 3.0 assessment. Individuals with one of the following MDS 3.0 items marked as yes were excluded: • Ventilator (O0100F1 =1 or O0100F2 =1) • Coma (B0100 =1) • Quadriplegic (I5100=1) • Hospice (O0100K1 = 1) In addition, we also excluded individuals whose age is less than 18 years. Overall, these exclusions resulted in 1.1% of all admissions being excluded. Missing data also resulted in individuals being excluded • Missing a discharge CARE Tool assessment (this resulted when individuals died or were hospitalized during their SNF stay) resulted in patients being excluded since one could not calculate a change from admission. Nationally approximately 21.6% of admissions to a SNF will be hospitalized during their therapy stay and 4.5% will die (based on analysis of SNF part A claims from 2009-2011). • Missing data on individual CARE Tool mobility assessment items on at least one item occurred 27.2% of the time. Approximately a third of all missing data related to just three items C7c walking 12 steps; C7d walking 4 steps and C7f car transfer but did not differ significantly between admission and discharge assessments. We did not impute any missing data for mobility items.	Living at discharge and age at admission are collected through the MDS.

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Risk Adjustment	Statistical risk model Each individuals change score was risk adjusted based on the following formula: Risk Adjusted Score for individual = (National Average Change Score – Predicted Change Score) + Actual Change Score. The National Average Change Score was calculated as a population average change score for all patients in all SNFs who had a CARE Tool mobility subscale assessment completed at admission and discharge. The change score is the difference in the aggregate of each individuals scale score from admission to discharge transformed to 0 to 100 scale. The Predicted Change Score is calculated based on logistic regression using the process outlined in 2b4. The Actual Change Score is the difference between the individual person's admission mobility score transformed to 0 to 100 scale and their discharge mobility score transformed to a 0 to 100 scale. Provided in response box S.15a	Stratification by risk category/subgroup This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average). The numerator is the facility´s average mobility functional change score. The denominator is meant to reflect the expected Mobility functional change score at the facility, if the facility had the same distribution of SNF-CMGs(impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	Not Applicable	See definition of the SNF-CMGs in the excel file provided.
Type Score	Continuous variable, e.g. average better quality = higher score	Ratio better quality = higher score
Algorithm	The facility-level mobility improvement scores are calculated using the following 15 steps. Step 1. Choose the 12 month window for which we will select episodes. This is the four consecutive calendar quarters ending with the most recent calendar quarter for which both MDS data and CARE Tool data are available for use in the measure. Step 2. Identify all MDS discharge assessments (in which we understand the CARE Tool items will be embedded) with a discharge date that fell within the 12 month window identified in Step 1. Step 3. For each MDS tool discharge assessment identified in Step 2, identify the corresponding MDS admission assessment (in which we understand the CARE Tool items will be embedded). An MDS assessment is identified as an admission assessment if A0310F == "01" (entry record). Note that the admission date may lie before the 12 month window defined in Step 1. The period of time from the admission	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total mobility change score for each of the remaining patients (sum of change at the patient level for all items (Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in the excel file). 5. Calculate the average rasch derived mobility change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility´s expected rasch derived average mobility change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the

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	date (corresponding with the MDS admission assessment) through to the discharge date (corresponding with the MDS discharge assessment) is called an “episode”. If no MDS admission assessment was found, discard the discharge assessment from all subsequent steps. Step 4. Identify all MDS admission assessments that indicate the admission to the SNF was from the hospital, another SNF or IRF. An MDS admission assessment indicates that the SNF admission was from a hospital when MDS item “A1800 Entered From” coded as “03 Acute Care Hospital” or “02 Another nursing home or swing bed” or “05 inpatient rehabilitation facility” or "09 Long Term Care Hospital". The MDS item A1600 indicates the date of entry to the SNF. Step 5. For any admission or discharge CARE Tool item (that enters the calculation of the mobility improvement scores) with letter code “S” (activity not attempted due to safety concerns), A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to “1” on a six point rating scale (indicating full functional dependence). Step 6. Apply the mobility improvement measure’s exclusions (see s.11), and exclude any episode that did not involve either physical or occupational therapy. The clinical measure exclusions are detailed in S.11 (Denominator exclusion details and codes). The exclusion of episodes not involving either occupational or physical therapy is as follows: We identify the patient as having received occupational therapy if on the MDS discharge assessment: The total number of minutes of occupational therapy in the last 7 days (O0400B1) is greater than zero; or The most recent occupational therapy regimen (starting on the date recorded in O0400B5, and ending on the date recorded in O0400B6) intersects the episode (beginning with the CARE admission assessment’s admission date and ending with the CARE discharge assessment’s discharge date). We identify the patient as having received physical therapy if on the MDS discharge assessment: The total number of minutes of physical therapy in the last 7 days (O0400C1) is greater	observed facility average mobility change score/facility´s national expected mobility change score.

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	than zero; or The most recent physical therapy regimen (starting on the date recorded in O0400C5, and ending on the date recorded in O0400C6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date). If the episode involves neither occupational nor physical therapy, as identified above, then exclude it from all subsequent steps in the calculation. Step 7. Map the CARE Tool B5a (walking) and B5b (wheeling) items to obtain a harmonious 1-6 score for all assessments, and recode walking items C7b, C7c, C7d and C7e to 1=dependent if resident cannot walk. First, consolidate the four sub-items B5a1, B5a2, B5a3 and B5a4 corresponding to different distances the resident can walk (if the patient can walk); and the four sub-items B5b1, B5b2, B5b3 and B5b4 corresponding to different distances the resident can wheel (if the patient cannot walk). To do this, use the crosswalk presented in Figure A1 in the Appendix. Call the resulting two items B5a and B5b. Second, consolidate the B5a and B5b items into a harmonious summary item called B5. To do this use the crosswalk presented in Figure A1 in the Appendix. This is the item used in the calculation of mobility outcome scores in the subsequent steps. Finally, if the patient is unable to walk (i.e., no values for the B5a and C7 items), recode each item C7a, C7b, C7d and C7e to 1 = dependent. Step 8. For each episode remaining after Step 6, using the CARE Tool items as transformed in Step 7, calculate a preliminary admission score and a discharge score as the sum of the values for the following CARE tool mobility items B1 (Lying to sitting on side of bed), B2 (Sit to stand), B3 (Chair/bed-to-chair transfer), B4 (Toilet transfer), B5 (Walking/wheeling), C3 (Roll left and right), C4 (Sit to lying), C7a (One step (curb)), C7b (Walking 50 feet with two turns), C7c (Walking 12 steps), C7d (Walking four steps), C7e (Walking 10 feet on uneven surfaces). Each of those 12 CARE Tool items takes an integer value of 1, 2, 3, 4, 5 or 6, and so the preliminary admission score will be an integer	

	2612: CARE: Improvement in Mobility	2774: : Functional Change: Change in Mobility Score for Skilled Nursing Facilities
	between 12 and 72, and the preliminary discharge score will be an integer between 12 and 72. Step 9. For each episode, linearly transform the preliminary admission score and preliminary discharge score so that it lies in the range 1-100 using the following equation: ["transformed mobility admission score"]=1.65×["preliminary mobility admission score"]-18.8 ["transformed mobility discharge score"]=1.65×["preliminary mobility discharge score"]-18.8 Step 10. For each episode, calculate the episode-level change score by subtracting the transformed discharge score from the transformed admission score. Each score will lie between -99 and 99. Step 11. Calculate the national average change score as the simple mean of all episode-level change scores calculated in Step 10. Step 12. For each episode, calculate the predicted change score using the risk adjustment methodology detailed in S.15a. That is, having prepared the risk adjustment variables in the way described in S.15a, apply the equation: [predicted change score] = 33.61 - 1.56×[patient is 85 years or older] -9.11×[dialysis while a resident] -5.08×[entered from SNF] -2.81×[oxygen while a patient] -4.23×[unhealed pressure ulcers] -8.85×[mental status] -4.75×[resident mood] -9.30×[psychiatric conditions] -6.91×[feeding tube or IV feeding] -4.10×[suctioning or tracheotomy] -3.98×[infections of the foot]. Step 13. For each episode, calculate the risk adjusted change score using the actual change score calculated in Step 10, the national average change score calculated in Step 11, and the predicted change score calculated in Step 12. The risk adjusted change score is: [risk adjusted change score] = ([national average change score] - [predicted change score]) + [actual change score]. Step 14. Exclude any facility that has fewer than 30 episodes for which we could calculate a risk adjusted change score. Step 15. For each facility remaining after Step 14, calculate its mobility improvement score as the simple mean of the risk adjusted change	

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	scores calculated in Step 13. No diagram provided	
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Not Applicable 5b.1 If competing, why superior or rationale for additive value: Not Applicable	5.1 Identified measures: 2612 : CARE: Improvement in Mobility 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: While the CARE items and the change in mobility items measure the same construct of functional (in)dependence, there are some key differences included in the measures, and in the measurement of the items. The mobility measure, submitted by UDS includes the following items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. The CARE items included in the measure submitted by AHCA include: : Roll left and right, Sit to lying, Lying to sitting on side of bed, Sit to stand, Chair/bed-to-chair transfer, Toilet transfer, Car transfer, Walk 10 feet, Walk 50 feet with 2 turns, Walk 150 feet, Walking 10 feet on uneven surfaces, 1 step, 4 steps, 12 steps, Pick up object. Once again there is great overlap in the items, There is great overlap between the items in the two measures, particularly in the transfer items, locomotion, and stairs. However while our measure contains only four items, the CMS measure contains 14 items. While our measure has the one locomotion item, for instance, the ACHA measure has four. Similarly, our measure contains one item for stairs, while the CMS measure contains three. This becomes burdensome on the provider to have to collect an additional 10 items and it hasn't been proven that there is additional value or specificity in the measure. Rasch analysis shows us that more items do not always mean better measurement. Finally, the UDSMS change in mobility measure is the exact same measure (same items, same rating scale, same adjustment) used in SNF, IRF and LTAC, offering consistency in measuring patient function across PAC venues, which has been an interest for PAC and is a current objective of the IMPACT ACT. 5b.1 If competing, why superior or rationale for additive value: The functional items have been collected in SNFs for over 20 years. This allows

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		for a historical perspective of function in the SNFs that the CARE items do not allow. In addition, the these items have been used in inpatient rehabilitation facilities for over 30 years, and therefore, a comparison in functional gains between IRFs and SNFs can be easily made should this measure be utilized in both venues of care.

Comparison of NQF #2612 and NQF #2775

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
Steward	American Health Care Association	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	The measure calculates a skilled nursing facility's (SNFs) average change in mobility for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in mobility score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status. This is a risk adjusted outcome measure, based on the mobility subscale of the Continuity Assessment and Record Evaluation (CARE) Tool and information from the admission MDS 3.0 assessment. The measure is calculated on a rolling 12 month, average updated quarterly.	Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items:Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome	Outcome
Data Source	Electronic Clinical Data, Other Resident Assessment Instrument Minimum Data Set (MDS) version 3.0 Continuity Assessment and Record Evaluation (CARE) Tool; Mobility subscale Available in attached appendix at A.1 No data dictionary	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission-635749892715380581.xlsx
Level	Facility	Facility
Setting	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
Numerator Statement	The measure assesses the change in mobility. The numerator is the risk adjusted sum of the change in the CARE Tool mobility subscale items between admission and discharge for each	Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change

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	individual admitted from a hospital or another post acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.	at the patient level/total number of patients). Cases aged less than 18 years at admission to the SNF or patients who died within the SNF are excluded.
Numerator Details	The numerator includes all residents admitted from a hospital or another post acute care setting that receive any PT or OT therapy for any reason in a SNF that have a completed mobility CARE tool assessment at admission and discharge (see denominator definition below). The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the CARE Tool assessment). The items included in the CARE Tool Mobility subscale include: • B1. Lying to Sitting on Side of Bed • B2. Sit to Stand • B3. Chair/Bed to Chair Transfer • B4. Toilet Transfer • B5a & B5b. Walking or Wheelchair Mobility • C3. Roll left / right • C4. Sit to Lying • C5. Picking up object • C7a. One Step Curb • C7b. Walk 50 ft. with Two Turns • C7c. Walk 12 Steps. • C7d. Walk Four Steps • C7e. Walking 10 ft. on Uneven Surface • C7f. Car Transfer The numerator is a facility's average risk adjusted change score on the mobility component of the CARE tool. The risk adjusted average change score is calculated in several steps: Step 1: Each individual's admission and discharge mobility scale score is calculated. Items rated as S. Not attempted due to safety concerns, A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to one. For each individual, the ratings for all the mobility items on the CARE tool at admission are summed and transformed to a 0-100 scale. The same is done for the discharge assessment. Step 2: Each individual's unadjusted change score is calculated by taking the admission score minus the discharge score. Step 3: The individual's unadjusted change score	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived motor functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	is risk adjusted (see risk adjustment section) Step 4: The facilities risk adjusted change score is the sum of all the individual's risk adjusted change scores divided by the denominator.	
Denominator Statement	The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed mobility CARE tool assessment at admission and discharge and do not meet any of the exclusion criteria. The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the mobility CARE tool assessment). The items included in the CARE Tool Mobility subscale include: • B1. Lying to Sitting on Side of Bed • B2. Sit to Stand • B3. Chair/Bed to Chair Transfer • B4. Toilet Transfer • B5a & B5b. Walking or Wheelchair Mobility • C3. Roll left / right • C4. Sit to Lying • C5. Picking up object • C7a. One Step Curb • C7b. Walk 50 ft. with Two Turns • C7c. Walk 12 Steps. • C7d. Walk Four Steps • C7e. Walking 10 ft. on Uneven Surface • C7f. Car Transfer	Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age.
Denominator Details	The denominator includes all residents admitted to a SNF who are receiving any PT or OT therapy for any reason. The denominator is based on admission from any hospital or post-acute care setting and is determined using information from MDS item "A1800 Entered From" coded as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" or "09 Long Term Care Hospital" regardless of payor status. They must receive either PT or OT therapy during their stay. A resident's stay is defined as an episode of care from admissions to discharge from the facility or discharge from therapy services (defined as completing a discharge CARE tool assessment). Overall, approximately 85% of all admissions from a	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 12 items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	hospital receive either PT or OT therapy based on SNF Part A claims (or MDS 3.0 data).	distribution of SNF-CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Patients are excluded for two broad reasons: 1. if they have conditions where improvement in mobility is very unlikely, OR 2. have missing data necessary to calculate the measure Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting their data.	Patients age at admission less than 18 years old Patients who died in the SNF.
Exclusion Details	Individuals with conditions where improvement in mobility (as determined by a panel of expert therapists) is very unlikely were excluded based on information from the admission MDS 3.0 assessment. Individuals with one of the following MDS 3.0 items marked as yes were excluded: • Ventilator (O0100F1 =1 or O0100F2 =1) • Coma (B0100 =1) • Quadriplegic (I5100=1) • Hospice (O0100K1 = 1) In addition, we also excluded individuals whose age is less than 18 years. Overall, these exclusions resulted in 1.1% of all admissions being excluded. Missing data also resulted in individuals being excluded • Missing a discharge CARE Tool assessment (this resulted when individuals died or were hospitalized during their SNF stay) resulted in patients being excluded since one could not calculate a change from admission. Nationally approximately 21.6% of admissions to a SNF will be hospitalized during their therapy stay and 4.5% will die (based on analysis of SNF part A claims from 2009-2011). • Missing data on individual CARE Tool mobility assessment items on at least one item occurred 27.2% of the time. Approximately a third of all missing data related to just three items C7c walking 12 steps; C7d walking 4 steps and C7f car transfer but did not differ significantly between admission and discharge assessments. We did not impute any missing	Living at discharge and age at admission are collected through the MDS.

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	data for mobility items.	
Risk Adjustment	Statistical risk model Each individuals change score was risk adjusted based on the following formula: Risk Adjusted Score for individual = (National Average Change Score – Predicted Change Score) + Actual Change Score. The National Average Change Score was calculated as a population average change score for all patients in all SNFs who had a CARE Tool mobility subscale assessment completed at admission and discharge. The change score is the difference in the aggregate of each individuals scale score from admission to discharge transformed to 0 to 100 scale. The Predicted Change Score is calculated based on logistic regression using the process outlined in 2b4. The Actual Change Score is the difference between the individual person's admission mobility score transformed to 0 to 100 scale and their discharge mobility score transformed to a 0 to 100 scale. Provided in response box S.15a	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average motor functional change score. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same distribution of SNF-CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	Not Applicable	See definition of the SNF-CMGs in the excel file provided.
Type Score	Continuous variable, e.g. average better quality = higher score	Ratio better quality = higher score
Algorithm	The facility-level mobility improvement scores are calculated using the following 15 steps. Step 1. Choose the 12 month window for which we will select episodes. This is the four consecutive calendar quarters ending with the most recent calendar quarter for which both MDS data and CARE Tool data are available for use in the measure. Step 2. Identify all MDS discharge assessments (in which we understand the CARE Tool items will be embedded) with a discharge date that fell within the 12 month window identified in Step 1. Step 3. For each MDS tool discharge assessment identified in Step 2, identify the corresponding MDS admission assessment (in which we understand the CARE Tool items will be embedded). An MDS assessment is identified as an admission assessment if A0310F == "01" (entry record). Note that the admission date may lie before the 12 month window defined in Step	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total motor change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in the attached excel file). 5. Calculate the average rasch derived motor change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average motor change

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	1. The period of time from the admission date (corresponding with the MDS admission assessment) through to the discharge date (corresponding with the MDS discharge assessment) is called an “episode”. If no MDS admission assessment was found, discard the discharge assessment from all subsequent steps. Step 4. Identify all MDS admission assessments that indicate the admission to the SNF was from the hospital, another SNF or IRF. An MDS admission assessment indicates that the SNF admission was from a hospital when MDS item “A1800 Entered From” coded as “03 Acute Care Hospital” or “02 Another nursing home or swing bed” or “05 inpatient rehabilitation facility” or "09 Long Term Care Hospital". The MDS item A1600 indicates the date of entry to the SNF. Step 5. For any admission or discharge CARE Tool item (that enters the calculation of the mobility improvement scores) with letter code “S” (activity not attempted due to safety concerns), A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to “1” on a six point rating scale (indicating full functional dependence). Step 6. Apply the mobility improvement measure’s exclusions (see s.11), and exclude any episode that did not involve either physical or occupational therapy. The clinical measure exclusions are detailed in S.11 (Denominator exclusion details and codes). The exclusion of episodes not involving either occupational or physical therapy is as follows: We identify the patient as having received occupational therapy if on the MDS discharge assessment: The total number of minutes of occupational therapy in the last 7 days (O0400B1) is greater than zero; or The most recent occupational therapy regimen (starting on the date recorded in O0400B5, and ending on the date recorded in O0400B6) intersects the episode (beginning with the CARE admission assessment’s admission date and ending with the CARE discharge assessment’s discharge date). We identify the patient as having received physical therapy if on the MDS discharge assessment: The total number of minutes of physical	score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average motor change score/facility's national expected motor change score. Available in attached appendix at A.1

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	therapy in the last 7 days (O0400C1) is greater than zero; or The most recent physical therapy regimen (starting on the date recorded in O0400C5, and ending on the date recorded in O0400C6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date). If the episode involves neither occupational nor physical therapy, as identified above, then exclude it from all subsequent steps in the calculation. Step 7. Map the CARE Tool B5a (walking) and B5b (wheeling) items to obtain a harmonious 1-6 score for all assessments, and recode walking items C7b, C7c, C7d and C7e to 1=dependent if resident cannot walk. First, consolidate the four sub-items B5a1, B5a2, B5a3 and B5a4 corresponding to different distances the resident can walk (if the patient can walk); and the four sub-items B5b1, B5b2, B5b3 and B5b4 corresponding to different distances the resident can wheel (if the patient cannot walk). To do this, use the crosswalk presented in Figure A1 in the Appendix. Call the resulting two items B5a and B5b. Second, consolidate the B5a and B5b items into a harmonious summary item called B5. To do this use the crosswalk presented in Figure A1 in the Appendix. This is the item used in the calculation of mobility outcome scores in the subsequent steps. Finally, if the patient is unable to walk (i.e., no values for the B5a and C7 items), recode each item C7a, C7b, C7d and C7e to 1 = dependent. Step 8. For each episode remaining after Step 6, using the CARE Tool items as transformed in Step 7, calculate a preliminary admission score and a discharge score as the sum of the values for the following CARE tool mobility items B1 (Lying to sitting on side of bed), B2 (Sit to stand), B3 (Chair/bed-to-chair transfer), B4 (Toilet transfer), B5 (Walking/wheeling), C3 (Roll left and right), C4 (Sit to lying), C7a (One step (curb)), C7b (Walking 50 feet with two turns), C7c (Walking 12 steps), C7d (Walking four steps), C7e (Walking 10 feet on uneven surfaces). Each of those 12 CARE Tool items takes an integer value of 1, 2, 3, 4, 5 or 6, and so the	

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	preliminary admission score will be an integer between 12 and 72, and the preliminary discharge score will be an integer between 12 and 72. Step 9. For each episode, linearly transform the preliminary admission score and preliminary discharge score so that it lies in the range 1-100 using the following equation: ["transformed mobility admission score"]=1.65×["preliminary mobility admission score"]-18.8 ["transformed mobility discharge score"]=1.65×["preliminary mobility discharge score"]-18.8 Step 10. For each episode, calculate the episode-level change score by subtracting the transformed discharge score from the transformed admission score. Each score will lie between -99 and 99. Step 11. Calculate the national average change score as the simple mean of all episode-level change scores calculated in Step 10. Step 12. For each episode, calculate the predicted change score using the risk adjustment methodology detailed in S.15a. That is, having prepared the risk adjustment variables in the way described in S.15a, apply the equation: [predicted change score] = 33.61 -1.56×[patient is 85 years or older] -9.11×[dialysis while a resident] -5.08×[entered from SNF] -2.81×[oxygen while a patient] -4.23×[unhealed pressure ulcers] -8.85×[mental status] -4.75×[resident mood] -9.30×[psychiatric conditions] -6.91×[feeding tube or IV feeding] -4.10×[suctioning or tracheotomy] -3.98×[infections of the foot]. Step 13. For each episode, calculate the risk adjusted change score using the actual change score calculated in Step 10, the national average change score calculated in Step 11, and the predicted change score calculated in Step 12. The risk adjusted change score is: [risk adjusted change score] = ([national average change score] - [predicted change score]) + [actual change score]. Step 14. Exclude any facility that has fewer than 30 episodes for which we could calculate a risk adjusted change score. Step 15. For each facility remaining after Step 14, calculate its mobility improvement score as	

	2612: CARE: Improvement in Mobility	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	the simple mean of the risk adjusted change scores calculated in Step 13. No diagram provided	
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Not Applicable 5b.1 If competing, why superior or rationale for additive value: Not Applicable	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

Comparison of NQF #2613 and NQF #2775

	2613: CARE: Improvement in Self Care	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
Steward	American Health Care Association	Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.
Description	The measure calculates a skilled nursing facility's (SNFs) average change in self care for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in self care score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status. This is a risk adjusted outcome measure, based on the self care subscale of the Continuity Assessment and Record Evaluation (CARE) Tool and information from the admission MDS 3.0 assessment. The measure is calculated on a rolling 12 month, average updated quarterly.	Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items:Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.
Type	Outcome	Outcome
Data Source	Electronic Clinical Data, Other Resident Assessment Instrument Minimum Data Set (MDS) version 3.0 Continuity Assessment and Record Evaluation (CARE) tool; Self Care subscale Available in attached appendix at A.1 No data dictionary	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Functional Change Form, as seen in the appendix. Available in attached appendix at A.1 Attachment NQF_Submission-635749892715380581.xlsx
Level	Facility	Facility
Setting	Post Acute/Long Term Care Facility : Nursing	Post Acute/Long Term Care Facility : Nursing

	2613: CARE: Improvement in Self Care	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	Home/Skilled Nursing Facility	Home/Skilled Nursing Facility
Numerator Statement	This outcome measure assesses the change in self-care. The numerator is the risk adjusted sum of the change in the CARE Tool self care subscale items between admission and discharge for each individual admitted from a hospital or another post-acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.	Average change in rasch derived motor functional score from admission to discharge at the facility level for short term rehabilitation patients. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the SNF or patients who died within the SNF are excluded.
Numerator Details	The numerator includes all residents admitted from a hospital or another post-acute care setting that receive any PT or OT therapy for any reason in a SNF that have a completed CARE Tool self care subscale assessment at admission and discharge (see denominator definition below). The self care items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for CARE Tool). The items included in the CARE Tool self care subscale include: • A1. Eating • A3. Oral Hygiene • A4. Toilet Hygiene • A5. Upper Body Dressing • A6. Lower Body Dressing • C1. Wash Upper Body • C2. Shower / Bathe • C6. Putting on / taking off footwear The numerator is facility's average risk adjusted change score on the self care subscale of the CARE tool. The risk adjusted average change score is calculated in several steps: Step 1: Each individual's admission and discharge self care subscale score is calculated. Items rated as S. Not attempted due to safety concerns, A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to one on a six point rating scale (e.g. dependent). For each individual, the ratings for all the self care items on the CARE tool at admission are summed and transformed to a 0-100 scale. The same is done for the discharge assessment. Step 2: Each individual's unadjusted change score is calculated by taking the admission score minus the discharge score. Step 3: The individual's unadjusted change score is risk adjusted (see S.14)	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. The numerator is the average change in rasch derived motor functional score from admission to discharge for each patient at the facility level, including items: Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as: (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) / total number of patients).

	2613: CARE: Improvement in Self Care	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	Step 4: The facility's risk adjusted change score is the sum of all the individual's risk adjusted change scores divided by the denominator.	
Denominator Statement	The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed self care subscale of the CARE Tool at admission and discharge and do not meet any of the exclusion criteria and do not have missing data. The self care items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for CARE Tool). The items included in the CARE Tool self care subscale include: • A1. Eating • A3. Oral Hygiene • A4. Toilet Hygiene • A5. Upper Body Dressing • A6. Lower Body Dressing • C1. Wash Upper Body • C2. Shower / Bathe • C6. Putting on / taking off footwear	Facility adjusted expected change in rasch derived values, adjusted for SNF-CMG (Skilled Nursing Facility Case Mix Group), based on impairment type, admission functional status, and age.
Denominator Details	The denominator includes all residents admitted to a SNF who are receiving any PT or OT therapy for any reason. The denominator is based on admission from any hospital or post-acute care setting and is determined using information from MDS item "A1800 Entered From" coded as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" or "09 Long Term Care Hospital (LTCH)", regardless of payor status. They must receive either PT or OT therapy during their stay. A resident's stay is defined as an episode of care from admissions to discharge from the facility or discharge from therapy services (defined as completing a discharge CARE Tool assessment).	The target population is all short term rehabilitation patients at the skilled nursing facility, at least 18 years old, who did not die in the SNF. Impairment type is defined as the primary medical reason for the SNF short term rehabilitation stay (such as stroke, joint replacement, brain injury, etc.). Admission functional status is the expected value of the average of the sum 12 items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs) at the facility level. Age is the age of the patient at the time of admission to the SNF. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the same distribution of SNF-CMGs (based on impairment type, functional status at admission, and age at admission). This adjustment procedure is an indirect standardization procedure (observed facility average/expected facility average).
Exclusions	Individual patients are excluded for two broad reasons:	Patients age at admission less than 18 years old Patients who died in the SNF.

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	1. if they have conditions where improvement in self-care is very unlikely, OR 2. have missing data necessary to calculate the measure Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting of their data.	
Exclusion Details	Individuals with conditions where improvement in self care (as determined by a panel of expert therapists) is very unlikely were excluded based on information from the admission MDS 3.0 assessment. Individuals with one of the following MDS 3.0 items marked as yes were excluded: • Ventilator (O0100F1 =1 or O0100F2 =1) • Coma (B0100 =1) • Quadriplegic (I5100=1) • Hospice (O0100K1 = 1) In addition, we also excluded individuals whose age is less than 18 years. Overall, these exclusions resulted in 1.1% of all admissions being excluded. Missing data also resulted in individuals being excluded, details are as follows: • Missing a discharge CARE Tool assessment (this resulted when individuals died or were hospitalized during their SNF stay) resulted in patients being excluded since one could not calculate a change from admission. Nationally approximately 21.6% of admissions to a SNF will be hospitalized during their therapy stay and 4.5% will die (based on analysis of SNF part A claims from 2009-2011). • Missing data on individual items on either the admission or discharge CARE Tool assessment resulted in the individual being excluded from calculation. For self care items, this occurred 4.4% of the time. We did not impute any missing data for self care items.	Living at discharge and age at admission are collected through the MDS.
Risk Adjustment	Statistical risk model Each individual's change score was risk adjusted based on the following formula: Risk Adjusted Score for individual = (National Average Change Score – Predicted Change Score) + Actual Change Score. The National Average Change Score was calculated as a population average change score	Stratification by risk category/subgroup This adjustment procedure is an indirect standarization procedure (observed facility average/expected facility average). The numerator is the facility's average motor functional change score. The denominator is meant to reflect the expected motor functional change score at the facility, if the facility had the

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	for all patients in all SNFs who had a CARE Tool self care subscale assessment completed at admission and discharge. The change score is the difference in the aggregate of each individuals scale score from admission to discharge transformed to 0 to 100 scale. The Predicted Change Score is calculated based on logistic regression using the process outlined in 2b4. The Actual Change Score is the difference between the individual person's admission self care score transformed to 0 to 100 scale and their discharge self care score transformed to a 0 to 100 scale. Provided in response box S.15a	same distribution of SNF-CMGs (impairment, functional status at admission, and age at admission). Available in attached Excel or csv file at S.2b
Stratification	Not Applicable	See definition of the SNF-CMGs in the excel file provided.
Type Score	Continuous variable, e.g. average better quality = higher score	Ratio better quality = higher score
Algorithm	The facility-level self care improvement scores are calculated using the following 14 steps. Step 1. Choose the 12 month window for which we will select episodes. This is the four consecutive calendar quarters ending with the most recent calendar quarter for which both MDS data and CARE tool data are available for use in the measure. Step 2. Identify all MDS discharge assessments (in which we understand the CARE tool items will be embedded) with a discharge date that fell within the 12 month window identified in Step 1. Step 3. For each MDS tool discharge assessment identified in Step 2, identify the corresponding MDS admission assessment (in which we understand the CARE tool items will be embedded). An MDS assessment is identified as an admission assessment if A0310F == "01" (entry record). Note that the admission date may lie before the 12 month window defined in Step 1. The period of time from the admission date (corresponding with the MDS admission assessment) through to the discharge date (corresponding with the MDS discharge assessment) is called an "episode". If no MDS admission assessment was found, discard the discharge assessment from all subsequent steps. Step 4. Identify all MDS admission assessments that indicate the admission to the SNF was from the hospital, another SNF or IRF. An MDS	1. Identify all short term rehabilitation patients during the assessment time frame (12 months). 2. Exclude any patients who died in the SNF. 3. Exclude any patients who are less than 18 at the time of admission to the SNF. 3. Calculate the total motor change score for each of the remaining patients (sum of change at the patient level for all items (Eating, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.) 4. Transform the patient level functional change scores to the rasch derived value (as stated in the attached excel file). 5. Calculate the average rasch derived motor change score at the facility level. 6. Using national data and previously described adjustment procedure, calculate the facility's expected rasch derived average motor change score for the time frame (12 months). 7. Calculate the ratio outcome by taking the observed facility average motor change score/facility's national expected motor change score. Available in attached appendix at A.1

	2613: CARE: Improvement in Self Care	2775: Functional Change: Change in Motor Score for Skilled Nursing Facilities
	admission assessment indicates that the SNF admission was from a hospital when MDS item "A1800 Entered From" coded as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" of "09 Long Term Care Hospital". The MDS item A1600 indicates the date of entry to the SNF. Step 5. For any admission or discharge CARE tool item (that enters the calculation of the self-care improvement scores) with letter code "S" (activity not attempted due to safety concerns), A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to "1" on a six point rating scale (indicating full functional dependence). Step 6. Apply the self care improvement measure's exclusions (see s.11), and exclude any episode that did not involve either physical or occupational therapy. The clinical measure exclusions are detailed in S.11 (Denominator exclusion details and codes). The exclusion of episodes not involving either occupational or physical therapy is as follows: We identify the patient as having received occupational therapy if on the MDS discharge assessment: The total number of minutes of occupational therapy in the last 7 days (O0400B1) is greater than zero; or The most recent occupational therapy regimen (starting on the date recorded in O0400B5, and ending on the date recorded in O0400B6) intersects the episode (beginning with the CARE admission assessment's date and ending with the CARE discharge assessment's date). We identify the patient as having received physical therapy if on the MDS discharge assessment: The total number of minutes of physical therapy in the last 7 days (O0400C1) is greater than zero; or The most recent physical therapy regimen (starting on the date recorded in O0400C5, and ending on the date recorded in O0400C6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date). If the episode involves neither occupational nor	

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	physical therapy, as identified above, then exclude it from all subsequent steps in the calculation. Step 7. For each episode remaining after Step 6, calculate a preliminary admission score and a discharge score as the sum of the values for the following CARE tool self care items A1 (Eating), A3 (Oral Hygiene), A4 (Toilet Hygiene), A5 (Upper Body Dressing), A6 (Lower Body Dressing), C1 (Wash Upper Body), C2 (Shower/Bath Self), C6 (Putting on/Taking off Footwear). Each of those 8 CARE tool items takes an integer value of 1, 2, 3, 4, 5 or 6, and so the preliminary admission score will be an integer between 8 and 48, and the preliminary discharge score will be an integer between 8 and 48. Step 8. For each episode, linearly transform the preliminary admission score and preliminary discharge score so that it lies in the range 1-100 using the following equation: ["transformed self-care admission score"]=2.475×["preliminary self-care admission score"]-18.8 ["transformed self-care discharge score"]=2.475×["preliminary self-care discharge score"]-18.8 Step 9. For each episode, calculate the episode-level change score by subtracting the transformed discharge score from the transformed admission score. Each score will lie between -99 and 99. Step 10. Calculate the national average change score as the simple mean of all episode-level change scores calculated in Step 9. Step 11. For each episode, calculate the predicted change score using the risk adjustment methodology detailed in S.15a. That is, having prepared the risk adjustment variables in the way described in S.15a, apply the equation: [predicted change score] = 25.98 - 0.28×[patient is 85 years or older] -4.43×[dialysis while a patient] -3.83×[entered from SNF] -2.37×[oxygen while a patient] -1.06×[catheterization/ostomy] -2.87×[unhealed pressure ulcers] -7.12×[mental status] -3.33×[resident mood] -8.11×[psychiatric conditions] -4.05×[feeding tube or IV feeding] -5.43×[suctioning or tracheotomy] -2.76×[infections of the foot].	

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	Step 12. For each episode, calculate the risk adjusted change score using the actual change score calculated in Step 9, the national average change score calculated in Step 10, and the predicted change score calculated in Step 11. The risk adjusted change score is: ["risk adjusted change score"]=(["national average change score"]-["predicted change score"])+["actual change score"] Step 13. Exclude any facility that has fewer than 30 episodes for which we could calculate a risk adjusted change score. Step 14. For each facility remaining after Step 13, calculate its self care improvement score as the simple mean of the risk adjusted change scores calculated in Step 12. No diagram provided	
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: Not Applicable	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

Appendix G: Pre-Evaluation Comments

Comments received as of May 10, 2016.

Topic	Commenter	Comment
2967: Home and Community Based Services (HCBS) Experience of Care (EoC) Measures	Submitted by Megan Burke, MSW, The SCAN Foundation	Identifying person- and family-centered (PFCC) quality measures for home and community-based services (HCBS) is important, especially in developing accountability for the person-centered care requirements in the Centers for Medicare & Medicaid Services HCBS regulations. PFCC quality measures for HCBS are also becoming increasingly important as health care and long-term services and supports become integrated. The HCBS Experience of Care measures collect information from the perspective of the individual, and as such have a person-centered focus. After reviewing the survey questions to be included for the HCBS measure, The SCAN Foundation (Foundation) recommends adjusting or removing the following questions. Staff listen and communicate well Survey items 29 and 42 identified as part of the outcome measure for staff listening and communicating well is phrased, "How often are the explanations [personal assistance/behavioral health staff] or [homemaker] gives you hard to understand because of an accent or the way he or she speaks English?" While it is important to identify whether communication between the personal assistance/behavioral health staff/homemaker and the individual receiving services is clearly understood, the way this question is phrased does not effectively address cultural competencies and potential language barriers as it assumes the person receiving care is a native English speaker. The Foundation suggests reframing or removing survey items 29 and 42 to capture whether someone is generally able to understand the provider, spoken to in a language they understand, and can effectively communicate instructions, wishes, and concerns with staff. We acknowledge that survey item 31, "How often do [personal assistance/behavioral health staff] explain things in a way that is easy to understand?" may already address the communication concern effectively. Physical safety measure

Topic	Commenter	Comment
		The Foundation applauds the inclusion of measures addressing physical safety. However, the proposed measure, "Do any staff that you have now hit you or hurt you?" included in isolation raises concerns. The survey question does not clearly identify new accounts of abuse as opposed to reports that have been addressed and does not appear to include follow up questions for to help with addressing any current concerns. If this measure is to be included, we recommend including additional questions to better understand the current situation in the event of an affirmative response and a clear protocol outlining how to the surveyor should respond to ensure the individual's safety.
2962: Shared Decision Making Process	Submitted by Ms. Suzanne Pope, American Urological Association	The SCAN Foundation acknowledges the importance of shared decision-making as part of person and family-centered care (PFCC). The proposed measures capture the time a doctor spent discussing pros and cons of a procedure, and the individual's choices. However, PFCC quality measures should also assess whether the provider elicited information from the individual about his/her goals, and discussed how treatments do or do not align with the stated goals.
0420: Pain Assessment and Follow-Up	Submitted by Ms. Suzanne Pope, American Urological Association	We support the pain assessment measure but it is not obvious if any specification for what a "standard" measure of this is—e.g. is a pain scale (what is your pain on a scale from 1-10) sufficient? Also, it is interesting to think about how this gets operationalized in the context of other efforts to try to mitigate overprescribing of opioids. We agree with the need for assessment of pain and a follow-up plan where pain is present, but it is not clear what is acceptable as a follow-up plan—just a prescription and a plan to reevaluate? Referral to pain specialist, PT, etc.?
2962: Shared Decision Making Process	Submitted by Ms. Suzanne Pope, American Urological Association	For consideration: should this measure also include patients who have radiation therapy for prostate cancer (i.e., why is SDM critical only for radical prostatectomy among the treatment options? What about active surveillance? It would seem that a more inclusive measure would be to measure SDM agnostic to what option was chosen.)
General Draft	Submitted by Megan Burke, MSW, The SCAN Foundation	The measures identified for Person and Family-Centered Care (PFCC) capture important information that help shape the health care delivery system to be more person-centered. The SCAN Foundation (Foundation) is pleased to see measures included that consider maintenance of or improvement in function as this is important to

Topic	Commenter	Comment
		document. The next step in moving toward PFCC would be to capture how information about an individual's functional abilities informs his/her care plan and services received. Additionally, the Foundation is pleased to see HCBS measures included. In order for care to be person and family-centered, it's important to examine quality along the continuum of care from health care services to home- and community-based services (HCBS). The Centers for Medicare & Medicaid Services included person-centered care as a HCBS requirement in 2015. It is imperative to develop a set of measures that accurately assess the quality of PFCC to develop accountability and accurately report what is important to the individuals receiving services.

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