



Measure Information

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

Brief Measure Information

NQF #: 0673

Corresponding Measures:

De.2. Measure Title: Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem

Co.1.1. Measure Steward: RAND Corporation

De.3. Brief Description of Measure: Percentage of long-stay nursing home patients 65 years old or older who have a new balance problem who receive physical therapy or nursing rehabilitation/restorative care

1b.1. Developer Rationale: Proactively treating balance problems can lead to a reduction in the number of falls and the related comorbidity and mortality.

S.4. Numerator Statement: Long-stay patients in the denominator who received physical therapy or nursing rehabilitation/restorative care

S.7. Denominator Statement: Long-stay nursing home patients 65 years or older with a new balance problem

S.10. Denominator Exclusions: Patients are excluded from the denominator if they are short-stay or have advanced dementia or a poor prognosis.

De.1. Measure Type: Process

S.23. Data Source: Claims

S.26. Level of Analysis: Facility, Health Plan, Integrated Delivery System, Other, Population : Community, County or City, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Mar 03, 2011 **Most Recent Endorsement Date:** Mar 03, 2011

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

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

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

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

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

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0673_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)
Proactively treating balance problems can lead to a reduction in the number of falls and the related comorbidity and mortality.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

This quality measure was implemented in a population of nursing home patients. The sample included Individuals 65 years and older enrolled in both Medicare and Medicaid continually residing in nursing homes during at least 5 of the last 6 months of 1998 who were residing in 19 counties in California. Patients received Medicaid through the Aged/Blind/Disabled eligibility category. Assessments were made during 1999 through 2000. Data included MDS assessments (1998 to 2000), Medicare and Medicaid eligibility files, and Medicare and Medicaid fee-for-service claims. Of 21,657 dually enrolled nursing home patients 65 years and older living in nursing homes in 19 California counties, 1,219 were eligible for this quality indicator, but only 34% received recommended care.(Zingmond 2009)

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

Zingmond DS, Saliba D, Wilber KH, et al. Measuring the quality of care provided to dually enrolled Medicare and Medicaid beneficiaries living in nursing homes. Med Care 2009;47:536-44

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

There are no published data on disparities concerning this measure. However, based on our implementation of the measure, we note that we did not identify differences by gender or age (among an older group): Males 36.8%, Females 33.2% (p=0.26). Age 65-75 35.8%, 75-85 38.4% and >85 33.8% (p=0.80). However, African American elders received lower quality care for this measure than White or Latino patients (21.4% v. 34.6 v. 37.6%, respectively, p<0.01 for comparison between African Americans and White and Latino patients).

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

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

The measure addresses:

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

1c.1. Demonstrated high priority aspect of healthcare

A leading cause of morbidity/mortality

1c.2. If Other:

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

Falls and mobility problems are common and serious problems facing older adults in the community and in nursing homes. Accidents are the fifth leading cause of death in older adults, with falls accounting for two-thirds of these accidental deaths (Rubenstein 1994). About one-third of those aged 65 and older living in the community fall at least once a year. This increases to one in two for those aged 80 and older (Blake 1988; O'Loughlin 1993). Although most falls result in no serious injury, in any given year, approximately 5%

of these older fallers experience a fracture or require hospitalization (Rubenstein 1994). The related problems of mobility disorders are also prevalent in older adults. Detectable gait abnormalities affect 20% to 40% of individuals aged 65 and older and 40% to 50% of those aged 85 and older (Alexander 1996; Trueblood 1991).

Falls are generally the result of multiple, diverse, and interacting etiologies. Several cohort studies have identified gait and balance disorders, functional impairment, visual deficits, cognitive impairment, and use of psychotropic medications as the most important risk factors for falling (Tromp 2001; Chu 2005; Tinetti 1988; Campbell 1989). Several studies have shown that the risk of falling increases dramatically as the number of risk factors increases. Three separate studies have reported that 65% to 100% of elderly individuals with three or more risk factors fell in a 12-month observation period, compared with 8% to 12% of persons with no risk factors (Rubenstein 1994); Nevitt 1997; Robbins 1989; Tinetti 1986).

However, the quality of falls care in vulnerable older adults remains suboptimal. One study found that only 34% of recommended care for falls and mobility disorders was completed (Wenger 2003).

1c.4. Citations for data demonstrating high priority provided in 1a.3

Rubenstein LZ, Roggins AG, Josephson KR. Falls in the nursing home. *Ann Intern Med* 1994;121:442–451.

Blake AJ, Morgan K, Bendall MJ et al. Falls by elderly people at home: Prevalence and associated factors. *Age Ageing* 1988;17:365–472.

O'Loughlin JL, Robitaille Y, Boivin JF et al. Incidence of and risk factors for falls and injurious falls among the community-dwelling elderly. *Am J Epidemiol* 1993;137:342–354.

Alexander NB. Gait disorders in older adults. *J Am Geriatr Soc* 1996;44:434–451.

Trueblood PR, Rubenstein LZ. Assessment of instability and gait in elderly persons. *Compr Ther* 1991;17:20–29.

Tromp AM, Pluijms SM, Smit JH et al. Fall-risk screening test: A prospective study on predictors for falls in community-dwelling elderly. *J Clin Epidemiol* 2001;54:837–844.

Chu LW, Chi I, Chiu AY. Incidence and predictors of falls in the Chinese elderly. *Ann Acad Med Singapore* 2005;34:60–72.

Tinetti ME, Speechley M, Ginter SF. Risk factors for falls among elderly persons living in the community. *N Engl J Med* 1988;319:1701–1707.

Campbell AJ, Borrie MJ, Spears GF. Risk factors for falls in a community-based prospective study of people 70 years and older. *J Gerontol* 1989;44:M112–M117.

Nevitt MC. Falls in the elderly: Risk factors and prevention. In: Masdeu JC, Sudarsky L, Wolfson L, eds. *Gait Disorders of Aging*. Philadelphia: Lippincott-Raven, 1997, pp 13–36.

Robbins AS, Rubenstein LZ, Josephson KR et al. Predictors of falls among elderly people: Results of two population-based studies. *Arch Intern Med* 1989;149:628–633.

Tinetti ME, Williams TF, Mayewski R. Fall risk index for elderly patients based on number of chronic conditions. *Am J Med* 1986;80:429–34.

Wenger NS, Solomon DH, Roth CP et al. The quality of medical care provided to vulnerable community-dwelling older patients. *Ann Intern Med* 2003;139:740–47

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

was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

[Musculoskeletal](#)

De.6. Non-Condition Specific (check all the areas that apply):

[Health and Functional Status : Change](#)

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

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

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [NH FALLS 5 Reference.doc](#)

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

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Long-stay patients in the denominator who received physical therapy or nursing rehabilitation/restorative care](#)

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

[All patients in the denominator whose quarterly MDS indicates a new balance problem \(compared to the prior MDS\) and who received physical therapy in the 4 months prior or 1 month after the noted new problem OR nursing rehabilitation/restorative care in the 7 days prior.](#)

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Physical therapy \(PT\):](#)

Administrative claim for PT (defined in previously submitted documentation) in the 4 months before or 1 month after the date describing the new balance problem
OR
MDS 3.0 data (O5f) indicates training and skill practice in walking for at least 15 minutes for at least 1 day in the 7 days prior to the date describing the new balance problem
OR MDS 3.0 data (O4c) indicates physical therapy for at least 15 minutes in the 7 days prior to the date describing the new balance problem

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Long-stay nursing home patients 65 years or older with a new balance problem

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

New balance problem:

Consecutive quarterly MDS reports contain measures of Balance During Transitions and Walking: Moving from seated to standing position (G3a) and the second indicates a worsening status from the first. Worsening status = worsening by at least 1 level. [0. Steady at all times; 1. Not steady, but able to stabilize without human assistance; 2. Not steady, only able to stabilize with human assistance]

NOTE: While this item has been somewhat modified in MDS 3.0, the essence of the content remains the same.

MDS 3.0:

Balance during Transitions and Walking

MDS 3.0 item G3a. Moving from seated to standing position [replaces MDS 2.0 Test for Balance G3a (while standing) and G3b (while sitting) per Saliba 2008]

0 = Steady at all times

1 = Not steady, but able to stabilize without human assistance

2 = Not steady, only able to stabilize with human assistance

Saliba D, Buchanan J. Development & Evaluation of a Revised Nursing Home Assessment Tool: MDS 3.0. RAND report, CMS MDS 3.0 Validation Contract No. 500-00-0027/Task Order #2, April 2008

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

Patients are excluded from the denominator if they are short-stay or have advanced dementia or a poor prognosis.

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

Patients are excluded from the denominator for short stay, advanced dementia or poor prognosis.

Short stay patients are excluded since inclusion requires 2 consecutive quarterly MDS evaluations

Advanced dementia: MDS-COGS score of at least 5 (Hartmaier 1994) OR BIMS score of 0-7 (Chodosh 2008).

MDS-COGS scoring is based on 8 MDS items:

Cognitive Patterns:

(MDS 2.0 B2a) MDS 3.0=C7: Short term memory (0-1; MDS=1, memory problem; MDS-COGS=1)

MS 2.0 B2b (MDS 3.0=C8): Long term memory (0-1; MDS=1, memory problem; MDS-COGS=1)

MDS 2.0 B3b (MDS 3.0=C9b): Location of own room (0-1; MDS=0, doesn't recall; MDS-COGS=1)

(MDS 2.0 B3d) MDS 3.0=C9d: Knows he/she in a nursing home (0-1; MDS=0, doesn't recall; MDS-COGS=1)
 (MDS 2.0 B3e) MDS 3.0=C9e: No orientation recalled (0-1; MDS=1, none recalled; MDS-COGS=1)
 (MDS 2.0 B4) MDS 3.0=C10: Decision making (0-3; MDS/MDS-COGS: 0=independent, 1=modified independence, 2=moderately impaired, 3=severely impaired)
 Communication patterns:
 (MDS 2.0 C4) MDS 3.0=B5: Making self understood (0-3; MDS-COGS: 1=never/rarely understood)
 Physical Functioning:
 (MDS 2.0 G1Ag) MDS 3.0=G1h or G1i: Dressing self performance (0-1; MDS-COGS: 1=total dependence, 1 or 2 person assist)
 OR
 BIMS (MDS 3.0): If the BIMS is completed (C2, C3a-c, C4a-c) rather than the items indicated above, a BIMS score of 0-7 would also qualify as severe dementia.

Poor prognosis: MDS 3.0 (J11) indicates life expectancy of 6 or fewer months OR (O1j) hospice care in the prior 14 days OR Medicare/Medicaid claim for hospice care (see additional reference document).

Hartmaier SL, Sloane PD, Guess HA, et al. The MDS cognition scale: a valid instrument for identifying and staging nursing home residents with dementia using the minimum data set. J Am Geriatr Soc 1994; 42:1173-1179

Chodosh J, Edelen MO, Buchanan J, et al. Nursing home assessment of cognitive impairment: Development and testing of a brief instrument of mental status. J Am Geriatr Soc 2008;56:2069-2075

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)
 None

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

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

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

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

S.16. Type of score:
 Ratio
 If other:

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

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

1. Identify all nursing home patients 65 years or older
2. Exclude patients with advanced dementia or poor prognosis (based on MDS and/or administrative data)
3. Determine patients who have 2 consecutive assessments of balance (MDS Test for Balance: Moving from seated to standing position) and the second assessment indicates a new balance problem based on a worsening status. Worsening status = worsening by at least 1 level for G3a. [0. Steady at all times 1. Not steady, but able to stabilize without human assistance 2. Not steady, only able to stabilize with human assistance]
4. The first such notation in the study period is the index denominator event
5. For this sample of patients, determine if MDS item (O5f) indicates nursing rehabilitation/restorative care for training and skill practice in walking OR MDS item (O4c) PT for at least 15 minutes within the 7 days prior to the index event OR administrative data indicate PT in the 4 months before or the 1 month after the index event

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

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

All long-stay nursing home patients 65 years and older are eligible for the measure.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Linked Medicare eligibility and claims data, Medicaid eligibility and claims data, and Minimum Data Set (MDS) 3.0

Physical therapy administrative data (see additional reference document)

Balance during transition and walking-Moving from seated to standing position: MDS 3.0 G3a

Nursing rehabilitation/restorative care-training and skill practice in walking for at least 15 minutes in prior 7 days: MDS 3.0 O5f

Therapies-Physical therapy for at least 15 minutes in the prior 7 days: MDS 3.0 O4c

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

URL

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Health Plan, Integrated Delivery System, Other, Population : Community, County or City, Population : Regional and State

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

<p>Post-Acute Care If other:</p>
<p>S.28. COMPOSITE Performance Measure - Additional Specifications <i>(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</i></p>
<p>2a. Reliability – See attached Measure Testing Submission Form 2b. Validity – See attached Measure Testing Submission Form 0673_MeasureTesting_MS5.0_Data.doc</p>

<p>3. Feasibility</p>
<p>Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.</p>
<p>3a. Byproduct of Care Processes For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p>3a.1. Data Elements Generated as Byproduct of Care Processes. Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims) If other:</p>
<p>3b. Electronic Sources The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.</p> <p>3b.1. To what extent are the specified data elements available electronically in defined fields? <i>(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)</i> Yes</p> <p>3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.</p> <p>3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Attachment:</p>
<p>3c. Data Collection Strategy Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.</p> <p>3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues. <u>IF a PRO-PM</u>, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.</p> <p>3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified <i>(e.g., value/code set, risk model, programming code, algorithm).</i></p>

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

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

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

4b. Improvement

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

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

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

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

This measure is susceptible to inaccuracies to the extent that all patient-level administrative data is susceptible to data-entry errors and does not capture instances when services are recommended by the clinician but refused.

Regarding the MDS, DAVE 2, the second phase of the Data Assessment and VERification (DAVE) program, came to a close September 30, 2007. The primary focus of DAVE 2 was to assure accuracy and reliability of MDS assessment data.

The DAVE 2 contract, which was awarded to Abt Associates in September 2005, consisted of onsite visits to nursing homes by trained nurse reviewers who examined resident records and conducted independent resident assessments to evaluate the accuracy of MDS assessments. They also provided educational support to nursing home staff.

CMS is continuing to work with Abt Associates on MDS 2.0 initiatives under the MDS Technical Support Contract. It also continues to develop training materials, based on the DAVE 2 findings, in order to improve MDS coding guidelines in the RAI User's Manual and to support nursing home staff in improving MDS data accuracy.

The DAVE projects developed MDS coding Tip Sheets for various sections of the MDS found to have higher discrepancy rates upon onsite accuracy review. There are currently four downloadable TIP Sheets on proper coding for the MDS Sections including Section G on Self Performance, Section P on Physician Visits (P7) and Physician Orders (P8), Section P on Therapies (P1b), and Section K on Parenteral/IV (K5a). The MDS Technical Support project plans to develop additional Tip Sheets in the coming year.

From: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp

New updated coding for the to-be-released MDS 3.0 will be developed for the proposed indicator by the developer.

For MDS 3.0: Reported pilot results indicate that improvements incorporated in MDS 3.0 produced a more efficient assessment: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, including items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including use of more valid items, direct inclusion of resident reports, improved clarity of retained items, deletion of poorly performing items, form redesign, and briefer assessment periods for clinical items.

Saliba D, Buchanan J. Development & Evaluation of a Revised Nursing Home Assessment Tool: MDS 3.0. RAND report, CMS MDS 3.0 Validation Contract No. 500-00-0027/Task Order #2, April 2008

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

<p>5.1a. List of related or competing measures (selected from NQF-endorsed measures)</p> <p>5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.</p>
<p>5a. Harmonization</p> <p>The measure specifications are harmonized with related measures; OR The differences in specifications are justified</p> <p>5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?</p> <p>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.</p>
<p>5b. Competing Measures</p> <p>The measure is superior to competing measures (e.g., is a more valid or efficient way to measure); OR Multiple measures are justified.</p> <p>5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.) Related Measures: Existing endorsed measures target assessment of falls/fall risk (#0101 Falls: Screening for fall risk; #0537 Multifactor fall risk assessment conducted in patients 65 and older), frequency of falls (#0141 Patient fall rate; #0202 Falls with injury), falls as a medication risk factor (#0624 Atrial fibrillation – warfarin therapy), patient report of a discussion of fall risk with a health care provider (#0035 Fall risk management in older adults: a. discussing fall risk, b. managing fall risk), or proportion of patients with a functional decline (#0195 Residents with a decline in their ability to move about in their room and the adjacent hall). None of these measures (other than the last) is directed to nursing home patients and none (including those in the National Voluntary Consensus Standards for Nursing Home Care) addresses the provision of an intervention as does the proposed indicator.</p>

<p>Appendix</p>
<p>A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. Attachment:</p>
<p>Contact Information</p>
<p>Co.1 Measure Steward (Intellectual Property Owner): RAND Corporation Co.2 Point of Contact: Carol, Roth, roth@rand.org, 310-393-0411-6425 Co.3 Measure Developer if different from Measure Steward: RAND Corporation Co.4 Point of Contact: Neil, Wenger, nwenger@mednet.ucla.edu, 310-794-2288-</p>
<p>Additional Information</p>
<p>Ad.1 Workgroup/Expert Panel involved in measure development</p>

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

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University of California, San Francisco, San Francisco, CA

Role of Expert Panel: Expanded and updated the Assessing Care of Vulnerable Elders (ACOVE) quality indicators via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of quality of care using a process that is an explicit combination of scientific evidence and professional consensus.

ACOVE-3 CLINICAL COMMITTEE MEMBERS:

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<p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.2 Year the measure was first released: 2001</p> <p>Ad.3 Month and Year of most recent revision: 10, 2007</p> <p>Ad.4 What is your frequency for review/update of this measure? Every 3-5 years</p> <p>Ad.5 When is the next scheduled review/update for this measure?</p>
<p>Ad.6 Copyright statement:</p> <p>Ad.7 Disclaimers:</p>
<p>Ad.8 Additional Information/Comments:</p>