



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 #: 0691

Corresponding Measures:

De.2. Measure Title: Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument

Co.1.1. Measure Steward: Agency for Healthcare Research and Quality

De.3. Brief Description of Measure: The CAHPS® Nursing Home Survey: Discharged Resident Instrument is a mail survey instrument to gather information on the experience of short stay (5 to 100 days) residents recently discharged from nursing homes. This survey can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and the Long Stay Resident Instrument. The survey instrument provides nursing home level scores on 4 global items. In addition, the survey provides nursing home level scores on summary measures valued by consumers; these summary measures or composites are currently being analyzed. The composites may include those valued by long stay residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities.

1b.1. Developer Rationale: The goal would be to use this resident survey as feedback to transform nursing home care to be resident-directed/centered and achieve the highest quality of life and quality of care for this nursing home population.

S.4. Numerator Statement: The following topics are measured for nursing homes from a resident's perspective:

Global Items:

Global Rating of care received from staff: sum of resident scores on 0 to 10 scale

Global Rating of special therapy care: sum of resident scores on 0 to 10 scale

Global Rating of overall nursing home: sum of resident scores on 0 to 10 scale

Global item whether respondent would recommend nursing home: sum of resident scores on item (see codebook for points assigned to each response category)

Composites: We expect some composites to be similar to the long stay resident instrument such as Environment, Care, and Communication & Respect. We are not sure if the Autonomy and Activities Composites will be relevant to short stay residents. Data analysis is currently being conducted.

S.7. Denominator Statement: The denominator is the total number of surveys for respondents that meet CAHPS completion standard (50% of key items answered) and any applicable screener.

S.10. Denominator Exclusions: We will exclude all residents whose length of stay (LOS) in the facility is less than 5 or greater than 100 days from the date of admission. Residents who are discharged to any hospital with return anticipated will not have their day count reset to zero when they return to the facility (AHRQ will harmonize its specification on short stay residents with CMS). AHRQ created a separate survey for long stay residents whose opinion can be obtained best through in-person administration because, on average, they have more cognitive impairment than short stay residents. In addition, the CAHPS team believed that a minimum number of days (5) was needed for a short stay resident to have sufficient experience with facility care. We also exclude residents who are under age 18 and those who were discharged more than 2 months prior to sample frame development date. Those who were discharged to another care facility and not discharged home and those who were deceased were also excluded.

De.1. Measure Type: Outcome: PRO-PM

S.23. Data Source: Survey : Patient

S.26. Level of Analysis: Facility/Agency

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
[0691_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)

The goal would be to use this resident survey as feedback to transform nursing home care to be resident-directed/centered and achieve the highest quality of life and quality of care for this nursing home population.

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.

The 2008 National Ombudsmen Reporting System (NORS) data showed that the top complaint of nursing home residents and their families, eliciting some 14,329 complaints to ombudsmen, was failing to respond to requests for assistance. Specific complaints relating to these items include lack of assistance with toileting which had 3,404 complaints; lack of assistance with drinking which had 2,899 complaints; and lack of assistance with eating which had 1,529 complaints (NORS, 2008). Complaints relating to dignity, respect and staff attitudes were also among the top ten.

Under contract with CMS, states conduct nursing home inspections, known as surveys, to assess compliance with federal quality and safety requirements, including requirements for resident rights and quality of life. According to the CMS Nursing Home Compare website, the US average number of nursing home deficiencies issued as of March 2010 was 8; however the range of deficiencies by state was 0 to 68.

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.

1. National Ombudsmen Reporting System (NORS, 2008). Top 20 complaints by category for nursing facilities (FFY 1996-2008). 2008 National Ombudsman Reporting System Data Tables (Unlettered Tables in Appendix B). Retrieved on December 31, 2009 from http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx.

2. CMS Nursing Home Compare website contains information on U.S. average number of deficiency citations at www.medicare.gov/NHCompare

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.
not available

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.

not available

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

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.

CMS estimates that in 2007 there were 1.96 million discharges who used the Medicare SNF benefit, the predominant means of financing short stays in nursing homes for post acute or rehabilitation purposes. This SNF population accounted for 67.9 million covered days of care with an average of 35 days per discharge and average reimbursement of \$11,305, or a average total reimbursement of \$22 billion dollars. The National Health Expenditures Accounts (CMS, 2009) estimate that nursing home costs totaled \$131 billion in 2008.

With the passage of the Omnibus Reconciliation Act of 1987 (OBRA'87) Congress responded to growing concerns about the quality of care that nursing home residents received by requiring reforms in the federal certification and oversight of nursing homes. OBRA'87 shifted evaluations of health care quality from a focus on structure, and process criteria to clinical outcomes, resident satisfaction and quality of life. Since OBRA'87 implementation, GAO (2005; 2007) has continued to investigate quality of care in nursing homes and quality oversight activities of CMS and the states.

Concurrent with changes from OBRA'87 implementation, a radical rethinking of the long term care system known as "culture change" began more than a decade ago. Culture change refers to the transformation of nursing homes from an "acute care" model to a consumer-directed model. Common themes of changes include: autonomy in personal choices for the residents, improved communication between residents and staff, and more homelike environments (www.pioneernetwork.net). The Pioneer Network estimates that 5% of nursing homes have fully adopted culture change (www.pioneernetwork.net). Resident/Patient Experience surveys are one tool for a nursing home to use to become more resident-centered. The Institute of Medicine (2010) includes patient-centeredness in its conceptual framework for categorizing health care quality and disparities measurement. The National Priorities Partnership (<http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?i>

The CMS Nursing Home Compare web site publishes separate quality performance measures for the short stay and long stay populations.

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

for CMS estimates of Medicare SNF users: <http://www.cms.hhs.gov/MedicareFeeForSvcPartsAB/Downloads/NationalSum2007.pdf>
CMS, Nursing Home Data Compendium, 2008 edition.

CMS National Health Expenditure Data is at <http://www.cms.gov/NationalHealthExpendData/>

GAO (Dec. 2005). "Despite increased oversight, challenges remain in ensuring high-quality care and resident safety" www.gao.gov/cgi-bin/getrpt?GAO-06-117.

GAO (May 2007). "Continued attention is needed to improve quality of care in small but significant share of homes."

www.gao.gov/cgi-bin/getrpt?GAO-07-794T.

Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports; Cheryl Ulmer, Michelle Bruno, and Sheila Burke, Editors; Future Directions for the National Healthcare Quality and Disparities Reports. Washington, DC: National Academy Press, 2010.

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):

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

[Person-and Family-Centered Care](#)

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:

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 following topics are measured for nursing homes from a resident's perspective:

Global Items:

Global Rating of care received from staff: sum of resident scores on 0 to 10 scale

Global Rating of special therapy care: sum of resident scores on 0 to 10 scale

Global Rating of overall nursing home: sum of resident scores on 0 to 10 scale

Global item whether respondent would recommend nursing home: sum of resident scores on item (see codebook for points)

assigned to each response category)

Composites: We expect some composites to be similar to the long stay resident instrument such as Environment, Care, and Communication & Respect. We are not sure if the Autonomy and Activities Composites will be relevant to short stay residents. Data analysis is currently being conducted.

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.)*
when resident was in nursing home

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.
to be finalized for each composite and global item when analysis is completed

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*
The denominator is the total number of surveys for respondents that meet CAHPS completion standard (50% of key items answered) and any applicable screener.

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)*
to be finalized for each composite and global item when analysis is completed

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*
We will exclude all residents whose length of stay (LOS) in the facility is less than 5 or greater than 100 days from the date of admission. Residents who are discharged to any hospital with return anticipated will not have their day count reset to zero when they return to the facility (AHRQ will harmonize its specification on short stay residents with CMS). AHRQ created a separate survey for long stay residents whose opinion can be obtained best through in-person administration because, on average, they have more cognitive impairment than short stay residents. In addition, the CAHPS team believed that a minimum number of days (5) was needed for a short stay resident to have sufficient experience with facility care. We also exclude residents who are under age 18 and those who were discharged more than 2 months prior to sample frame development date. Those who were discharged to another care facility and not discharged home and those who were deceased were also excluded.

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)*
self-explanatory

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)*
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)
Statistical risk model
If other: to be finalized when analysis of 2009 data is completed

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)

We will use a similar methodology to that used for the Family Member survey found on pages 26-33 of the AIR Final Report. Variables to be used as case mix adjusters will be finalized when analysis is completed.

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:

Non-weighted score/composite/scale

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.)

to be finalized for each composite and global item when analysis of 2009 data is completed

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.

Survey Administration Guidelines are being developed by the CAHPS User Support Contract (similar to those on web site for Family Member Instrument and Long Stay Resident Instrument) as part of the finalization of the Discharged Resident Instrument.

The recommended minimum sample size will be finalized when analyses of the 2009 MHCC field test are completed. The 2006 Harvard Final report, Table 28c on page 88, suggests minimum sample sizes for the 5 composites for the mail sample (discharged resident) survey based on an N=123. The sample sizes needed are no more than 39 completes to achieve reliability of 0.7 for all 5 composites, much smaller than the sample size needed for the Long Stay Resident (interview sample).

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.

Survey : Patient

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 CAHPS - Discharged Resident Survey BETA Version February 2007](#)

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*)

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

[Facility/Agency](#)

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

[Nursing home \(NH\) /Skilled Nursing Facility \(SNF\)](#)

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

[0691_MeasureTesting_MS5.0_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.

[Other](#)

If other: [Survey](#)

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.

[this is a survey measure so electronic capture is not part of design](#)

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.

Lessons learned from 2005 CAHPS Field test:

DESIGN & PROCEDURES

Short-term nursing home residents' stays are usually primarily a medical event, not a total living experience. The cognitive problems that are so prevalent among long-term residents are much less prevalent in the short-term population. The survey instrument for long-term residents was adapted slightly (adding a question about therapy received and deleting questions about help with hearing aids, and eye and dental care) and put into a mail survey form for the short-term residents. For convenience and timing, the short-term residents of the nursing homes participating in the long-term field test were used as the sample frame for this effort.

At the same time the nursing homes participating in the long-term resident survey were providing data about their long-term residents, they were also asked to provide a list of all those who had been discharged from the nursing home within the past 2 months.

SAMPLE:

Eligible respondents were residents who had been in the home for at least 5 days and who had not been in the home for more than 90 days and who were not deceased or discharged to another care facility. We excluded residents whose most recent MDS assessment indicated that they were "severely impaired in cognitive skills for daily decision making", that they were comatose, and those for whom a legal guardian

was required to make medical decisions were excluded.

PROTOCOL:

The protocol was to send an initial mailing, with a cover letter, fact sheet, copy of a self-administered questionnaire, and a postage-paid return envelope. A packet with a second

questionnaire was to be sent after two weeks to the non-responders. Then, nonresponders

were to get a reminder call to make sure they had received the questionnaire, answer any questions, and urge participation. The first mailing was on June 28. Unfortunately, 5 nursing homes could not provide their completed samples until well into July. Because of a hard deadline for data collection of mid-August, there was not time for follow-up mailings to those nursing homes. Those homes received their first (and only) mailing

at the same time as the other 6 received their second mailing. One nursing home was not recruited until the end of July. Although in-person interviews were collected, this home did not participate in the mail portion of the field test. CSR called everyone who had not yet returned a completed questionnaire to prompt people to return the written survey. Telephone reminder calls were conducted by professional interviewers. Each case had up

to 3 calls made on different days and at different times of the day to attempt to make contact with the appropriate respondent.

FINDINGS:

1. Sampling and Eligibility

The initial sample consisted of 381 residents from 11 nursing homes. 133 residents were ineligible because they did not meet the eligibility criteria. The major reason for ineligibility was being discharged to another care facility or being deceased. Very few in the sample were ineligible because of cognitive impairment or having a legal guardian/legal oversight. In order to obtain sufficient levels of response for

reporting results by individual nursing home, future research might consider different sampling options, including using a rolling sample, where residents over several months are surveyed, rather than just the 2 month window that was used for the field test.

2. Data Collection

We found that the quality of the contact information was generally fairly good. About 70% of the sample sent from the nursing homes included phone numbers. Only one nursing home was unable to provide any phone numbers. Overall, almost 52% of the eligible sample returned a completed survey. With time to implement a good mail protocol (including an option of telephone interview), this field test experience would suggest acceptable rates of return could be achieved. Discharged residents who received the more standard 2-mailings had a 57% response rate, while those that only received one mailing had a 43% response rate. There were very few explicit refusals to participate.

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	
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.

There could be issues if the entity collecting the data does not follow the guidelines for survey administration (e.g., drawing the sample and assuring confidentiality). Unless the sponsor permits direct access to the resident records for random sampling, it is possible that the nursing home may select discharged residents likely to give more favorable responses (or exclude those likely to give unfavorable responses) when selecting records for the sample. In addition, errors could be introduced if an entity adds non-Nursing Home CAHPS items before any of the core survey questions in the Nursing Home CAHPS Discharged Resident Survey. The core survey items are all those questions prior to the "About You" section of the survey. AHRQ has a CAHPS User Group support contract that is available to provide technical assistance for entities wishing to implement this survey- this can help reduce errors.

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.)

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.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [Agency for Healthcare Research and Quality](#)

Co.2 Point of Contact: [Pamela, Owens, Pam.Owens@ahrq.hhs.gov, 301-427-1412-](#)

Co.3 Measure Developer if different from Measure Steward: [Agency for Healthcare Research and Quality](#)

Co.4 Point of Contact: [Judith, Sangl, jsangl@ahrq.gov , 301-427-1308-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

The development of the NHCAHPS resident instrument was a multi-phase process. In the initial phase, CMS requested AHRQ and the CAHPS team to investigate the methodological challenges of conducting a survey with nursing home residents. This phase examined sampling issues, cognitive screeners, data collection methods, and possible survey content. The CAHPS team conducted interviews on these topics with the following experts: Steve Albert, Kitty Buckwalter, Tim Case, Ann Gruber-Baldini, Catherine Hawes, Ted Johnson, Rosalie Kane, Powell Lawton, Vince Mor, John Morris, Peter Norton, Sandra Simmons, Phil Sloan, Joan Teno, Gwen Uman, Sheryl Zimmerman, and Jackie Zinn. AHRQ and the CAHPS team convened a Methodological Expert Group (MEG) to further explore these issues. The MEG included: Robert and Rosalie Kane; Farida Ejaz, Catherine Hawes; Kathleen Buckwalter; Andrew Kramer; Powell Lawton; Jay Magaziner; Vincent Mor; Rudolph Moos; John Schnelle; Philip Sloane; Liane Soberman; Joan Teno; and Sheryl Zimmerman. At the end this initial Phase, CMS, AHRQ, and the CAHPS team concluded that it was feasible to obtain reliable reports of experiences in the nursing home from many long stay nursing home residents by conducting in-person surveys. AHRQ also had extensive consultations with CMS and the Kanes when working on the merger of the Quality of Life items with the Quality of Care items.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2007](#)

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure? [2nd field test done fall 2009 to get larger sample size for analyses](#)

Ad.5 When is the next scheduled review/update for this measure? [01, 2011](#)

Ad.6 Copyright statement: [CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. This CAHPS® questionnaire should be used without modification to the core set of questions.](#)

[Supplemental questions may be added after the core set of questions and before the demographic question section. Please consult Guidelines for Modifying and Naming CAHPS Surveys at https://www.cahps.ahrq.gov/content/products/PROD_ModifySurveys.asp](#)

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments:

