Identifier	Reference or indicator source	Link	Short title	Denominator	Numerator	Adapted title	Level of evidence	Type of indicator	Category	Setting/Perspective	Dimension
1	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Detection of Falls	ALL vulnerable elders	Vulnerable elders (VEs) should have documentation that they have been asked annually about the occurrence of recent falls	Percentage of vulnerable elderly patients who have had any recent falls	5	Process	Geriatric CC	Inpatient and ambulatory care	Safety
2	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Basic Fall History (Including Medication Review and Functional Status)	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year,	THEN there should be documentation of a basic fall history (circumstances, medications, chronic conditions, mobility, alcohol intake) within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks)	Percentage of vulnerable elderly people, who have suffered at least 2 falls in the last year (or 1 with injuries), in whom a basic history of falls has been completed (Circumstances, medication, chronic diseases, mobility and alcohol consumption)	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
3	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Orthostatic Vital Signs	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year,	THEN there should be documentation of orthostatic vital signs (blood pressure and pulse) within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks)	Percentage of vulnerable elderly people who have suffered at least 2 falls in the last year (or 1 with injuries), in whom orthostatic vital signs (blood pressure and pulse) have been recorded	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
4	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Gait and Balance Evaluation for Falls and Mobility Disorders	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year,	THEN there should be documentation of a basic gait, balance, and strength evaluation within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks);	Percentage of vulnerable elderly people who have suffered at least 2 falls in the last year (or 1 with injuries) in whom an examination of gait, balance and strength has been documented.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

5	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Gait and Balance Evaluation for Falls and Mobility Disorders b	IF a VE has new or worsening difficulty with ambulation, balance, or mobility,	THEN there should be documentation of a basic gait, balance, and strength evaluation within 3 months of the report;	Percentage of vulnerable seniors reporting difficulty or worsening gait, balance, or mobility in which a walk, balance, and strength examination has been documented.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
6	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Cognitive Assessment	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year,	THEN there should be documentation of an assessment of cognitive status in the previous 6 months or within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks),	Percentage of vulnerable elderly people who have suffered at least 2 falls in the last year (or 1 with injuries) in which an assessment of cognitive status (mini-mental) has been recorded.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
7	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Home Hazard Assessment and Modification	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year,	There should be documentation of an assessment and modification of home hazards recommended in the previous year or within 3 months of the report,	Percentage of vulnerable seniors who have suffered at least 2 falls in the past year (or 1 with injuries) in whom a home risk assessment record and recommendations have been completed.	2	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
8	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Assistive Device	IF a VE demonstrates poor balance or proprioception or excessive postural sway and does not have an assistive device,	THEN an evaluation or prescription for an assistive device should be offered within 3 months,	Percentage of vulnerable elderly who demonstrate poor balance, proprioception, or excessive postural deviation and do not have an assistive device for whom an evaluation and prescription of an assistive device has been	4	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
9	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Assistive Device b	IF a VE reports a history of two or more falls (or 1 fall with injury) in the previous year and has an assistive device,	THEN there should be documentation of an assistive device review in the previous 6 months or within 3 months of the report (or within 4 weeks of the report if the most recent fall occurred in the previous 4 weeks),	Percentage of vulnerable elderly patients who have suffered at least 2 falls in the last year (or 1 with injuries) who use an assistive device in which a revision of the same has been registered.	4	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

10	Chang JT, Ganz DA. Quality indicators for falls and mobility problems in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S327-34.	http://doi.wiley.com/10.1111/j.1532-5415.2007.01339.x	Exercise Programs	IF a VE is found to have a problem with gait, balance, strength, or endurance	THEN there should be documentation of a structured or supervised exercise program offered in the previous 6 months or within 3 months of the report,	Percentage of vulnerable seniors demonstrating poor gait, balance, strength, or endurance who have been offered a structured and supervised exercise program.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
11	Grossman JM, MacLean CH. Quality indicators for the management of osteoporosis in vulnerable elders. Ann Intern Med. 2001 Oct 16;135(8 Pt 2):722-30. PubMed PMID: 11601955.	https://annals.org/aim/fullarticle/714865/quality-indicators-management-osteoporosis-vulnerable-elders	Exercise Therapy for Patients with a New Osteoporotic Fracture	IF an ambulatory vulnerable elder has an osteoporotic fracture diagnosed	THEN physical therapy or an exercise program should be offered within 3 months	Percentage of vulnerable elderly people with a fracture due to osteoporosis in whom a physiotherapeutic exercise program has been offered.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
12	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA.111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627679	Management to reduce spasticity	All stroke patients	Percentage of patients receiving a standardized assessment for spasticity at admission and before discharge.	Percentage of stroke patients in whom a standardized assessment for spasticity at admission and before discharge has been performed.	5	Process	Neurology CC	Inpatient and ambulatory care	Effectiveness

13	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627680	Recovery of mobility	All stroke patients who were immobile at admission	Percentage of patients who are able to move at least independently using a wheelchair at discharge (Barthel Index item "Mobility" ≥ 5)1 of those patients who were immobile at admission (Barthel Index item "Mobility" = 0)	Percentage of stroke patients immobile on admission who can move independently in a wheelchair at discharge.	5	Outcome	Neurology CC	Inpatient and ambulatory care	Effectiveness
14	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627681	Recovery of walking function	All stroke patients who were immobile or dependent on a wheelchair at admission	Percentage of patients who are able to move independently at discharge (Barthel Index item "Mobility" = 15)1 of those patients who were immobile or dependent on a wheelchair at admission (Barthel Index item "Mobility" < 15)	Percentage of patients with stroke while immobile or in a wheelchair at admission who can move independently at discharge	5	Outcome	Neurology CC	Inpatient and ambulatory care	Effectiveness

15	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627682	Recovery of assistive upper limb function	All stroke patients who could not pick up a ball with both hands so at admission	Percentage of patients who can pick up a ball with both hands (item 5 of the arm section of the Rivermead Motor Assessment)2 at discharge of those who could not do so at admission	Percentage of stroke patients unable to catch a ball with both hands on admission who are able to discharge.	5	Outcome	Neurology	CC	Inpatient and ambulatory care	Effectiveness
16	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627683	Recovery of functional upper limb function	All stroke patients who could not pick up a piece of paper from a table an release it five times at admission	Percentage of patients who can pick up a piece of paper from a table an release it five times (item 8 of the arm section of the Rivermead Motor Assessment) at discharge of those who could not at admission	Percentage of stroke patients unable to grab and drop a piece of paper 5 times on admission who are able to discharge	5	Outcome	Neurology	CC	Inpatient and ambulatory care	Effectiveness

17	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627684	Application for/ facilitation of further rehabilitation or therapy	All stroke patients	Percentage of patients who receive at least one of the following four services: - application for further outpatient rehabilitation - individual counselling on further rehabilitation - a list of ambulant therapists close to the patient's residence - phone contact to the physician responsible for further treatment	Percentage of stroke patients who have received at least 1 of these 4 services (request for additional outpatient rehabilitation, individual counseling for additional rehabilitation, a list of therapists near the patient's residence, telephone contact with the responsible doctor of additional treatment).	5	Process	Neurology	CC	Inpatient and ambulatory care	Effectiveness
18	Grube MM, Dohle C, Djouchadar D, Rech P, Bienek K, Dietz-Fricke U, Jöbges M, Kohler M, Missala I, Schönherr B, Werner C, Zeytountchian H, Wissel J, Heuschmann PU. Evidence-based quality indicators for stroke rehabilitation. Stroke. 2012 Jan;43(1):142-6. doi: 0.1161/STROKEAHA .111.627679. Epub 2011 Oct 20. PubMed PMID: 22020037.	https://www.ahajournals.org/doi/pdf/10.1161/STROKEAHA.111.627685	Record of complications	All stroke patients	Existence of a written record of complications which covers at least three of the following domains: - infections - falls - pressure ulcers	Percentage of stroke patients in whom complications have been recorded covering at least three of the following areas (infections, falls, pressure ulcers)	5	Structure	Neurology	CC	Inpatient and ambulatory care	Effectiveness

19	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	EPOCDerivación E1	Todo paciente con una disnea de 2 o más puntos de la MRCm a pesar de un tratamiento farmacológico adecuado	Número de pacientes a los que se les solicita valoración de RR (rehabilitación respiratoria)	Percentage of patients with dyspnea despite adequate pharmacological treatment in whom an assessment of respiratory rehabilitation has been requested.	1	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
20	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	IndicaciónE2	Todo paciente con EPOC remitido a una unidad de RR si su BODE es al menos de 3 puntos o la disnea MRCm (escala del Medical Research Council modificada)≥2	Número de pacientes incluidos en un programa de RR	Percentage of patients with Chronic Obstructive Pulmonary Disease who have been included in a respiratory rehabilitation program.	1	Process	Pneumology CC	Ambulatory care	Effectiveness

21	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	ERCDLE3	Todo paciente con una disnea de 2 o más puntos de la MRCm a pesar de un tratamiento adecuado	Número de pacientes que reciben RR	Percentage of patients with dyspnea despite treatment in which respiratory rehabilitation has been received.	2	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
22	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Enfermedades hipersecretoras E4	Todos los pacientes hipersecretores con fibrosis quística o bronquiectasias	Número de pacientes incluidos en un programa de RR	Percentage of hypersecretory patients with cystic fibrosis or bronchiectasis who are included in respiratory rehabilitation.	1	Process	Pneumology CC	Ambulatory care	Effectiveness

23	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Enfermedades neuromusculares E5	Todos los pacientes con enfermedad neuromuscular y tos ineficaz deben recibir RR	Número de pacientes que reciben RR	Percentage of patients with neuromuscular disease and ineffective cough who have received respiratory rehabilitation.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
24	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Cirugía torácica E6	Todos los pacientes que precisen cirugía torácica	Número de pacientes que reciben RR	Percentage of patients requiring thoracic surgery in whom respiratory rehabilitation has been received.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

25	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Derivación del pacienteE7	Número de pacientes remitidos a RR	Número de pacientes remitidos con documento firmado y completado por el médico de referencia	Percentage of patients referred to respiratory rehabilitation in which a document signed and completed by the referring physician has been presented.	5	Process	Pneumology CC	Inpatient and ambulatory care	Safety
26	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Consentimiento informadoE8	Número de pacientes remitidos al programa de RR	Número de pacientes que firman el consentimiento informado	Percentage of patients referred to the respiratory rehabilitation program who have signed the informed consent.	5	Process	Pneumology CC	Inpatient and ambulatory care	Safety

27	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Evaluación clínicaInicialE9	Número total de historias clínicas de pacientes remitidos a RR	Número de historias clínicas donde se recoge completamente esta información	Percentage of medical records of patients referred to respiratory rehabilitation in which information has been collected, influencing the symptoms (dyspnea, cough and / or expectoration).	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
28	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Exploración físicaE10	Número total de pacientes remitidos a RR	Número de pacientes con exploración física completa incidiendo en: morfología y movilidad del tórax, asimetrías. Ritmo respiratorio. Auscultación respiratoria. Fuerza muscular periférica. SpO2	Percentage of patients referred to respiratory rehabilitation who underwent a complete physical examination (morphology and mobility of the chest, asymmetries. Respiratory rhythm. Respiratory auscultation. Peripheral muscular strength. SpO2)	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

29	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Evaluación de la disneaE11	Número total de pacientes remitidos a RR con disnea en AVDs	Nº pacientes con evaluación de MRCmAl esfuerzo: Borg/EVA	Percentage of patients referred to respiratory rehabilitation with dyspnea in activities of daily living who have been evaluated for exertional dyspnea.	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
30	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Exploraciones complementariasE12	Número total de pacientes remitidos a RR	En la primera evaluación se deberán realizar:Radiografía de tóraxECGEspirometría simple+PBDPrueba de 6 minutos marcha+ BORGEvaluación nutricional: IMCEvaluación de la CVRS	Percentage of patients referred to respiratory rehabilitation in whom, in the first evaluation, chest radiography, electrocardiogram, simple spirometry and bronchodilator test, 6-minute walk and BORG, nutritional evaluation with body mass index and evaluation of the Quality of life related to health.	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

31	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Exploraciones complementarias (NAAP)E13	Número total de pacientes remitidos a RR	Pacientes con exploración de Volúmenes, difusiónPIM/PEM (Si existe Insuficiencia Respiratoria: gasometría arterial, Prueba de esfuerzo progresiva o Shuttle test)	Percentage of patients referred to respiratory rehabilitation in which a Volume examination, PIM / PEM diffusion (PIM: maximum inspiratory pressure; PEM: maximum expiratory pressure) has been performed.	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
32	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Exploraciones complementariasE. NeuromuscularesE14	Número total de pacientes remitidos a RR y con capacidad para realizar las maniobras	Pacientes con EspirometríaPIM/PEM o SNIF/SNEFPFTMIC (Si existe Insuficiencia Respiratoria: gasometría arterial)	Percentage of patients referred to respiratory rehabilitation with the ability to perform the maneuvers in which PIM / PEM or SNIF / SNEF, PFT, MIC Spirometry examinations (SNIF, SNEF: maximum inspiratory and expiratory nasal pressure; PFT: peak flow with cough; MIC: maximum insufflation capacity).	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

33	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Evaluación finalE15	Número total de pacientes remitidos a RR	Evaluación disnea (MRCm)Prueba de 6 minutos marcha + BORGEvaluación CVRS al alta	Percentage of patients referred to respiratory rehabilitation in whom the evaluation of dyspnea, 6-minute walk test, BORG and evaluation of quality of life at discharge have been performed.	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
34	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Entrenamiento al ejercicio de miembros superiores e inferioresE16	Numero de pacientes incluidos en programa de rr con EPOC, ERCDL, Trasnplante de pulmón, cirugía de reducción de volumen	Número de pacientes que reciben entrenamiento de miembros superiores e inferiores	Percentage of patients included in the respiratory rehabilitation program with chronic obstructive pulmonary disease, chronic respiratory diseases with limiting dyspnea, lung transplantation, volume reduction surgery in whom training has been received for upper and lower limbs.	2	Process	Pneumology CC	Ambulatory care	Effectiveness

35	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Entrenamiento de músculos respiratoriosE17	Pacientes en programa de RR con debilidad de musculatura respiratoria y una de las siguientes: EPOC, bronquiostasias, fibrosis quística, ERCDL	Pacientes que reciben entrenamiento de músculos respiratorios	Percentage of patients included in the respiratory rehabilitation program with weakness of said musculature in one of the following pathologies (chronic obstructive pulmonary disease, bronchiostasis, cystic fibrosis, chronic respiratory diseases with limiting dyspnea) in whom respiratory muscle training has been received.	3	Process	Pneumology CC	Ambulatory care	Effectiveness
36	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Técnicas de fisioterapia respiratoriaE18	Total de pacientes con EPOC, ERCDL, Bronquiostásias, fibrosis quística, enfermedades neuromusculares y cirugía torácica	Número de pacientes que reciben fisioterapia respiratoria	Percentage of patients with Chronic Obstructive Pulmonary Disease, Bronchiostasis, cystic fibrosis, neuromuscular diseases, thoracic surgery, Chronic respiratory diseases with limiting dyspnea in whom respiratory physiotherapy has been received.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

37	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	EducaciónE19	Total de paciente en rehabilitación respiratoria	Número de pacientes que reciben educación	Percentage of patients in respiratory rehabilitation who have received education.	2	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
38	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Entrenamiento Intensidad Ejercicio aeróbico E21	Número de programas evaluados	Número de programas que cumplen: En los ejercicios de piernas, la carga de trabajo se establece en relación al máximo alcanzado en la prueba de esfuerzo (Wmax) y se va incrementando según tolerancia del paciente (progresión del entrenamiento). En general, niveles altos de intensidad, entre el 60-80% del Wmax son más eficaces y son los recomendados, salvo intolerancia del paciente o circunstancias que así lo aconsejen. Un nivel de entrenamiento bajo (< 50% Wmax) también puede ser eficaz En los ejercicios de brazos: se realiza en general con pesas, iniciando con ½ kg en cada brazo e incrementando progresivamente según tolerancia	Percentage of evaluated respiratory rehabilitation programs in which leg exercises have been completed with the established workload in relation to the maximum reached in the stress test and is increasing according to the patient's tolerance.	1	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

39	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Ejercicio de fuerza E22	Número de programas evaluados	Número de programas que realizan entrenamientos con una de las sigueintes opciones: 1. Pesos bajos/muchas repeticiones: dirigido a mejorar la resistencia muscular (iniciar con ½ kg en cada brazo e incrementar según tolerancia) 2Peso alto/pocas repeticiones: dirigido a incrementar la fuerza y masa musculares. Nivel de intensidad superior al 65% del 1RM	Percentage of evaluated respiratory rehabilitation programs in which different options have been performed with low weights and many repetitions (aimed at improving muscular endurance) or high weight and few repetitions (aimed at increasing strength and muscle mass).	5	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
40	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Entrenamiento de los músculos respiratorios E23	Número de programas evaluados	Número de programas en elos que La carga de entrenamiento debe establecerse entre el 30-40% de la PIM y/o de la PEM	Percentage of evaluated respiratory rehabilitation programs in which a training load has been established between 30-40% of the maximum inspiratory pressure and / or the maximum expiratory pressure.	2	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

41	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Entrenamiento de los músculos respiratorios E23	Número de programas evaluados	Número de programas que incluyen: Técnicas de permeabilización bronquial Técnicas de relajación Técnicas de reeducación respiratoria	Percentage of respiratory rehabilitation programs evaluated in which bronchial permeabilization, relaxation and respiratory reeducation techniques have been included.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
42	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	duración de la fisioterapia	Número de programas evaluados	Número de programas que duran al menos 1 mes	Percentage of evaluated respiratory rehabilitation programs lasting at least 1 month.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

43	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Duración del entrenmaiento general	Número de programas evaluados	Número de programas que realizan entrenamiento 8-12 semanas al menos 60 min, incluyendo 20-30 min de ejercicio de brazos y 20-30 min de piernas	Percentage of evaluated respiratory rehabilitation programs in which training has been performed for 8-12 weeks for at least 60 min, including 20-30 min of arm exercise and 20-30 min of leg exercise.	1	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
44	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Duración del entrenamiento de los músculos respiratorios	Número de programas evaluados	Número de programas que entrenan de 8-12 semanas 30 min al día todos los días, en una sola sesión o bien en 2 sesiones de 15 min	Percentage of evaluated respiratory rehabilitation programs in which they have trained for 8-12 weeks 30 minutes a day, every day, in a single session or in 2 sessions of 15 minutes.	2	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

45	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Frecuencia de fisioterapia	Número de programas evaluados	Número de programas que realizan 2-3 sesiones semanales de fisioterapia	Percentage of evaluated respiratory rehabilitation programs in which 2 to 3 weekly sessions of physical therapy have been carried out	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
46	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Frecuencia de entrenamiento	Número de programas evaluados	Número de programas que realizan entrenamiento un mínimo de 3 sesiones semanales y un máximo de 5	Percentage of evaluated respiratory rehabilitation programs in which training has been carried out for a minimum of 3 weekly sessions and a maximum of 5.	1	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

47	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Ubicación de programas	Número de pacientes en los que está indicado un programa de atención domiciliaria	Número de pacientes en programas domiciliarios	Percentage of respiratory rehabilitation patients in whom a home care program has been indicated.	1	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness
48	Maria Rosa Güell, Pilar Cejudo, Gema Rodríguez-Trigo, Juan Bautista Gàldiz, Vinyet Casolive, Mônica Regueiro, Juan Jose Soler-Cataluña. Estándares de calidad asistencial en rehabilitación respiratoria en pacientes con enfermedad pulmonar crónica. Archivos de bronconeumología. 2012 Vol. 48. Núm. 11: 396-404. DOI: 10.1016/j.arbres.2012.05.009	https://www.archbronconeumol.org/es-pdf-S0300289612002074	Mantenimiento	Número de pacientes que han realizado un programa Rehabilitación respiratoria	Número pacientes a los que se le ha hecho de continuar con un plan de ejercicios en el domicilio la recomendación	Percentage of patients who have undergone a respiratory rehabilitation program in which a home exercise plan has been recommended.	3	Process	Pneumology CC	Inpatient and ambulatory care	Effectiveness

49	Khanna D, Arnold EL, Pencharz JN, Grossman JM, Traina SB, Lal A, MacLean CH. Measuring process of arthritis care: the Arthritis Foundation's quality indicator set for rheumatoid arthritis. Semin Arthritis Rheum. 2006 Feb;35(4):211-37. Review. PubMed PMID: 16461068.	https://www.sciencedirect.com/science/article/abs/pii/S0049017205001617?via%3Dihub	Quality Indicator 12	IF a patient has a diagnosis ofRAand has no contraindications to exercise and is physically and mentally able to exercise	THEN a directed or supervised muscle strengthening or aerobic exercise program should have been prescribed at least once and reviewed at least once per year	Percentage of patients with rheumatoid arthritis, physically and mentally able to carry out exercise, without contraindications in which a supervised aerobic or strength exercise program has been prescribed at least 1 time.	1	Process	Rheumatology CC	Ambulatory care	Effectiveness
50	Khanna D, Arnold EL, Pencharz JN, Grossman JM, Traina SB, Lal A, MacLean CH. Measuring process of arthritis care: the Arthritis Foundation's quality indicator set for rheumatoid arthritis. Semin Arthritis Rheum. 2006 Feb;35(4):211-37. Review. PubMed PMID: 16461068.	https://www.sciencedirect.com/science/article/abs/pii/S0049017205001617?via%3Dihub	Quality Indicator 13	IF a patient has a diagnosis of RA and reports having difficulty with walking because of either stiffness, pain, or instability,	THEN patient's walking ability should be assessed for need for ambulatory assistive devices including a cane, insoles, and orthotics	Percentage of patients with rheumatoid arthritis and difficulty walking (due to stiffness, pain, or instability) in whom the need for healthcare devices (cane, insoles, and orthotics) has been evaluated.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness

51	Khanna D, Arnold EL, Pencharz JN, Grossman JM, Traina SB, Lal A, MacLean CH. Measuring process of arthritis care: the Arthritis Foundation's quality indicator set for rheumatoid arthritis. Semin Arthritis Rheum. 2006 Feb;35(4):211-37. Review. PubMed PMID: 16461068.	https://www.sciencedirect.com/science/article/abs/pii/S0049017205001617?via%3Dihub	Quality Indicator 14	IF a patient has a diagnosis of RA and reports having difficulties with activities of daily living because of either stiffness or pain,	THEN the patient's functional ability with the compliant tasks should be assessed for need of assistive devices to aid with compliant tasks	Percentage of patients with rheumatoid arthritis and difficulty in activities of daily living due to stiffness or pain, in whom the functional capacity of the affected tasks has been evaluated to define the need for assistive devices.	2	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness
52	Khanna D, Arnold EL, Pencharz JN, Grossman JM, Traina SB, Lal A, MacLean CH. Measuring process of arthritis care: the Arthritis Foundation's quality indicator set for rheumatoid arthritis. Semin Arthritis Rheum. 2006 Feb;35(4):211-37. Review. PubMed PMID: 16461068.	https://www.sciencedirect.com/science/article/abs/pii/S0049017205001617?via%3Dihub	Quality Indicator 15	IF a patient has a diagnosis of RA and reports having difficulties performing tasks involving use of their hands and wrists because of either stiffness or pain,	THEN the patient's functional ability with their hands and wrists should be assessed for need of hand or wrist splints (orthoses)	Percentage of patient with rheumatoid arthritis and difficulty performing tasks using hands and wrists due to stiffness or pain in which the functional capacity to define the need for splints has been evaluated.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness

53	Livingstone, I., Hefele, J.G., Nadash, P., Barch, D., & Leland, N.E. (2019). The Relationship Between Quality of Care, Physical Therapy, and Occupational Therapy Staffing Levels in Nursing Homes in 4 Years' Follow-up. Journal of the American Medical Directors Association, 20 4, 462-469 .	https://www.jamda.com/article/S1525-8610(19)30228-2/fulltext	National Quality Forum (NQF) (NQF 0674)	The percentage of long-term care residents experiencing 1 or more falls with major injury	Pacientes hospitalizados	Percentage of hospitalized patients who have experienced 1 or more falls with serious injuries.	5	Outcome	Geriatric CC	Inpatient care	Safety
54	MacLean CH, Pencharz JN, Saag KG. Quality indicators for the care of osteoarthritis in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S383-91. Review. PubMed PMID: 17910561.	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01346.x	Weight Loss	IF a vulnerable elder (VE) is mobese (body mass index (BMI) 30 kg/m2),	THEN he or she should be advised annually to lose weight,	Percentage of vulnerable obese elderly people who have been advised to lose weight.	4	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
55	MacLean CH, Pencharz JN, Saag KG. Quality indicators for the care of osteoarthritis in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S383-91. Review. PubMed PMID: 17910561.	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01346.x	Pain and Functional Assessment 1	A VE has symptomatic OA of the knee or hip,	THEN pain should be assessed when new to a primary care or musculoskeletal disease practice and annually	Percentage of vulnerable elderly with symptomatic knee or hip osteoarthritis in whom pain has been evaluated.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

56	MacLean CH, Pencharz JN, Saag KG. Quality indicators for the care of osteoarthritis in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S383-91. Review. PubMed PMID: 17910561.	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01346.x	Pain and Functional Assessment 2	IF a VE has symptomatic OA of the knee or hip,	THEN functional status should be assessed when new to a primary care or musculoskeletal disease practice and annually,	Percentage of vulnerable elderly with symptomatic osteoarthritis of the knee or hip in whom functional status has been evaluated.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
57	MacLean CH, Pencharz JN, Saag KG. Quality indicators for the care of osteoarthritis in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S383-91. Review. PubMed PMID: 17910561.	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01346.x	Exercise Therapy	IF an ambulatory VE has symptomatic OA of the knee or hip for longer than 3 months and is able to exercise,	THEN a directed or supervised muscle strengthening or aerobic exercise program should be recommended and activity reviewed annually,	Percentage of vulnerable elderly with symptomatic knee or hip osteoarthritis from 3 months and able to exercise in which a directed or supervised program of muscle strengthening or aerobic exercise has been recommended.	1	Process	Geriatric CC	Ambulatory care	Effectiveness
58	MacLean CH, Pencharz JN, Saag KG. Quality indicators for the care of osteoarthritis in vulnerable elders. J Am Geriatr Soc. 2007 Oct;55 Suppl 2:S383-91. Review. PubMed PMID: 17910561.	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01346.x	Assistive Devices	IF a VE has symptomatic OA of the hip or knee and has difficulty walking that makes activities of daily living (ADLs) difficult for longer than 3 months,	THEN the need for ambulatory assistive devices should be assessed,	Percentage of vulnerable elderly with symptomatic knee or hip osteoarthritis and difficulty walking (limits activities of daily living) in whom the need for assistive devices has been evaluated.	4	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

59	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Physical Examination	IF a patient begins a treatment for lateral epicondylalgia,	THEN evidence that the affected tendon was examined should be documented (at least orthopaedic tests).	Percentage of patients starting treatment for lateral epicondylitis in whom the affected tendon has been examined (at least orthopedic tests).	3	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
60	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Pain and functional assessment A	IF a patient has symptomatic lateral epicondylalgia,	THEN functional status should be assessed upon initiation of a new treatment at least once.	Percentage of patients with symptomatic lateral epicondylitis in whom pain has been evaluated at the start of a new treatment.	3	Process	Musculoskeletal CC	Ambulatory care	Effectiveness

61	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Pain and functional assessment B	IF a patient has symptomatic lateral epicondylalgia,	THEN functional status should be assessed upon initiation of a new treatment at least once.	Percentage of patients with symptomatic lateral epicondylitis in whom functional status has been assessed at the start of a new treatment.	3	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
62	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Education	IF a patient has symptomatic lateral epicondylalgia,	THEN education about self-management of risk factors (repetitive movements, etc.) should be given or recommended at least once.	Percentage of patients with symptomatic lateral epicondylitis in whom education on risk factors has been recommended.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness

63	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Physical therapy First line A	IF a patient is started on physical therapy to treat lateral epicondylalgia,	THEN a program of exercise therapy (training epicondyle muscles excentrically and concentrically) should be tried first.	Percentage of patients who begin physical therapy to treat lateral epicondylitis in whom treatment with concentric and eccentric exercises is started.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
64	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Physical therapy First line B	IF a patient is started on physical therapy to treat lateral epicondylalgia	THEN manual therapy by mobilization with movement should be tried first.	Percentage of patients who begin physical therapy to treat lateral epicondylitis in whom treatment is started by mobilizing with movement.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness

65	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Physical therapy First line C	IF a patient is started on physical therapy to treat lateral epicondylalgia,	THEN laser therapy should be tried first.	Percentage of patients who start physiotherapy to treat lateral epicondylitis in whom treatment with laser therapy is started.	2	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
66	Minaya-Muñoz F, Medina-Mirapeix F, Valera-Garrido F. Quality measures for the care of patients with lateral epicondylalgia. BMC Musculoskelet Disord. 2013 Oct 30;14:310. doi: 10.1186/1471-2474-14-310. PubMed PMID: 24172311; PubMed Central PMCID: PMC3816543.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816543/	Time to referral	IF a patient is treated with corticosteroid injection for lateral epicondylalgia	THEN a multimodal program of physical therapy should be initiated early before 14 days.	Percentage of patients with lateral epicondylitis treated with injectable corticosteroids in whom a multimodal physical therapy program was started before 14 days.	2	Process	Musculoskeletal CC	Ambulatory care	Effectiveness

67	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1133	The physiotherapist should assess health-related problems according to all five domains of the International Classification of Functioning, Disability and Health (ICF).	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months and in whom the health-related problems are assessed according to all five domains of the ICF.	Percentage of patients with osteoattritis of the hip or knee who have been treated in the previous 12 months in which health-related problems have been evaluated according to the 5 categories of the International Classification of Functioning, Disability and Health.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
68	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1134	The physiotherapist should assess barriers and facilitators for PT treatment.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months and in whom barriers and facilitators for PT treatment are assessed.	Percentage of patients with osteoattritis of the hip or knee who have been treated in the previous 12 months in which barriers and facilitators for physiotherapy treatment have been evaluated.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

69	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1135	The physiotherapist should evaluate red flags specific for HKOA.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months and in whom red flags specific for HKOA are evaluated.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months in which specific red flags have been evaluated for their pathology.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
70	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1136	Based on clinical reasoning and shared decisionmaking, the physiotherapist should set specific,measurable, attainable, results-orientated and timely (SMART) treatment goals.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months and in whom, based on clinical reasoning and shared decision making, SMART treatment goals are set.	Percentage of patients with osteoattritis of the hip or knee who have been treated in the previous 12 months in which specific, measurable, achievable, results-oriented and timely treatment objectives have been established.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

71	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1137	The physiotherapist should provide information regarding a healthy lifestyle (physical activity, risk of overweight) and the relationship between the mental and physical load and load-bearing capacity.	The number of patients with HKOA who have been treated during the previous 12 months and in whom information regarding a healthy lifestyle (physical activity, risk of overweight) and the relationship between the mental and physical load and load-bearing capacity is provided.	The total number of patients with HKOA who have been treated during the previous 12 months.	Percentage of patients with osteoattritis of the hip or knee who have been treated in the previous 12 months in which information on a healthy lifestyle (physical activity, risk of overweight) and the relationship between mental and physical load and ability have been provided of support.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
72	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1138	The physiotherapist should provide information regarding knowledge, understanding and possible consequences of progression of HKOA.	The total number of patients with HKOA who have been treated during the previous 12 months	The number of patients with HKOA who have been treated during the previous 12 months and in whom information regarding knowledge, understanding and possible consequences of progression of HKOA is provided.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months in which information on the knowledge, understanding and possible consequences of the progression of the disease has been provided.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

73	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1139	The physiotherapist should provide information regarding joint protection and the use of walking aids.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months in whom information regarding joint protection and the use of walking aids is provided.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months in whom information has been provided on the protection of the joint and the use of walking aids.	2	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
74	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1140	If there is a lack of muscular strength, then the physiotherapist should provide muscle-strengthening exercises.	The total number of patients with HKOA and lack of muscular strength who have been treated during the previous 12 months.	The number of patients with HKOA and lack of muscular strength who have been treated during the previous 12 months in whom muscle-strengthening exercises are provided.	Percentage of patients with osteoatritis of the hip or knee and lack of muscle strength who have been treated in the previous 12 months in which muscle strengthening exercises have been provided.	1	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

75	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1141	If the aerobic capacity is decreased, then the physiotherapist should provide exercise therapy to improve the aerobic capacity.	The total number of patients with HKOA and decreased aerobic capacity who have been treated during the previous 12 months.	The number of patients with HKOA and decreased aerobic capacity who have been treated during the previous 12 months in whom exercises to improve the aerobic capacity are provided.	Percentage of patients with osteoatritis of the hip or knee and decreased aerobic capacity who have been treated in the previous 12 months in which exercises have been provided to improve aerobic capacity.	1	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
76	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1142	The physiotherapist should provide functional exercises aimed at specific individualized tasks.	The total number of patients with HKOA and decreased aerobic capacity who have been treated during the previous 12 months	The number of patients with HKOA who have been treated during the previous 12 months in whom functional exercises to improve specific individualized tasks are provided.	Percentage of patients with osteoattritis of the hip or knee and decreased aerobic capacity who have been treated the previous 12 months in which functional exercises have been provided to improve specific individualized tasks.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

77	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1143	If a patient underwent joint replacement surgery, then the physiotherapist should provide at least muscle strengthening exercises and functional exercises aimed at specific individualized tasks.	The total number of patients with HKOA who have been treated during the previous 12 months after joint replacement surgery.	The number of patients with HKOA who have been treated during the previous 12 months after joint replacement surgery in whom strengthening exercises and functional exercises to improve specific individualized tasks are provided.	Percentage of patients with osteoattritis of the hip or knee who have been treated the previous 12 months after joint replacement surgery in which functional and strengthening exercises have been provided to improve specific individualized tasks.	1	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
78	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1144	If there is severe pain and a reversible limitation in range of motion of the joint, then the physiotherapist should provide a combination of active exercise therapy and passive exercise therapy such as stretching, range of motion exercises and manual therapy.	The total number of patients with HKOA, severe pain and a reversible limitation in range of motion of the joint who have been treated during the previous 12 months.	The number of patients with HKOA, severe pain and a reversible limitation in range of motion of the joint who have been treated during the previous 12 months, in whom a combination of active exercise therapy and passive exercise therapy (such as stretching, range of motion exercises and manual therapy) is provided.	Percentage of patients with osteoattritis of the hip or knee, severe pain, and a reversible limitation in the range of motion of the joint, treated in the previous 12 months, providing a combination of active and passive exercise therapy (such as stretching, range of motion exercises and manual therapy).	1	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

79	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1145	If there is patello-femoral osteoarthritis, then the physiotherapist should provide a combination of taping and functional exercises aimed at specific individualized tasks.	The total number of patients with patella-femoral osteoarthritis who have been treated during the previous 12months.	The number of patients with patella-femoral osteoarthritis who have been treated during the previous 12 months in whom a combination of taping and functional exercises aimed at specific individualized tasks is provided.	Percentage of patients with patellofemoral osteoatritis who have been treated in the previous 12 months in which a combination of tape and functional exercises have been provided for specific individualized tasks.	1	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
80	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1146	The physiotherapist should motivate and stimulate the patient to do recreational physical activities in order to maintain an adequate and healthy level of physical functioning.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months who are motivated and stimulated to do recreational physical activities in order to maintain an adequate and healthy level of physical functioning.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months and who have been motivated to carry out recreational physical activities to maintain an adequate and healthy level of function / physical activity.	5	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

81	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1147	The physiotherapist should evaluate treatment by using a questionnaire recommended in the PT guideline for HKOA.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months in whom a recommended questionnaire to evaluate treatment is used.	Percentage of patients with osteoattritis of the hip or knee who have been treated in the previous 12 months in which a recommended questionnaire has been used to evaluate the treatment.	4	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
82	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1148	The physiotherapist should evaluate treatment by using a performance-based test recommended in the PT guideline for HKOA.	The total number of patients with HKOA who have been treated during the previous 12 months.	The number of patients with HKOA who have been treated during the previous 12 months in whom a recommended performance-based test to evaluate treatment is used.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months in which a recommended performance-based test has been used to assess treatment.	3	Process	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

83	Peter WF, Hurkmans EJ, van der Wees PJ, Hendriks EJ, van Bodegom-Vos L, Vliet Vlieland TP. Healthcare Quality Indicators for Physiotherapy Management in Hip and Knee Osteoarthritis and Rheumatoid Arthritis: A Delphi Study. Musculoskeletal Care. 2016 Dec;14(4):219-232. doi: 10.1002/msc.1133. Epub 2016 Jan 22. PubMed PMID: 26799718.	https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1149	In using a recommended measurement instrument to evaluate PT treatment outcome, there should be an improvement of at least 20%.	The total number of patients with HKOA who have been treated during the previous 12 months after joint replacement surgery	The number of patients with HKOA who have been treated during the previous 12 months in whom an improvement of at least 20% is achieved, measured using an instrument recommended in the PT guideline.	Percentage of patients with osteoatritis of the hip or knee who have been treated in the previous 12 months after joint replacement surgery in whom an improvement of at least 20% has been achieved.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
84	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Quality of Life for Patients with Neurotology Disorders	Patients aged 18 years with neurotologyspecific diagnosis (see code descriptions) seen at least 2 times during the measurement period.	Patients with age-appropriate quality-of-life assessment whose most recent scores were maintained or improved on the same age appropriate quality-of-life assessment administered twice during the measurement period.	Percentage of patients over 18 years of age with a specific neurological diagnosis and quality of life evaluation in whom the scores obtained have been maintained or improved	1	Outcome	Neurology CC	Inpatient and ambulatory care	Effectiveness

85	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Vestibular Rehabilitation for Unilateral or Bilateral Vestibular Hypofunction	Patients diagnosed with unilateral or bilateral vestibular hypofunction	Patients with an order for a referral to physical therapy or occupational therapy for vestibular rehabilitation OR prescription for vestibular rehabilitation OR documentation that vestibular rehabilitation was recommended OR documentation that vestibular rehabilitation was provided.	Percentage of patients diagnosed with vestibular function problems who have received vestibular rehabilitation	1	Process	Neurology CC	Inpatient and ambulatory care	Effectiveness
86	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Inquiring about Falls	ALL vulnerable elders	ALL vulnerable elders should have documentation that they were asked at least annually about the occurrence of recent falls	Percentage of vulnerable elderly patients in whom the occurrence of recent falls has been asked.	3	Process	Geriatric CC	Inpatient and ambulatory care	Safety

87	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Detecting Balance and Gait Disturbances	ALL vulnerable elders	ALL vulnerable elders should have documentation that they were asked about or examined for the presence of balance or gait disturbances at least once	Percentage of vulnerable elderly patients in whom balance or gait disturbances have been asked or examined.	3	Process	Geriatric CC	Inpatient and ambulatory care	Safety
88	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Basic Fall Evaluation	IF a vulnerable elder reported two or more falls in the past year, or a single fall with injury requiring treatment,	THEN there should be documentation that a basic fall evaluation was performed that resulted in specific diagnostic and therapeutic recommendations	Percentage of vulnerable elderly, who have suffered at least 2 falls in the last year or a single fall with an injury, in whom a basic evaluation of falls has been completed establishing a specific diagnosis and therapeutic recommendations.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

89	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194598187909 47. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Gait–Mobility and Balance Evaluation	IF a vulnerable elder reports or is found to have new or worsening difficulty with ambulation, balance, or mobility,	THEN there should be documentation that a basic gait, mobility, and balance evaluation was performed within 6 months that resulted in specific diagnostic and therapeutic recommendations	Percentage of vulnerable elderly people with difficulties in walking, balance and mobility in which a basic evaluation has been carried out establishing therapeutic recommendations and specific diagnosis.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
90	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194598187909 47. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Exercise and Assistive-Device Prescription for Balance Problems	IF a vulnerable elder demonstrates decreased balance or proprioception, or increased postural sway,	THEN an appropriate exercise program should be offered and an evaluation for an assistive device performed	Percentage of vulnerable elderly people, who demonstrate a decrease in balance or porpioception or an increase in postural deviation, in whom an adequate exercise program has been offered and the need for an assistive device has been evaluated.	1	Process	Geriatric CC	Inpatient and ambulatory care	Safety

91	Rizk H, Agrawal Y, Barthel S, Bennett ML, Doherty JK, Gerend P, Gold DR, Morrill D, Oas JG, Roberts JK, Woodson E, Zapala DA, Bennett A, Shenoy AM. Quality Improvement in Neurology: Neurotology Quality measurement Set. Otolaryngol Head Neck Surg. 2018 Oct;159(4):603-607. doi: 10.1177/0194599818790947. Epub 2018 Aug 31. Review. PubMed PMID: 30168353.	https://journals.sagepub.com/doi/suppl/10.1177/0194599818790947	Exercise Prescription for Gait Problems and Weakness	IF a vulnerable elder is found to have problems with gait, strength (for example, #4 out of 5 on manual muscle testing, or the need to use his or her arms to rise from a chair), or endurance (for example, dyspnea on mild exertion),	THEN an exercise program should be offered	Percentage of vulnerable seniors, who have gait, strength, or endurance problems, who have been offered an exercise program.	1	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
92	Salvat-Plana M, Abilleira S, Jiménez C, et al. Priorización de indicadores de calidad de la atención al paciente con ictus a partir de un método de consenso. Rev calid asist. 2011;26(3):174–83.	https://www.elsevier.es/es-revista-revista-calidad-asistencial-256-articulo-priorizacion-indicadores-calidad-atencion-al-S1134282X11000315	Movilización precoz 48 h	ictus agudo (a excepción de coma, ictus progresivo, hipotensión ortostática, IAM, TVP hasta que ACO efectiva)	Porcentaje de ictus agudos movilizados y fuera de la cama en las primeras 48 h (a excepción de coma, ictus progresivo, hipotensión ortostática, IAM, TVP hasta que ACO efectiva)	Percentage of patients with an acute stroke in whom they have moved and gotten out of bed in the first 48 hours.	5	Process	Neurology CC	Inpatient and ambulatory care	Effectiveness

93	Salvat-Plana M, Abilleira S, Jiménez C, et al. Priorización de indicadores de calidad de la atención al paciente con ictus a partir de un método de consenso. Rev calid asist. 2011;26(3):174–83.	https://www.elsevier.es/es-revista-revista-calidad-asistencial-256-articulo-priorizacion-indicadores-calidad-atencion-al-S1134282X11000316	Evaluación tratamiento rehabilitador < 48 h	Porcentaje de pacientes con ictus	Porcentaje de pacientes con ictus con evaluación de las necesidades de tratamiento rehabilitador en las primeras 48 h	Percentage of stroke patients in which the need for rehabilitation treatment in the first 48 hours has been evaluated.	5	Process	Neurology	CC	Inpatient and ambulatory care	Effectiveness
94	Salvat-Plana M, Abilleira S, Jiménez C, et al. Priorización de indicadores de calidad de la atención al paciente con ictus a partir de un método de consenso. Rev calid asist. 2011;26(3):174–83.	https://www.elsevier.es/es-revista-revista-calidad-asistencial-256-articulo-priorizacion-indicadores-calidad-atencion-al-S1134282X11000317	Rehabilitación precoz (fisioterapia/ terapia ocupacional)	pacientes con paresia y situación funcional basal desfavorable (mRS ≥ 3 o IB ≤ 70). AIT excluidos (accidente isquémico transitorio)	Porcentaje de pacientes con paresia y situación funcional basal desfavorable (mRS ≥ 3 o IB ≤ 70) vistos o tratados por FS/TO en los primeros 2 días tras ingreso. AIT excluidos	Percentage of patients, excluding transient ischemic accident, with paresis and unfavorable baseline functional situation in those who were treated by a physiotherapist in the first 2 days after admission.	5	Process	Neurology	CC	Inpatient and ambulatory care	Effectiveness
95	Salvat-Plana M, Abilleira S, Jiménez C, et al. Priorización de indicadores de calidad de la atención al paciente con ictus a partir de un método de consenso. Rev calid asist. 2011;26(3):174–83.	https://www.elsevier.es/es-revista-revista-calidad-asistencial-256-articulo-priorizacion-indicadores-calidad-atencion-al-S1134282X11000318	Evaluación neurológica	Ictus agudos	Porcentaje de de ictus agudos con una anamnesis/exploración neurológica en su HC	Percentage of patients with acute strokes in which an anamnesis or neurological examination has been recorded in their medical history.	5	Process	Neurology	CC	Inpatient and ambulatory care	Effectiveness

96	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12715	Chronic pain Clinical history	All patients with chronic pain	All patients with chronic pain should have a documented clinical history	Percentage of patients with chronic pain who have had a documented medical history.	3	Process	Chronic pain CC	Inpatient and ambulatory care	Effectiveness
97	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12716	Physical examination	All patients with chronic pain	All patients with chronic pain should have a physical examination, including: Neurological and musculoskeletal examinations.	Percentage of patients with chronic pain who have undergone a physical examination including neurological and musculoskeletal examinations.	3	Process	Chronic pain CC	Inpatient and ambulatory care	Effectiveness

98	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12717	Non-specific low back pain exercise	Patientes with non-specific low back pain	Percentage of patients seen with non-specific low back pain with evidence of inclusion in an educational programme for a return to normal activity.	Percentage of patient with non-specific low back pain in those who have been included in an educational program to return to normal activity.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
99	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12718	Non-specific low back pain education	Patients with non-specific low back pain	Percentage of patients seen with non-specific low back pain with evidence of inclusion in a therapeutic exercise programme.	Percentage of patient with non-specific low-back pain in those who have been included in a therapeutic exercise program.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness

100	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12719	Cognitive behaviour treatment programmes for non-specific low back pain	Patients with non-specific low back pain	Percentage of patients seen with non-specific low back pain with evidence of inclusion in a cognitive behaviour programme	Percentage of patient with non-specific low-back pain in those who have been included in a cognitive behavioral therapy.	1	Process	Musculoskeletal CC	Ambulatory care	Effectiveness
101	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12720	Supervised therapeutic exercise for Osteoarthritis	Patients with osteoarthritis in hip and knee	Percentage of patients being treated for osteoarthritis included in a supervised therapeutic exercise programme.	Percentage of patients with osteoarthritis of the hip and knee who have been included in a supervised therapeutic exercise program.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness

102	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12721	Assess the need for walking aids for Osteoarthritis		Percentage of patients with osteoarthritis experiencing difficulties with walking and daily life activities for more than 3 months advised to use a walking aid.	Percentage of patients with osteoarthritis experiencing difficulties in walking and activities of daily life in whom it has been advised to use a technical aid for walking.	3	Process	Rheumatology CC	Inpatient and ambulatory care	Safety
103	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12722	Assessment of disease activity in reumatoid arthritis	Patients with rheumatoid arthritis	Percentage of patients seen with rheumatoid arthritis whose disease activity is measured regularly using standardised measurement systems such as DAS or DAS28.	Percentage of patients with rheumatoid arthritis in whom disease activity has been measured with Disease Activity Score.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness

104	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12723	Supervised therapeutic exercise treatment for reumatoid arthritis	Patients with rheumatoid arthritis	Percentage of patients with rheumatoid arthritis included in a supervised low-intensity exercise programme.	Percentage of rheumatoid arthritis patients who have been included in a supervised low-intensity exercise program.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness
105	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12724	Assessment of disease impact in fibromyalgia	Patients seen with fibromyalgia	Percentage of patients seen with fibromyalgia given a validated questionnaire to assess disease impact.	Percentage of fibromyalgia patients in whom a validated questionnaire has been administered to assess the impact of the disease.	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness

106	Saturno, P. J., Ángel-García, D. , Martínez-Nicolás, I. , López Soriano, F. , Escolar Reina, M. P., Guerrero Díaz, M. B., Ros Martínez, M. E., Medina Mirapeix, F. and Saturno Marcos, M. (2019), Development and Pilot Test of a New Set of Good Practice Indicators for Chronic Nonmalignant Pain Management. Pain Pract, 19: 37-51. doi:10.1111/papr.12715	https://onlinelibrary.wiley.com/doi/full/10.1111/papr.12725	Aerobic exercise treatment. For fibromyalgia	Patients seen with fibromyalgia	Percentage of patients with fibromyalgia included in a supervised aerobic exercise programme	Percentage of fibromyalgia patients who have been included in a supervised aerobic exercise program	1	Process	Rheumatology CC	Inpatient and ambulatory care	Effectiveness
107	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00015	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Initial Evaluation: Detection of Incontinence a	ALL vulnerable elders	ALL vulnerable elders should have documentation of the presence or absence of urinary incontinence during the initial evaluation.	Percentage of vulnerable elderly people in whom the presence or absence of urinary incontinence has been documented in the initial evaluation.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness

108	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00016	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Initial Evaluation: Detection of Incontinence b	ALL vulnerable elders	ALL vulnerable elders should have annual documentation of the presence or absence of urinary incontinence	Percentage of vulnerable elderly people in whom the presence or absence of urinary incontinence has been documented annually.	5	Process	Geriatric CC	Inpatient and ambulatory care	Effectiveness
109	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00017	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Targeted History	IF a vulnerable elder has new urinary incontinence that persists for more than 1 month or urinary incontinence at the time of a new evaluation,	THEN a targeted history should be obtained that documents each of the following: 1) characteristics of voiding, 2) ability to get to the toilet, 3) previous treatment for urinary incontinence, 4) importance of the problem to the patient, and 5) mental status	Percentage of vulnerable elderly people with urinary incontinence in whom a specific medical history has been completed (characteristics of urination, ability to go to the bathroom, previous treatment for urinary incontinence, importance of the problem for the patient and mental state)	4	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness
110	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00018	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Targeted Physical Examination	IF a vulnerable elder has new urinary incontinence that persists for more than 1 month or urinary incontinence at the time of a new evaluation,	THEN a targeted physical examination should be performed that documents 1) a rectal examination and 2) a genital system examination (including a pelvic examination for women)	Percentage of vulnerable elderly people with urinary incontinence who have undergone a rectal and genital examination (including the pelvic floor, in the case of women)	4	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness

111	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00019	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Discuss Treatment Options for Urinary Incontinence	IF a vulnerable elder has new urinary incontinence or urinary incontinence at the time of a new evaluation,	THEN treatment options should be discussed	Percentage of vulnerable elderly people with urinary incontinence in whom treatment options have been discussed.	4	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Patient-centered care
112	Schnelle J, Smith RL. Quality Indicators for the Management of Urinary Incontinence in Vulnerable Community-Dwelling Elders. Ann Intern Med. 2001;135:752–758. doi: 10.7326/0003-4819-135-8_Part_2-200110161-00020	https://annals.org/aim/fullarticle/714869/quality-indicators-management-urinary-incontinence-vulnerable-community-dwelling-elders	Behavioral Therapy	IF a cognitively intact vulnerable elder who is capable of independent toileting has documented stress, urge, or mixed incontinence without evidence of hematuria or high post-void residual,	THEN behavioral treatment should be offered	Percentage of vulnerable elderly, cognitively intact and independent for hygiene, who document stress, mixed and urgent urinary incontinence in whom behavioral treatment has been offered.	2	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness
113	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Evolution of mobility/ functionality	Total number of patients subjected to mobility/functionality evaluation	Total number of patients who reached the reference value in the score (Functional Independence Measure (FIM) score for adults, and the Alberta Infant Motor Scale for children.)	Percentage of patients subdued to a mobility or functionality assessment in which the reference value in the adult and child score has been reached, using the Functional Independence Measure or the Alberta Infant Motor Scale.	5	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

114	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Perception of dyspnea	Total number of patients subjected to dyspnea evaluation	Total number of respiratory patients who reduce the score 2 points in the Borg scale from the initial evaluation	Percentage of patients with dyspnea in whom the score on the Borg scale has been reduced by 2 points compared to the initial evaluation.	5	Outcome	Pneumology CC	Inpatient and ambulatory care	Effectiveness
115	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Spontaneous breathing trial	Total number of patients subjected to the SBT	Total number of patients subjected to the SBT for over 2 hours	Percentage of patients undergoing the Spontaneous Breathing Test who undergo more than 2 hours.	5	Process	Pneumology CC	Inpatient care	Effectiveness

116	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Extubation failure	Total number of patients who passed the SBT and were extubated	Total number of patients intubated within 48 hours after extubation enrolled in the protocol	Percentage of patients who passed the Spontaneous Breathing Test and were extubated in those who had been intubated within 48 hours after extubation.	5	Outcome	Pneumology CC	Inpatient care	Safety
117	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Change in physical activity levels	Total number of individuals subjected to counseling and tracking of physical activity	Total number of individuals who changed their physical activity level (+1 point in the physical activity evaluation)	Percentage of patients undergoing counseling and monitoring of physical activity in whom their level of physical activity has been improved.	5	Outcome	all patients CC	Ambulatory care	Effectiveness

118	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Assess the adherence to physical therapy protocols	Total number of patients who meet the protocol inclusion criteria	Total number of patients enrolled in the protocol	Percentage of patients who meet inclusion criteria in a physiotherapy protocol that have finally been included.	5	Outcome	all patients CC	Inpatient and ambulatory care	Accessibility
119	Cavalheiro LV, Eid RA, Talerman C, Prado Cd, Gobbi FC, Andreoli PB. Design of an instrument to measure the quality of care in Physical Therapy. Einstein (Sao Paulo). 2015 Apr-Jun;13(2):260-8. doi: 0.1590/S1679-45082015GS3248. English, Portuguese. PubMed PMID: 26154548; PubMed Central PMCID: PMC4943820.	http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1679-45082015000200016&lng=en&nrm=iso&tlng=en	Measure whether the prognostic treatment outcome was achieved	Total number of objectives proposed for each patient	Total number of objectives achieved for each patient	Percentage of objectives proposed for each patient that have been achieved.	5	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

120	Anger JT, Alas A, Litwin MS, Chu SD, Bresee C, Roth CP, Rashid R, Shekelle P, Wenger NS. The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings. J Urol. 2016 Oct;196(4):1196-200. doi: 10.1016/j.juro.2016.05.005. Epub 2016 May 7. PubMed PMID: 27164512; PubMed Central PMCID: PMC5067158	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067158/	Diagnosis: Targeted Evaluation/Basic History	A woman presenting with complaints of new or worsening bothersome UI	Should have a targeted history, including: a. Determining whether stress, urge, or both symptoms are present. b. Any previous pharmaceutical treatment. c. Lifestyle factors (fluid intake) if urge urinary incontinence (UUI) is present. d. Severity assessment	Percentage of women with urinary incontinence in whom a specific history has been completed, including the presence of stress or urgency, any previous pharmaceutical treatment, lifestyle factors (fluid intake) and evaluation of severity.	3	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness
121	Anger JT, Alas A, Litwin MS, Chu SD, Bresee C, Roth CP, Rashid R, Shekelle P, Wenger NS. The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings. J Urol. 2016 Oct;196(4):1196-200. doi: 10.1016/j.juro.2016.05.005. Epub 2016 May 7. PubMed PMID: 27164512; PubMed Central PMCID: PMC5067158	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067158/	Targeted Physical Exam	A woman presenting with complaints of new/worsening bothersome UI symptoms	Should hace a targeted physical exam, including: Vaginal exam to assess for contributors to UI (fibroids, pelvic organ prolapse), including assessment of pelvic floor muscle strength (ability to perform Kegel exercises).	Percentage of women who have urinary incontinence in which a specific physical examination has been performed. (vaginal examination and evaluation of pelvic floor strength)	3	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness

122	Anger JT, Alas A, Litwin MS, Chu SD, Bresee C, Roth CP, Rashid R, Shekelle P, Wenger NS. The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings. J Urol. 2016 Oct;196(4):1196-200. doi: 10.1016/j.juro.2016.05.005. Epub 2016 May 7. PubMed PMID: 27164512; PubMed Central PMCID: PMC5067158	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067158/	Treatment/Management UI	A woman who presents with new or worsening bothersome UI	Should initially be offered pelvic floor muscle training (PFMT).	Percentage of women who report difficulty or worsening of urinary incontinence in which pelvic floor musculature training has been offered.	1	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness
123	Anger JT, Alas A, Litwin MS, Chu SD, Bresee C, Roth CP, Rashid R, Shekelle P, Wenger NS. The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings. J Urol. 2016 Oct;196(4):1196-200. doi: 10.1016/j.juro.2016.05.005. Epub 2016 May 7. PubMed PMID: 27164512; PubMed Central PMCID: PMC5067158	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067158/	Treatment/Management of UUI 1	If a woman presents with new or worsening bothersome UUI	Then a history about fluid intake should be obtained	Percentage of women who report difficulty or worsening of urge urinary incontinence in which a history of fluid intake has been completed.	3	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness

124	Anger JT, Alas A, Litwin MS, Chu SD, Bresee C, Roth CP, Rashid R, Shekelle P, Wenger NS. The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings. J Urol. 2016 Oct;196(4):1196-200. doi: 10.1016/j.juro.2016.05.005. Epub 2016 May 7. PubMed PMID: 27164512; PubMed Central PMCID: PMC5067158	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067158/	Treatment/Management of UUI 2	A woman presenting with new or worsening symptoms of UUI/OAB	Should initially be counseled about behavioral modification, including fluid restriction and bladder training.	Percentage of women with urge urinary incontinence or overactive bladder who have been advised on behavior modification, including fluid restriction and bladder training.	1	Process	Gynaecology / urology / proctology CC	Inpatient and ambulatory care	Effectiveness
125	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2015	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	Referral for pulmonary rehabilitation 1		Evidence that pulmonary rehabilitation programmes accept referral of patients who have previously undertaken pulmonary rehabilitation.	Evidence that pulmonary rehabilitation programs admit patients who have previously had pulmonary rehabilitation	1	Structure	Pneumology CC	Ambulatory care	Equity

126	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2021	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	Tailored pulmonary rehabilitation programs 1	Number of people enrolled onto pulmonary rehabilitation.	Number of people receiving an individually prescribed and progressive aerobic exercise programme.	Percentage of patients enrolled in pulmonary rehabilitation who have received an individual and progressive aerobic exercise program.	1	Process	Pneumology CC	Ambulatory care	Effectiveness
127	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2022	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	Tailored pulmonary rehabilitation programs 2	Number of people enrolled onto pulmonary rehabilitation.	Number of people receiving an individually prescribed and progressive resistance exercise programme	Percentage of patients enrolled in pulmonary rehabilitation who have received an individual and progressive exercise program.	1	Process	Pneumology CC	Ambulatory care	Effectiveness
128	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2023	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	Pulmonary rehabilitation programmes include a defined, structured education programme.	The number of pulmonary rehabilitation programmes nationally.	Number of pulmonary rehabilitation programmes providing a structured education programme in line with the BTS Pulmonary Rehabilitation Guideline.	Percentage of pulmonary rehabilitation programs nationwide in which a structured education program has been offered, according to clinical practice guidelines.	5	Process	Pneumology CC	Ambulatory care	Patient-centered care

129	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2024	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	People completing pulmonary rehabilitation are provided with an individualised structured, written plan for ongoing exercise maintenance.	The total number of people completing pulmonary rehabilitation.	The number of people completing pulmonary rehabilitation who have an individualised written exercise plan	Percentage of patients completing pulmonary rehabilitation who have been given an individualized written exercise plan.	2	Process	Pneumology CC	Ambulatory care	Effectiveness
130	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2025	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	People attending pulmonary rehabilitation have the outcome of treatment assessed using as a minimum, measures of exercise capacity, dyspnoea and health status. 1	Number of people attending initial assessment for pulmonary rehabilitation.	Number of people completing assessments of health status, dyspnoea and exercise capacity at outset /initial assessment	Percentage of patients attending the initial evaluation for pulmonary rehabilitation in which the evaluations of health status, dyspnea and exercise capacity have been completed.	1	Process	Pneumology CC	Ambulatory care	Effectiveness
131	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2026	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	People attending pulmonary rehabilitation have the outcome of treatment assessed using as a minimum, measures of exercise capacity, dyspnoea and health status. 2	Number of people completing pulmonary rehabilitation.	Number of people completing assessments of health status, dyspnoea and exercise capacity after completion of pulmonary rehabilitation.	Percentage of patients completing pulmonary rehabilitation who have completed a final assessment of health status, dyspnea, and exercise capacity.	1	Process	Pneumology CC	Ambulatory care	Effectiveness

132	Quality Standards for Pulmonary Rehabilitation in Adults. MAY 2014 ISSN 2040-2023. BRITISH THORACIC SOCIETY REPORTS VOL. 6 NO. 2 2028	https://www.brit-thoracic.org.uk/document-library/quality-standards/pulmonary-rehabilitation/bts-quality-standards-for-pulmonary-rehabilitation-in-adults/	Pulmonary rehabilitation programmes conduct an annual audit of individual outcomes and process. 2	Number of people enrolled to pulmonary rehabilitation	Number of people completing pulmonary rehabilitation who achieve the minimum clinically important improvement in the chosen outcome measures	Percentage of patients enrolled in pulmonary rehabilitation who complete the program and achieve minimal clinically important improvement on selected outcome measures.	5	Outcome	Pneumology CC	Ambulatory care	Effectiveness
133	Petersson IF, Strömbeck B, Andersen L, et alDevelopment of healthcare quality indicators for rheumatoid arthritis in Europe: the eumusc.net projectAnnals of the Rheumatic Diseases 2014;73:906-908.	https://ard.bmj.com/content/73/5/906	HCQI RA 2	If a patient is newly diagnosed with RA,	then, he or she should be given individually tailored education by relevant health professionals about the natural history, treatment, and self management of the disease within 3 months.	Percentage of patients with a new diagnosis of rheumatoid arthritis who have been provided with individualized education on the natural history of the disease, the treatment and self-management of the disease in the first three months.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
134	Petersson IF, Strömbeck B, Andersen L, et alDevelopment of healthcare quality indicators for rheumatoid arthritis in Europe: the eumusc.net projectAnnals of the Rheumatic Diseases 2014;73:906-908.	https://ard.bmj.com/content/73/5/907	HCQI RA 7	If a patient has RA	Then he/she should have a treatment plan developed between him/her and his/her clinician/ health professionals at each visit.	Percentage of patients with rheumatoid arthritis in whom a treatment plan has been developed between him and the physical therapist at each visit.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care

135	Petersson IF, Strömbeck B, Andersen L, et alDevelopment of healthcare quality indicators for rheumatoid arthritis in Europe: the eumusc.net projectAnnals of the Rheumatic Diseases 2014;73:906-908.	https://ard.bmj.com/content/73/5/909	HCQI RA 13	If a patient is diagnosed with RA and reports difficulties in ambulatory and/or non ambulatory activities of daily living	Then the need of assistive devices, appropriate orthoses and environmental adaptations should be assessed and addressed.	Percentage of patients diagnosed with rheumatoid arthritis who report difficulties in activities of daily living in which assistive devices, orthoses and environmental adaptations have been evaluated and addressed.	5	Process	Rheumatology CC	Ambulatory care	Effectiveness
136	Petersson IF, Strömbeck B, Andersen L, et alDevelopment of healthcare quality indicators for rheumatoid arthritis in Europe: the eumusc.net projectAnnals of the Rheumatic Diseases 2014;73:906-908.	https://ard.bmj.com/content/73/5/910	HCQI RA 14	If a patient is diagnosed with active RA (i.e. DAS* 28 over 3.2)	Then the disease activity should be low (i.e. DAS28 below 3.2) 6 months after treatment has started.	Percentage of patients with active rheumatoid arthritis in whom the activity of the disease has decreased 6 months after the start of treatment.	5	Outcome	Rheumatology CC	Ambulatory care	Effectiveness
137	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Information about joint problem	If a patient is diagnosed with osteoarthritis	Then must have been given information about osteoarthritis from a health professional	Percentage of patients diagnosed with osteoarthritis who have received information about their disease.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
138	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Information about treatment	If a patient is diagnosed with osteoarthritis	Then must have been given information about different treatment alternatives	Percentage of patients diagnosed with osteoarthritis who have received information about the different treatment alternatives	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care

139	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Advice on managing/living with OA	If a patient is diagnosed with osteoarthritis	Then must have been given information about how you can self-manage the disease	Percentage of patients diagnosed with osteoarthritis in whom information has been received on the self-management of the disease.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
140	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Information about exercise	If a patient is diagnosed with osteoarthritis	THEN must have been given information about the importance of physical activity and exercise	Percentage of patients diagnosed with osteoarthritis in whom information has been received on the importance of physical activity and exercise.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
141	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Referred for physical activity	If a patient is diagnosed with osteoarthritis	THEN must have been referred or offered a referral to a health professional who can advise you about physical activity and exercise	Percentage of patients diagnosed with osteoarthritis who have been referred for advice on physical activity and exercise.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
142	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Advised to lose weight	If a patient is diagnosed with osteoarthritis and is overweigth	THEN must have been advised to lose weight, if you are overweight	Percentage of overweight osteoarthritis patients who have been advised to lose weight.	5	Process	Rheumatology CC	Ambulatory care	Patient-centered care
143	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Assessment of problems in daily activities	If a patient is diagnosed with osteoarthritis and have problmes with daily activities	THEN must have had these problems been assessed by a health professional	Percentage of patients diagnosed with osteoarthritis and who have problems in activities of daily living in which these problems have been evaluated.	5	Process	Rheumatology CC	Ambulatory care	Effectiveness
144	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Assessed for walking aid	If a patient is diagnosed with osteoarthritis and have problmes with walking	THEN aid for walking must be assesed	Percentage of patients diagnosed with osteoarthritis and who have walking problems in which the need for technical walking aids has been evaluated.	5	Process	Rheumatology CC	Ambulatory care	Effectiveness

145	Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623369/	Assessment of pain	If a patient is diagnosed with osteoarthritis and have pain	THEN must have been assesed for joint pain by a health professional	Percentage of patients diagnosed with osteoarthritis and who have pain in whom joint pain has been evaluated.	5	Process	Rheumatology CC	Ambulatory care	Effectiveness
146	AHRQ QI™ ICD-10-CM/PCS Specification v2019. PSI 08 In Hospital Fall with Hip Fracture Rate. Available at: www.qualityindicators.ahrq.gov	https://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10_v2019.aspx	Patient Safety Indicator 08 (PSI 08) In Hospital Fall with Hip Fracture Rate	Discharges, ages 18 years and older, in a medical DRG (Appendix C: MEDIC2R) or in a surgical DRG (Appendix E: SURGI2R), with any listed ICD-10-PCS procedure codes for an operating room procedure (Appendix A: ORPROC).	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for hip fracture (HIPFXID*).	Percentage of discharges, from 18 years of age, with surgical intervention in which there has been a fall with hip fracture during their stay.	3	Outcome	Other Surgeries CC	Inpatient and ambulatory care	Safety
147	AHRQ QI™ ICD-10-CM/PCS Specification v2019. PSI 08 In Hospital Fall with Hip Fracture Rate. Available at: www.qualityindicators.ahrq.gov	https://data.gov.uk/dataset/380b1301-ee8f-450a-9bf6-62a8a81286b5/proportion-of-older-people-65-and-over-who-were-still-at-home-91-days-after-discharge-from-hospital-into-reablement-rehabilitation-services-nhsof-3-6-i	*Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (NHSOF 3.6.i)*	Older people (aged 65 and over)	Who, after a period of reablement/rehabilitation, maintain their independence by remaining or returning to their home or previous residence 91 days after leaving hospital	Percentage of elderly people in whom, after a period of rehabilitation, independence has been preserved by staying or returning to their home or residence, 91 days after leaving the hospital.	5	Outcome	Geriatric CC	Inpatient and ambulatory care	Effectiveness
148	AHRQ QI™ ICD-10-CM/PCS Specification v2019. PSI 08 In Hospital Fall with Hip Fracture Rate. Available at: www.qualityindicators.ahrq.gov	http://data.gov.uk/dataset/66928b05-33d4-4273-8156-908891c01ec2	*Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital (NHSOF 3.6.ii)*	Older people (aged 65 and over)	Who are offered reablement services when they leave hospital	Percentage of the elderly in whom rehabilitation services have been offered after discharge from hospital.	5	Process	Geriatric CC	Ambulatory care	Accessibility

149	Joint Commission	https://manual.jointcommission.org/releases/TJC2019A1/MIF0287.html	Modified Rankin Score (mRS at 90 Days) - CSTK-02	Ischemic stroke patients treated with IV or IA alteplase therapy or who undergo mechanical endovascular reperfusion therapy.	Ischemic stroke patients for whom a 90 day (≥75 days and ≤105 days) mRS is obtained via telephone or in-person	Percentage of patients with ischemic stroke, treated with thrombolytic therapy or mechanical endovascular reperfusion, who obtained a score of disability or dependency in daily activities with the Modified Rankin Score at 90 days.	5	Process	Cardiology and circulatory system CC	Inpatient care	Effectiveness
150	Joint Commission	https://manual.jointcommission.org/releases/TJC2019A1/MIF0388.html	Modified Rankin Score (mRS at 90 Days: Favorable Outcome) - CSTK-10	Ischemic stroke patients treated with IV or IA alteplase therapy or who undergo mechanical endovascular reperfusion therapy.	Ischemic stroke patients with a mRS less than or equal to 2 at 90 days (≥75 days and ≤105 days)	Percentage of patients with ischemic stroke, treated with thrombolytic therapy or mechanical endovascular reperfusion, in whom a score of disability or dependency in daily activities was obtained with a Modified Rankin Score of less than 2 at 90 days.	5	Outcome	Cardiology and circulatory system CC	Inpatient care	Effectiveness
151	Joint Commission	https://manual.jointcommission.org/releases/TJC2019A1/MIF0357.html	Postoperative Ambulation on Day of Surgery - THKR-IP-2 //THKR-OP-2	Patients undergoing a total hip or total knee replacement.	Patients undergoing total hip or total knee replacement who ambulated postoperatively the day of surgery or ambulated in the Post-Anesthesia Care Unit (PACU) or within 4 hours of discharge from the PACU.	Percentage of patients who underwent total hip or knee prostheses who were walked on the day of the operation or in the post-anesthesia resuscitation unit.	1	Process	Musculoskeletal CC	Inpatient care	Effectiveness
152	Joint Commission	https://manual.jointcommission.org/releases/TJC2019A1/MIF0365.html	Preoperative Functional/Health Status Assessment - THKR-IP-4 // THKR-OP-4	Patients undergoing total hip or total knee replacement.	Percentage of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days prior to surgery.	Percentage of total hip or knee prosthesis patients in whom the general health status and specific functional condition of the joints have been evaluated within 90 days prior to surgery	5	Process	Musculoskeletal CC	Inpatient care	Effectiveness

153	NQF	http://www.qualityforum.org/QPS/0429	Change in Basic Mobility as Measured by the AM-PAC	All patients in a risk adjusted diagnostic category with a mobility goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or alternatively, based on CPT codes relevant to treatment goals focused on Basic Mobility function.	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Basic Mobility functioning. We recommend that the target threshold is based on the percentage of patients who exceed one or more Minimal Detectable Change (MDC) thresholds. The percentage threshold is derived from a normative database used for benchmarking. MDC is considered the minimal amount of change that is not likely to be due to measurement error. It is one of the more common change indices, which can be used to identify reliable changes in an outcome like Basic Mobility function adjusting for the amount of measurement error inherent in the measurement. MDC can be reported at different confidence levels. (see Haley & Fragala, 2006)	Percentage of patients in a risk diagnostic category who have a mobility objective, where an improvement in mobility has been achieved above a target threshold (based on minimum detectable change).	5	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

154	NQF	http://www.qualityforum.org/QPS/0430	Change in Daily Activity Function as Measured by the AM-PAC	All patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or alternatively, based on CPT codes relevant to treatment goals focused on Daily Activity function.	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Daily Activity (i.e., ADL and IADL) functioning. We recommend that the target threshold is based on the percentage of patients who exceed one or more Minimal Detectable Change (MDC) thresholds. The percentage threshold is derived from a normative database used for benchmarking. MDC is considered the minimal amount of change that is not likely to be due to measurement error. It is one of the more common change indices, which can be used to identify reliable changes in an outcome like Daily Activity function adjusting for the amount of measurement error inherent in the measurement. MDC can be reported at different confidence levels (see Haley & Fragala, 2006).	Percentage of patients in a risk diagnostic category who have a goal of daily life activities, where an improvement in daily life activities has been achieved above a target threshold (based on minimal detectable change).	5	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

155	NQF	http://www.qualityforum.org/QPS/2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	The denominator is computed with the same model used for the numerator. It is the model developed using all non-excluded IRF stays in the national data. For a particular facility the model is applied to the patient population, but the facility effect term is 0. In effect, it is the number of readmissions that would be expected for that patient population at the average IRF. The measure includes all the IRF stays in the measurement period that are observed in national Medicare FFS data and do not fall into an excluded category.	The numerator is mathematically related to the number of patients in the target population who have the event of an unplanned readmission in the 30- day post-discharge window. The measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method used does not make the observed number of readmissions the numerator and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix.	Adjusted rate of patients with unscheduled readmission up to 30 days after discharge from rehabilitation services.	3	Outcome	all patients CC	Inpatient care	Effectiveness

156	NQF	http://www.qualityforum.org/QPS/3479	Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities (IRF)	The measure denominator is the risk-adjusted expected number of discharges to community. This estimate includes risk-adjustment for patient characteristics with the facility effect removed. The "expected" number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility. The logistic regression model used to calculate the denominator is developed using all non-excluded facility stays in the national data. The denominator is computed in the same way as the numerator, but the facility effect is set at the average. (Ver definición completa en enlace)	The measure numerator is the risk-adjusted predicted estimate of the number of patients who are discharged to the community, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. (Ver definición completa)	Adjusted rate of patients discharged from the community and who do not have readmission or death, up to 30 days after discharge from rehabilitation services.	4	Outcome	all patients CC	Inpatient care	Effectiveness
157	NQF	http://www.qualityforum.org/QPS/0202	Falls with injury	Denominator Statement: Patient days by Type of Unit during the calendar month.	Total number of patient falls of injury level minor or greater (whether or not assisted by a staff member) by eligible hospital unit during the calendar month X 1000.	Fall rate with injury per 1000 patient days.	3	Outcome	all patients CC	Inpatient and ambulatory care	Safety

158	NQF	http://www.qualityforum.org/QPS/0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	A) Screening for Future Fall Risk: All patients aged 65 years and older seen by an eligible provider in the past year. B & C) Falls Risk Assessment & Plan of Care for Falls: All patients aged 65 years and older seen by an eligible provider in the past year with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year).	This measure has three rates. The numerators for the three rates are as follows: A) Screening for Future Fall Risk: Patients who were screened for future fall* risk** at last once within 12 months B) Falls Risk Assessment: Patients who had a risk assessment*** for falls completed within 12 months C) Plan of Care for Falls: Patients with a plan of care**** for falls documented within 12 months.	Composite indicator: A) Percentage of patients over 65 years who undergo falls screening once a year. B) Percentage of patients older than 65 years with a history of falls (2 or more, or 1 with injury, in the last year) in whom fall risk assessment is performed once a year. C) Percentage of patients older than 65 years with a history of falls (2 or more, or 1 with injury, in the last year) who have documented a treatment plan for falls during that year.	2	Process	Geriatric CC	Ambulatory care	Safety
159	NQF	http://www.qualityforum.org/QPS/0701	Functional Capacity in COPD patients before and after Pulmonary Rehabilitation	All patients with clinician diagnosed COPD at PR program entry who completed PR during the measurement period and who completed at least 10 PR sessions within 3 months of PR program entry.	Number of patients who are found to increase their functional capacity by at least 25 meters (82 feet), as measured by 6MWT distance at PR program entry and completion.	Percentage of COPD patients who completed a Pulmonary Rehabilitation program, with at least a minimum number of sessions, who found an improvement in functional capacity of at least 25 meters in the 6-minute walk test.	1	Outcome	Pneumology CC	Ambulatory care	Effectiveness
160	NQF	http://www.qualityforum.org/QPS/2321	Functional Change: Change in Mobility Score	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Case Mix Group level.	Average change in rasch derived mobility functional score from admission to discharge at the facility level. Includes the following FIM items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the facility or patients who died within the facility are excluded.	Ratio of change in mobility observed versus change in mobility expected for the hospital and patient group.	4	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

161	NQF	http://www.qualityforum.org/QPS/2287	Functional Change: Change in Motor Score	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Case Mix Group level.	Average change in rasch derived motor functional score from admission to discharge at the facility level. Average is calculated as (sum of change at the patient level/total number of patients). Cases aged less than 18 years at admission to the IRF or patients who died within the IRF are excluded.	Ratio of change in motor function observed versus change in motor function expected for the hospital and patient group.	4	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness
162	NQF	http://www.qualityforum.org/QPS/2286	Functional Change: Change in Self Care Score	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Case Mix Group level.	Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. Average is calculated as: (sum of change at the patient level for all items (Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory) /	Ratio of change in observed functional state versus change in expected functional state for the hospital and patient group.	4	Outcome	all patients CC	Inpatient and ambulatory care	Effectiveness

163	NQF	http://www.qualityforum.org/QPS/0427	Functional status change for patients with elbow, wrist and hand impairments	All patients 14 years and older with elbow, wrist or hand impairments who have initiated rehabilitation treatment and completed the FOTO (elbow, wrist and hand) PROM.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment). Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for elbow, wrist and hand impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12 month time period for elbow, wrist and hand impairments.	Rate of change in functional status in patients over 14 years of age with disabilities in the elbow, wrist or hand who have started a rehabilitation treatment in which the functional status was scored at the beginning and at the end of the treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
164	NQF	http://www.qualityforum.org/QPS/0424	Functional status change for patients with Foot and Ankle impairments	All patients 14 years and older with foot or ankle impairments who have initiated rehabilitation treatment and completed the FOTO foot and ankle PROM at admission and discharge	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment) Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for foot and or ankle impairment. Clinic Level: The average of residuals in patients who were treated by a clinic in a 12 month time period for foot and or ankle impairment.	Rate of change in functional status in patients over 14 years of age with foot or ankle disabilities who have started rehabilitation treatment in which functional status was scored at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

165	NQF	http://www.qualityforum.org/QPS/0428	Functional status change for patients with General orthopaedic impairments	All patients 14 years and older with general orthopaedic impairments who have initiated rehabilitation treatment and completed the FOTO (general orthopaedic) PROM.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment). Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for general orthopaedic impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12 month time period for general orthopaedic impairment.	Rate of change in functional status in patients older than 14 years with general orthopedic disability who have started rehabilitation treatment in which functional status was scored at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
166	NQF	http://www.qualityforum.org/QPS/0423	Functional status change for patients with Hip impairments	All patients 14 years and older with hip impairments who have initiated rehabilitation treatment and complete the FOTO hip FS PROM at admission and discharge.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment. Individual Clinician Level: The average residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for hip impairment. Clinic Level: The average residuals in functional status scores in patients who were treated by a clinic in a 12 month time period for hip impairment.	Rate of change in functional status in patients over 14 years of age with hip disability who have started rehabilitation treatment in which functional status was scored at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

167	NQF	http://www.qualityforum.org/QPS/0422	Functional status change for patients with Knee impairments	All patients 14 years and older with knee impairments who have initiated rehabilitation treatment and completed the FOTO knee FS PROM at admission and discharge.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for knee impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12 month time period for knee impairment.	Rate of change in functional status in patients over 14 years of age with knee disability who have started rehabilitation treatment in which functional status was scored at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
168	NQF	http://www.qualityforum.org/QPS/0425	Functional status change for patients with lumbar impairments	All patients 14 years and older with a lumbar impairment who have initiated rehabilitation treatment and completed the FOTO (lumbar) PROM.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment). Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for lumbar impairment. Clinic Level: The average of residuals) in functional status scores in patients who were treated by a clinic in a 12 month time period for lumbar impairment.	Rate of change in functional status in patients over 14 years of age with lumbar disability who have started rehabilitation treatment in which functional status was scored at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness

169	NQF	http://www.qualityforum.org/QPS/0426	Functional status change for patients with Shoulder impairments	All patients 14 years and older with shoulder impairments who have initiated rehabilitation treatment and completed the FOTO shoulder FS outcome instrument at admission and discharge.	Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12 month time period for shoulder impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12 month time period for shoulder impairment.	Rate of change in functional status in patients over 14 years of age with shoulder disability who have started rehabilitation treatment and who have completed a functional status assessment at the beginning and at the end of treatment.	5	Outcome	Musculoskeletal CC	Inpatient and ambulatory care	Effectiveness
170	NQF	http://www.qualityforum.org/QPS/0700	Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation	All patients with clinician diagnosed COPD at PR program entry who completed one of the 3 valid and reliable HRQoL instruments at the beginning and end of PR during the measurement period.	Number of patients with clinician diagnosed COPD who have participated in PR and have been found to improve their HRQOL score by the minimum clinical important difference (MCID) as measured by the Chronic Respiratory Disease Questionnaire (CRQ), St. George's Respiratory Questionnaire (SGRQ), or the COPD Assessment Test (CAT) at the beginning and the end of PR.	Percentage of patients diagnosed with chronic obstructive pulmonary disease (COPD) who have completed a pulmonary rehabilitation program and completed the Chronic Respiratory Disease Questionnaire (CRQ), St. George's Respiratory Questionnaire (SGRQ), or COPD Assessment Test (CAT) in whom has found an improvement greater than the clinically important minimum difference.	5	Outcome	Pneumology CC	Ambulatory care	Effectiveness

171	NQF	http://www.qualityforum.org/QPS/2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	The denominator is the number of Inpatient Rehabilitation Facility Medicare Part A and C patient stays, except those that meet the exclusion criteria.	The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in mobility score between admission and discharge among Inpatient Rehabilitation Facility (IRF) Medicare Part A and C patients age 21 and older. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.	Adjusted rate of change in admission-discharge mobility score in patients over 21 years hospitalized with physical therapy treatment.	2	Outcome	all patients CC	Inpatient care	Effectiveness
172	NQF	http://www.qualityforum.org/QPS/2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	The denominator is the number of Inpatient Rehabilitation Facility Medicare patient stays, except those that meet the exclusion criteria.	The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in self-care score between admission and discharge among Inpatient Rehabilitation Facility (IRF) Medicare patients age 21 or older. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.	Adjusted rate of change in admission-discharge self-care score in patients over 21 years hospitalized with physical therapy treatment.	2	Outcome	all patients CC	Inpatient care	Patient-centered care
173	NQF	http://www.qualityforum.org/QPS/2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	IRF patients included in this measure are at least 21 years of age, Medicare Part A and C beneficiaries, and have complete stays.	The numerator is the number of patients in an IRF with an observed discharge mobility score that is equal to or higher than a calculated expected discharge mobility score.	Observed versus expected ratio of change in admission-discharge mobility score in patients older than 21 years hospitalized with physical therapy treatment.	2	Outcome	all patients CC	Inpatient care	Effectiveness

174	NQF	http://www.qualityforum.org/QPS/2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Inpatient Rehabilitation Facility patients included in this measure are at least 21 years of age, Medicare Part A and C beneficiaries, and have complete stays.	The numerator is the number of patients in an IRF with an observed discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.	Observed versus expected ratio of change in admission-discharge self-care score in patients over 21 years hospitalized with physical therapy treatment.	2	Outcome	all patients CC	Inpatient care	Patient-centered care
175	NQF	http://www.qualityforum.org/QPS/0141	Patient Fall Rate	Denominator Statement: Patient days by hospital unit during the calendar month times 1000.	Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by hospital unit during the calendar month X 1000.	Rate of fallen patients, with or without injury or assistance, per 1000 days/patient.	3	Outcome	all patients CC	Inpatient and ambulatory care	Safety

176	CMS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=515#tab1	Screening for Depression and Follow-Up Plan: Age 18 and Older	The denominator for this measure includes Medicaid beneficiaries age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups: 1. Those beneficiaries with a positive screen for clinical depression during an outpatient visit using a standardized tool with a follow-up plan documented. 2. Those beneficiaries with a negative screen for clinical depression during an outpatient visit using a standardized tool.	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.	Percentage of patients over 18 years of age with an outpatient visit who are screened for depression using a validated tool. (Includes making a follow-up plan in case of positive screening)	5	Process	Mental Health CC	Ambulatory care	Patient-centered care
177	CMS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1247#tab1	Falls: Screening for Future Fall Risk	Patients aged 65 years and older with a visit during the measurement period	Patients who were screened for future fall risk at least once within the measurement period	Percentage of elderly (> 65 years) in whom a risk assessment of future falls has been carried out.	5	Process	Geriatric CC	Inpatient and ambulatory care	Safety

178	NICE indicator menu	https://www.nice.org.uk/Media/Default/Standards-and-indicators/CCGOIS%20Indicators%20Key%20Documents/ccg22-hipfracture-2016-for-web.pdf	Indicator CCG22: The proportion of people with hip fracture, who receive a multifactorial risk assessment of future falls risk	The number of people on the National Hip Fracture Database.	The number in the denominator who have received a multifactorial risk assessment from the hipfracture programme team.	Percentage of hip fracture patients who have received a multifactorial assessment of the risk of future falls.	2	Process	Musculoskeletal CC	Inpatient and ambulatory care	Safety