



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 sub criterion 1b).

Brief Measure Information

NQF #: 2612

Corresponding Measures:

De.2. Measure Title: CARE: Improvement in Mobility

Co.1.1. Measure Steward: American Health Care Association

De.3. Brief Description of Measure: The measure calculates a skilled nursing facility's (SNFs) average change in mobility for patients admitted from a hospital who are receiving therapy. The measure calculates the average change in mobility score between admission and discharge for all residents admitted to a SNF from a hospital or another post-acute care setting for therapy (i.e., PT or OT) regardless of payor status. This is a risk adjusted outcome measure, based on the mobility subscale of the Continuity Assessment and Record Evaluation (CARE) Tool and information from the admission MDS 3.0 assessment. The measure is calculated on a rolling 12 month, average updated quarterly.

1b.1. Developer Rationale: Therapies in skilled nursing facilities (SNFs) serve a critical role in helping individuals achieve and maintain maximum physical and functional well-being following hospitalization. One of the principle reasons individuals are discharged from a hospital to a SNF is to improve their functional abilities so they can return to their prior living situation. The Medicare SNF Part A benefit is designed principally for the purpose of either providing therapy to individuals who were hospitalized or to complete their nursing care in a less intensive setting. Over 85% of all Medicare Beneficiaries admitted to SNFs receive therapy services. The level of improvement in function (self care and mobility) is a strong predictor of a person's ability to reside in the community independently (Granger et al., 1979).

Currently, there is no standard assessment tool used across all post-acute care (PAC) providers. Many of the current therapy companies have developed their own or use existing therapy related assessment tools; none of these assessments are standardized. This lack of consistency prevents industry wide comparison. Consumers need a standard measure in order to make educated choices in selecting high quality care providers to maximize outcomes. Educated consumers who make decisions regarding care based on validated measures will also promote accountability and quality among PAC providers. PAC providers, in turn, need standardized assessments to evaluate the quality of services provided, identify areas where improvement is needed, and present data to demonstrate the value of therapy services. Research by Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying areas related to mobility; (2) formulating the evaluation, diagnosis, and prognosis; (3) designing the plan of care; and (4) helping to evaluate the success of physical and occupational therapy interventions.

Potter, K., Fulk, G.D., Salem, Y., Sullivan, J. "Outcome Measures in Neurological Physical Therapy Practice: Part I. Making Sound Decisions". Journal of Neurologic Physical Therapy (2011): 57-64.

Granger, C.V., Dewis, L.S., Peters, N.C., Sherwood, C.C. & Barrett, J.E. (1979). "Stroke rehabilitation: Analysis of repeated Barthel index measures". Arch Phys Med Rehabil 60.1 (1979): 14-7.

S.4. Numerator Statement: The measure assesses the change in mobility. The numerator is the risk adjusted sum of the change in the CARE Tool mobility subscale items between admission and discharge for each individual admitted from a hospital or another post acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.

S.6. Denominator Statement: The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed mobility CARE tool assessment at admission and discharge and do not meet any of the exclusion criteria. The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the mobility CARE tool assessment).

The items included in the CARE Tool Mobility subscale include:

- B1. Lying to Sitting on Side of Bed
- B2. Sit to Stand
- B3. Chair/Bed to Chair Transfer
- B4. Toilet Transfer
- B5a & B5b. Walking or Wheelchair Mobility
- C3. Roll left / right
- C4. Sit to Lying
- C5. Picking up object
- C7a. One Step Curb
- C7b. Walk 50 ft. with Two Turns
- C7c. Walk 12 Steps.
- C7d. Walk Four Steps
- C7e. Walking 10 ft. on Uneven Surface
- C7f. Car Transfer

S.8. Denominator Exclusions: Patients are excluded for two broad reasons:

1. if they have conditions where improvement in mobility is very unlikely,
OR
2. have missing data necessary to calculate the measure

Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting their data.

De.1. Measure Type: Outcome

S.17. Data Source: Electronic Health Records, Other

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Jul 23, 2015 **Most Recent Endorsement Date:** Jul 23, 2015

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? Not Applicable

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[Mobility_Evidence_Submission_Form_2612.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Therapies in skilled nursing facilities (SNFs) serve a critical role in helping individuals achieve and maintain maximum physical and functional well-being following hospitalization. One of the principle reasons individuals are discharged from a hospital to a SNF is to improve their functional abilities so they can return to their prior living situation. The Medicare SNF Part A benefit is designed principally for the purpose of either providing therapy to individuals who were hospitalized or to complete their nursing care in a less intensive setting. Over 85% of all Medicare Beneficiaries admitted to SNFs receive therapy services. The level of improvement in function (self care and mobility) is a strong predictor of a person's ability to reside in the community independently (Granger et al., 1979).

Currently, there is no standard assessment tool used across all post-acute care (PAC) providers. Many of the current therapy companies have developed their own or use existing therapy related assessment tools; none of these assessments are standardized. This lack of consistency prevents industry wide comparison. Consumers need a standard measure in order to make educated choices in selecting high quality care providers to maximize outcomes. Educated consumers who make decisions regarding care based on validated measures will also promote accountability and quality among PAC providers. PAC providers, in turn, need standardized assessments to evaluate the quality of services provided, identify areas where improvement is needed, and present data to demonstrate the value of therapy services. Research by Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying areas related to mobility; (2) formulating the evaluation, diagnosis, and prognosis; (3) designing the plan of care; and (4) helping to evaluate the success of physical and occupational therapy interventions.

Potter, K., Fulk, G.D., Salem, Y., Sullivan, J. "Outcome Measures in Neurological Physical Therapy Practice: Part I. Making Sound Decisions". Journal of Neurologic Physical Therapy (2011): 57-64.

Granger, C.V., Dewis, L.S., Peters, N.C., Sherwood, C.C. & Barrett, J.E. (1979). "Stroke rehabilitation: Analysis of repeated Barthel index measures". Arch Phys Med Rehabil 60.1 (1979): 14-7.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Using data from Jan 2012 to Dec 2012 from two large therapy companies representing 360 SNFs and 60,146 matched (admission-discharge) patient assessments. The frequency distribution of the SNFs' average mobility change scores are shown in Figure A3 in the Appendix. The mean = 26.8, std dev=2.1, min=18.4, max=31.0, 1st quartile = 25.4, 3rd quartile = 28.4, 1st decile = 23.9, 2nd decile = 25.1, 3rd decile = 25.7, 4th decile = 26.5, 5th decile = 27.1, 6th decile = 27.6, 7th decile = 28.1, 8th decile = 28.7, 9th decile = 29.2.

Additionally, table A1 in the Appendix shows the distribution of facilities and risk adjusted mobility change scores by facility bed count, ownership type, and by urban/rural location.

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.

Not Applicable

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Specific data on disparities was not included in this measure as specified by current NQF requirements; however, due to the potential for widespread use of this measure we have included distribution of SNF admissions by gender, age and ethnicity in SNFs

from the second quarter of 2014, based on the MDS 3.0 (see Appendix tables A2-A4). Nationally, 66% of all admissions to SNFs are female. Approximately three-quarters are between the ages of 65 and 95 years. Based on the MDS, the majority are considered white (76%) with 14% African American, 5% Hispanic, 2% Asian and less than 1% each native Hawaiian or other pacific islander and American Indian or Alaska native. A state by state break down is provide in the appendix. This makes stratification at a facility level extremely difficult because sample sizes for ethnic groups within a facility are small and frequently below the minimum denominator size of 30.

We are not able to present information on insurance status based on the MDS, as it is not reliable due to the accuracy of the information submitted by providers, the ambiguity of payer status at admission, the number of patients with multiple payers and patient's whose payor status changes during the course of care in the SNF.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

A PubMed search on disparities related to therapy outcomes in skilled nursing facility residents did not produce any meaningful results. There is some evidence that suggest differences in access and utilization of post-acute rehabilitation care by ethnicity but none on differences in the quality of care delivered or outcomes within a single provider. A patient can receive post-acute rehabilitation care in inpatient rehabilitation facilities, skilled nursing homes, or through home health care; the former provides more hours of care than the latter when viewed on a continuum. Freburger et al. (2012) found that minorities and those with lower socioeconomic statuses receive lower volumes of rehabilitation care. These individuals are more likely to be discharged home and receive care in a SNF verses an inpatient rehabilitation facility. This finding is also supported by earlier research showing that racial minorities, women, older individuals, and those with lower incomes are more likely to receive care in SNFs or home health (Freburger et al., 2011). However, no studies looked at difference in volume of therapy services by ethnicity within SNFs just across different types of PAC providers.

There is evidence that racial disparities exist in care provided in different nursing homes. An article by Smith et al. (2007) suggests that racial segregation in nursing homes mirrors that which occurs in metropolitan areas. Black nursing home residents are 1.41 times more likely to be in a facility cited with a deficiency causing actual harm or immediate jeopardy to residents. Forty percent of African American patients are in lower tier facilities, those with higher number of Medicaid patients and limited resources, compared to nine percent of white residents. The lower tier facilities are shown to have fewer nurses, lower occupancy rates, and more health-related deficiencies (Mor et al., 2004). However, the outcomes of these individuals did not differ from other residents in the same facility. Thus, suggesting differences are related to the facility's location and practice not differences related to ethnicity or social economic status of the residents. A 2013 study also found that the differences in quality between SNFs with higher proportion of African American residents was mediated by the overall financial health of the facility and overall quality in the facility, rather than the racial mix (Chisholm et al., 2103). In summary, the literature suggests that ethnic and social economic status differences are related to inter-facility differences not to intra-facility differences in care. Therefore, it is unclear based on the literature if social economic status should be risk adjusted.

Chisholm, L., Weech-Maldonado, R., Laberge, A., Lin, F. & Hyer, K. "Nursing home quality and financial performance: Does the racial composition of residents matter?" Health Services Research. (2013): 2060- 2080.

Fennell, M. L., Miller, S. C., & Mor, V. "Facility effects on racial differences in nursing home quality of care". American Journal of Medical Quality. 15.4 (2000): 174-181.

Freburger, J.K., Holmes, G.M., & Ku, L.J. "Postacute rehabilitation care for hip fracture: Who gets the most care?". J Am Geriatr Soc. 60.10 (2012):1929-1935.

Freburger, J.K., Holmes, G.M., Ku, L.J., Cutchin, M.P., Heatwole-Shank, K. & Edwards, L.J. "Disparities in postacute rehabilitation care for stroke: An analysis of the state inpatient databases". Arch Phys Med Rehabil. 92.8 (2011): 1220-1229.

Grabowski, D.C. "The admission of blacks to high-deficiency nursing homes". Medical Care. 42.5 (2004): 456-464.

Harada, N.D., Chun, A., Chiu, V. & Pakalniskis, A. "Patterns of rehabilitation utilization after hip fracture in acute hospitals and skilled nursing facilities". Medical Care. 38.11 (2000): 1119-1130.

Holmes, G.M., Freburger, J.K. & Ku, L.J. "Decomposing racial and ethnic disparities in the use of postacute rehabilitation care". *Health Serv Res.* 47.3 (2012): 1158-1178.

McCallum, C.A. "Access to physical therapy services among medically underserved adults: A mixed-method study". *Phys Ther.* 90.5 (2010):735-747.

Mor, V., Zinn, J., Angelelli, J., Teno, J.M., & Miller, S.C. "Driven to tiers: Socioeconomic and racial disparities in the quality of nursing home care". *The Milbank Quarterly.* 82.2 (2004): 227-156.

Smith, D.B., Fang, Z., Fennell, M.L, Zinn, J.S. & Mor, V. "Separate and unequal: Racial segregation and disparities in quality across U.S. nursing homes". *Health Affairs.* 26.5 (2007): 1448-1458.

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 sub criteria 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*):

[Health and Functional Status](#) : [Change](#)

De.7. Target Population Category (*Check all the populations for which the measure is specified and tested if any*):

[Elderly, Populations at Risk](#) : [Dual eligible beneficiaries](#)

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.*)

[Not Applicable](#)

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)

[This is not an eMeasure](#) **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*)

[No data dictionary](#) **Attachment:**

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Not Applicable

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) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The measure assesses the change in mobility. The numerator is the risk adjusted sum of the change in the CARE Tool mobility subscale items between admission and discharge for each individual admitted from a hospital or another post acute care setting regardless of payor status and are receiving therapy (PT or OT) for any reason in a skilled nursing center.

S.5. 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, time period for data collection, 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 (S.14).

The numerator includes all residents admitted from a hospital or another post acute care setting that receive any PT or OT therapy for any reason in a SNF that have a completed mobility CARE tool assessment at admission and discharge (see denominator definition below). The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the CARE Tool assessment).

The items included in the CARE Tool Mobility subscale include:

- B1. Lying to Sitting on Side of Bed
- B2. Sit to Stand
- B3. Chair/Bed to Chair Transfer
- B4. Toilet Transfer
- B5a & B5b. Walking or Wheelchair Mobility
- C3. Roll left / right
- C4. Sit to Lying
- C5. Picking up object
- C7a. One Step Curb
- C7b. Walk 50 ft. with Two Turns
- C7c. Walk 12 Steps.
- C7d. Walk Four Steps
- C7e. Walking 10 ft. on Uneven Surface
- C7f. Car Transfer

The numerator is a facility's average risk adjusted change score on the mobility component of the CARE tool. The risk adjusted average change score is calculated in several steps:

Step 1: Each individual's admission and discharge mobility scale score is calculated. Items rated as S. Not attempted due to safety concerns, A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to one. For each individual, the ratings for all the mobility items on the CARE tool at admission are summed and transformed to a 0-100 scale. The same is done for the discharge assessment.

Step 2: Each individual's unadjusted change score is calculated by taking the admission score minus the discharge score.

Step 3: The individual's unadjusted change score is risk adjusted (see risk adjustment section)

Step 4: The facilities risk adjusted change score is the sum of all the individual's risk adjusted change scores divided by the denominator.

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

The denominator includes all residents admitted to a SNF from a hospital or another post-acute care setting who receive either PT or OT therapy for any reason during their stay regardless of payor status, have a completed mobility CARE tool assessment at admission and discharge and do not meet any of the exclusion criteria. The mobility items used from the CARE tool are listed below and rated on a 1-6 scale (see Appendix for copy of the mobility CARE tool assessment).

The items included in the CARE Tool Mobility subscale include:

- B1. Lying to Sitting on Side of Bed
- B2. Sit to Stand
- B3. Chair/Bed to Chair Transfer
- B4. Toilet Transfer
- B5a & B5b. Walking or Wheelchair Mobility
- C3. Roll left / right
- C4. Sit to Lying
- C5. Picking up object
- C7a. One Step Curb
- C7b. Walk 50 ft. with Two Turns
- C7c. Walk 12 Steps.
- C7d. Walk Four Steps
- C7e. Walking 10 ft. on Uneven Surface
- C7f. Car Transfer

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The denominator includes all residents admitted to a SNF who are receiving any PT or OT therapy for any reason.

The denominator is based on admission from any hospital or post-acute care setting and is determined using information from MDS item "A1800 Entered From" coded as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" or "09 Long Term Care Hospital" regardless of payor status. They must receive either PT or OT therapy during their stay. A resident's stay is defined as an episode of care from admissions to discharge from the facility or discharge from therapy services (defined as completing a discharge CARE tool assessment). Overall, approximately 85% of all admissions from a hospital receive either PT or OT therapy based on SNF Part A claims (or MDS 3.0 data).

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Patients are excluded for two broad reasons:

1. if they have conditions where improvement in mobility is very unlikely,
- OR
2. have missing data necessary to calculate the measure

Additionally, facilities with denominator size of fewer than 30 patients during a 12 month period are excluded from reporting their data.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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.)*

Individuals with conditions where improvement in mobility (as determined by a panel of expert therapists) is very unlikely were excluded based on information from the admission MDS 3.0 assessment. Individuals with one of the following MDS 3.0 items marked as yes were excluded:

- Ventilator (O0100F1 =1 or O0100F2 =1)
- Coma (B0100 =1)
- Quadriplegic (I5100=1)
- Hospice (O0100K1 = 1)

In addition, we also excluded individuals whose age is less than 18 years.
Overall, these exclusions resulted in 1.1% of all admissions being excluded.

Missing data also resulted in individuals being excluded

- Missing a discharge CARE Tool assessment (this resulted when individuals died or were hospitalized during their SNF stay) resulted in patients being excluded since one could not calculate a change from admission. Nationally approximately 21.6% of admissions to a SNF will be hospitalized during their therapy stay and 4.5% will die (based on analysis of SNF part A claims from 2009-2011).
- Missing data on individual CARE Tool mobility assessment items on at least one item occurred 27.2% of the time. Approximately a third of all missing data related to just three items C7c walking 12 steps; C7d walking 4 steps and C7f car transfer but did not differ significantly between admission and discharge assessments. We did not impute any missing data for mobility items.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

Statistical risk model

If other:

S.12. Type of score:

Continuous variable, e.g. average

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)

The facility-level mobility improvement scores are calculated using the following 15 steps.

Step 1. Choose the 12 month window for which we will select episodes. This is the four consecutive calendar quarters ending with the most recent calendar quarter for which both MDS data and CARE Tool data are available for use in the measure.

Step 2. Identify all MDS discharge assessments (in which we understand the CARE Tool items will be embedded) with a discharge date that fell within the 12 month window identified in Step 1.

Step 3. For each MDS tool discharge assessment identified in Step 2, identify the corresponding MDS admission assessment (in which we understand the CARE Tool items will be embedded). An MDS assessment is identified as an admission assessment if A0310F == "01" (entry record). Note that the admission date may lie before the 12 month window defined in Step 1. The period of time from the admission date (corresponding with the MDS admission assessment) through to the discharge date (corresponding with the MDS discharge assessment) is called an "episode". If no MDS admission assessment was found, discard the discharge assessment from all subsequent steps.

Step 4. Identify all MDS admission assessments that indicate the admission to the SNF was from the hospital, another SNF or IRF. An MDS admission assessment indicates that the SNF admission was from a hospital when MDS item "A1800 Entered From" coded

as "03 Acute Care Hospital" or "02 Another nursing home or swing bed" or "05 inpatient rehabilitation facility" or "09 Long Term Care Hospital". The MDS item A1600 indicates the date of entry to the SNF.

Step 5. For any admission or discharge CARE Tool item (that enters the calculation of the mobility improvement scores) with letter code "S" (activity not attempted due to safety concerns), A. Task attempted but not completed, N. Not applicable and P. Patient Refused were recoded to "1" on a six point rating scale (indicating full functional dependence).

Step 6. Apply the mobility improvement measure's exclusions (see s.11), and exclude any episode that did not involve either physical or occupational therapy. The clinical measure exclusions are detailed in S.11 (Denominator exclusion details and codes). The exclusion of episodes not involving either occupational or physical therapy is as follows:

We identify the patient as having received occupational therapy if on the MDS discharge assessment:

The total number of minutes of occupational therapy in the last 7 days (O0400B1) is greater than zero; or

The most recent occupational therapy regimen (starting on the date recorded in O0400B5, and ending on the date recorded in O0400B6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date).

We identify the patient as having received physical therapy if on the MDS discharge assessment:

The total number of minutes of physical therapy in the last 7 days (O0400C1) is greater than zero; or

The most recent physical therapy regimen (starting on the date recorded in O0400C5, and ending on the date recorded in O0400C6) intersects the episode (beginning with the CARE admission assessment's admission date and ending with the CARE discharge assessment's discharge date).

If the episode involves neither occupational nor physical therapy, as identified above, then exclude it from all subsequent steps in the calculation.

Step 7. Map the CARE Tool B5a (walking) and B5b (wheeling) items to obtain a harmonious 1-6 score for all assessments, and recode walking items C7b, C7c, C7d and C7e to 1=dependent if resident cannot walk. First, consolidate the four sub-items B5a1, B5a2, B5a3 and B5a4 corresponding to different distances the resident can walk (if the patient can walk); and the four sub-items B5b1, B5b2, B5b3 and B5b4 corresponding to different distances the resident can wheel (if the patient cannot walk). To do this, use the crosswalk presented in Figure A1 in the Appendix. Call the resulting two items B5a and B5b.

Second, consolidate the B5a and B5b items into a harmonious summary item called B5. To do this use the crosswalk presented in Figure A1 in the Appendix. This is the item used in the calculation of mobility outcome scores in the subsequent steps.

Finally, if the patient is unable to walk (i.e., no values for the B5a and C7 items), recode each item C7a, C7b, C7d and C7e to 1 = dependent.

Step 8. For each episode remaining after Step 6, using the CARE Tool items as transformed in Step 7, calculate a preliminary admission score and a discharge score as the sum of the values for the following CARE tool mobility items B1 (Lying to sitting on side of bed), B2 (Sit to stand), B3 (Chair/bed-to-chair transfer), B4 (Toilet transfer), B5 (Walking/wheeling), C3 (Roll left and right), C4 (Sit to lying), C7a (One step (curb)), C7b (Walking 50 feet with two turns), C7c (Walking 12 steps), C7d (Walking four steps), C7e (Walking 10 feet on uneven surfaces).

Each of those 12 CARE Tool items takes an integer value of 1, 2, 3, 4, 5 or 6, and so the preliminary admission score will be an integer between 12 and 72, and the preliminary discharge score will be an integer between 12 and 72.

Step 9. For each episode, linearly transform the preliminary admission score and preliminary discharge score so that it lies in the range 1-100 using the following equation:

["transformed mobility admission score"] = $1.65 \times [\text{"preliminary mobility admission score"}] - 18.8$

["transformed mobility discharge score"] = $1.65 \times [\text{"preliminary mobility discharge score"}] - 18.8$

Step 10. For each episode, calculate the episode-level change score by subtracting the transformed discharge score from the transformed admission score. Each score will lie between -99 and 99.

Step 11. Calculate the national average change score as the simple mean of all episode-level change scores calculated in Step 10.

Step 12. For each episode, calculate the predicted change score using the risk adjustment methodology detailed in S.15a. That is, having prepared the risk adjustment variables in the way described in S.15a, apply the equation: $[\text{predicted change score}] = 33.61 - 1.56 \times [\text{patient is 85 years or older}] - 9.11 \times [\text{dialysis while a resident}] - 5.08 \times [\text{entered from SNF}] - 2.81 \times [\text{oxygen while a patient}] -$

4.23×[unhealed pressure ulcers] -8.85×[mental status] -4.75×[resident mood] -9.30×[psychiatric conditions] -6.91×[feeding tube or IV feeding] -4.10×[suctioning or tracheotomy] -3.98×[infections of the foot].

Step 13. For each episode, calculate the risk adjusted change score using the actual change score calculated in Step 10, the national average change score calculated in Step 11, and the predicted change score calculated in Step 12. The risk adjusted change score is: [risk adjusted change score] = ([national average change score] - [predicted change score]) + [actual change score].

Step 14. Exclude any facility that has fewer than 30 episodes for which we could calculate a risk adjusted change score.

Step 15. For each facility remaining after Step 14, calculate its mobility improvement score as the simple mean of the risk adjusted change scores calculated in Step 13.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not Applicable

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

Not Applicable

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Electronic Health Records, Other

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Resident Assessment Instrument Minimum Data Set (MDS) version 3.0

Continuity Assessment and Record Evaluation (CARE) Tool; Mobility subscale

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Nursing Home / SNF

If other:

S.22. 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.)

Not Applicable

2. Validity – See attached Measure Testing Submission Form

Mobility_Testing_Submission_Form_2612-635509010775453804.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

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) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

The CARE Tool is currently available in a PDF document, which can be completed in written format. However, a number of software vendors for rehabilitation therapy providers have begun the process of adding the CARE item set to their online documentation systems. Two of the largest therapy software companies now provide the CARE Tool in electronic format. Currently over 48 organizations representing 1016 SNFs have begun to use the CARE tool. One software therapy company has also developed an online secure portal where providers can submit their data to a larger database and receive confidential, secure outcome performance reports.

Skilled nursing care centers encode and electronically transmit the MDS 3.0 data set, as required by the federal government.

The IMPACT act of 2014 recently passed by congress and signed by the President; requires the incorporation of standardized assessments for mobility and self-care into the MDS by October 2018 (fiscal year 2019). This will make the data collection for this measure extremely feasible as it will be universally collected on all admissions and discharges to all SNFs in the country. The IMPACT act also requires the public reporting of functional outcome measures for SNFs.

United States. Cong. House of Representatives. IMPACT Act of 2014. 113th Cong., HR 4994. Washington: GPO, 2014.

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

In developing this measure, 89 skilled nursing centers agreed to complete and collect the mobility subscale of the Continuity Assessment and Record Evaluation (CARE) tool. A basic training program to the CARE tool was established, requiring therapists to pass a post-test. 425 therapists were trained with a 95% pass rate on the post-test. A key challenge identified was the CARE tool's method of rating the patient's usual level of performance, rather than the lowest level of performance which is commonly used in various proprietary tools (e.g., MBI, FOM and ROM) as well as in the MDS 3.0 scale. This was addressed by focusing the training and design of the clinical vignettes used in the training and test to highlight the difference in rating between the usual level of performance versus the most dependent/independent level of performance. Overall, therapists did not report any significant issues in understanding or assessing patients using the CARE scale, nor did they report that the CARE scale was more burdensome than the proprietary scales currently in use. The two commonly reported data collection issues were the inconvenience of completing a written scale and the need to complete all items on the scale. The first issue, completing a written scale, is currently being addressed by software vendors (see 3b.1.) and per the IMPACT act of 2014 will be incorporated into the MDS in the near future. The second issue, completing all items on the scale, must become an industry standard. When the CARE core mobility items are incorporated into the MDS, per the IMPACT act of 2014, we anticipate that all items will be required as this is the current standard of the MDS 3.0 tool. Common practices among many therapy providers are to complete only items which are the focus of care. However, moving to a practice of completing all items on the CARE assessment form is integral to quality improvement and measurement efforts. This was supported by the therapy providers that participated in this study. Currently the therapy companies that do not require therapists to complete all items on their proprietary scales are also not able to generate an overall quality measure score.

One section on the original CARE scale that caused therapists confusion was the Mode of Mobility question in section C7 (see Appendix). This question asks if the patient primarily walks or uses a wheelchair, then has the therapist test a series of walking or wheelchair tasks dependent on their response. Confusion arose around how to respond if the patient both walks and uses a wheelchair or the therapy plan or care included goals for both walking and wheelchair locomotion. The form was changed to add a response option denoting "both" and allowing therapists to rate patients on all walking or wheeling tasks. This also maintains consistency with question B5 (see Appendix).

In addition, one letter code from the original CARE scale developed by CMS was dropped. This code identified "M. Not attempted due to medical condition." It was determined that this letter code was unnecessary because the codes "1. Dependent" and "S. Not attempted due to safety concerns" would replace the code M in any situation.

We used the core mobility items and scoring on the functional status section of the CARE tool and when implemented in the MDS this measure will be able to be calculated from these items.

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).

No fees or licensing requirements for use of CARE Tool or the use of the submitted quality measure. The CARE Tool is currently available in the public domain. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/CARE-Institutional-Admission-Assessment-Tool.pdf>.

Additionally, no fees are required for the utilization of the MDS 3.0, it is publicly available at <http://www.resdac.org/cms-data/files/mds-3.0>.

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.

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

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

Not Applicable

4a1.2. 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?)

The CARE Tool currently is not required by CMS or others and is not part of the MDS. As a result, data on all the SNFs in the country are not available for public reporting. However, the IMPACT Act of 2014 passed by Congress and signed into law by the President in October 2014 requires the adoption of a standardized functional assessment tool in all post-acute care settings and public reporting of self care and mobility quality measures. The CARE tool (including self care and mobility assessment scales), developed by CMS, is the only assessment tool validated across all the PAC settings (Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Inpatient Rehab Facilities (IRFs) and LTACHs Long Term Acute Care Hospitals).

4a1.3. 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.)

American Health Care Association (AHCA) and National Association of the Support of Long Term Care (NASL) who jointly sponsored the development of this measure have actively supported the IMPACT Act. They also participated in the development of the CARE Tool and support its use and adoption by their respective members as a means for standardized assessment of our patients. AHCA represents nearly 10,000 of the approximately 15,000 SNFs in the country. NASL represents therapy companies as well as software vendors supporting therapy services. The AHCA Board of Governors and NASL have both endorsed the mobility quality measure. AHCA and NASL have met with CMS asking that the CARE Tool mobility assessment be adopted in SNFs so that outcome measures can be developed for public reporting and eventually incorporated into new payment models.

MedPAC has also called on CMS to adopt the CARE Tool to measure outcome measures (MedPAC annual report to congress 2014; page 174 Chapter 7 Post Acute Care Provider: Steps toward broad payment reforms.

[http://www.medpac.gov/documents/reports/chapter-7-post-acute-care-providers-steps-toward-broad-payment-reforms-\(march-](http://www.medpac.gov/documents/reports/chapter-7-post-acute-care-providers-steps-toward-broad-payment-reforms-(march-)

2014-report).pdf?sfvrsn=2).

As a result of these efforts, NASL members, including one of the largest software companies that supports therapy services in SNFs, has already incorporated the CARE Tool into their software and is working with AHCA to incorporate this quality measure into their software. This has resulted in 48 organizations representing 1,016 SNFs adopting the use of the CARE tool. To date, they have completed CARE Tool assessments on over 48,971 of patients. AHCA is also reaching out to other software companies that support therapy in SNFs to adopt the CARE Tool mobility assessment and provide the necessary information to calculate the quality measures. In addition, two large NF chains will adopt the CARE tool mobility assessment starting in early 2015.

AHCA also plans to incorporate this quality measure into its web-based reporting/benchmarking tool – Long Term Care Trend Tracker. This tool allows SNFs to calculate and trend a wide array of quality metrics over time and benchmark to peers – see http://www.ahcancal.org/research_data/trendtracker/Pages/default.aspx. We are currently working on a portal to allow SNFs of therapy companies to upload their mobility quality measure scores and benchmark to peers. The AHCA Board of Governors has approved funds to build this portal in 2015. This information will help individuals SNFs with their internal quality improvement efforts as they look at their trends over time in improvement in mobility. In addition, one of the large rehabilitation software vendors is developing similar ability for providers not using their software to upload their mobility change score for quality improvement tracking and bench-marking against others. We are in the process of providing the specifications and algorithms necessary for these software vendors and NF companies to calculate the mobility quality measure.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

In the Pacific Northwest, the Marquis Companies and Consonus Healthcare organizations have been collecting CARE scores for both self-care and mobility for the past 2.5 years. Results of their scoring are fed into a live analytics tool that allows a user to filter results by facility, by diagnosis, by hospital, and even by payer. To date they have collected over 1.3 million assessment measures (1,346,620) for 20,446 patients. On a quarterly basis these organizations meet to review results, look for trends, and focus on an improvement process. The overarching goal of these meetings is to find the optimal point for discharge by diagnosis in terms of optimal mobility and self-care stability.

At present there are 36 facilities feeding functional improvement data into the Consonus system. All of these skilled nursing facilities are capturing self-care and mobility scores at admission and discharge for all rehab patients.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Results are accessible to the authorized facility personnel via a live web portal. Both self-care and mobility reporting includes start scores, end scores, and points of improvement. Length of stay is also available via the reporting.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

The measure has been incorporated into a larger existing tool by Consonus that facilities were already using. So no feedback on implementation has been obtained. In terms of performance, most users are pleased to have this data element and no critical feedback has been received. Any feedback is/was obtained through oral communication during quarterly meetings with the facilities using the measure.

4a2.2.2. Summarize the feedback obtained from those being measured.

Generally speaking, all of the users are pleased to have the data that determines functional improvement. Many are concerned that reducing length of stay without considering the mobility and self-care capabilities of the patient could have harmful impacts in terms of increased readmissions, fall, and or other harmful results to the patient population.

4a2.2.3. Summarize the feedback obtained from other users

No feedback has been received by the users of the measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Our measure has not been modified or revised.

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.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)

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.

Not Applicable

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Not Applicable

4b2.2. Please explain any unexpected benefits from implementation of this measure.

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.

Yes

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 of Related Measures

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 harmonized to the extent possible?

No

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

Not Applicable

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.)

[Not Applicable](#)

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](#) **Attachment:** [Mobility_Appendix_2612.docx](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [American Health Care Association](#)

Co.2 Point of Contact: [Katherine, Almendinger](#), kalmendinger@ahca.org, 202-898-6320-

Co.3 Measure Developer if different from Measure Steward: [The Moran Company](#)

Co.4 Point of Contact: [Rachel, Feldman](#), rlfeldman@themorancompany.com, 703-841-8405-

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.

[Mary Ousley, Ousley and Associates- Expert Panel Co-chair](#)

[Howie Groff, Tealwood Care Centers- Expert Panel Co-chair](#)

Members of the Expert Panel Include:

[Cynthia Morton, NASL](#)

[Martha Schram, Aegis Therapies](#)

[Bill Goulding, Aegis Therapies](#)

[Mary Van De Kamp, Kindred/Rehab Care](#)

[Matt Sivret, Kindred/Rehab Care](#)

[Phil Fogg, Marquis Companies](#)

[Tracy Fritts, Consonus Healthcare](#)

[Garry Pezzano, Genesis Rehab Services](#)

[Felicia Chew, Genesis Rehab Services](#)

[Mike Morris, Genesis Rehab Services](#)

[John Barber, White Oak Manor](#)

[Rick Black, HCR Manor Care](#)

[Leigh Ann Frick, Heritage Health Care](#)

[Doug Burr, Health Care Navigator](#)

[Katarika Lewis, Halcyon Rehabilitation](#)

[Victoria Cruce Hollar, Halcyon Rehabilitation](#)

[Chris Castel, Accelerated Care Plus](#)

[Ellen Strunk, Rehab, Resources and Consulting](#)

[The expert panel met regularly and provided guidance on risk adjustment, exclusions, measure specifications and use of the](#)

measure.

Observers:

Mary Pratt, CMS

Tara McMullen, CMS

Members of measure steward, American Healthcare Association:

David Gifford

Courtney Bishnoi

Urvi Patel

James Muller

Members of the project contractor, The Moran Company:

Iara Woody

Chris Young

Rachel Feldman

Peter Gruhn

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2014

Ad.3 Month and Year of most recent revision: 06, 2014

Ad.4 What is your frequency for review/update of this measure? Two Years

Ad.5 When is the next scheduled review/update for this measure? 12, 2015

Ad.6 Copyright statement: None

Ad.7 Disclaimers: None

Ad.8 Additional Information/Comments: None