



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 #: 3001

Corresponding Measures:

De.2. Measure Title: PACE Participant Fall Rate

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

De.3. Brief Description of Measure: The quarterly incidence rate of falls amongst PACE participants per 1,000 participant days.

1b.1. Developer Rationale: Fall Rates have been found to be an important safety concern in acute care and long-term care settings. There is evidence that falls are one of the most common adverse patient events in hospitals, and they are a source of significant injury, disability, and/or death. Nearly one-third of community-dwelling individuals over age 65 fall each year (Currie, 2008). In 2013, this accounted for nearly 2.5 million injury falls—with nearly two-thirds of this number experienced by females (CDC, 2013). Several national health care organizations—including the National Quality Strategy, the Partnership for Patients, and the CMS Hospital-Acquired Condition (HAC) Reduction Program—have identified patient falls as a patient safety concern.

Every fall carries a risk of injury. Clinicians can reduce injuries in part by reducing the risk of falling. Focusing prevention efforts solely on falls with injury is a faulty approach for improving patient safety. To some extent, falls with injury are a function of patient frailty; by contrast, the total fall rate is not influenced by differences among patients' susceptibility to injury.

Many if not most falls may result in no injury or only minor injury. Nevertheless, any fall may result in emotional distress and increased risk of falling in the future. Preventing falls among the frail elderly contributes to the maintenance of the participant's functional status and place in the community and the prevention of costs of treatment associated with falls. It is important to monitor all falls, not just falls with injury.

Citations:

CDC. (2013, December). WISQARS. Retrieved December 1, 2014 from Leading Causes of Nonfatal Injury Reports, 2001–2013: <http://www.cdc.gov/injury/wisqars/nonfatal.html>.

Currie, L. (2008). Fall and Injury Prevention. In R. Hughes (Ed.). Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville, MD: AHRQ. Retrieved November 18, 2014 from <http://www.ncbi.nlm.nih.gov/books/NBK2653/>.

S.4. Numerator Statement: Falls experienced by Participants in the PACE program during the month.

S.6. Denominator Statement: The denominator represents exposure of PACE participants to the risk of falling.

S.8. Denominator Exclusions: Exclude persons who were not enrolled as PACE participants, or who were not in their home location.

De.1. Measure Type: Outcome

S.17. Data Source: Management Data, Other, Paper Medical Records

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Jan 26, 2017 **Most Recent Endorsement Date:** Jan 26, 2017

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 paired or grouped.

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

[Falls_Evidence_NQF.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.

Fall Rates have been found to be an important safety concern in acute care and long-term care settings. There is evidence that falls are one of the most common adverse patient events in hospitals, and they are a source of significant injury, disability, and/or death. Nearly one-third of community-dwelling individuals over age 65 fall each year (Currie, 2008). In 2013, this accounted for nearly 2.5 million injury falls—with nearly two-thirds of this number experienced by females (CDC, 2013). Several national health care organizations—including the National Quality Strategy, the Partnership for Patients, and the CMS Hospital-Acquired Condition (HAC) Reduction Program—have identified patient falls as a patient safety concern.

Every fall carries a risk of injury. Clinicians can reduce injuries in part by reducing the risk of falling. Focusing prevention efforts solely on falls with injury is a faulty approach for improving patient safety. To some extent, falls with injury are a function of patient frailty; by contrast, the total fall rate is not influenced by differences among patients' susceptibility to injury.

Many if not most falls may result in no injury or only minor injury. Nevertheless, any fall may result in emotional distress and increased risk of falling in the future. Preventing falls among the frail elderly contributes to the maintenance of the participant's functional status and place in the community and the prevention of costs of treatment associated with falls. It is important to monitor all falls, not just falls with injury.

Citations:

CDC. (2013, December). WISQARS. Retrieved December 1, 2014 from Leading Causes of Nonfatal Injury Reports, 2001–2013: <http://www.cdc.gov/injury/wisqars/nonfatal.html>.

Currie, L. (2008). Fall and Injury Prevention. In R. Hughes (Ed.). Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville, MD: AHRQ. Retrieved November 18, 2014 from <http://www.ncbi.nlm.nih.gov/books/NBK2653/>.

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.*

A sample of 50 sites was randomly selected out of a total of 114 PACE sites. Additionally, the oldest and two newest PACE sites were included in the sample. A total of 34 of these sites submitted data from January - March 2015 for the Fall Rate. There was one (1) large outlier with 24.79 falls per 1,000 participant days. This site has an unusually low number of participant days (121) because it had only one (1) participant in January and February 2015 and two (2) participants in March 2015. This site was excluded from the analysis and site-level descriptive statistics for total participant days and total fall rates. The table below shows the descriptive

statistics requested for total participant days and total falls.

Mean, Std. Dev., Median, Min, Max

Total participant days in January-March 2015 (n=33)

15,719 13,846 13,097 2,728, 77,419

Total participant falls per 1,000 participant day (n=33)

4.27 1.53 4.44 1.88, 8.59

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.

Most of the published evidence available is primarily from hospital-based studies. Those data do show considerable variation in patient fall rates.

- Bouldin et al. (2013) examined fall rates on medical, surgical, and medical-surgical units. Fall rates were highest on medical units (4.03 falls per 1,000 patient days (PD)) and lowest on surgical units (2.56 falls per 1,000 PD).
- He et al. (2012) identified trends in fall rates by hospital unit type. The analysis showed that fall rates remained stable or declined for most unit types between 2004 and 2009. Rates for surgical units, however, increased over time, from 2.74 falls/1,000 PD to 3.19/1,000 PD in 2008, decreasing to 2.89/1,000 PD in 2009.
- Lake et al. (2010) found that fall rates were 5 percent lower in hospitals that had achieved American Nurses Credentialing Center Magnet status than in non-Magnet hospitals.

Citations:

Bouldin, E. L., Andresen, E. M., Dunton, N. E., Simon, M., Waters, T. M., Liu, M., ... Shorr, R. I. (2013). Falls among adult patients hospitalized in the United States: Prevalence and trends. *Journal of Patient Safety*, 9(1), 13–17.

He, J., Dunton, N., & Staggs, V. (2012). Unit-level time trends in inpatient fall rates of US hospitals. *Medical Care*, 50, 801–807.

Lake, E. T., Shang, J., Klaus, S., & Dunton, N. E. (2010). Patient falls: Association with hospital Magnet status and nursing unit staffing. *Research in Nursing & Health*, 33(5), 413–425.

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.

PACE participants are frail elderly in each site, thus they may be considered a single population. We did examine fall rates based on two demographic variables—age and gender—so that the potential for sociodemographic adjustment can be assessed.

- Age is defined as the participant age at the end of the reporting month. It is to be recorded in single years from 55 through 89. To comply with Health Insurance Portability and Accountability Act (HIPAA requirements), all participants aged 90 and above will be top coded at 90.
- Gender is to be classified as male or female.

We examined correlations among total fall rates and PACE site characteristics. Pearson product-moment correlation coefficient, or “r”, was used. Pearson’s r is a measure of the strength and direction of the linear relationship between two variables. To interpret the correlations between variables, we used the following parameters: r = 0.80 or higher is a very strong relationship; r = 0.60-0.79 is a strong relationship; r = 0.40-0.59 is a moderate relationship; r = 0.20-0.39 is a weak relationship; and r < 0.19 is a very weak relationship. (Evans, 1996).

Data from the feasibility study showed that the average age of PACE participants who had a fall was 77.54 with a standard deviation of 10.20 indicating that total falls are fairly tightly distributed across age for PACE participants. Almost 70% of those who had a fall were female, reflecting the gender distribution of this population. Both PACE-site mean participant age and mean proportion of males had very weak correlations with total fall rates (r = 0.08 and r = -0.14, respectively).

Citation:

Evans, J.D. (1996). *Straightforward statistics for the behavioral sciences*. Pacific Grove, CA: Brooks/Cole Publishing.

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

Several studies have demonstrated a difference in falls rates for specific populations. Disparities have been identified according to age (Fhon et al, 2013; CDC, 2006), gender (Steven & Sogolow, 2005; CDC, 2006), disability (Lavedan, 2014; Ranaweera et al, 2013; Lee & Stokic, 2008), and race/ethnicity (CDC, 2006). Hospitalization for hip fractures due to falls is significantly higher for females than for males. However, fatality rates due to falls are higher for men than for women, and higher for Caucasians compared to African-Americans (CDC, 2006). Among community-dwelling older women, age-adjusted fall rates are not different between African-Americans and Caucasians. However, the authors did find racial differences for location of falls and biomechanics of falls (falling forward vs. laterally), which may explain differing fall-related fracture risk between Caucasian and African-American women (Faulkner et al., 2005).

Citations:

Centers for Disease Control (CDC; 2006). Fatalities and injuries from fall among older adults – United States, 1993-2003 and 2001-2005. Morbidity and Mortality Weekly Report, 55(45), 1221-1224.

Faulkner, K. A., Cauley, J. A., Zmuda, J. M., Landsittel, D. P., Nevitt, M. C., Newman, A. B., ... Redfern, M. S. (2005). Ethnic differences in the frequency and circumstances of falling in older community-dwelling women. *Journal of the American Geriatrics Society*, 53(10), 1774–1779. <http://doi.org/10.1111/j.1532-5415.2005.53514.x>

Fhon, J. R., Rosset, I., Freitas, C. P., Silva, A. O., Santos, J. L., & Rodrigues, R. A. (2013). Prevalence of falls among frail elderly adults. *Rev Saude Publica*, 47(2), 266-273. doi: 10.1590/s0034-8910.2013047003468.

Lavedan Santamaria, A., Jurschik Gimenez, P., Botigue Satorra, T., Nuin Orrio, C., & Viladrosa Montoy, M. (2014). [Prevalence and associated factors of falls in community-dwelling elderly.]. *Aten Primaria*. doi: 10.1016/j.aprim.2014.07.012.

Lee, J. E., & Stokic, D. S. (2008). Risk factors for falls during inpatient rehabilitation. *Am J Phys Med Rehabil*, 87(5), 341-350; quiz 351, 422. doi: 10.1097/PHM.0b013e31816ddc01.

Ranaweera, A. D., Fonseka, P., PattiyaArachchi, A., & Siribaddana, S. H. (2013). Incidence and risk factors of falls among the elderly in the District of Colombo. *Ceylon Med J*, 58(3), 100-106. doi: 10.4038/cmj.v58i3.5080.

Stevens, J. A., Sogolow, E. D. (2005). Gender differences for non-fatal unintentional fall related injuries among older adults. *Injury Prevention: Journal of the International Society for Child and Adolescent Injury Prevention*. 11, 115–119. doi: 10.1136/ip.2004.005835.

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):

Safety

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, 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.)

[None at this time.](#)

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)

[Attachment Attachment: Falls_Data_Collection_Code_Sheet-636558696855402397-637267064754360395.xlsx](#)

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.

[No, this is not an instrument-based measure 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.

[Not an instrument-based measure](#)

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).

[Falls experienced by Participants in the PACE program during the month.](#)

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).

[A PACE participant fall is a sudden, unanticipated descent in which a participant comes to rest on the floor or some other surface, person, or object.](#)

Inclusion Criteria:

- [All PACE participant falls occurring in the participants home; in assisted living facilities, if that is their usual place of residence; in the PACE center, or in the care of a PACE transportation operator.](#)
- [Participants who are assisted to the floor by a care provider \(assisted fall\) are to be included in the count of falls.](#)

Exclusion Criteria:

- [Participants who fall \(or sink\) back to a bed, chair, car seat, walker seat, or toilet are excluded in the count of falls.](#)
- [Exclude falls in the participant home by staff, visitors, family members, or others who were not PACE participants](#)
- [Exclude participants who were not in their home location. For example, exclude participants who were in an emergency room, hospitalized, in a long term care facility, in a hospice facility, in skilled nursing care, in a rehabilitation setting.](#)

Specific data collection items and responses:

- Fall Auto No.
- Month of Fall
 - January = 1
 - February = 2
 - Etc.
- Age (at end of month):
 - Age in years if 55–89
 - Age greater >89 = 90+
 - Unknown = 99
- Gender:
 - Male = 1
 - Female = 2
 - Unknown = 99

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

The denominator represents exposure of PACE participants to the risk of falling.

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).

Total number of PACE participant days during the calendar month. This is calculated as the sum of the PACE site participant census for each day in the month, aggregated quarterly.

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

Exclude persons who were not enrolled as PACE participants, or who were not in their home location.

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.)

- Exclude persons who were not enrolled as PACE participants on the specific day of the month.
- Exclude participants who were not in their home location. For example, exclude participants who were hospitalized, in a long term care facility, in a hospice facility, in skilled nursing care, in a rehabilitation setting.
- Exclude participants who were deceased for each day after the date of death.

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.)

Stratification will be based on characteristics of PACE programs, including caseload size, location, region of the country and academic affiliation, and years of operation.

- Caseload size varies significantly across PACE sites. Categories of caseload size will be determined after we gather information on the size of each program and size of fluctuations over the course of a year. With just over 100 PACE programs, we anticipate having no more than 3 categories so that there is a sufficient sample size to produce reliable rates in each group.

Per the U.S. Office of Management and Budget definition:

- Location
 - Metropolitan is a county or group of contiguous counties, of which one or more has a core urban area with a population of 50,000 or more. The counties are linked by social and economic integration.
 - Micropolitan is a county or group of contiguous counties, of which one or more has an urban area with at least 10,000 persons but less than 50,000 population.
 - Non-Metropolitan is a county that is not associated with a Metropolitan or Micropolitan group of counties.

- Academic affiliation will have two categories: Yes and No. Yes indicates a site that is operated by the primary clinical site for a School of Medicine. No indicates that a site is operated by another organization.
- Years of operation for PACE programs vary widely; one program has been in operation for only a few months, while another has been in operation for more than 17 years. Years of Operation is indicated in whole years and months in a partial year. At most, three categories of “Years of Operation” will be identified in order to maintain a sufficient sample in each category to support reliable reporting.

Risk Adjustment Type:

Risk stratification will be used rather than risk adjustment. Stratification will be based on PACE site characteristics. Because PACE participants are frail elderly in each site, they may be considered a single population, not requiring risk adjustment to account for different populations across PACE sites.

Two demographic variables—age and gender—will be collected so that the potential for sociodemographic adjustment can be assessed.

- Age is defined as the participant age at the end of the reporting month. It is to be recorded in single years from 55 through 89. To comply with HIPAA requirements, all participants aged 90 and above will be top coded at 90.
- Gender is to be classified as male or female.

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

Stratification by risk category/subgroup

If other:

S.12. Type of score:

Ratio

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 = Lower 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 Fall Rate is calculated as the number of falls to PACE participants per 1,000 participant days during a calendar quarter. Data are collected monthly. The calculation steps are as follows:

1. Sum the number of falls for each of the 3 months in the quarter.
2. Multiply the numerator by 1,000. This step merely facilitates interpretation of results because it reduces leading zeros in the rate.
3. List the number of PACE site participants in the census for each day in the months included in the quarter.
4. Sum the number of participants across each day.
5. Sum the number of participant days in each month.
6. Rate calculation: (Number of falls x 1,000) / (Total number of participant days).

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.

No sampling is involved in data gathering for the Fall Rate.

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.

Management Data, Other, Paper Medical Records

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.

The data collection instrument is uploaded to this application as an appendix (A.1). Data are to be collected from participant clinical records, both paper and electronic. The data sources are participant clinical records from clinicians affiliated with the PACE program, including registered nurses (RNs), physical therapists (PTs), occupational therapists (OTs), physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAs). If the PACE participant was in an institutional setting during the reporting period, include falls documented in the clinical records from the institution, whether a hospital, emergency room, nursing home, skilled nursing facility, rehabilitation, or some other institutional setting. Data collectors should extract fall information from clinical records in those organizations as well.

Participant Days data are to be collected from participant census data. Data collectors should record the number of PACE participants on each day in the quarter and note this information in the form presented in Table 2. Partial days count as 1 day for the purpose of this measure.

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*)

Other

If other: PACE programs provide services to participants who live in their own homes (or in home-like settings) in the community. Participants attend PACE centers regularly (e.g., 3 days per week) for a variety of activities and support services. If a participant i

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

Falls_Testing_NQF-635987552473066799.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), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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).

Some PACE Organizations do not use electronic medical records. All organizations will abstract data manually for this measure from either their electronic or paper charts.

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.

After collecting data from PACE sites for feasibility and reliability testing, we conducted a post-data collection survey to ask PACE sites about data that they did not have available, data collection burden, and other issues. Overall, the data collection time was reasonable at 3-4 hours. While the sites reported a fairly high data collection burden, this was balanced by the fact that over half of the sites stated that the data were very easy to obtain. Further, all of the sites stated that fall rates are useful for quality improvement and 64% were supportive of national PACE comparison data. Thus, although there is a perceived data collection burden, this is outweighed by the usefulness of the data and comparative benchmarks. Because of the high reported ease of obtaining the data, we anticipate that the perceived data collection burden will decrease as sites become more familiar with the data collection and submission process.

- Sites said that it took between 3 and 4 hours to collect the fall rate data and another hour to submit the data on-line.
- 73% of PACE sites reported that they considered the data collection burden to be medium or high burden.

- 69% of the sites reported that they collected falls data from electronic health records, although the large majority said they did manual extraction from electronic records.
- 54% of the sites said that it was very easy to obtain the data.
- 100% of responding sites said that the fall rates would be useful for quality improvement.
- 64% said that they strongly agreed with the statement that national comparison data would be helpful for quality improvement.

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).

None.

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	
Not in use	

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 currently in use.

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 is a new measure. CMS is evaluating its use in upcoming PACE quality programs.

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.)

CMS is considering the use of the PACE Participant Fall Rate in accountability applications within the next two years.

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.

The measure has not been implemented, so no results or data have been provided.

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.

The measure has not been implemented, so no results or data have been provided

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.

Not applicable.

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

Not applicable.

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

Not applicable.

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.

Not applicable.

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.

Improvement data will be obtained once the measure has been implemented and tracked over time.

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.

No negative unintended consequences have been identified.

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)

0141 : Patient Fall Rate

0266 : Patient Fall

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

Not applicable.

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 numerator for the fall measure being developed for the PACE program is closely aligned with NQF-endorsed measures 0141. They use the same definition of falls, however, the proposed measure uses a different denominator that reflects fall exposure in PACE programs as opposed to hospitals. NQF-endorsed measure 0266 is limited to ambulatory surgical centers (ASCs) and is expressed per admission rather than per day.

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:** [AppendixA1_Falls_Data_Collection_Sheet-635987585006812369.docx](#)

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, 410-786-7214-

Co.3 Measure Developer if different from Measure Steward: Econometrica, Inc.

Co.4 Point of Contact: Kristie, McNealy, kmcnealy@econometricainc.com, 301-657-9883-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

The Fall Rate measure was developed in partnership with CMS by a team lead by Econometrica, Inc. consisting of Econometrica (prime contractor); the University Of Kansas Medical Center Research Institute (KUMCRI; subcontractor); Drs. Rosemary Kennedy and Barbara Resnick, and Ms. Heidi Bossley (consultants).

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision:

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:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: