Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures

July 14-15, 2021

Summary Report

February 2022

Acumen, LLC
500 Airport Blvd., Suite 365
Burlingame, CA 94010

Contents

1 INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) of 2010 and Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 require public reporting of quality and cost measures through Post-Acute Care (PAC) Quality Reporting Programs (QRPs). The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, and Abt Associates (hereafter referred to as the PAC QRP Support team) to develop and maintain measures for each PAC QRP, which includes Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). Acumen, LLC operates under the *Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare* contract (75FCMC18D0015/Task Order 75FCMC19F0003). Abt Associates operates under the *Home Health and Hospice Quality Reporting Program Quality Measures and Assessment Instruments Development, Modification and Maintenance, & Quality Reporting Program Oversight Support* contract (75FCMC18D0014/Task Order 75FCMC19F0001).

This report provides a summary of the feedback shared by panelists during the July 14 and 15, 2021, Technical Expert Panel (TEP) meetings, which focused on refinement and continued development of the PAC QRP function measure portfolio. The remainder of this section briefly introduces the PAC QRP project. Section 2 outlines the structure, materials, and composition of the TEP. Section 3 presents a summary of the presentation, panelist discussion, and key findings for each session. Finally, Section 4 outlines the next steps for this project that take into account the feedback obtained from the TEP.

1.1 Project Context

Under this project, the PAC QRP Support team supports CMS in the development of quality and cost measures for use in the IRF, LTCH, SNF, and HH QRPs and the Nursing Home Quality Initiative (NHQI). These measures are designed to improve care quality and to enable Medicare beneficiaries to make informed choices when selecting a healthcare provider. The suite of PAC QRP measures covers several domains relevant to care quality, including function – a dimension of care that is especially salient to each of the PAC settings. Over the last decade, CMS has introduced several measures addressing function. To ensure these and any newly developed function measures meet CMS program requirements and goals while maintaining high levels of scientific acceptability, the PAC QRP Support team convened a Technical Expert Panel (TEP). The PAC QRP Support team sought guidance on the identification of measure concepts for setting-specific and cross-setting function measures, the development and prioritization of

cross-setting function measures for the PAC setting, and the identification of measurement gaps in the function domain.

1.2 TEP Panelists

The PAC QRP Functions TEP comprised 15 stakeholders with diverse perspectives and areas of expertise, as listed in Table 1. The panelists included expert stakeholders representing clinical, policy and program, measures development, and technical expertise.

Table 1. Function Measure TEP Composition

Name, Credentials, Professional Role	Organizational Affiliation, City, State	PAC Area(s) of Expertise	Consumer Perspective	Clinical Content	Performance Measurement	Coding and Informatics	Conflict of Interest Disclosure
Alice Bell, PT, DPT, Physical Therapist, Payment Specialist	American Physical Therapy Association, Alexandria, VA	IRF, LTCH, SNF/NH, Acute Care Hospital, HH, Hospice Care, Rural Practice, Measure Development	-	X	X	X	N
Amy J. Stewart, MSN, RAC-MT, RAC-MTA, DNS-MT, QCP-MT, Vice President of Post-Acute Care Nursing	American Association of Post-Acute Care Nursing, Denver, CO	SNF/NH	X	X	-	-	N
Amy Mayer-Barger, RN, BS, COS-C, Manager of Outcomes Achievement, and Quality Assurance	Advocate Aurora Health, Continuing Health, Oak Brook, IL	HH	X	X	X	-	N
Anthony D'Alonzo, PT, DPT, MBA, Division Director and Vice President of Clinical Strategy and Innovation	BAYADA Home Health Care, Pennsauken, NJ	HH, Hospice Care Hospital	X	X	X	X	N
Cindy Krafft, PT, MS, HCS-O, Physical Therapist and Business Owner - Home Health Education and Consulting Firm	Kornetti & Krafft Health Care Solutions, Fernandina Beach, FL	HH	-	X	X	-	N

Name, Credentials, Professional Role	Organizational Affiliation, City, State	PAC Area(s) of Expertise	Consumer Perspective	Clinical Content	Performance Measurement	Coding and Informatics	Conflict of Interest Disclosure
Elizabeth Dupont, MBA, ORT/L, CAPS, ECHM, COS-C, Director of Clinical Services	Franklin County Home Health Agency, St. Albans, VT	HH	-	X	-	-	N
Elizabeth Marfeo, PhD, MPH, OTR/L, Associate Professor with Tenure	Tufts University Department of Occupational Therapy, Medford, MA	IRF, LTCH, SNF/NH, HH	-	X	X	-	N
Jennifer Stevens-Lapsley, PT, PhD, Professor of Physical Therapy and Clinical Researcher	University of Colorado, Aurora, CO	SNF/NH, Acute Care Hospital, HH	-	X	X	-	N
Kathleen Weissberg, MS, OTD, OTR/L, MCDCP, CDP, National Director of Education	Select Rehabilitation, Glenview, IL	SNF/NH, HH	-	X	X	X	N
Pamela Roberts, PhD, OTR/L, SCFES, FAOTA, CPHQ, FNAP, FACRM, Executive Director and Professor	Cedars-Sinai, Los Angeles, CA	IRF, Acute Care Hospital	-	-	-	-	-

Name, Credentials, Professional Role	Organizational Affiliation, City, State	PAC Area(s) of Expertise	Consumer Perspective	Clinical Content	Performance Measurement	Coding and Informatics	Conflict of Interest Disclosure
Robert Rosati, PhD, Vice President of Research and Quality	VNA Health Group, Holmdel, NJ	-	-	-	-	-	-
Roger Herr, PT, MPA, Vice President	Visiting Nurse Service of New York, New York, NY	HH	-	X	X	-	N
Shannon Liem, MS, CCC-SLP, COS-C, National Clinical Director for Home Health	Aegis Therapies, Frisco, TX	-	-	-	-	-	-
Steve Gnatz, MD, MHA, Chief Medical Officer	Integrated Rehab Consultants, Chicago, IL	IRF, SNF/NH, Acute Care Hospital, Outpatient Rehabilitation	-	X	X	X	N
Susan M. Battaglia, GERO-BC, RAC-CT, Director of Case Mix Management & Clinical Services	Tara Cares, Orchard Park, NY	SNF/NH	-	X	X	X	N

2 MEETING OVERVIEW

This section provides an overview of the TEP orientation and the TEP meetings. The PAC QRP Support team convened an hour-long webinar for TEP orientation on July 1, 2021. The TEP met via two 4-hour webinars on July 14 and July 15, 2021.

2.1 Structure

The TEP orientation was a brief introduction to the current state of function measurement in the PAC QRP. The TEP meeting included six topic-driven sessions across the two days. Table 2 below provides the agenda for the TEP orientation and each day of the TEP meetings. The orientation established an understanding of the project goals, and panelists completed a pre-TEP survey to convey their priorities for function measurement in the PAC QRP and to share their clinical experience using the assessment item codes. During the TEP, the PAC QRP Support team sought specific feedback on the function-related assessment items across the PAC settings, utilization patterns of the activity not attempted (ANA) codes, the existing PAC QRP function measures, developing the composite score for a cross-setting functional outcome measure development, addressing ANAs in a cross-setting functional outcome measure, and current measurement gaps within the functional domain.

Table 2. TEP Orientation and Meeting Agenda

Session	Topic	Section
	Orientation	
1-A	Introductions and Project Overview	3.1
1-B	Overview of Function Measurement in Post-Acute Care	3.1
1-C	Meeting Structure and Materials	3.1
	Day 1	
2-A	Function Related Assessment Items Across PAC Settings	3.2
2-B	Activity Not Attempted (ANA) Investigations	3.3
	Day 2	
3-A	Review of Existing Function Measures Across Settings	3.4
3-B	Developing the Composite Score for a Cross-Setting Functional Outcome Measure	3.5
3-C	Addressing ANAs in a Cross-Setting Functional Outcome Measure	3.6
3-D	Measurement Gaps in the Functional Domain	3.7

The PAC QRP Support team presented targeted questions to facilitate the discussion and to solicit feedback to inform next steps for refining the PAC QRP function measure portfolio. Bulleted highlights of those discussions are presented at the end of each section in this report.

2.2 Meeting Materials

Prior to the TEP, the *Technical Expert Panel: Charter,* outlining the purpose of the TEP and level of commitment expected, was distributed to the panelists for review. The PAC QRP team also provided panelists with a meeting agenda, background materials on assessment items and function measures, and a survey to gather preliminary feedback on concepts relevant to the meeting agenda. The background materials included:

- IMPACT Act webpage[1]
- Assessment instrument manuals (Table C1 in Appendix C)
- QRP websites (Table C2)
- Quality measure informational pages (Table C3)
- Quality measure specifications (Table C4)

After the TEP, the PAC QRP Support team disseminated a follow-up survey to offer panelists the chance to provide additional feedback.

[1] Center of Medicare & Medicaid Services, Post-Acute Care Quality Initiatives, 2021, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures

3 SUMMARY OF THE TEP PRESENTATION AND DISCUSSION

This section summarizes feedback shared by TEP panelists and is organized into seven subsections. Section 3.1 outlines background information provided during orientation, and Sections 3.2 through 3.7 outline the discussions during the July 14-15, 2021 meeting as outlined in Table 2. Each subsection summarizes the material presented to the TEP, the discussion among TEP panelists in response to the material, and the key findings extracted from that discussion.

3.1 Session 1-B: Overview of Function Measurement in Post-Acute Care

During this orientation session, the PAC QRP Support team reviewed the parameters guiding function measure development, the function assessment items available in each PAC setting, and the current PAC QRP function measure portfolio.

3.1.1 Parameters for Function Measure Development

The PAC QRP Support team reviewed the parameters defining the scope of the current function measure refinement and development effort:

- Measure calculation methodology of existing function measures can be modified.
- The PAC QRP measure portfolio can be modified. New measures can be added, and existing measures can be retired.
- Adding new items to the assessment instruments would take time under normal circumstances, and the Public Health Emergency (PHE) has caused even further delays in instrument updates. Therefore, discussions related to measure modification during the TEP are restricted to the currently available assessment items.
- The IMPACT Act requires CMS to retain at least one cross-setting function measure in the PAC QRP that uses items within Section GG of the assessment instruments.

3.1.2 Function Assessment Items

Section GG of each PAC assessment instrument includes standardized patient assessment data elements that measure functional status. The functional status data elements (hereafter referred to as "items") (Appendix B) used in the PAC QRP function measures assess a patient's capacity to perform daily activities related to self-care (GG0130) and mobility (GG0170) at admission/start of care (SOC)/resumption of care (ROC)[2] and discharge. Providers score patients

[2] GG items are collected at SOC/ROC in HH and at admission in LTCH, IRF, and SNF

on their level of independence in completing the activities reflected in each item using a scale of 6 (completely independent) to 1 (completely dependent). If providers are unable to determine the performance code for an activity, they record the reason using one of the Activity Not Attempted (ANA) codes. Table 3 presents the meaning of each item score and ANA code.

Table 3. Item Scores and ANA Codes Available for GG0130 and GG0170

Category	Code	Description
Item Scores	1	Dependent
	2	Substantial/maximal assistance
	3	Partial/moderate assistance
	4	Supervision or touching assistance
	5	Setup or clean-up assistance
	6	Independent
ANA Codes	7	Patient refused
	9	Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.
	10	Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
	88	Not attempted due to medical condition or safety concerns
	^	Skip
	-	Dash

3.1.3 PAC QRP Function Measures

There are currently six function measures across the PAC QRPs based on section GG items, including one process measure and five functional outcome measures. Table 4 lists the function measures available in each setting and the starting point of data collection for each measure.

The process measure evaluates how often PAC providers assess a Self-Care (GG0130) and Mobility (GG0170) items on admission/SOC/ROC, sets a discharge goal for at least one of the items, and assesses the corresponding Self-Care (GG0130) and Mobility (GG0170) item at discharge. The five risk-adjusted outcome measures calculate the gap between observed function and risk-adjusted expected function. The two Discharge function measures use the function score at discharge as the outcome, whereas the three Change in function measures use the difference in function scores between admission and discharge as the outcome.

Table 4. PAC QRP Function Measures

Short Name	Measure*	Data Collection Start			
		LTCH	IRF	SNF	HH
Application of Functional Assessment/Care Plan	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function Measure (NQF #2631)	2016	2016	2016	2019
Discharge Self-Care Score	Functional Outcome Measure: Discharge Self-Care Score (NQF #2635)	-	2016	2018	-
Discharge Mobility Score	Functional Outcome Measure: Discharge Mobility Score (NQF #2636)	-	2016	2018	-
Change in Self-Care Score	Functional Outcome Measure: Change in Self-Care Score (NQF #2633)	-	2016	2018	-
Change in Mobility Score	Functional Outcome Measure: Change in Mobility Score (NQF #2634)	-	2016	2018	-
Change in Mobility Score for Ventilated Patients	Change in Mobility among Patients Requiring Ventilator Support (NQF #2632)	2015	-	-	-

* See Table C4 in Appendix C for the QM manuals with specifications for each function measure

3.2 Session 2-A: Functional Related Assessment Items Across PAC Setting

During this session, the PAC QRP Support team presented and solicited feedback on characterizations of the 2019 assessment data for Self-Care (GG0130) and Mobility (GG0170) items.

3.2.1 Summary of Presentation

The PAC QRP Support team assessed attributes of the data collected across settings for each GG self-care and mobility item to understand how the features of the underlying data should shape the function measure refinement and development effort. The PAC QRP Support team determined rates of ANA usage, levels of patient and resident functional improvement, and the correlation between assessed scores (1-6) from individual items. Functional improvement was identified as patients with a higher discharge score than admission score. For the item correlation results, the items were grouped by functional domain as described in Table 5 (self-care, bed mobility, transfers, walking, wheeling, advanced walking, other), and each item was correlated with the other items in its domain. Results reported in this section are averages of those Pearson correlation coefficients.

Table 5. GG Items by Functional Domain

Domain	GG Items*
Self-Care	Eating (GG0130A), Oral Hygiene (GG0130B), Toileting Hygiene (GG0130C), Wash Upper Body (GG0130D), Shower/bathe self (GG0130E), Upper Body Dressing (GG0130F), Lower Body Dressing (GG0130G), Putting On/Taking Off Footwear (GG0130H)
Bed Mobility	Roll Left and Right (GG0170A), Sit to Lying (GG0170B), Lying to Sitting on Side of Bed (GG0170C)
Transfers	Sit to Stand (GG0170D), Chair/Bed-to-Chair Transfer (GG0170E), Toilet Transfer (GG0170F), Car Transfer (GG0170G)
Walking	Walk 10 Feet (GG0170I), Walk 50 Feet with 2 Turns (GG0170J), Walk 150 Feet (GG0170K)
Wheeling	Wheel 50 Feet with 2 Turns (GG0170R), Wheel 150 Feet (GG0170S)
Advanced Walking	Walk 10 Feet on Uneven Surfaces (GG0170L), 1 Step (Curb) (GG0170M), 4 Steps (GG0170N), 12 Steps (GG0170O)
Other	Picking Up an Object (GG0170P)

*See Appendix B for the availability of the GG items in each PAC setting

Self-Care

ANA rates for self-care items were low – below 7% for most items across settings at both admission/SOC/ROC and discharge. The only exception was the Eating item (GG0130A) in LTCH, which showed a 21% ANA rate at admission and 10% ANA rate at discharge. Roughly 80% of patients improved function across self-care items in IRF, SNF and HH. In LTCH, patients showed lower levels of improvement across items (41-50%). Self-care item correlations varied across settings and across individual items. In LTCH, all four available self-care items were strongly correlated (>0.70). In IRF, SNF and HH, the Eating (GG0130A) and the Oral Hygiene (GG0130B) items were less correlated with the other self-care items (0.40-0.80) at both admission/SOC/ROC and discharge. In IRF, scores for the remaining self-care items were less correlated at admission (0.40-0.60) than discharge (0.70-0.89). In SNF and HH, the remaining self-care items were more highly correlated at both admission/SOC/ROC and discharge (0.66-0.89).

Bed Mobility

ANA rates in bed mobility items were generally low – under 7% for most items across settings at both admission/SOC/ROC and discharge. In LTCH, ANA codes were more common in the Sit to Lying (GG0170B) and Lying to Sitting on Side of Bed (GG0170C) items at admission (18-22%) and discharge (8-11%). Patients tended to improve in function on bed mobility items in IRF, SNF, and HH (67-84%), while LTCH patients showed lower levels of improvement (50-55%). Bed mobility scores are highly correlated across settings at both admission/SOC/ROC and discharge (0.80-0.96).

Transfers

ANA rates for transfer items varied across settings and across individual items. In IRF, SNF, and HH, most items exhibited low ANA rates (0-14%), except Car Transfer (GG0170G), for which 34-74% of admission/SOC/ROC records and 18-41% of discharge records had an ANA. In LTCH, Sit to Stand (GG0170D), Chair/Bed-to-Chair (GG0170E), and Toilet Transfer (GG 0170F) were frequently ANA at admission (33-47%) and discharge (14-28%). In IRF, SNF and HH, patients typically improved function on transfer items (74-87%). In LTCH, patients had lower level of improvements on the available transfer items (53-57%). Most transfer items showed high correlation with other transfer items (>0.70). The level of correlation across transfer items is particularly high in LTCH (>0.95). Car Transfer (GG0170G) is slightly less correlated with other transfer items (0.64-0.78).

Walking

ANA rates for walking items varied across settings and across individual items. In LTCH, walking items were frequently ANA at both admission (65-78%) and discharge (44-58%). For IRF, SNF, and HH, ANA rates were also fairly high and increased with the difficulty of the item: Walk 10 Feet (admission/SOC/ROC: 12-29%; discharge: 8-15%), Walk 50 Feet with 2 Turns (admission/SOC/ROC: 31-51%; discharge: 15-21%), and Walk 150 Feet (admission/SOC/ROC: 51-76%; discharge: 24-33%). In IRF, SNF, and HH, patients tended to improve walking function when assessed (73-85%). LTCH patients exhibited lower rates of improvement (44-51%). Walking item scores were highly correlated across settings (0.79-0.97), especially in LTCH (>0.94).

Wheeling

ANA rates for wheeling items were higher in LTCH and HH (admission/SOC/ROC: 87-93%; discharge: 84-90%) than IRF and SNF (admission: 43-59%; discharge: 43-55%). LTCH and HH also exhibited lower rates of patient improvement when assessed (45-53%) compared to IRF and SNF (56-76%). Wheeling item scores were highly correlated across settings (0.84-0.94).

Advanced Walking

ANA rates for advanced walking items were higher in SNF (admission: 78-91%; discharge: 47-76%) than IRF (admission: 57-89%; discharge (22-48%) and HH (SOC/ROC: 53-73%; discharge: 28-56%). Patients also improved less in advanced walking items in SNF (66-73%) than IRF (74-81%) and HH (81% patient improvement on all four items). Advanced walking item scores where highly correlated across settings (0.71-0.90).

Other

At both admission and discharge, ANA rates for Picking Up an Object were higher in IRF (admission: 71%; discharge: 35%) and SNF (admission: 59%; discharge: 36%) than HH (SOC/ROC: 29%; discharge: 18%). Patients tended to improve across settings (70-80%). Picking Up an Object exhibited moderate correlation with the other mobility items (0.49-0.73).

Pre-Meeting Survey Responses

TEP members were asked in a pre-meeting survey to rank the items within each domain according to how important the item was in evaluating a patient's functional status in the primary setting in which they worked. There were no unanimous votes, but there was some consensus. As shown in Table 6, panelists tended to rank more advanced transfer, walking and wheeling items as less important and medium difficulty self-care, bed mobility, transfer, and walking items as more important.

Table 6. Preliminary Feedback on Item Importance from Pre-TEP Survey

Domain	Less Important	More Important
Self-Care	-	GG0130E Shower/Bathe Self GG0130C Toileting Hygiene
Bed Mobility	-	GG0170C Lying to Sitting on Side
Transfers	GG0170G Car Transfer	GG0170D Sit to Stand GG0170F Toilet Transfer
Walking/Wheeling	GG0170S Wheel 150 Feet	GG0170J Walk 50 Feet with 2 Turns
Advanced Walking/Other	GG0170O 12 Steps	-

3.2.2 Panelist Discussion

The PAC QRP Support team asked the panelists during the meeting if their opinions about which items are important had changed after having reviewed the item characterization and survey results. The questions posed were:

- Which GG items are important to meaningfully capture functional abilities in your setting?

- Which items are less helpful for meaningful capture of functional abilities?

Panelists offered their perspectives on the relative importance of each GG item in capturing functional status in their respective PAC settings. Panelists emphasized that the salience of functional item is setting-specific and patient-dependent. For instance, some panelists mentioned that for patients receiving HH services, the less difficult activities are less important since HH patients tend to generally have higher levels of function. In HH, mid-distance walking items are relevant, but the Walking 150 Feet (GG0170S) item is often not completed because of space limitations in patients' homes. One panelist offered that mobility items may be more helpful than self-care items in IRF. Another panelist mentioned that bed mobility, walking, and wheeling items seem most relevant in SNF.

Panelists discussed whether certain GG items overlap in how they capture functional status. Many panelists pointed to high item score correlation to suggest that certain items in the same domain may be redundant. Panelists coalesced around similar recommendations as communicated through the pre-TEP survey (Table 6).

3.2.3 Key Findings

- Panelists identified medium difficulty self-care, bed mobility, transfer, and walking items as important for capturing functional status across settings.
- Panelists mentioned higher difficulty transfer, walking, and wheeling items – specifically Car Transfer (GG0170G), Wheel 150 Feet (GG0170S), and 12 Step (GG0170) – as less important for capturing patient function.

3.3 Session 2-B: Activity Not Attempted (ANA) Investigations

During this session, the PAC QRP Support team provided an overview of patterns in Activity Not Attempted (ANA) utilization for GG0130 and GG0170 item sets.

3.3.1 Summary of Presentation

The PAC QRP Support team investigated ANA utilization in the GG items and focused on four research questions:

- How often do PAC stays have ANAs recorded across multiple GG items?
- For which patients are ANAs recorded?
- What does discharge function look like for patients with ANAs at admission?
- Is there evidence of errors in ANA coding?

First, the PAC QRP Support team presented results showing the volume of ANAs across multiple GG items for the same PAC stay. Because ANA utilization within the self-care GG

items is infrequent across all settings, stays with multiple self-care ANAs were rare. Stays with multiple mobility ANAs were much more common. Over a quarter of PAC stays across all settings are missing four or more mobility items at discharge.

Second, the PAC QRP Support team analyzed which types of patients tend to receive ANAs on mobility items. Across settings, patients who are dual eligible (Medicare-Medicaid), non-white, and admitted from a nursing home were more likely to have ANAs recorded on mobility items. In IRF, patients who have orthopedic or medical complex conditions as their primary medical condition tended to have higher ANA rates. These characteristics may reflect nursing home long-term patients likely to be less mobile and recent orthopedic patients with limited mobility, respectively.

Third, to study patient function in items with ANAs compared to items scored as dependent (1), the PAC QRP Support team identified a population of stays with an ANA at admission and a score of 1-6 at discharge for a particular item. Compared to stays where patients were scored as dependent at admission (dependent admissions), stays with ANAs at admission/SOC/ROC (ANA admissions) had higher average item scores at discharge, and average discharge score varied by the ANA admission code (7, 9, 10, 88, ^, -). These results suggest that ANA admissions may substantively differ in their functional outcomes from dependent admissions.

Fourth, the PAC QRP Support team sought to measure rates of ANA coding errors and focused on the "Not Applicable Code" (9) code. Per the coding guidance, this code is used when the specified activity was not attempted and the patients did not perform the activity prior to the current illness, exacerbation, or injury. It would be expected that, if a "Not Applicable Code" (9) is recorded at admission/SOC/ROC, it would also be applied at discharge, and vice versa. The PAC QRP Support team identified stays where the "Not Applicable Code" (9) is applied only at admission/SOC/ROC or discharge and reported low rates of this scenario among PAC stays – at or under 1%, on average, for self-care items and under 4% for mobility items.

Additionally, the PAC QRP team reviewed the guidance provided to practitioners and considered how the quality and clarity of the coding guidance might directly affect the data quality.

Pre-Meeting Survey Responses

The PAC QRP team reviewed the pre-TEP survey where the TEP members answered questions regarding ANA utilization. In response to the question, "Are ANAs Accurately Applied?" the majority of TEP members responded "About Half of the Time." In response to the question, "Do ANAs Provide Useful Information?" the majority of TEP members responded

"Almost Never." And in response to the question, "Do Clinicians Understand ANA Use?" a majority of TEP members responded "Somewhat."

3.3.2 Panelist Discussion

The PAC QRP team presented the following questions to the TEP panelists:

- In your PAC setting, for what types of clinical scenarios are ANAs used?
- How do you interpret the ANA patterns discussed?

Panelists distinguished between reliability and usefulness of the ANA codes. Many panelists argued that the ANA codes are not reliable because ANAs are not consistently applied across different providers. Panelists pointed to differential understanding of coding guidance across healthcare disciplines as one source of inconsistent coding. Further, panelists mentioned that the coding guidance leaves room for interpretation that can cause variation in how ANA codes are selected. For instance, many scenarios could fall under the heading of "not assessed due to safety concerns" or "not assessed due to medical conditions", both of which are represented by the code "88." The panelists pointed out that these could be two very different situations, such as a patient having an order for lower extremity non-weight-bearing versus a clinician who did not feel safe assessing a patient's ambulation because they had no one present to assist them. Since both circumstances would be coded as "88", panelists thought the data offer less useful information than if medical conditions were separately coded. The panelists also agreed that it was sensible to observe less ANA usage at discharge and suspected that the discharge codes would be more reliably coded. Since providers know their patients better by discharge, they have stronger understanding of functional status and feel less inclined to record an ANA code.

Panelists discussed the usefulness of the information ANAs provide. Several panelists did not find the ANA codes helpful in providing information about patient functional status. First, codes like "Not Attempted due to Patient Refused" (7) and "Not Attempted due to Environmental Limitations" (10) do not offer information about patient function but rather indicate other reasons why an assessment was not completed. Second, panelists thought that, if reliably recorded, the codes indicating "Not Attempted due to Medical Condition/Safety Concerns" (88) or "Not Applicable" (9) could indicate functional dependence. However, as discussed above, panelists do not expect these codes to be reliably applied. Additionally, panelists agreed that a medical condition or contraindication would more likely indicate a functional dependence (1) while a safety concern may not. The code for "Not Attempted due to Medical Condition/Safety Concerns" (88) conflates medical conditions and/or contraindications with safety concerns and therefore does not offer useable information about patient function. Some panelists mentioned that the ANA codes do provide value for care planning since the

codes can be used in conjunction with other information in medical records to influence care rendered. A few panelists offered that the ANA codes are also helpful for facilities to improve their clinical and data collection processes.

Panelists discussed how modifying the way ANAs are coded and the education for clinicians on ANA coding could help improve the reliability and overuse of ANA codes moving forward. Many panelists suggested ANA coding could be improved by separating "Not Attempted due to Medical Conditions" from "Not Attempted due to Safety Concerns." Other panelists offered that reducing the number of ANA codes available to use could help. One panelist mentioned confusion about how to code intubated patients and proposed improving education around common patient scenarios. One panelist suggested the language in the code definition could be simplified such that all disciplines, regardless of depth and focus of medical training, can understand how to apply ANA codes.

3.3.3 Key Findings

- Generally, panelists expressed concerns about the reliability and accuracy of ANAs as they are currently used.
- Panelists offered suggestions for ways ANA coding, guidance, and education could be improved to help increase ANA reliability and usefulness, including separating "Not Attempted due to Medical Conditions" into its own code.

3.4 Session 3-A: Review of Existing Function Measures across Setting

During this session, the PAC QRP Support team presented analyses on the six function measures currently implemented across the PAC QRPs.

3.4.1 Summary of Presentation

The PAC QRP Support team provided statistics for function measures describing the performance distribution, internal consistency, reliability, and correlation to other PAC QRP quality measures.

Application of Functional Assessment/Care Plan (NQF #2631)

The process measure, Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631), was topped out with a mean provider score exceeding 96% in HH and 99% in LTCH, IRF, and SNF. Because this measure was very high performing and did not offer meaningful differentiation between providers, the provider scores were poorly correlated to the functional outcome measures available in LTCH, IRF, and SNF (Spearman correlation coefficients less than 0.10).

Change in Self-Care Score (NQF #2633) and Discharge Self-Care Score (NQF #2635)

The Functional Outcome Measure: Change in Self-Care Score (NQF #2633) and Functional Outcome Measure: Discharge Self-Care Score (NQF #2635) (available in IRF and SNF) exhibited desirable properties for quality measures. There was sufficient variation in provider scores and high reliability (>0.80). The individual GG self-care item scores demonstrated high internal consistency at both admission and discharge (Cronbach's alphas: 0.86-0.96). The provider scores on these self-care functional outcome measures also correlated to a reasonable degree with scores from Discharge to Community (NQF #3481), which supports measure validity since more functionally independent patients are more likely to be successfully discharged to the community. The scores for the two self-care measures, the Change in Self-Care Score (NQF #2633) and Discharge Self-Care Score (NQF #2635), were very highly correlated in both IRF (0.97) and SNF (0.93).

Change in Mobility Score (NQF #2634) & Discharge Mobility Score (NQF #2636)

The Functional Outcome Measure: Change in Mobility Score (NQF #2633) and Functional Outcome Measure: Discharge Mobility Score (NQF #2636) measures (available in IRF and SNF) also demonstrated sufficient provider score variation, high reliability, high internal consistency, and positive correlation with Discharge to Community (NQF #3481). Similar to the self-care measures, the scores for the Change in Mobility Score (NQF #2634) and Discharge Mobility Score (NQF #2636) measures were very highly correlated in both IRF (0.98) and SNF (0.95).

Change in Mobility for Ventilated Patients (NQF #2632)

The PAC QRP Support team assessed the properties of the Change in Mobility among Patients Requiring Ventilator Support measure (NQF #2632) and found sufficient variation in provider score, high reliability, high internal consistency, and positive correlation with Discharge to Community (NQF #3481).

3.4.2 Panelist Discussion

Acumen posed the following questions for the TEP:

- Given the high correlation between the Change and Discharge measures, would one measure (Change or Discharge) be sufficient to measure functional ability? If one measure were to ultimately be selected, which measure does the TEP prefer?

Panelists discussed whether the PAC QRP should continue to maintain both the Change and Discharge function measures for self-care and mobility. Some panelists articulated that it could be helpful to maintain both measures since the scores are reported in different ways and may offer distinct information. Other panelists thought that, given the high

correlation between the Change and Discharge measures for both self-care and mobility, it would be sensible to retire either the Change or Discharge measure for both self-care and mobility. Based on the responses to the post-TEP survey, the majority of panelists (9 out of 12 respondents) suggested that only one measure is necessary. Of those 9 respondents, 6 preferred the Discharge Score measure over the Change in Score measure.

3.4.3 Key Findings

- The process measure, Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), does not meaningfully distinguish provider quality.
- Panelists tended to favor the Discharge in Self-Care Score (NQF #2635) and Discharge in Mobility Score (NQF #2636) measures over the Change in Self-Care Score (NQF # 2633) and Change in Mobility Score (NQF #2634) measures.

3.5 Session 3-B: Developing the Composite Score for a Cross-Setting Functional Outcome Measure

During this session, the PAC QRP Support team facilitated a discussion on how to calculate the composite score for a cross-setting functional outcome measure from individual GG items.

3.5.1 Summary of Presentation

The PAC QRP Support team presented the TEP with considerations for combining individual GG item scores into a functional outcome composite score. Panelists provided input on which items to use for measure construction and whether to weight each individual item score equally.

A challenge with developing a functional outcome measure that works across PAC settings is deciding which GG items to use. First, these assessment items may not be equally clinically meaningful across settings. Second, the items are not consistently collected across PAC settings. Only 3 of 8 self-care GG items are collected in all four settings, whereas 11 of 17 mobility GG items are collected in all four settings. The primary reason is that many GG items are not currently collected in LTCH and will not be until FY2023 at the earliest. Any cross-setting functional outcome measure developed in the meantime must only use the items currently available in LTCH. Because more mobility items than self-care items are available across all four PAC settings, the PAC QRP Support team constructed "Uniform Mobility" measures in LTCH, IRF, and SNF that use the uniform item set described in Table 7.

In LTCH, the Change in Mobility for Ventilated Patients measure (NQF #2632) already uses the uniform item set but differs from the Discharge Mobility Score (#2636) and Change in

Mobility Score (NQF #2634) measures for IRF and SNF in two ways. First, the Change in Mobility for Ventilated Patients measure (NQF #2632) only considers a subgroup of patients (i.e., ventilated patients). Second, the risk adjustors used diverge from the model specifications for the Discharge Mobility Score (#2636) and Change in Mobility Score (NQF #2634) measures. The PAC QRP Support team constructed Uniform Discharge Mobility and Uniform Change in Mobility measures for all LTCH stays (regardless of patient ventilation status) with a risk adjustment model aligned with the IRF and SNF measures. The Uniform Mobility Measures exhibited desirable properties, with high correlation to the current Change in Mobility for Ventilated Patients measure (NQF #2632).

Table 7. Uniform Item Set

Item	Description
GG0170A	Roll left and right
GG0170B	Sit to lying
GG0170C	Lying to sitting on side of bed
GG0170D	Sit to stand
GG0170E	Bed-to-chair transfer
GG0170F	Toilet transfer
GG0170I	Walk 10 feet
GG0170J	Walk 50 feet with two turns
GG0170K	Walk 150 feet
GG0170R	Wheel 50 feet with two turns
GG0170S	Wheel 150 feet

The Discharge Mobility Score (#2636) and Change in Mobility Score (NQF #2634) measures in IRF and SNF use all 17 mobility items (Table B2). To calculate Uniform Discharge Mobility Score and Uniform Change in Mobility Score measures in IRF and SNF, the PAC QRP Support team only used items from the uniform item set (Table 3). The PAC QRP Support team compared the Uniform Mobility Measures to the current measures and demonstrated that the risk adjustment model fit is similar and the final provider scores are highly correlated.

Another step of measure construction is combining the individual GG item scores into a composite score. The Change in Mobility Score for Ventilated Patients (NQF #2362) Change in Mobility Score (NQF #2634) and Discharge Mobility Score (NQF #2636) measures use an unweighted sum of each individual GG item score, such that each item contributes equal weight to the composite score.

3.5.2 Panelist Discussion

The PAC QRP Support team posed the following questions for the TEP:

- Does the TEP support using all of the items from the uniform item set in a cross-setting functional outcome measure?
- Does the TEP recommend removing additional items?
- Is it appropriate to give each item score equal weight when combining them into a composite score?

Uniform Item Set

Some panelists supported using the uniform item set as it stands to develop a cross-setting functional outcome measure. Others offered modifications to the uniform item set for consideration. Two panelists suggested adding some self-care items to produce a cross-setting measure that considers both self-care and mobility. Many panelists agreed that the uniform item set could be further pared down based both on clinical sensibility and the item correlation results (Section 3.2). Panelists also proposed eliminating items that redundantly measure a particular domain of mobility (bed mobility, transfers, walking). The conversation emphasized that patients differ across each PAC setting in terms of their expected levels of function, and an item set used to measure function across settings must be sensitive to differential function inside each setting. For example, the goal should be to maintain items that will distinguish between more functionally independent HH patients while simultaneously differentiating abilities in more functionally dependent LTCH patients. The discussion gravitated toward removing the longest distance walking and wheeling items (150 feet) for a cross-setting functional outcome measure, which was supported by the results of the post-TEP survey.

Item Score Weighting

Panelists discussed whether weighting individual item scores based on their relative importance to function has merit for calculating the composite score for a cross-setting function measure. Panelists agreed that it would be difficult to establish a weighting method that would apply to patients across PAC settings, given the setting-specific expectations for functional status. A few panelists offered that it could be desirable to curate an item set that has equal representation from each functional domain, such that the composite provides equal weight to each domain.

3.5.3 Key Findings

- LTCH's current measure – Change in Mobility Score for Ventilated Patients (NQF #2632) – only considers ventilation stays, but Change and Discharge function measures can be constructed using all LTCH stays with performance similar to the current IRF and SNF measures.

- Panelists agreed that moving forward with cross-setting functional outcome measure development with a set of GG items that are currently available is preferable to waiting for the full suite to be available in LTCH.
- Panelists encouraged removal of specific mobility items that do not provide additional information about patient function.
- Panelists recommended against differentially weighting individual item scores when calculating the composite score for a cross-setting functional outcome measure.

3.6 Session 3-C: Addressing ANAs in a Cross-Setting Functional Outcome Measure

During this session, the PAC QRP Support team reviewed options for addressing high levels of Activity Not Attempted responses (ANAs) in GG items when specifying a cross-setting functional outcome measure.

3.6.1 Summary of Presentation

Developing a robust cross-setting functional outcome measure that relies on the GG items requires careful attention to how ANA responses are handled. As demonstrated in Section 3.2, the mobility items are especially prone to high ANA rates. An ideal approach to addressing these ANAs during measure construction would be to accurately estimate missing item scores, discourage overutilization of ANAs on GG items, include as many stays as possible, and at the same time be transparent to stakeholders.

The current specification for existing PAC QRP functional outcome measures recodes all ANA responses at admission/SOC/ROC and discharge to dependent (1). This approach assumes that all ANAs reflect functional dependence (1) for the specified activity. In order to investigate whether recoding all ANAs as dependent is the best means of accounting for ANAs, the PAC QRP Support team conducted population analysis, as described in Section 3.3, and found that ANA codes may not always reflect dependence in functional ability. Additionally, utilization of dependent (1) and ANA codes at admission/SOC/ROC varied among patient populations by gender, dual eligibility, and primary medical condition. For instance, stays with 88 at admission/SOC/ROC were more likely to reflect female, non-dual eligible, and orthopedic patients when compared to stays with a 1 at admission/SOC/ROC.

Given these findings, the PAC QRP Support team prompted TEP panelists to consider two alternative approaches for handling ANAs during measure construction: (1) re-scaling and (2) imputation. In the first method, when a stay has ANAs on some GG items, the available item scores are summed and then re-scaled to estimate a composite score that reflects the full item set.

For instance, consider a stay with an ANA recorded for 2 of the 11 items in the uniform item set, where the total discharge score for the 9 available items is 27. To calculate a re-scaled composite score, this total discharge score would be re-scaled by multiplying it by the inverse of the fraction of available items to total items $(27\ x\ \frac{11}{9} = 33)$. This approach provides a relatively simple framework that estimates item scores for ANA responses by using information from the other function items, rather than assuming all ANAs represent functional dependence (1). However, without additional restrictions, this method would produce composite scores that are biased toward performance on easier items and that underestimate functional improvement within PAC stays. As part of these restrictions, stays with too many ANAs would be excluded. Furthermore, this specification would not discourage ANA use and may add incentive to code ANA at discharge.

The second alternative to the current ANA re-code is statistical imputation, whereby a model would estimate missing item scores, based on responses to non-missing items and other patient and stay characteristics (e.g., health characteristics). This method may produce an unbiased estimate of the function score for each activity coded ANA and would require fewer restrictions than the re-scale approach. However, imputation is complex, both to implement and to communicate to stakeholders, and would not discourage ANA use.

3.6.2 Panelist Discussion

The PAC QRP Support team presented the following question to the TEP panelists:

- In considering the uniform item set and exploring potential alternatives for recoding ANAs in measure score calculations, which of the following goals does the TEP consider most important?

Table 8 Goals for Approach to Addressing ANAs

Goal	Considerations
A) Capturing patients' overall functional level	Imputation explicitly attempts to model missing data.
B) Using information from all patients	Re-scaling requires excluding stays with too many ANAs. Imputation may, too.
C) Encouraging fewer ANAs	Neither re-scaling nor imputation penalize ANAs.
D) Simplicity	Re-scaling is relatively simple; imputation is complex.

Panelists considered how ANAs should be treated in cross-setting functional outcome measure construction. A few panelists pointed out that using some version of the uniform item set would alleviate the ANA issue because many items with high ANA rates would be eliminated. Panelists then provided issues to consider when developing a method to address

ANAs in the remaining items. Panelists agreed that the current re-code specification is not ideal because not every ANA record will reflect functional dependence (1) on the specified activity. It both depends on which ANA code was used and how the providers completing the assessment chose to use that code. First, certain codes (e.g., "Not Attempted due to Environmental Limitations") do not sensibly translate to the patient being fully dependent on others to complete an activity. Second, interpreting the ANA codes is complicated by provider behavior, especially for "Not Attempted due to Medical Condition/Safety Concerns" (88). Clinicians seem to use ANAs differently and may record ANAs when a score of 1-6 could have been rendered. Panelists agreed that true medical conditions and/or contraindications for not completing an activity would reflect functional dependence (1), but it would be impossible to discern those cases with the current coding scheme.

The remaining discussion centered on balancing accurate estimation of function for stays with ANAs with keeping the methodology for measure construction simple enough to be digestible by providers and consumers. One panelist wondered if excluding ANAs from measure calculation could be a viable approach. The PAC QRP team responded that an ANA exclusion would reduce the number of episodes available for measure calculation and could bias the population toward particular types of patients (e.g. higher functioning patients in HH). Regarding the alternative methods presented, one panelist expressed concern that the re-scale method may rely too much on easier items. Some panelists worried that statistical imputation may be too complex to provide actionable information for providers and consumers.

In the post-TEP survey, panelists were asked to rank the goals from Table 8 in the post-TEP survey (1 = most important, 4 = least important). Table 9 presents the average rank that the 12 respondents assigned each goal. Panelists found *Capturing Patients' Overall Functional Level* to be the most important goal of an approach to addressing ANAs. In their responses, panelists stressed the importance of providing a measure that allows consumers and health systems to make informed choices about where to receive/refer care, as well as a measure that gives actionable data for PAC providers.

Table 9. Average Rank Order of ANA Recode Goals

Support Equal Weight	Average Participant Rank
Capturing Patients' Overall Functional Level	1.25
Keeping Things Simple	2.50
Encouraging Fewer ANAs	2.75
Using Information from All Patients	3.50

3.6.3 Key Findings

- Panelists agreed that the current specification to recode all ANAs to functional dependence (1) does not accurately estimate function.
- Panelists recommended updates to coding guidance for ANA use for GG items.
- Panelists identified accurate capture of patient functional ability and methodological simplicity as important goals for cross-setting functional outcome measure development and supported continued exploration of the optimal approach to achieve that balance.

3.7 Session 3-D: Measurement Gaps within the Functional Domain

During this session, Acumen presented and solicited feedback on perceived measurement gaps within the function domain of the PAC QRP.

3.7.1 Summary of Presentation

The PAC QRP Support team conducted a literature scan to identify salient dimensions of function that are not currently captured through the PAC assessment instruments and identified three areas where measurement of functional status might be improved:

- Formal Balance Assessment
- Gait Speed
- Patient Self-Reported Items

3.7.2 Panelist Discussion

The PAC QRP Support team posed the following question to the panelists:

- Does the TEP perceive any gaps in how function is measured in the PAC QRPs?

Panelists largely agreed with the measurement gaps Acumen presented. Panelists agreed that many of the functional tests currently used in the PAC setting are limited in terms of capacity. For example, walking assessments are all very simple and completed in a safe and controlled environment, limiting the validity of the tests. Additionally, many panelist agreed with incorporating a gait speed measurement into the assessment items. Three panelists suggested incorporating gait speed into a physical assessment battery, which would include balance, gait speed, and chair stand assessment. Furthermore, many of the panelists thought a time component was missing from the current functional measures.

Additionally, several panelists shared their thoughts on further measurement gaps. One panelist thought patient pain, cognition, and tremors are measurement gaps. Another panelist found Activities of Daily Living (ADL), in conjunction with a walking assessment should be

considered in future functional measure development. Lastly, panelists found patient vision to be overlooked and should be considered in future measure development.

3.7.3 Key Findings

- Formal Balance, Gait Speed, and Patient Self-Reported Items are all current measurement gaps within the functional domain and should be considered for incorporation into future function measures.
- Pain, cognition, tremors, vision, and Activities of Daily Living should all be considered for incorporation into future functional measures.

4 NEXT STEPS

The input provided by this TEP will provide guidance to the PAC QRP Support team throughout the function measure refinement and development effort. This section will discuss how we plan to address and incorporate the feedback received from this TEP meeting.

4.1 Refinement of Existing Function Measure Portfolio

The panelists were generally supportive of removing the Change in Self-Care Score and Change in Mobility Score measures from the PAC QRPs since the measures do not provide unique information from the Discharge Self-Care Score and Discharge Mobility Score measures. This input will be taken into consideration as we work with CMS to continue to refine the PAC QRP function measure portfolio.

4.2 Item Set for a Cross-Setting Function Measure

Panelists agreed on moving forward with developing a cross-setting functional outcome measure with the GG items currently available across all settings. Panelists also recommended approaches for further reducing the item set, including specific suggestions for items that could be removed. We plan to use the information provided by the panelists to optimize the item set for a cross-setting functional outcome measure.

4.3 Addressing ANAs for a Cross-Setting Function Measure

Panelists expressed that the current strategy for handling ANAs during functional outcome measure calculation (i.e., recoding all ANAs to 1) does not accurately estimate patient function. Panelists provided feedback on our proposed alternative methods (i.e., re-scaling and statistical imputation). Panelists supported continued exploration of optimal approaches to ANAs during measure calculation. We appreciate the feedback on our proposals and will take the input into consideration as we develop a framework to handle ANAs for a cross-setting functional outcome measure.

5 APPENDIX A: PAC QRP FUNCTION MEASURE DEVELOPMENT TEAM

The PAC QRP Support team is multidisciplinary and includes individuals with knowledge and expertise in the areas of measure development, clinician payment policy, health economics, clinical practice, public reporting, pay-for-performance, and value-based purchasing and quality improvement. The following individuals from the project team attended the TEP:

- Morris Hamilton, Associate Research Manager
- Betty Fout, Senior Research Manager
- Margot Schwartz, Associate Research Manager
- Linda Krulish, Clinical Subject Matter Expert
- Marian Essey, Clinical Subject Matter Expert
- Stephen McKean, Research Manager
- Ellen Strunk, Clinical Lead
- Rebecca Clearwater, Senior Clinical Researcher
- Kristine Mattivi, Associate Research Manager
- Mikhail Pyatigorsky, Associate Research Manager
- Zeb Kessler, Policy Lead
- Cynthia Jung, Data & Policy Analyst
- Max Lowndes, Data & Policy Analyst
- Nico Robinson, Data & Policy Analyst
- Zhizhi Min, Data & Policy Analyst

6 APPENDIX B: PAC QRP FUNCTION ASSESSMENT ITEMS

The following tables report when data collection for each self-care (Table B1) and each mobility (Table B2) GG item started.

Table B1. Self-Care Assessment Item Data Collection Start Dates

Item	Description	IRF	LTCH	SNF	HH
GG0130A	Eating	2016	2016	2016	2019
GG0130B	Oral Hygiene	2016	2016	2016	2019
GG0130C	Toileting Hygiene	2016	2016	2016	2019
GG0130D	Wash Upper Body	-	2016	-	-
GG0130E	Shower/Bathe Self	2016	-	2018	2019
GG0130F	Upper Body Dressing	2016	-	2018	2019
GG0130G	Lower Body Dressing	2016	-	2018	2019
GG0130H	On/Off Footwear	2016	-	2018	2019

Table B2. Mobility Assessment Item Data Collection Start Dates

Item	Description	IRF	LTCH	SNF	HH
GG0170A	Roll Left and Right	2016	2016	2018	2019
GG0170B	Sit to Lying	2016	2016	2016	2019
GG0170C	Lying to Sitting on Side	2016	2016	2016	2017
GG0170D	Sit to Stand	2016	2016	2016	2019
GG0170E	Chair/Bed-to-Chair Transfer	2016	2016	2016	2019
GG0170F	Toilet Transfer	2016	2016	2016	2019
GG0170G	Car Transfer	2016	TBD	2016	2019
GG0170I	Walk 10 Feet	2016	2016	2018	2019
GG0170J	Walk 50 Feet with 2 Turns	2016	2016	2016	2019
GG0170K	Walk 150 Feet	2016	2016	2016	2019
GG0170L	Walk 10 Feet – Uneven Surface	2016	TBD	2018	2019
GG0170M	1 Step (Curb)	2016	TBD	2018	2019
GG0170N	4 Steps	2016	TBD	2018	2019
GG0170O	12 Steps	2016	TBD	2018	2019
GG0170P	Picking Up an Object	2016	TBD	2018	2019
GG0170R	Wheel 50 Feet with 2 Turns	2016	2016	2016	2019
GG0170S	Wheel 150 Feet	2016	2016	2016	2019

7 APPENDIX C: BACKGROUND MATERIALS

The following tables present the background materials provided to the TEP panelists for review prior to the TEP meeting.

Table C1. Assessment Instrument Manuals

Setting	Manual Version	URL
HH	OASIS-D	Home Health (HH) OASIS-D Instrument and Manuals
IRF	IRF-PAI v3.0	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) and Manuals
LTCH	LCDS v4.0	Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) Instrument and Manuals
SNF	MDS 3.0	Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) and Manuals

Table C2. Quality Reporting Program Websites

Setting	URL
HH	Home Health (HH) Quality Reporting Program (QRP)
IRF	Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
LTCH	Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
SNF	Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

Table C3. Quality Measure Informational Pages

Setting	URL
HH	Home Health (HH) Quality Reporting Program (QRP) Measures Informational Page
IRF	Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Measure Informational Page
LTCH	Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Measures Informational Page
SNF	Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Measures and Technical Informational Page

Table C4. Quality Measure Specifications

Setting	QM Manual Version	URL
HH	v1.0	Home-Health-QRP-QM-Users-Manual-V1.0-August-2019.pdf
IRF	v3.1	IRF-Measure-Calculations-and-Reporting-Users-Manual-V3.1-508C.pdf
LTCH	v3.1	LTCH-Measure-Calculations-and-Reporting-Users-Manual-V3.1-508C.pdf
SNF	v3.0	SNF-Measure-Calculations-and-Reporting-Users-Manual-V3.0 -508C.pdf