



## 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 #: 2631**

**Corresponding Measures:**

**De.2. Measure Title:** Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

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

**De.3. Brief Description of Measure:** This quality measure reports the percentage of all Long-Term Care Hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.

**1b.1. Developer Rationale:** Many Long-Term Care Hospital (LTCH) patients have functional limitations and are at high risk for functional decline during the hospital stay; therefore, this measure addresses the assessment of functional status on admission and discharge and the inclusion of function in the patient's care plan, as evidenced by a goal for at least one of the self-care or mobility function assessment items.

The importance of using standardized functional assessment items in LTCH populations is supported by the high prevalence of therapy services provided in this setting, and the need for good care coordination. Whether an LTCH patient is discharged home or to another care setting for continuing healthcare, the patient's functional status is an important aspect of a person's health status to document at the time of the transition.

This quality measure will inform LTCH providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.

**S.4. Numerator Statement:** The numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

**S.6. Denominator Statement:** The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

**S.8. Denominator Exclusions:** There are no denominator exclusions for this measure.

**De.1. Measure Type:** Process

**S.17. Data Source:** 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

[NQF\\_Evidence\\_LTCH\\_Process\\_QM\\_Final.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.*

Many Long-Term Care Hospital (LTCH) patients have functional limitations and are at high risk for functional decline during the hospital stay; therefore, this measure addresses the assessment of functional status on admission and discharge and the inclusion of function in the patient's care plan, as evidenced by a goal for at least one of the self-care or mobility function assessment items.

The importance of using standardized functional assessment items in LTCH populations is supported by the high prevalence of therapy services provided in this setting, and the need for good care coordination. Whether an LTCH patient is discharged home or to another care setting for continuing healthcare, the patient's functional status is an important aspect of a person's health status to document at the time of the transition.

This quality measure will inform LTCH providers about opportunities to improve care in the area of function and strengthen incentives for quality improvement related to patient function.

**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.

Not applicable. See 1b.3. below.

**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.**

An increasing body of evidence has reported on the safety and feasibility of early mobilization and rehabilitation of critically ill but stable patients in LTCH and intensive care unit settings with minimal adverse events and risk to the patient (Adler & Malone, 2012; Drolet et al., 2013; Kress, 2009; Schweickert & Kress, 2011; Schweickert et al., 2009; Zanni et al., 2010). Early mobility and rehabilitation in these settings have been associated with several improved patient outcomes, such as (1) improved strength (Dang, 2013; Li, Peng, Zhu, Zhang, & Xi, 2013; Schweickert & Kress, 2011) and functional status (Adler & Malone, 2012; Li et al., 2013; Schweickert & Kress, 2011); (2) earlier achievement of mobilization milestones, such as out-of-bed mobilization (Adler & Malone, 2012; Morris, 2007); (3) improvement in mobility and self-care function scores from admission to discharge (Li et al., 2013; Scheinhorn et al., 2007); (4) greater incidence of return to functional baseline in mobility and self-care, greater unassisted walking and walking distances, and improved self-reported physical function scores at hospital discharge compared with persons not participating in early mobility and rehabilitation (Adler & Malone, 2012); (5) enhanced recovery of functional exercise capacity (Dang, 2013); (6) improved self-perceived functional status (Dang, 2013); (7) reduced physiological and cognitive complications (Dang, 2013); and (8) improved cognitive function (Li et al., 2013). Early mobility and rehabilitation have also been associated with (1) reduced ICU and hospital length of stay (Adler & Malone, 2012; Dang, 2013; Engel, Needham, Morris, & Gropper, 2013; Kress, 2009; Li et al., 2013; Schweickert & Kress, 2011), (2) reduced incidence of delirium and improved patient awareness (Adler & Malone, 2012; Schweickert & Kress, 2011), (3) increased ventilator-free days and improved weaning outcomes (Adler & Malone, 2012; Dang, 2013; Li et al., 2013), (4) greater incidence of discharge home directly after hospitalization compared with patients not receiving early mobilization (Engel et al., 2013; Schweickert et al., 2009), and (5) reduced hospital readmission or death in the year after hospitalization (Adler & Malone, 2012; Li et al., 2013).

Mobility activities that are feasible to assess in LTCH and ICU settings include bed mobility, sitting at the edge of the bed, transferring from bed to chair, sitting in a chair, out-of-bed mobility, standing, and ambulation (Adler & Malone, 2012; Bailey et al., 2007; Morris, 2007; Schweickert et al., 2009). In a sample of 103 patients with respiratory failure undergoing 1,449 activity events in a respiratory intensive care unit, more than one-half of the activity events were reported to be ambulation, and 40% of the activity events occurred in intubated, mechanically ventilated patients at the end of the respiratory ICU stay. Moreover, 69.4% of survivors ambulated more than 100 feet, 8.2% ambulated less than 100 feet, 15.3% could sit in a chair, 4.7% could sit on the edge of the bed, and 2.4% did not accomplish any of these activities (Bailey et al., 2007). Self-care items that are feasible to assess in LTCH and ICU settings include bathing, dressing, eating, grooming, and using the toilet (Schweickert and Kress, 2011; Schweickert et al., 2009; Zanni et al., 2010). In a study of 19 medical intensive care unit patients who received physical and/or occupational therapy services, 48% participated in grooming activities and 46% participated in bathing activities (Zanni et al., 2010).

Short- and long-term cognitive impairments are very frequent complications of critical illness and negatively influence survivors' ability to function independently (Brummel et al., 2012; Pandharipande, Girard, & Ely, 2014; Wilcox et al., 2013). Delirium during hospitalization is highly prevalent in critically ill patients and has been associated with longer lengths of stay, increased duration of mechanical ventilation, and higher risk of death (Wilcox et al., 2013). A longer duration of delirium has been associated with worse short- and long-term cognition and executive function (Pandharipande et al., 2014; Wilcox et al., 2013). Given these adverse consequences, the importance of early assessment of cognitive function, including possible delirium, and early initiation of cognitive rehabilitation in critical care settings is being increasingly recognized (Brummel et al., 2012; Miller, Patton, Graham, & Hollins, 2000). Also, given the positive effects of physical exercise on cognitive function in other populations, the potential positive influence of exercise on cognitive function in the critically ill population is being examined by researchers (Brummel et al., 2012).

**Citations**

- Adler, J., & Malone, D. (2012). Early mobilization in the intensive care unit: A systematic review. *Cardiopulmonary Physical Therapy Journal*, 23(1), 5–13.
- Bailey, P., Thomsen, G. E., Spuhler, V. J., Blair, R., Jewkes, J., Bezdjian, L., ... Hopkins, R. O. (2007). Early activity is feasible and safe in respiratory failure patients. *Critical Care Medicine*, 35, 139–145.
- Brummel, N. E., Jackson, J. C., Girard, T. D., Pandharipande, P. P., Schiro, E., Work, B., ... Ely, E. W. (2012). A combined early cognitive and physical rehabilitation program for people who are critically ill: The Activity and Cognitive Therapy in the Intensive Care Unit (ACT-ICU) trial. *Physical Therapy*, 92, 1580–1592.
- Dang, S. L. (2013). ABCDEs of ICU: Early mobility. *Critical Care Nursing Quarterly*, 36, 163–168.

- Drolet, A., DeJulio, P., Harkless, S., Henricks, S., Kamin, E., Leddy, E. A., & Williams, S. (2013). Move to improve: The feasibility of using an early mobility protocol to increase ambulation in the intensive and intermediate care settings. *Physical Therapy*, 93, 197–207.
- Engel, H. J., Needham, D. M., Morris, P. E., & Gropper, M. A. (2013). ICU early mobilization: From recommendation to implementation at three medical centers. *Critical Care Medicine*, 41(Suppl. 9), S69–S80. doi:10.1097/CCM.0b013e3182a240d5
- Kress, J. P. (2009). Clinical trials of early mobilization of critically ill patients. *Critical Care Medicine*, 37, S442–S447.
- Li, Z., Peng, X., Zhu, B., Zhang, Y., & Xi, X. (2013). Active mobilization for mechanically ventilated patients: A systematic review. *Archives of Physical Medicine and Rehabilitation*, 94, 551–561.
- Miller, R. S., Patton, M., Graham, R. M., & Hollins, D. (2000). Outcomes of trauma patients who survive prolonged lengths of stay in the intensive care unit. *Journal of Trauma*, 48, 229–234.
- Morris, P. E. (2007). Moving our critically ill patients: Mobility barriers and benefits. *Critical Care Clinics*, 23, 1–20.
- Pandharipande, P. P., Girard, T. D., & Ely, E. W. (2014). Long-term cognitive impairment after critical illness [response to correspondence]. *New England Journal of Medicine*, 370, 185–186.
- Rochester, C. L. (2009). Rehabilitation in the intensive care unit. *Seminars in Respiratory and Critical Care Medicine*, 30, 656–669. doi:10.1055/s-0029-1242635
- Scheinhorn, D. J., Hassenpflug, M. S., Votto, J. J., Chao, D. C., Epstein, S. K., Doig, G. S., ... Petrak, R. A. (2007). Post-ICU mechanical ventilation at 23 long-term care hospitals: A multicenter outcomes study. *Chest*, 131, 85–93. doi:10.1378/chest.06-1081
- Schweickert, W. D., Pohlman, M. C., Pohlman, A. S., Nigos, C., Pawlik, A. J., Esbrook, C. L., ... Kress, J. P. (2009). Early physical and occupational therapy in mechanically ventilated, critically ill patients: A randomised controlled trial. *Lancet*, 373(9678), 1874–1882. doi:10.1016/s0140-6736(09)60658-9
- Schweickert, W. D., & Kress, J. P. (2011). Implementing early mobilization interventions in mechanically ventilated patients in the ICU. *Chest*, 140, 1612–1617. doi:10.1378/chest.10-2829
- Skinner, E. H., Berney, S., Warrillow, S., & Denehy, L. (2009). Development of a physical function outcome measure (PFIT) and a pilot exercise training protocol for use in intensive care. *Critical Care and Resuscitation*, 11, 110–115.
- Wilcox, M. E., Brummel, N. E., Archer, K., Ely, E. W., Jackson, J. C., & Hopkins, R. O. (2013). Cognitive dysfunction in ICU patients: Risk factors, predictors, and rehabilitation interventions. *Critical Care Medicine*, 41(Suppl. 9), S81–S98.
- Zanni, J. M., Korupolu, R., Fan, E., Pradhan, P., Janjua, K., Palmer, J. B., ... Needham, D. M. (2010). Rehabilitation therapy and outcomes in acute respiratory failure: An observational pilot project. *Journal of Critical Care*, 25, 254–262. doi:10.1016/j.jcrc.2009.10.010

**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.

Not applicable.

**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**

We were unable to identify literature that reported disparities data (race/ethnicity, gender, age, insurance status, socioeconomic status or disability status) related to functional assessment and care planning in LTCHs.

## 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).

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

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

Cardiovascular : Congestive Heart Failure, Neurology : Stroke/Transient Ischemic Attack (TIA), Respiratory : Chronic Obstructive Pulmonary Disease (COPD), Respiratory : Pneumonia

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

Care Coordination, 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 : Individuals with multiple chronic conditions

**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.)

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Quality-Measures-Users-Manual-V-20-June-2017-Final.pdf>

**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.

No

**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 numerator for this quality measure is the number of Long-Term Care Hospital (LTCH) patients with complete functional assessment data and at least one self-care or mobility goal.

For patients with a complete stay, all three of the following are required for the patient to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and (3) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or

could not be assessed, for each of the functional assessment items on the discharge assessment.

For patients who have an incomplete stay, discharge data are not required. It can be challenging to gather accurate discharge functional assessment data for patients who experience incomplete stays. The following are required for the patients who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's status or response, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the admission assessment; and (2) a valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

Patients who have incomplete stays are defined as those patients (1) with incomplete stays due to a medical emergency, including LTCH length of stay less than 3 days, (2) who leave the LTCH against medical advice, or (3) who die while in the LTCH. Discharge functional status data are not required for these patients because these data may be difficult to collect at the time of the medical emergency, if the patient dies or if the patient leaves against medical advice.

**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).*

For patients with a complete stay, each functional assessment item listed below must have a valid score or code at admission and discharge and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. Providers use the 6-point rating scale when coding discharge goals.

For patients with an incomplete stay, each functional assessment item listed below must have a valid score or code at admission and at least one of the self-care or mobility items must have a valid numeric code as a discharge goal. No discharge data are required for patients with incomplete stays.

The self-care functional assessment items are:

GG0130A. Eating  
GG0130B. Oral hygiene  
GG0130C. Toileting hygiene  
GG0130D. Wash upper body

Valid scores/codes for the self-care functional assessment items are:

06 - Independent  
05 - Setup or clean-up assistance  
04 - Supervision or touching assistance  
03 - Partial/moderate assistance  
02 - Substantial/maximal assistance  
01 - Dependent  
07 - Patient refused  
09 - Not applicable  
88 - Not attempted due to medical condition or safety concerns

The mobility functional assessment items are:

GG0170A. Roll left and right  
GG0170B. Sit to lying  
GG0170C. Lying to sitting on side of bed  
GG0170D. Sit to stand  
GG0170E. Chair/bed-to-chair transfer  
GG0170F. Toilet transfer  
For patients who are walking:  
GG0170I. Walk 10 feet

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

GG0170J. Walk 50 feet with two turns

GG0170K. Walk 150 feet

For patients who use a wheelchair, complete the following items:

GG0170R. Wheel 50 feet with two turns

GG0170RR1. Indicate the type of wheelchair/scooter used

GG0170S. Wheel 150 feet

GG0170SS1. Indicate the type of wheelchair/scooter used

Valid scores/codes for the mobility functional assessment items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance

01 - Dependent

07 - Patient refused

09 - Not applicable

88 - Not attempted due to medical condition or safety concerns

Valid scores/codes for the self-care and mobility discharge goal items are:

06 - Independent

05 - Setup or clean-up assistance

04 - Supervision or touching assistance

03 - Partial/moderate assistance

02 - Substantial/maximal assistance

01 – Dependent

Cognitive Function

C1610A-E2. Signs and Symptoms of Delirium (CAM © [Confusion Assessment Method]):

C1610A. and C1610B. Acute Onset and Fluctuating Course

C1610C. Inattention

C1610D. Disorganized Thinking

C1610E1 and C160E2. Altered Level of Consciousness

Valid codes for C1610-Signs and Symptoms of Delirium are:

1 - Yes

0 - No

Communication: Understanding and Expression

BB0700. Expression of Ideas and Wants

Valid codes are:

4 - Expresses without difficulty

3 - Expresses with some difficulty

2 - Frequently exhibits difficulty with expressing needs and ideas

1 - Rarely/Never expresses self or speech is very difficult to understand

BB0800. Understanding Verbal Content:

Valid codes are:

4 - Understands

3 - Usually understands

2 - Sometimes understands

1 - Rarely/Never understands

Bladder Continence



#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

**H0350. Bladder Continence**

Valid codes are:

- 0 - Always continent
- 1 - Stress incontinence only
- 2 - Incontinent less than daily
- 3 - Incontinent daily
- 4 - Always incontinent
- 5 - No urine output
- 9 - Not applicable

For patients with incomplete stays, admission data and at least one goal are required for the patient to be counted in the numerator. No discharge data are required. Patients with incomplete stays are identified based on the following data elements:

1) Patients with incomplete stays due to a medical emergency. These patients are excluded if:

- a) Item A0250. Reason for Assessment is coded 11 = Unplanned discharge OR
- b) The length of stay is less than 3 days based on item A0220. Admission Date and A0270: Discharge Date OR
- c) Item A2110. Discharge Location is coded 04 = Hospital emergency department OR 05 = Short-stay acute care hospital OR 06 = Long-term care hospital OR 08 = Psychiatric hospital or unit.

2) Patients who leave the LTCH against medical advice. These patients are identified based on the reason for the assessment:

- a) Item A0250. Reason for Assessment is coded as 11 = Unplanned discharge OR
- b) Item A2110. Discharge Location is coded 12 = Discharged Against Medical Advice.

3) No discharge functional status data are required if a patient dies while in the LTCH.

These patients are identified based on the reason for the assessment:

- a) Item A0250. Reason for Assessment is coded 12 = Expired.

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

The denominator is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.

**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 LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period, including patients of all ages and patients with all payer sources. Patients are selected based on submitted LTCH CARE Data Set Admission and Discharge forms.

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

There are no denominator exclusions for this measure.

**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.)

There are no denominator exclusions for this measure.

**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.)

This measure does not use stratification.

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification



#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

<p>If other:</p>
<p><b>S.12. Type of score:</b>  Rate/proportion  If other:</p> <p><b>S.13. Interpretation of Score</b> (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</p> <p><b>S.14. Calculation Algorithm/Measure Logic</b> (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.)  1) For each LTCH, the stay records of patients discharged during the 12 month target time period are identified and counted. This count is the denominator.  2) The records of patients with complete stays are identified and the number of these patient stays with complete admission functional assessment data AND at least one self-care or mobility discharge goal AND complete discharge functional assessment data is counted.  3) The records of patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data AND at least one self-care or mobility discharge goal is counted.  4) The counts from step 2 (complete LTCH stays) and step 3 (incomplete LTCH stays) are summed. The sum is the numerator count.  5) The numerator count is divided by the denominator count to calculate this quality measure.</p> <p>For the numerator, complete data are defined as:  1. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the admission assessment; and  2. a valid numeric score for one or more of the self-care or mobility items that is a discharge goal;  3. a valid numeric score indicating the patient's status, or a valid code indicating the activity did not occur or could not be assessed, for each of the functional assessment items on the discharge assessment. (Note: Discharge data are not required for patients with incomplete LTCH stays.)</p> <p>Denominator: The denominator for this quality measure is the number of LTCH patients discharged during the targeted 12 month (i.e., 4 quarters) time period.</p>
<p><b>S.15. Sampling</b> (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.  This measure does not use sampling.</p> <p><b>S.16. Survey/Patient-reported data</b> (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.  This measure is not based on a survey.</p>
<p><b>S.17. Data Source</b> (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).  If other, please describe in S.18.  Other</p> <p><b>S.18. Data Source or Collection Instrument</b> (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.  The Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 3.00 (LTCH CARE Data Set v3.00)</p> <p><b>S.19. Data Source or Collection Instrument</b> (available at measure-specific Web page URL identified in S.1 OR in attached appendix at</p>

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

A.1)  
[No data collection instrument provided](#)

**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)  
[Post-Acute Care](#)  
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**  
[NQF\\_Testing\\_LTCH\\_Process\\_QM\\_Final.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**.

ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

**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).

**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.

Many Long-Term Care Hospitals (LTCHs) collect functional assessment data, but the assessment items and instruments are not standardized across LTCHs. As part of the Post-Acute Care Payment Reform Demonstration, clinicians collected functional assessment data in LTCHs and we noted some functional assessment items, such as stair climbing and walking on uneven surfaces, were often not attempted due to medical or safety concerns among LTCH patients. We have not included items in this quality measure that had a high proportion of LTCH patient records with codes indicating the activity was not attempted during the Post-Acute Care Payment Reform Demonstration.

The functional assessment items included in this quality measure will be included in a future version of the LTCH CARE Data Set (Version 3.00). The LTCH CARE Data Set has been the assessment data set used in LTCHs since 2012, when the LTCH Quality Reporting Program was implemented, as required by the Patient Protection and Affordable Care Act.

**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).

Not applicable.

## **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

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

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

This quality measure is not currently used in an accountability application.

**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?)**

This quality measure is not currently reported or used in an accountability application because development has only recently been completed and the measure is being submitted to the National Quality Forum for initial endorsement.

**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.)**

Data collection for this quality measure begins on April 1, 2016 as part of the Long-Term Care Hospital Quality Reporting Program. LTCHs that do not collect and submit data for this measure by the submission deadline may be subject to a 2 percentage point reduction in the annual payment update for fiscal year 2018 and subsequent years. Proposed plans for the public reporting of this quality measure will be included in future rulemaking published in the Federal Register.

A recently enacted law requires the establishment of functional status quality measures in LTCHs. More specifically, the Improving Medicare Post-Acute Care Transformation Act of 2014 (Public Law No: 113-185) directs the Secretary of Health and Human Services to:

- 1) require post-acute care providers, including LTCHs, to report standardized patient assessment data, including functional status, such as mobility and self-care
- 2) establish quality measures, including measures relating to functional status and changes in function in post-acute care settings, including LTCHs.
- 3) arrange for public reporting of post-acute care provider (including LTCH) performance on quality, resource use, and other measures.

**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.

N/A

**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.**

N/A

**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.**

N/A

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

N/A

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

N/A

**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.**

N/A

**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.

This quality measure is not currently used in a quality improvement program, but a goal of this measure is to provide LTCHs with information that may be used for quality improvement. This quality measure was developed with significant and ongoing input by several technical expert panels convened by the measure developer contractor. Expert panel members provided input on functional status items, quality metrics, including the performance score, the target population, and exclusion criteria.

**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.**

We did not identify any negative unintended consequences to individuals or populations during testing.

**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)**

0167 : Improvement in Ambulation/locomotion

0174 : Improvement in bathing

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

0175 : Improvement in bed transferring  
 0183 : Low-risk residents who frequently lose control of their bowel or bladder  
 0184 : Residents who have a catheter in the bladder at any time during the 14-day assessment period. (risk adjusted)  
 0185 : Recently hospitalized residents with symptoms of delirium (risk-adjusted)  
 0422 : Functional status change for patients with Knee impairments  
 0423 : Functional status change for patients with Hip impairments  
 0425 : Functional Status Change for Patients with Low Back Impairments  
 0426 : Functional status change for patients with Shoulder impairments  
 0427 : Functional status change for patients with elbow, wrist and hand impairments  
 0428 : Functional status change for patients with General orthopaedic impairments  
 0429 : Change in Basic Mobility as Measured by the AM-PAC:  
 0430 : Change in Daily Activity Function as Measured by the AM-PAC:  
 0685 : Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)  
 0686 : Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)

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

- 1) Osteoarthritis: Function and Pain Assessment (No longer NQF Endorsed) - American Medical Association - Physician Consortium for Performance Improvement
- 2) Functional Communication Measure: Spoken Language Comprehension (no longer NQF endorsed # 0445) - American Speech Hearing Association
- 3) Functional Communication Measure: Spoken Language Expression (no longer NQF endorsed #0444) - American Speech Hearing Association
- 4) Functional Communication Measure: Memory (no longer NQF endorsed #0448) - American Speech Hearing Association

**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.**

The quality measures listed above focus on functional activities and impairments but do not apply to the same patient population (patients who are chronically critically ill)

**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.)**

There are no competing measures that are NQF endorsed.

## 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

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

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:**

### Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Helen, Dollar-Maples, [Helen.Dollar-Maples@cms.hhs.gov](mailto:Helen.Dollar-Maples@cms.hhs.gov), 410-786-7214-

**Co.3 Measure Developer if different from Measure Steward:** RTI International

**Co.4 Point of Contact:** Anne, Deutsch, [adeutsch@rti.org](mailto:adeutsch@rti.org)

### 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.**

This quality measure was developed with significant and ongoing input by several technical expert panels. Expert panel members provided input on the functional assessment items, the performance score, the target population, and exclusion criteria. Some expert panel meetings focused on measuring functional status across post-acute care settings, and other meetings focused on functional assessment and functional outcomes for LTCH patients.

The first expert panel meeting, held as part of a project titled Analysis of Crosscutting Medicare Quality Metrics Using the Uniform Assessment Tool Developed and Tested as Part of the CMS Post-Acute Care Payment Reform Demonstration, was funded by the Assistant Secretary for Planning and Evaluation. The expert panel meeting was held on August 15, 2012, in Washington, DC, with the following expert panel members:

James Farrell, Chief Nursing Officer, HealthSouth

David Gifford, MD, MPH, Senior Vice President for Quality & Regulatory Affairs at American Health Care Association

Eileen Bach, PT, MEd, DPT, Compliance Specialist, Director Quality and Patient Safety at Visiting Nurse Service of New York

Linda Resnik, PhD, PT, Associate Professor of Health Services, Policy and Practice at Brown University

Trudy Mallinson, PhD, OT, Assistant Professor at University of Southern California, Department of Occupational Science and Occupational Therapy

Margaret Stineman, MD, Professor of Physical Medicine and Rehabilitation, Vice Chair & Director, Research, Department of Physical Medicine & Rehabilitation at University of Pennsylvania

Margaret Rogers, PhD, Chief Staff Officer for Science & Research at American Speech-Language-Hearing Association

Pam Roberts, PhD, OTR/L, CPHQ, FAOTA, Manager at Cedars-Sinai Medical Center

Bruce Gans, MD, Executive Vice President and Chief Medical Officer at Kessler Institute

William Pesce, DO, Chief of Physical Medicine & Rehabilitation at Hospital for Special Care

Roger Herr, PT, MPA, COS-C, Vice President Quality Management at Independence Care System

A second expert panel meeting was held on April 15, 2013, as part of a project entitled Symptom Management Measure Development. The following LTCH experts were included on this panel:

Alfred Chiplin, JD, Senior Policy Attorney at Center for Medicare Advocacy

Dexanne Clohan, MD, Senior Vice President and Chief Medical Officer at HealthSouth

Margaret Crane, RN, CEO at Barlow Respiratory Hospital

Jean M de Leon, MD, Medical Director Wound Care at Baylor Specialty Hospital

Thomas Durkin, MHA, CRRN, RN, Executive Vice President at Vibra Healthcare

Maura A. Hopkins, RN, MSN, NEA-BC, Vice President, Patient Care Services/Chief Nursing Officer at RML Specialty Hospital

Gary Kempf, RN, Chief Clinical Executive at Christus Dubuis Health System

Dana Mukamel, PhD, Professor in the Department of Medicine at the Health Policy Research Institute at the University of California, Irvine

Sean Muldoon, MD, MPH, Chief Medical Officer at Kindred Healthcare

Terrence O'Malley, MD, Medical Director, Non-Acute Care Services for Partners Healthcare

Lisa Snyder, MD, MPH, Chief Quality Officer at Select Medical Corporation

Sharon Sprenger, MPA, RHIA, CPHQ, Senior Advisor, Measurement Outreach, Division of Healthcare Quality Evaluation at The Joint Commission



#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

Patricia M. Stimac, MS, RD, LDN, NHA, Director of Quality Management, Nursing Home Administrator Director of Nutrition at Spartanburg Hospital for Restorative Care

John J. Votto, DO, President and CEO at Hospital for Special Care

A third expert panel meeting was held in Baltimore, MD, on September 9, 2013, as part of a project titled Symptom Management Measure Development. The following experts served on this panel:

Lawrence Miller, MD, Clinical Professor of Medicine at the University of California, Los Angeles

Richard Black, MD, Corporate Rehabilitation Consultant at HCR Manor Care

Mary Van de Kamp, MS, CCC-SLP, Senior Vice President of Quality and Care Management at Kindred

Timothy Reistetter, PhD, OTR, Associate Professor at University of Texas Medical Branch

Ellen Strunk, PT, MS, GCS, Consultant at Rehab Resources & Consulting, Inc.

Saad Naaman, MD, MS, Clinician at Physiatry (Physical Medicine & Rehabilitation) Practice

Linda Ladesich, MD, Medical Director Sunflower State Health

Paulette Niewczyk, MPH, PhD, Director of Research at the Uniform Data System for Medical Rehabilitation

Camille Haycock, RN, MS, Vice President, Care Continuum at Catholic Health Initiatives

Elizabeth Newman, OTD, OT/L, Director of Occupational Therapy, Rehabilitation Engineering, and Clinical, Informatics at Medstar National Rehabilitation Hospital

Karon Cook, PhD, Research Associate Professor at Northwestern University

Richard Riggs, MD, Chairman and Medical Director for Cedars-Sinai Medical Center

Michelle Camicia, MSN, RN, Director of Operations at Kaiser Foundation Rehabilitation Center

Jill Bolte Taylor, PhD, Author, My Stroke of Insight. This quality measure was developed with significant and ongoing input by several Technical Expert Panels (TEPs). Expert panel members provided input on status quality metrics, including the performance score, the target population, exclusion criteria and case-mix adjustment factors and methodology.

The first expert panel meeting was held as part of a project entitled Analysis of Crosscutting Medicare Quality Metrics Using the Uniform Assessment Tool Developed and Tested as Part of the CMS Post-Acute Care Payment Reform Demonstration, and was funded by the Assistant Secretary for Planning and Evaluation. The expert panel meeting was held on August 15, 2012 in Washington, DC, and the expert panel members were:

James Farrell, CNO, Clinical Consultant at Medware Information Systems

David Gifford, MD, MPH Senior VP for Quality & Regulatory Affairs at American Health Care Association

Eileen Bach, PT, M.Ed., DPT, Compliance Specialist, Director Quality and Patient Safety at Visiting Nurse Service of New York

Linda Resnik, PhD, PT, Associate Professor of Health Services, Policy and Practice at Brown University

Trudy Mallinson, PhD, OT, Assistant Professor at University of Southern California, Department of Occupational Science and Occupational Therapy

Margaret Stineman, MD, Professor of Physical Medicine and Rehabilitation, Vice Chair & Director, Research, Department of Physical Medicine & Rehabilitation at University of Pennsylvania

Margaret Rogers, PhD, Chief Staff Officer for Science & Research at American Speech-Language-Hearing Association

Pam Roberts, PhD, OTR/L, CPHQ, FAOTA Manager at Cedars-Sinai Medical Center

Bruce Gans, MD Executive Vice President and Chief Medical Officer at Kessler Institute

William Pesce, DO, Chief of Physical Medicine & Rehabilitation at Hospital for Special Care

Roger Herr, PT, MPA, COS-C, Vice President Quality Management at Independence Care System

A second expert panel meeting was held on April 15, 2013 as part of a project entitled Symptom Management Measure Development. The LTCH experts included on this panel included:

Alfred Chiplin, JD, Senior Policy Attorney at Center for Medicare Advocacy

Dexanne Clohan, MD, Senior Vice President and Chief Medical Officer at HealthSouth

Margaret Crane, RN, CEO at Barlow Respiratory Hospital

Jean M de Leon, MD, Medical Director Wound Care at Baylor Specialty Hospital

Thomas Durkin, MHA, CRRN, RN Executive Vice President at Vibra Healthcare

Maura A. Hopkins, RN, MSN, NEA-BC, Vice President, Patient Care Services / Chief Nursing Officer at RML Specialty Hospital

Gary Kempf, RN Chief Clinical Executive at Christus Dubuis Health System

Dana Mukamel, PhD, Professor in the Department of Medicine at the Health Policy Research Institute at the University of California, Irvine

Sean Muldoon, MD, MPH, Chief Medical Officer at Kindred Healthcare

#2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, Last Updated: Mar 30, 2020

Terrence O'Malley, MD Medical Director, Non-Acute Care Services for Partners Healthcare  
 Lisa Snyder, MD, MPH Chief Quality Officer at Select Medical Corporation  
 Sharon Sprenger, MPA, RHIA, CPHQ, Senior Advisor, Measurement Outreach, Division of Healthcare Quality Evaluation at The Joint Commission  
 Patricia M. Stimac, MS, RD, LDN, NHA, Director of Quality Management, Nursing Home Administrator Director of Nutrition at Spartanburg Hospital for Restorative Care  
 John J. Votto, D.O. , President and CEO at Hospital for Special Care

A third expert panel meeting was held in Baltimore, MD on September 9, 2013 as part of a project entitled Symptom Management Measures. Experts on this panel included:

Lawrence Miller, MD, Clinical Professor of Medicine at UCLA  
 Richard Black, MD, Corporate Rehabilitation Consultant at HCR Manor Care  
 Mary Van de Kamp, MS, CCC-SLP, Senior Vice President of Quality and Care Management at Kindred  
 Timothy Reistetter, PhD, OTR, Associate Professor at University of Texas Medical Branch  
 Ellen Strunk, PT, MS, GCS, Consultant at Rehab Resources & Consulting, Inc.  
 Saad Naaman, MD, MS, Clinician at Physiatry (Physical Medicine & Rehabilitation) Practice  
 Linda Ladesich, MD, Medical Director Sunflower State Health  
 Paulette Niewczyk, MPH, PhD, Director of Research at UDSMR  
 Camille Haycock, RN, MS, Vice President, Care Continuum at Catholic Health Initiatives  
 Elizabeth Newman, OTD, OT/L, Director of Occupational Therapy, Rehabilitation Engineering and Clinical, Informatics at Medstar National Rehabilitation Hospital  
 Karon Cook, PhD, Research Associate Professor at Northwestern University  
 Richard Riggs, MD, Chairman and Medical Director for Cedars-Sinai Medical Center  
 Michelle Camicia, MSN, RN, Director of Operations at Kaiser Foundation Rehabilitation Center  
 Jill Bolte Taylor, PhD, Author: My Stroke of Insight, Inc

**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:** 10, 2014

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

**Ad.5 When is the next scheduled review/update for this measure?**

**Ad.6 Copyright statement:** Not applicable.

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**