



## 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 #:** 0685

**Corresponding Measures:**

**De.2. Measure Title:** Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)

**Co.1.1. Measure Steward:** Centers for Medicare & Medicaid Services

**De.3. Brief Description of Measure:** This measure updates CMS' MDS 2.0 QM on bowel and bladder control. It is based on data from Minimum Data Set (MDS) 3.0 assessments of low risk long-stay nursing facility residents (those whose cumulative days in the facility is greater than 100 days). This measure reports the percent of long-stay residents with a selected target assessment who are frequently or always bladder or bowel incontinent as indicated on the target MDS assessment (OBRA, PPS or discharge) during the selected quarter (3-month period).

**1b.1. Developer Rationale:** CMS expects nursing facilities will monitor and increase their efforts to address or manage incontinence due to the prevalence of this condition and the potential to improve this clinical condition with bladder or bowel training programs.

**S.4. Numerator Statement:** The numerator is the number of long-stay residents with a selected target assessment who are frequently or always incontinent of bowel or bladder.

**S.7. Denominator Statement:** The denominator is all long-stay residents in the nursing facility with a target assessment (OBRA, PPS or discharge) except those with exclusions.

**S.10. Denominator Exclusions:** A resident is excluded from the denominator if the selected MDS 3.0 assessment was conducted within 14 days of admission (A0310A = 01) or if there is missing data in the response fields for the relevant questions in the MDS. Other exclusions include residents with severe cognitive impairment, total dependence in mobility, comatose, or with an indwelling catheter.

Nursing facilities are excluded from public reporting if their samples include fewer than 30 residents.

**De.1. Measure Type:** Outcome

**S.23. Data Source:** Electronic Health Records

**S.26. Level of Analysis:** Facility

**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?** The recommendation of the Steering Committee [to pair this measure with measure NH-020-10: Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder] is noted and will be communicated to the business owner component of CMS.

### 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**  
[0685\\_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) CMS expects nursing facilities will monitor and increase their efforts to address or manage incontinence due to the prevalence of this condition and the potential to improve this clinical condition with bladder or bowel training programs.

**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.

A version of this quality measure, drawing on data from a similar but less detailed MDS 2.0 item, has been in use by CMS since 2002. An analysis by the Division of Health Care Policy and Research at the University of Colorado at Denver found that the measure demonstrated variability among facilities. The analytic team examined the rates for the measure at the facility level. Below are the measure scores from current use (description of scores [e.g., distribution by quartile, mean, median, standard deviation, etc.] and identification of statistically significant and meaningful differences in performance). For 11,928 facilities, the mean rate of incontinence was 48.4% with a standard deviation of 14.9%. See attached Table 1: Measure Variability Across Facilities.

**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.**

Brega A, Hittle D, Goodrich G, Kramer A, Conway K, Levy C. Empirical review of publicly reported nursing home quality measures. Denver: Division of Health Care Policy and Research University of Colorado at Denver; Abt Associates, Inc, 2007.

**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.

Racial segregation between nursing homes has been shown to be a major factor in disparities in the nursing home population, primarily for African Americans. In 2000, a study drawing on national MDS and Online Survey, Certification, and Reporting (OSCAR) data found that two thirds of all black residents were living in just 10% of all facilities.(1) A 2002 survey of a stratified sample of 39 nursing homes and 181 residential care/assisted living facilities in four states had similar findings.(2) Facilities serving African Americans demonstrate a lower level of quality of care than those serving whites, with lower staff to resident ratios and higher deficiency ratings.(3) Minority groups in general and African Americans in particular experience more limited access to nursing home care than whites.(4)

Although research suggests racial disparities in the quality of care in nursing homes between African Americans and whites,(1, 2, 3, 4) no analyses have been conducted that specifically examine racial disparities in bladder or bowel incontinence. No other research has been conducted on other types of disparities (e.g., ethnicity, rural/urban, or income) for this measure.

**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.**

1. Smith D, Feng Z, Fennell M, Zinn J, Mor V. Separate and unequal: racial segregation and disparities in quality across U.S. nursing homes. Health Aff (Millwood). 2007;26(5):1448-558.

2. Howard D, Sloane P, Zimmerman S, Eckert J, Walsh J, Buie V, Taylor P, Koch G. Distribution of African Americans in residential care/assisted living and nursing homes: more evidence of racial disparity? Am J Public Health. 2002;92(8):1272-7.

3. Grabowski D. The admission of blacks to high-deficiency nursing homes. Med Care. 2004;42(5):456-64.

4. National Center for Health Statistics (NCHS). Health, United States, 1996–97, and injury chartbook. Hyattsville, MD: NCHS, 1997.

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

The measure addresses:

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

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, Patient/societal consequences of poor quality

**1c.2. If Other:**

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

**List citations in 1c.4.**

At least 17 million Americans have urinary incontinence (UI); it's the second leading cause of institutionalization of the elderly and occurs in more than 50% of nursing home residents.(1) It is important to treat as its prevention may reduce the likelihood of infections, pressure ulcers, and other health complications from poor health hygiene. Prevalence of urinary and fecal incontinence in nursing homes is reported to be between 30% and 65%.(2) For the second quarter of 2008, the current measure (Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder) based on MDS 2.0 data averages 49.4% nationally, with statewide averages ranging from 37.2% to 71.0%.(3)

Although incontinence is often the result of age-related changes, it is not a normal part of aging. Loss of bowel or bladder control can often be successfully treated in cognitively intact residents.(4) The impact of incontinence profoundly affects nursing home residents as well as staff. Incontinence can cause feelings of shame and embarrassment for the resident and increases the burden of care for caregivers. General health and quality of life factors, such as emotional well-being and social functioning, are also affected by incontinence. Nursing home staff may view incontinence care as both difficult and burdensome. As a result, it is frequently managed inappropriately.(5)

Loss of bowel and bladder control can be caused by:

- physical problems (e.g., constipation, muscle weakness, or a bladder infection),
- location problems (e.g., the bathroom is too far away),
- reaction to medication,
- limited ability to walk or move around,
- diet and fluid intake,
- toilet routine (e.g., timing trips to the bathroom),
- whether someone can provide assistance when needed, and
- certain medical conditions (e.g., residents with diabetes, dementia, spinal cord injury, or neurological disease are at a higher risk of losing bowel and bladder control).(4)

Incontinence, particularly reversible conditions of incontinence, is treatable in many cases, and incontinence programs do make a difference. Nursing facility residents who are incontinent of urine should have a targeted physical examination, including a urinalysis and a determination of postvoid residual urine volume done by catheterization or ultrasonography.(5) Scheduled toileting and bladder programs can be successfully implemented among nursing home residents. The key to the success of these programs is to appropriately identify residents who should be targeted for each specific program.(6) As with urinary incontinence, fecal incontinence may also be caused by potentially reversible conditions. After such conditions are excluded, fecal incontinence can generally be managed effectively by avoiding fecal impaction and by using a systematic bowel-training protocol.(5)

Determining the cause of and initiating treatment for problems with bowel and bladder control are important for many reasons. Physically, managing bowel and bladder control can help prevent infections, pressure ulcers, and other complications from poor health hygiene. Mentally, treatment can promote the well-being of the resident by restoring dignity and social interaction.

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

1. Lekan-Rutledge D, Colling J. Urinary incontinence in the frail elderly. Am J Nurs. 2003;103(3 suppl.):36-46.

[http://www.nursingcenter.com/library/JournalArticle.asp?Article\\_ID=404352](http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=404352).

2. Centers for Medicare & Medicaid Services. Appendix PP, rev. 15. F315 urinary incontinence. In: State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, pp. 187-224. 2006. Available from [http://cms.hhs.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltc.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltc.pdf).

3. Centers for Medicare & Medicaid Services. MDS quality measure/indicator report. Available from [http://www.cms.hhs.gov/MDSPubQlandResRep/02\\_qmreport.asp#TopOfPage](http://www.cms.hhs.gov/MDSPubQlandResRep/02_qmreport.asp#TopOfPage).

4. Quality Measures Management Information System (QMIS). Measure details: Measure 10177. Available from <https://www.qualitynet.org/qmis/measureDetailView.htm?measureId=10177&viewType=1>.

5. Ouslander J, Schnelle J. Incontinence in the nursing home. *Ann Int Med*. 1995;122(6):438-49.

6. Newman DK, Palmer MH. Incontinence and PPS: a new era. *Ostomy Wound Manage*. 1999;45(12):32-49.

**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):

[Genitourinary \(GU\)](#), [Genitourinary \(GU\) : Incontinence/pelvic floor disorders](#)

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

**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)

**URL Attachment:**

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

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

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

The numerator is the number of long-stay residents with a selected target assessment who are frequently or always incontinent of bowel or bladder.

**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.)

Numerator data come from the MDS 3.0 annual, quarterly, significant change or significant correction assessments during each quarter (3-month period).

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

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

Residents are counted if they are long-stay residents, defined as residents whose cumulative days in the nursing facility of greater than 100 days. Residents who return to the nursing home following a hospital discharge will not have their stay reset to zero. Residents are counted if they are incontinent of bowel (H0400 = 02 or 03) or bladder (H0300 = 02 or 03). H0300 = 02 = Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). H0300 = 03 = Always incontinent (no episodes of continent voiding). H0400 = 02 = frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement). H0400 = 03 = Always incontinent (no episodes of continent bowel movements).

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

The denominator is all long-stay residents in the nursing facility with a target assessment (OBRA, PPS or discharge) except those with exclusions.

**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)

Residents are counted if they are long-stay residents defined as residents whose cumulative days in the facility is greater than 100 days. Residents who return to the nursing home following a hospital discharge will not have their day count reset to zero. The target population includes all long-stay residents with a target assessment (A0310A = 02, 03, 04, 05, 06; A0310B = 02, 03, 04, 05; A0310F = 10,11) except those with exclusions.

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

A resident is excluded from the denominator if the selected MDS 3.0 assessment was conducted within 14 days of admission (A0310A = 01) or if there is missing data in the response fields for the relevant questions in the MDS. Other exclusions include residents with severe cognitive impairment, total dependence in mobility, comatose, or with an indwelling catheter.

Nursing facilities are excluded from public reporting if their samples include fewer than 30 residents.

**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)

"1. Target assessment is an admission assessment (A0310A = [01]) or a PPS 5-day or readmission/return assessment (A0310B = [01, 06]).

2. Resident is not in numerator and H0300 = [-] OR H0400 = [-].

3. Residents who have any of the following high risk conditions:

- a. Severe cognitive impairment on the target assessment as indicated by (C1000 = [03] and C0700 = [01]) OR (C0500<=[07]).
- b. Totally dependent in bed mobility self-performance (G0110A1 = [04, 07, 08]).
- c. Totally dependent in transfer self-performance (G0110B1 = [04, 07, 08]).
- d. Totally dependent in locomotion on unit self-performance (G0110E1 = [04, 07, 08]).
- 4. Resident does not qualify as high risk (see #3 above) and both of the following two conditions are true for the target assessment:
  - a. C0500 = [99, ^, -], and
  - b. C0700 = [^, -] or C1000 = [^, -].
- 5. Resident does not qualify as high risk (see #3 above) and any of the following three conditions are true:
  - a. G0110A1 = [-]
  - b. G0110B1 = [-]
  - c. G0110E1E = [-].
- 6. Resident is comatose (B0100 = [01]) or comatose status is missing (B0100 = [-]) on the target assessment.
- 7. Resident has an indwelling catheter (H0100A = [01]) or indwelling catheter status is missing (H0100A = [-]) on the target assessment.
- 8. Resident has an ostomy (H0100C = [01]) or ostomy status is missing (H0100C = [-]) on the target assessment."

**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)

This is not applicable.

**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)

This is not applicable.

**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.)

For each facility, the number of residents meeting the numerator criteria and the number of (non-excluded) residents meeting the denominator criteria are counted. The facility observed score for the measure is a prevalence score calculated as the number of residents in the facility in the numerator divided by all non-excluded residents in the denominator.

**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.

This is not applicable.

**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.

Electronic Health Records

**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.

Nursing Home Minimum Data Set 3.0

**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

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

Post-Acute Care

If other:

**S.28. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

0685\_MeasureTesting\_MSF5.0\_Data.doc

### 3. Feasibility

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

#### 3a. Byproduct of Care Processes

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

##### 3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

### 3b. Electronic Sources

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

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

No

**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.**

Not applicable.

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

Attachment:

### 3c. Data Collection Strategy

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

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

The data collection method is already in operational use. However, the MDS items used for cognitive function are new (BIMS scale) and the incontinence categories have been slightly revised.

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

## 4. Usability and Use

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

### 4a. Accountability and Transparency

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

#### 4.1. Current and Planned Use

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

| Planned          | Current Use (for current use provide URL) |
|------------------|-------------------------------------------|
| Public Reporting |                                           |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>Quality Improvement (Internal to the specific organization)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <p><b>4a.1. For each CURRENT use, checked above, provide:</b></p> <ul style="list-style-type: none"> <li>• Name of program and sponsor</li> <li>• Purpose</li> <li>• Geographic area and number and percentage of accountable entities and patients included</li> </ul> <p><b>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?</b> (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)</p> <p><b>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.</b> (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.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <p><b>4b. Improvement</b></p> <p>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.</p> <p><b>4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)</b></p> <p>Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:</p> <ul style="list-style-type: none"> <li>• Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)</li> <li>• Geographic area and number and percentage of accountable entities and patients included</li> </ul> <p><b>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.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| <p><b>4c. Unintended Consequences</b></p> <p>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).</p> <p><b>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.</b></p> <p>Because of the possible lack of correspondence between the staff-assessment and BIMS items, it may be difficult to specify a score on the BIMS that would trigger the severe cognitive impairment exclusion exactly as the staff-assessment items do. The implication is that residents may trigger the exclusion differently depending on which set of data are available. Although the BIMS may be the better set of items, it cannot be completed for all residents. Thus, it may be reasonable to complete the staff-assessment items for all residents and use these as the source of the severe cognitive impairment exclusion for the Incontinence measure.<sup>(1)</sup></p> <p>1. Brega A, Goodrich G, Nuccio E, Hittle D. Transition of publicly reported nursing home quality measures to MDS 3.0—draft. Contract HHS-500-2005-CO001c Modification Number 0009. Denver: Division of Health Care Policy and Research University of Colorado at Denver, 2008.</p> |  |

## 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.

#### 5.1a. List of related or competing measures (selected from NQF-endorsed measures)

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

### 5a. Harmonization

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

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

**Are the measure specifications completely harmonized?**

#### 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

#### 5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

**Related Measures:** This measure is intended to replace NQF # 0183 Low risk residents who frequently lose control of their bowel or bladder because the data source has changed; the MDS 2.0 is being replaced by the MDS 3.0. The measure is related to the following endorsed measures; NQF # 0030 Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment, NQF # 0098 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women, NQF # 0099 Urinary Incontinence: Characterization of Urinary Incontinence in Women, NQF # 0100 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women.

## Appendix

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Attachment:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Contact Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b>Co.1 Measure Steward (Intellectual Property Owner):</b> Centers for Medicare &amp; Medicaid Services</p> <p><b>Co.2 Point of Contact:</b> Corette, Byrd, corette.byrd@cms.hhs.gov, 410-786-8532-</p> <p><b>Co.3 Measure Developer if different from Measure Steward:</b> Centers for Medicare &amp; Medicaid Services</p> <p><b>Co.4 Point of Contact:</b> Cheryl, Wiseman, Cheryl.Wiseman2@CMS.hhs.gov, 410-786-6738-</p>                                                                                                                                                   |
| <b>Additional Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <p><b>Ad.1 Workgroup/Expert Panel involved in measure development</b><br/>         Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.<br/> <a href="#">See Table 3: Nursing Home Quality Measures Technical Expert Panel (January 2009).</a></p> <p><a href="#">This technical expert panel met over 2 days in January 2009 to review the environmental scan of the current quality measures and make recommendations regarding their transition from MDS 2.0 to MDS 3.0.</a></p> |
| <p><b>Measure Developer/Steward Updates and Ongoing Maintenance</b></p> <p><b>Ad.2 Year the measure was first released:</b> 2002</p> <p><b>Ad.3 Month and Year of most recent revision:</b> 02, 2010</p> <p><b>Ad.4 What is your frequency for review/update of this measure?</b> Every 3 years</p> <p><b>Ad.5 When is the next scheduled review/update for this measure?</b> 02, 2013</p>                                                                                                                                                                                         |
| <p><b>Ad.6 Copyright statement:</b></p> <p><b>Ad.7 Disclaimers:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Ad.8 Additional Information/Comments:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |