Specifications for the Cross-Setting Function Quality Measure Adopted in the Home Health Quality Reporting Program

August 2018

Prepared for:

Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Submitted by:

Abt Associates
10 Fawcett Street
Cambridge, MA 02138
CMS Contract No. HHSM-500-2013-13001I
Task Order HHSM-500T0002

Specifications for the Cross-Setting Function Quality Measure Adopted in the Home Health Quality Reporting Program

Abt Associates

CMS Contract No. HHSM-500-2013-13001I; Task Order HHSM-500T0002

August 2018

CONTENTS

BACKGROUND

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted Oct. 6, 2014, directs the Secretary of Health and Human Services to "specify quality measures on which Post-Acute Care (PAC) providers are required under the applicable reporting provisions to submit standardized patient assessment data" in several domains, including functional status , skin integrity, and incidence of major falls. The IMPACT Act requires the implementation of measures to address these measure domains in home health agencies (HHAs), skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs).

The IMPACT Act also requires, to the extent possible, the submission of such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use. For HHAs, the Outcome and Assessment Information Set (OASIS) will be used.

The reporting of quality data by HHAs is mandated by Section 1895(b)(3)(B)(v)(II) of the Social Security Act ("the Act"). For more information on the statutory history of the HH Quality Reporting Program (QRP), please refer to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html. More information on the IMPACT Act is available at https://www.govtrack.us/congress/bills/113/hr4994.

This document describes the specifications for the cross-setting function quality measure adopted in the HH QRP. The quality measure is:

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631);

QUALITY MEASURE SPECIFICATIONS

1.1 Quality Measure Description

The cross-setting function quality measure is a process measure that is an application of the quality measure Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). This quality measure reports the percent of episodes with a Start of Care (SOC) /Resumption of Care (ROC) and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient.

This process quality measure requires the collection of SOC/ROC and discharge functional status data by clinicians using standardized clinical assessment items or data elements that assess specific functional activities, that is, self-care and mobility activities. The self-care and mobility function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity. A higher score indicates greater independence. If an activity is not attempted, the reason that the activity did not occur is coded. For this quality measure, documentation of a goal for one of the function items reflects that the patient's care plan addresses function. The functional goal is recorded at start or resumption of care for at least one of the standardized self-care or mobility function items using the 6-level rating scale. Subsequent to the SOC/ROC assessment, goal setting and establishment of a care plan to achieve the goal, at the time of discharge the self-care and mobility functional performance is reassessed using the same 6-level rating scale, enabling the ability to re-assess the patient's functional abilities. This quality measure will be calculated using data from the Outcome and Assessment Information Set (OASIS).

1.1.1 Purpose/Rationale for the Quality Measure

The National Committee on Vital and Health Statistics, Subcommittee on Health[1] noted: "[i]nformation on functional status is becoming increasingly essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life span of the effects of people's health conditions on their ability to do basic activities and participate in life situations, that is, their functional status." This statement is supported by research showing that patient functioning is associated with important patient outcomes such as discharge destination and length of stay in inpatient settings[2] as well as

[1] Subcommittee on Health National Committee on Vital and Health Statistics, "Classifying and Reporting Functional Status" (2001).

[2] Reistetter T. A., Graham J. E., Granger C. V., Deutsch A, Ottenbacher K. J. (2010). Utility of Functional Status for Classifying Community Versus Institutional Discharges after Inpatient Rehabilitation for Stroke. Archives of Physical Medicine and Rehabilitation; 91:345-350.

risk of nursing home placement and hospitalization of older adults living the in community.[3] Functioning is important to patients and their family members.[4] [5] [6]

The primary goal of home care is to provide restorative care where improvement is expected, maintain function and health status when improvement is not expected, and/or facilitate transition to end-of-life care when appropriate.[7] Many patients who receive post-acute care (PAC) services, such as care provided by home health agencies (HHAs), have functional limitations and are at risk for further decline in function due to limited mobility and ambulation.[8]

Given the variation in patient populations across the PAC providers, the functional activities that are typically assessed by clinicians for each type of PAC provider may vary. For example, the activity of rolling left and right in bed is an example of a functional activity that may be most relevant for low-functioning patients who are chronically critically ill. However, certain functional activities, such as eating, oral hygiene, lying to sitting on the side of the bed, toilet transfers, and walking or wheelchair mobility, are important activities for patients/residents in each PAC setting. These activities are included in the cross-setting measure. The patient populations treated by home health agencies (HHAs) vary in their functional abilities at the time of the home health (HH) admission and their goals of care. For HH patients who are home-bound, achieving independence within the living environment and promoting community mobility may be the goal of care. For other HH patients, the goal of care may be to slow the rate of functional decline to avoid institutionalization.[9] The clinical practice guideline, Assessment of Physical Function,[10] recommends that clinicians document functional status at baseline and over time to validate capacity, decline, or progress. These quality measures will inform HH providers about opportunities to improve care in the area of self-care and function and strengthen incentives for quality improvement related to patient function.

Although functional assessment data are currently collected in HH, this data collection has employed different assessment instruments, scales, and items relative to other PAC providers. The data collected cover similar topics, but are not standardized across PAC settings. Further, the different sets of functional assessment items are coupled with different rating scales, making communication about patient functioning challenging when patients/residents transition

---

3 Miller E.A., Weissert W. G. (2000) Predicting Elderly People's Risk for Nursing Home Placement, Hospitalization, Functional Impairment, and Mortality: A Synthesis. Medical Care Research and Review, 57; 3: 259-297.

4 Kurz, A. E., Saint-Louis, N., Burke, J. P., & Stineman, M. G. (2008). Exploring the personal reality of disability and recovery: a tool for empowering the rehabilitation process. Qual Health Res, 18(1), 90-105.

5 Kramer, A. M. (1997). Rehabilitation care and outcomes from the patient's perspective. Med Care, 35(6 Suppl), JS48-57.

6 Stineman, M. G., Rist, P. M., Kurichi, J. E., & Maislin, G. (2009). Disability meanings according to patients and clinicians: imagined recovery choice pathways. Quality of Life Research, 18(3), 389-398.

7 Riggs, J. S. & Madigan, E. A. (2012). Describing variation in home health care episodes for patients with heart failure. Home Health Care Management and Practice, 24(3): 146-152.

8 Kortebein P, Ferrando A, Lombebeida J, Wolfe R, Evans WJ (2007). Effect of 10 days of bed rest on skeletal muscle in health adults. JAMA; 297(16):1772-4.

9 Ellenbecker CH, Samia L, Cushman MJ, Alster K (2008). Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 13.

10 Kresevic DM. Assessment of physical function. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). (2012). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company, p. 89-103.

from one type of provider to another. Collection of standardized functional assessment data across all PAC settings, using standardized data items, would establish a common language for patient/resident functioning, which may facilitate communication and care coordination as patients/residents transition from one type of provider to another. The collection of standardized functional status data may also help improve patient/resident functioning during an episode of care by ensuring that basic daily activities are assessed at the start and end of each episode of care with the aim of determining whether at least one functional goal is established.

The functional assessment items included in the functional status quality measure were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PAC PRD) version of the Continuity Assessment Record and Evaluation (CARE) Item Set, which was designed to standardize assessment of patient's/resident's status across acute and post-acute providers, including skilled nursing facilities (SNFs), HHAs, long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or discharge to determine patients'/residents' needs, evaluate patient/resident progress and prepare patients/residents and families for a transition to home or to another provider.

The development of the CARE Item Set and a description and rationale for each item is described in a report entitled "The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set: Volume 1 of 3."[11] Reliability and validity testing were conducted as part of CMS' Post-Acute Care Payment Reform Demonstration, and we concluded that the functional status items have acceptable reliability and validity. A description of the testing methodology and results are available in several reports, including the report entitled "The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report On Reliability Testing: Volume 2 of 3"[12] and the report entitled "The Development and Testing of The Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report on Care Item Set and Current Assessment Comparisons: Volume 3 of 3."[13] The reports are available on CMS' Post-Acute Care Quality Initiatives webpage at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html.

1.1.2 Denominator Statement

Number of Medicare/Medicaid (including Advantage programs) covered home health episodes of care for patients who are at least 18 years of age, ending during the reporting period that do not meet the generic exclusions described below.

---

[11] Research Triangle International. The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set (Contract HHSM-500-2005-00291) 2012, August.

[12] *IBID*

[13] *IBID*

1.1.3 Denominator Details

All home health episodes of care, defined as a start/resumption of care assessment (OASIS item M0100) (Reason for Assessment) = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer/death assessment (M0100 (Reason for Assessment) = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by generic and measure-specific denominator exclusions.

1.1.4 Numerator Statement

The numerator for this quality measure is the number of home health quality episodes with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.

1.1.5 Numerator Details

All three of the following are required for the patient to be counted in the numerator:

1. A valid numeric score indicating the patient's functional status, or a valid code indicating the activity was not attempted or could not be assessed for each of the functional assessment items on the SOC/ROC assessment;
2. A valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the SOC/ROC assessment; and
3. A valid numeric score indicating the patient's functional status, or a valid code indicating the activity was not attempted or could not be assessed, for each of the functional assessment items on the discharge assessment.

1.1.6 Incomplete Episode

For home health episodes ending in a qualifying admission to an inpatient facility [Transfer], or a Death at Home, the discharge functional status data would not be required for the episode to be included in the numerator. For episodes ending in transfer or death at home, the following are required for these patients to be counted in the numerator:

1. A valid numeric score indicating the patient's functional status, or a valid code indicating the activity was not attempted or could not be assessed for each of the functional assessment items on the SOC/ROC assessment; and
2. A valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the SOC/ROC assessment.

1.1.7 Items Included in the Quality Measure

An important consideration when measuring functional status is that certain activities may not be relevant or feasible to assess for all home health patients. For example, walking may not occur at the start or resumption of care because it is not safe for a patient to ambulate. In this situation, a clinician would code that a functional activity was not attempted because it was not safe or feasible for the patient to perform the activity.

The following functional status items are included in this measure:

Self-Care Items

Eating (GG0130A): The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

Oral hygiene (GG0130B): The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

Toileting hygiene (GG0130C): The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Mobility Items

Sit to lying (GG0170B): The ability to move from sitting on side of bed to lying flat on the bed.

Lying to sitting on side of bed (GG0170C): The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

Sit to stand (GG0170D): The ability to safely come to a standing position from sitting in a chair or on the side of the bed.

Chair/bed-to-chair transfer (GG0170E): The ability to safely transfer to and from a bed to a chair (or wheelchair).

Toilet transfer (GG0170F): The ability to safely get on and off a toilet or commode.

For patients/residents who are walking, complete the following items:

Walk 50 feet with two turns (GG0170J): Once standing, the ability to walk at least 50 feet and make two turns.

Walk 150 feet (GG0170K): Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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

Wheel 50 feet with two turns (GG0170R): Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Indicate the type of wheelchair/scooter used (GG0170RR).

1. **Manual**
2. **Motorized**

Wheel 150 feet (GG0170S): Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

Indicate the type of wheelchair/scooter used (GG0170SS).

1. **Manual**
2. **Motorized**

Self-Care and Mobility Rating Scale: Codes and Code Definitions

6. **Independent** – Patient/resident completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient/resident completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient/resident completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient/resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the patient/resident to complete the activity.

If activity was not attempted, code reason:

07. Patient/resident refused

09. 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

1.1.8 Risk Adjustment

This is a process measure and not risk-adjusted

1.1.9 Quality Measure Calculation Algorithm

1. For each provider, the records of patients meeting the inclusion criteria (i.e., denominator) discharged during the 12 month target time period are identified and counted. This count is the denominator.
3. The records of patients not transferred to an inpatient facility or who did not die at home are identified and the number of these episodes with complete SOC/ROC functional assessment data (codes 1 through 6 or 7, 9, 10 or 88) AND at least one self-care or mobility goal (codes 1 through 6 or 7, 9, 10 or 88) AND complete discharge functional assessment data (codes 1 through 6 or 7, 9, 10 or 88) is counted.
4. The records of patients who are transferred to an inpatient facility or who died at home are identified, and the number of these patient records with complete SOC/ROC functional status data (codes 1 through 6 or 7, 9,10 or 88) AND at least one self-care or mobility goal (codes 1 through 6 or 7, 9,10 or 88) is counted.
5. The counts from step 2 and step 3 are summed. The sum is the numerator count.
6. The numerator count is divided by the denominator count to calculate this quality measure, and converted to a percent value by multiplying by 100.

1.1.10 Denominator Exclusions

There are no measure-specific exclusions.

1.1.11 Numerator Exclusions

Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over), non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. Publicly reported data for HHAs on CMS's Home Health Compare Web site require that the HHA have at least 20 observations for the quality measure and that the HHA has been in operation at least six months.

Appendix 1

FUNCTION ITEMS INCLUDED IN THE PROCESS FUNCTION QUALITY MEASURE FOR HH, IRF, SNF, AND LTCH QUALITY REPORTING PROGRAMS

Table 1 shows the items included in the function quality measures that are process measures. For the HH, IRF, SNF and LTCH settings, the cross-setting measure, an *Application* of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; endorsed), is listed.

Table 1: Function Items Included in the Process Function Quality Measures for HH, IRF, SNF, and LTCH QRPs

Item Identifier	Item Name	HH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	IRF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	SNF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
SELF-CARE	**GG0130**					
A	Eating	✓	✓	✓	✓	✓
B	Oral hygiene	✓	✓	✓	✓	✓
C	Toileting hygiene	✓	✓	✓	✓	✓
D	Wash upper body	—	—	—	—	✓
E	Shower/ bathe self	—	—	—	—	—
F	Upper body dressing	—	—	—	—	—
G	Lower body dressing	—	—	—	—	—

Item Identifier	Item Name	HH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	IRF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	SNF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
H	Putting on/taking off footwear	—	—	—	—	—
MOBILITY	**GG0170**					
A	Roll left and right	—	—	—	—	✓
B	Sit to lying	✓	✓	✓	✓	✓
C	Lying to sitting on side of bed	✓	✓	✓	✓	✓
D	Sit to stand	✓	✓	✓	✓	✓
E	Chair/bed-to-chair transfer	✓	✓	✓	✓	✓
F	Toilet transfer	✓	✓	✓	✓	✓
G	Car transfer	—	—	—	—	—
I	Walk 10 feet	—	—	—	—	✓
J	Walk 50 feet with two turns	✓	✓	✓	✓	✓
K	Walk 150 feet	✓	✓	✓	✓	✓

Item Identifier	Item Name	HH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	IRF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	SNF QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)	LTCH QRP Percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF #2631; endorsed)*
L	Walking 10 feet on uneven surface	—	—	—	—	—
M	1 step (curb)	—	—	—	—	—
N	4 steps	—	—	—	—	—
O	12 steps	—	—	—	—	—
P	Picking up object	—	—	—	—	—
Q	*Does patient use wheelchair /scooter?*	✓	✓	✓	✓	✓
R	Wheel 50 feet with two turns	✓	✓	✓	✓	✓
RR	Type of wheelchair /scooter	✓	✓	✓	✓	✓
S	Wheel 150 feet	✓	✓	✓	✓	✓
SS	Type of wheelchair /scooter	✓	✓	✓	✓	✓

NOTES:
✓ = Item is included in the quality measure.
— = Item is not included in the quality measure.
* This process measure was adopted for the LTCH QRP through the FY 2015 IPPS/LTCH PPS final rule (79 FR 50298 through 50301)

Table 2:
Self-Care and Mobility Data Elements Included in Section GG of the Post-Acute Care Item Sets (2018/2019)

Data Element Identifier	Data Element Label	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Version 2.0 Oct 2018	Minimum Data Set (MDS) 3.0 Version 1.16.0 Oct 2018	Long-Term Care Hospital CARE Data Set Version 4.00 July 2018	Outcome and Assessment Information Set (OASIS-D) Jan 2019
SELF-CARE	**GG0130**				
GG0130A*	Eating	✓	✓	✓	✓
GG0130B*	Oral hygiene	✓	✓	✓	✓
GG0130C*	Toileting hygiene	✓	✓	✓	✓
GG0130D	Wash upper body	—	—	✓	—
GG0130E	Shower/bathe self	✓	✓	—	✓
GG0130F	Upper body dressing	✓	✓	—	✓
GG0130G	Lower body dressing	✓	✓	—	✓
GG0130H	Putting on/taking off footwear	✓	✓	—	✓
MOBILITY	**GG0170**				
GG0170A	Roll left and right	✓	✓	✓	✓
GG0170B*	Sit to lying	✓	✓	✓	✓
GG0170C*	Lying to sitting on side of bed	✓	✓	✓	✓
GG0170D*	Sit to stand	✓	✓	✓	✓
GG0170E*	Chair/bed-to-chair transfer	✓	✓	✓	✓
GG0170F*	Toilet transfer	✓	✓	✓	✓
GG0170G	Car transfer	✓	✓	—	✓
GG0170I*	Walk 10 feet	✓	✓	✓	✓
GG0170J*	Walk 50 feet with two turns	✓	✓	✓	✓
GG0170K*	Walk 150 feet	✓	✓	✓	✓

Data Element Identifier	Data Element Label	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Version 2.0 Oct 2018	Minimum Data Set (MDS) 3.0 Version 1.16.0 Oct 2018	Long-Term Care Hospital CARE Data Set Version 4.00 July 2018	Outcome and Assessment Information Set (OASIS-D) Jan 2019
GG0170L	Walking 10 feet on uneven surface	✓	✓	—	✓
GG0170M	1 step (curb)	✓	✓	—	✓
GG0170N	4 steps	✓	✓	—	✓
GG0170O	12 steps	✓	✓	—	✓
GG0170P	Picking up object	✓	✓	—	✓
GG0170Q	Does the patient/resident use a wheelchair and/or scooter?	✓	✓	✓	✓
GG0170R*	Wheel 50 feet with two turns	✓	✓	✓	✓
GG0170RR*	Indicate the type of wheelchair or scooter used.	✓	✓	✓	✓
GG0170S*	Wheel 150 feet	✓	✓	✓	✓
GG0170SS*	Indicate the type of wheelchair or scooter used.	✓	✓	✓	✓

Notes:

✓ = Data element is included in the item set.

— = Data element is not included in the item set

* Data elements included in the cross-setting function quality measure, Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)