In 2005, NQF endorsed 15 performance measures for home health care that are used by the Centers for Medicare & Medicaid Services (CMS) for their Home Health Compare web site. This new project focuses on additional measures developed for the home health setting using the CMS Outcomes and Assessment Information Set (OASIS) tool, review and maintenance of the previously endorsed measures and the Home Health patient experience of care instruments. Of the 15 previously endorsed measures, seven were substantially revised based on feedback by users over several years and thus, were considered and evaluated as new measures by the Committees.

Based on the comments received and after reviewing additional information received from the developer, the Steering Committee recommended to:

- include measure #0176 Improvement in Oral Medications for vote
- remove the following emergent care measures
  - #0168 Emergent care for wound infections, deteriorating wound status
  - #0169 Emergent care for improper medication administration or medication side effects and
  - #170 Emergent care for hypo/hyperglycemia

NQF Member Voting
Information for electronic voting for the measurement framework has been sent to NQF Member organization primary contacts. Please note that voting concludes on February 26, 2009 at 6:00 PM Eastern Daylight Time.
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Executive Summary

There has been growing recognition of the importance of home health in the continuum of care, especially among those with chronic, co-morbid illnesses. Home health care services are delivered by approximately 9,284 agencies to patients at home who are recovering from care in hospitals or nursing homes; patients who are disabled; the frail elderly; and chronically or terminally ill persons in need of medical, nursing, or therapeutic treatment as well as assistance with the essential activities of daily living. Approximately 7.6 million individuals currently receive care from 83,000 providers because of acute illness, long-term health conditions, permanent disability, or terminal illness. In 2007, annual expenditures for home health care were projected to be $57.6 billion. As in all areas of health care, the quality of home health care provided is a vital concern.

In 2005, NQF endorsed 15 performance measures specific to home health quality as described in the report, National Voluntary Consensus Standards for Home Health Measures. This current effort seeks to update, revise and expand consensus standards for home health. Candidate standards were evaluated though the NQF Consensus Development Process, which included a search for measures via an open “Call for Measures” in September and October 2008, and a search by NQF staff through literature reviews and the National Quality Measures Clearinghouse. Topic areas could include, but were not limited to patient experience of care, immunization, medication management, pain management, fall prevention, depression screening/intervention, care coordination, risk assessment, heart failure, and diabetes. Harmonization of similar measures was a priority for this project. In addition, as a part of the NQF’s ongoing measures maintenance process, the 15 home health measures endorsed in 2005 were reconsidered alongside the newly submitted candidate standards. Seven of those 15 measures were substantially revised based on feedback by user over the years and they were considered as new measures. A Patient Experience of Care Technical Advisory Panel was convened to provide a preliminary review of the Home Health CAHPS® submission. A total of 57 consensus standards ultimately were identified and evaluated by the Home Health Steering Committee for appropriateness as voluntary consensus standards for accountability and public reporting.


- Acute care hospitalization
- Emergent care (risk adjusted)
- Timely initiation of care
- Drug education on medications provided to patients/caregiver during episode
- Influenza immunization received for current flu season
- Pneumococcal polysaccharide vaccine (PPV) ever received
- Improvement in oral medications
- Heart failure symptoms addressed
- Diabetic foot care and patient education implemented
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- Improvement in dyspnea
- Improvement in pain interfering with activity
- Pain assessment conducted
- Pain interventions implemented
- Depression assessment conducted
- Improvement in status of surgical wounds
- Increase in the number of pressure ulcers
- Improvement in ambulation/locomotion
- Improvement in bathing
- Improvement in bed transferring
- Home Health CAHPS®
NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR HOME HEALTH CARE:
ADDITIONAL PERFORMANCE MEASURES 2008
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NQF VOTING DRAFT—DO NOT CITE OR QUOTE
NQF MEMBER VOTES DUE TO NQF BY TUESDAY, FEBRUARY 26, 2009 AT 6:00PM ET
Background

There has been growing recognition of the importance of home health in the continuum of care, especially among those with chronic, co-morbid illnesses. Home health care services are delivered by approximately 9,284 agencies\(^1\) to patients at home who are recovering from care in hospitals or nursing homes; patients who are disabled; the frail elderly; and chronically or terminally ill persons in need of medical, nursing, or therapeutic treatment as assistance with the essential activities of daily living. Approximately 7.6 million individuals currently receive care from 83,000 providers because of acute illness, long-term health conditions, permanent disability, or terminal illness\(^2\). In 2007, annual expenditures for home health care were projected to be $57.6 billion\(^3\). As in all areas of health care, the quality of care provided is of concern to consumers, purchasers, providers and other stakeholders.

To date, NQF has endorsed 15 performance measures specific to home health quality as part of the 2004-2005 *National Voluntary Consensus Standards for Additional Home Health Measures* project. Appendix B provides an overview of that original endorsement project and its recommendations as well as information related to the Outcomes and Assessment Information Set (OASIS) instrument including the new version, OASIS-C that is currently in development.

**Strategic Directions for NQF**

As NQF nears completion of its first decade, consideration of strategic issues to guide current and future activities have resulted in an expansion of NQF’s mission to include three parts: 1) establishing priorities and goals for performance improvement; 2) endorsing performance measures; and 3) education and outreach. As greater numbers quality measures are developed and brought to NQF for consideration of endorsement, it is incumbent on NQF to assist stakeholders to “measure what makes a difference” and address what is important to achieve the best outcomes for patients and populations. An updated Measurement Framework, reviewed by NQF Members in December 2007, promotes shared accountability and measurement across episodes of care with a focus on outcomes, appropriateness, and cost/resource use measures, coupled with quality measures.
The original home health endorsed measures were the first outcomes measures to meet NQF’s “gold standard” and thus set the stage for endorsing outcomes measures in other settings. During review in this project, the Steering Committee applied more stringent evaluation criteria including feedback on measure use, which assisted in identifying measures that would advance the field of performance measurement in home health care.

Several strategic issues have been identified to guide consideration of candidate measures:

**Driving toward high performance.** Stakeholders have expressed concern with multiple process measures that are too far removed from the outcome of interest. These measures ultimately drive attention towards a single accountable entity rather than placing the focus on much-needed system-level improvement.

**Emphasis on composite measures.** Composite measures are more meaningful and comprehensible to consumers of health care. The Steering Committee has proposed a research recommendation to combine multiple specific activities of daily living measures into a functional status composite in order to produce a more meaningful view of this very important clinical area.

**Moving towards outcomes measurement.** Stakeholders have indicated that outcomes measures provide the most useful and actionable information - particularly for the purposes of consumer and purchaser decision-making. The Steering Committee agreed that outcomes are the best way to understand care but felt some of the original endorsed measures did not meet the current evaluation criteria and should not be used for public reporting but should remain on the current CMS Outcomes Based Quality Improvement (QBQI) reports used for internal quality improvement.

**Consider disparities in all that we do.** There is a strong interest in routine data collection of race, ethnicity, and language to allow for stratification of quality measures in an effort to reduce disparities in health care.

Neither the OASIS-B nor the OASIS-C instruments allow for the collection of the patient’s primary language preference.

**Evaluating Potential Home Health Consensus Standards**

To date, NQF has endorsed 15 performance measures specific to home health care quality as part of the 2004-2005 *National Voluntary Consensus Standards for Additional Home Health Measures* project.
this project, candidate standards were solicited through the NQF Consensus Development Process, which included an open “Call for Measures” in September and October 2008, and were actively sought by NQF staff through literature reviews and a search of the National Quality Measures Clearinghouse. Topic areas could include, but were not limited to: patient experience of care, immunization, medication management, pain management, fall prevention, depression screening/intervention, care coordination, risk assessment, heart failure, and diabetes. Harmonization of similar measures was a priority for this project. The measures were evaluated using NQF’s standard measure evaluation criteria¹.

In addition, as a part of the NQF’s ongoing measures maintenance process, the 15 home health measures endorsed in 2005 were reconsidered alongside the newly submitted candidate standards. Seven of those 15 measures were substantially revised based on feedback by users over the years and thus were considered as new measures. A Patient Experience of Care Technical Advisory Panel was convened to provide a preliminary view of the Home Health CAHPS submission. A total of 57 consensus standards ultimately were identified and evaluated by the Home Health Steering Committee for appropriateness as voluntary consensus standards for accountability and public reporting on performance of home health care.

**Steering Committee Recommendations**

The Committee noted some global issues and concern regarding home health care:

- Home care is not a 24/7 healthcare setting. The home care staff can only react to what they are aware of. Many times families or patients seek medical care without notifying their home health providers. This may mean visiting an emergency department, seeking additional medications (prescription or over the counter), or rearranging furnishing within the home that makes it unsafe.

- There is limited formal research regarding quality in the home health field, especially around specific disease topics. While there is focused literature, it is often not in recognized peer reviewed journals. Also guidelines in this setting are often only consensus driven.

Additionally, the Steering Committee noted several global issues about the measures:

- Many of the data collection items required to calculate the quality measures are found on the OASIS-C instrument. This is a newly revised instrument that is currently going through the federal clearance

¹ Revised August 2008 [http://www.qualityforum.org/about/leadership/measure_evaluation.asp](http://www.qualityforum.org/about/leadership/measure_evaluation.asp)
process as outlined by the Office of Management and Budget. Some of the measures will not be possible if the items are not approved. Approval is expected April 2009.

- The Committee notes that many of the measures have received time limited endorsement. They request that there be time allowed for collection of adequate data which can be accrued for analyses to assure content validity before these measures are be used for public reporting.

- While the Committee did not recommend continued endorsement of some of the previously endorsed measures for public reporting, they felt strongly that the measures were still important for quality improvement and should remain in the CMS OBQI reports.

- The process and outcome measures were submitted with the typical CMS exclusions e.g., patients under 18, maternity cases, and long stay patients. CMS currently reports in its Home Health Quality Initiative systems (specifically the OBQI reports and the publicly-reported Home Health Compare website). These reports are based on a rolling 12-month period, in which an episode of care must start AND end within a specific twelve-month period in order for the measure to be included in agency-level reporting. For this reason, home health care patients who are require service for an extremely long period of time are excluded from an agency’s report unless they are admitted to an inpatient facility. CMS was already considering relaxing the restrictions, so that long-stay patients would no longer be excluded from the reports, and different timeframes could be selected by users to better meet their data needs.

- The Steering Committee felt that the maternity exclusion should be removed so that the measures could be used by non-CMS entities caring for non-Medicare/non-Medicaid Patients. Medicare-certified home health agencies are currently required to collect and submit OASIS data only on Medicare and Medicaid patients who are receiving skilled home health care. The OASIS-C items were tested on this population only, and the existing risk adjustment models used in CMS systems such as the Home Health Compare website, are based on data for this population only. However, the OASIS items and related measures could be used for other adult, non-maternity home health care patients, ideally with further testing and possible recalibration of the risk adjustment models. The developer stressed that the OASIS instrument has not been tested on pediatric patients (<18 years of age).
Proposed Voluntary Consensus Standards for Home Health Care

This report presents 20 performance measures for home health care for 2008 (Table 1) and also recommends that 4 previously endorsed home health consensus standards be retired. The purpose of these consensus standards is to improve the quality of healthcare through accountability and public reporting by standardizing quality measurement in all relevant care settings. Although these measures have been used almost exclusively by CMS using their OASIS data collection tool, the specifications are written so that other measurement programs can use the measures.

The recommended measures meet various National Priorities Partnership (NPP) goals including capturing patient and caregiver experience of care, providing preventive services recommended by the U.S. Preventive Services Task Force, creating a culture of safety by reducing adverse events such as pressure ulcers, wound infections, and medication errors, decreasing avoidable emergent care or acute care hospitalization, and providing information on medications at care transitions. The measures not specifically meeting a NPP goal assess a high impact area of care such as functional status or specific clinical topics such as heart failure and diabetes.

After the review period the Committee evaluated additional information from the measure stewards as well as comments received from NQF Members and the public. Based on these comments, the Committee will continue their recommendation for endorsement of all process measures related to education and interventions only if the developer modifies the specifications to add an exclusion that removes patients from the denominator who receive a recertification (RFA 04) OASIS assessment between SOC/ROC (01/03) to Discharge OASIS. This stipulation will provide a more adequate view of the care provided by home health agencies since the denominator will include patients who receive one episode of care or less (<60 days). About eight percent of cases are recertifications and the care provided by the HHA would not be credited to the HHA if the specifications were not changed for the process measures. The measure developer has agreed to the revision as specified by the Committee. Based upon additional comments received, additional actions are to recommend “improvement in oral medications” measure and to not recommend for endorsement the emergent care “submeasures” for specific clinical areas as noted below.

The Committee also agreed to recommend a revised multi-factorial falls measure for patients age 65 years and older which will be considered in a future project.
Table 1. National Voluntary Consensus Standards for Home Health Care: 2008

All measures were submitted by the Centers for Medicare & Medicaid Services and the level of analysis is the home health agency.

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Review Measure ID</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely initiation of care</td>
<td>AHH-041-08</td>
<td>The percentage of patients with timely start of care of resumption of home health care</td>
</tr>
<tr>
<td>Drug education on medications provided to patients/caregiver during episode</td>
<td>AHH-021-08</td>
<td>The percentage of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems</td>
</tr>
<tr>
<td>Improvement in Oral Medications</td>
<td>0176</td>
<td>The percentage of patients who get better at taking their medicines correctly.</td>
</tr>
<tr>
<td>Diabetic foot care and patient education implemented</td>
<td>AHH-018-08</td>
<td>The percentage of diabetic patients for whom physician ordered monitoring got the presence of skin lesions on the lower extremities and patient education on proper foot care were implemented during their episode of care</td>
</tr>
<tr>
<td>Influenza immunization received for current flu season</td>
<td>AHH-027-08</td>
<td>Percent of patients who received influenza immunization for the current flu season from this home health agency</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide vaccine (PPV) ever received</td>
<td>AHH-033-08</td>
<td>Percent of patients who have ever received Pneumococcal Polysaccharide Vaccine (PPV)</td>
</tr>
<tr>
<td>Depression assessment conducted</td>
<td>AHH-001-08</td>
<td>The percent of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care</td>
</tr>
<tr>
<td>Pain assessment conducted</td>
<td>AHH-029-08</td>
<td>The percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care</td>
</tr>
<tr>
<td>Pain interventions implemented</td>
<td>AHH-030-08</td>
<td>The percent of patients with pain for whom steps to monitor and mitigate pain were implemented during their episode of care</td>
</tr>
<tr>
<td>Improvement in pain interfering with activity</td>
<td>0177</td>
<td>The percentage of patients who have less pain when moving around</td>
</tr>
<tr>
<td>Heart failure symptoms addressed</td>
<td>AHH-025-08</td>
<td>The percentage of patients exhibiting symptoms of heart failure for which appropriate actions were taken</td>
</tr>
</tbody>
</table>

1 Previously endorsed measures have a 4-digit numeric ID; New measures by the convention AHH-0XX-08 or PEC-XXX-08
Improvement in dyspnea 0179  The percentage of patients who are short of breath less often

Improvement in status of surgical wounds 0178  The percentage of patients whose wounds improved or healed after an operation

Increase in the number of pressure ulcers 0181  The percentage of patients who had an increase in the number of unhealed pressure ulcer

Improvement in ambulation/locomotion 0167  The percentage of patients who get better at walking or moving around in a wheelchair safely

Improvement in bathing 0174  The percentage of patients who get better at washing their entire body safely

Improvement in bed transferring 0175  The percentage of patients who get better at getting in and out of bed

Emergent care (risk adjusted) 0173  The percentage of patients who had to use a hospital emergency department

Acute care hospitalization 0171  The percentage of patients who had to be admitted to the hospital

Home Health CAHPS® PEC-001-08  Measures home health patients' perspectives on their home health care

**Recommended Measures**

**Timely initiation of care**

AHH-041-08 *Timely initiation of care* (Centers for Medicare & Medicaid Services)

This outcome measure assesses the percentage of patients with timely start of home health care. Preliminary findings from an upcoming study note very small differences in outcomes for patients with start of care within 24 hours vs. 48 hours following hospital discharge. However, the outcomes for patients whose care started more than 48 hours after hospital discharge were significantly lower than the group who started within 24-28 hours. The Committee agreed it is important to have care begin in a timely fashion. The start of care is the later of the original referral date, physician order date, or discharge from the hospital.

**Patient/Caregiver Education**

AHH-021-08 *Drug education on medications provided to patients/caregiver during episode* (Centers for Medicare & Medicaid Services)

The measure reports the percentage of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and other aspects of medication management.
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effects, and how and when to report problems. The measure was submitted as Drug education on all medications provided to patients/caregiver during episodes but was edited at the request of the Committee to take out the word “all”. The Committee felt the time of discharge from home health care was the best time to capture this information but would expect teaching to begin at the start or resumption of care, throughout the home health care episode and a review of the medication at the end of the episode. The Steering Committee felt it is not appropriate, nor would it likely be practical, for all medication education to occur immediately at the time of transfer.

0176 Improvement in oral medications (Centers for Medicare & Medicaid Services)
The Committee initially noted there is variability in documentation of this measure and the measure reflects only a one-day point in time. They also noted that some patients will always need to take meds and will not improve. The measure may reflect being better at answering the questions but not necessarily improving patient outcomes. It may also have unintended consequence of negatively impacting those agencies that care for many cognitively impaired patients. However after additional information regarding past performance and improvement efforts was shared by the measure developer, the Committee reconsidered and agreed to recommend the measure.

HH-018-08 Diabetic foot care and patient education implemented (Centers for Medicare & Medicaid Services)
This process measure reports the percentage of diabetic patients for whom physician ordered monitoring of the presence of skin lesions on the lower extremities and patient education on proper foot care were implemented during their episode of care. Patient education should include “If you have diabetes, your blood sugar levels are too high. Over time, this can damage your nerves or blood vessels. Nerve damage from diabetes can cause you to lose feeling in your feet. You may not feel a cut, a blister or a sore. Foot injuries such as these can cause ulcers and infections. Serious cases may even lead to amputation. Damage to the blood vessels can also mean that your feet do not get enough blood and oxygen. It is harder for your foot to heal, if you do get a sore or infection⁵.” The Committee agrees this is an important part of care but notes that home care also needs to demonstrate that they are making a difference in the disease process.

Preventive Services
AHH-027-08 Influenza immunization received for current flu season (Centers for Medicare & Medicaid Services)
This outcome measure utilizes the NQF endorsed harmonized, standard measure specifications for
influenza immunizations. Every year in the United States, on average 5% to 20% of the population gets
the flu; more than 200,000 people are hospitalized from flu complications, and; about 36,000 people die
from flu. Some people, such as older people, young children, and people with certain health conditions, are
at high risk for serious flu complications. The Committee noted this measure allows for immunizations
given by the agency or received at another setting.

AHH-033-08 Pneumococcal polysaccharide vaccine (PPV) ever received (Centers for Medicare &
Medicaid Services)
This outcome measure utilizes the NQF endorsed harmonized measure specifications for PPV. Each year
in the United States, there are an estimated 175,000 hospitalized cases of pneumococcal pneumonia; it is a
common bacterial complication of influenza and measles. In addition, in terms of invasive disease, there
are more than 50,000 cases of bacteremia and 3,000 to 6,000 cases of meningitis annually. Invasive disease
bacteremia and meningitis is responsible for the highest rates of death among the elderly and patients who
have underlying medical conditions. According to the Centers for Disease Control and Prevention (CDC),
invasive pneumococcal disease causes more than 6,000 deaths annually. More than half of these cases
involve adults for whom vaccination against pneumococcal disease is recommended. The Committee
noted this measure allows for immunizations given by the agency or received at another setting.

AHH-001-08 Depression assessment conducted (Centers for Medicare & Medicaid Services)
This process measure is contingent on approval of the OASIS-C items required for its calculation and
measures the percent of patients who were screened for depression (using a standardized depression
screening tool) at start or resumption of home health care. The World Health Organization identified
major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than
either ischemic heart disease or cerebrovascular disease. In primary care settings, the point prevalence of
major depression ranges from 5 to 9 percent among adults, and up to 50 percent of depressed patients are
not recognized. Depressive disorders are also relatively common in younger persons, with estimated
prevalence of 0.8 to 2.0 percent in children and 4.5 percent in adolescents. Up to 80% of those treated
for depression show an improvement in their symptoms generally within four to six weeks of beginning
medication, psychotherapy, attending support groups or a combination of these treatments (National
Institute of Health, 1998). Despite its high treatment success rate, nearly two out of three people suffering

1 National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations
http://www.qualityforum.org/projects/ongoing/imunization/
with depression do not actively seek nor receive proper treatment (DBSA, 1996). The Committee felt this was an important aspect of care since it directly affects the patient’s ability to improve.

Pain
More than one-quarter of Americans (26%) age 20 years and over - or, an estimated 76.5 million Americans - report that they have had a problem with pain of any sort that persisted for more than 24 hours in duration. The annual cost of chronic pain in the United States, including healthcare expenses, lost income, and lost productivity, is estimated to be $100 billion. The Steering Committee agrees that pain must be assessed and effectively addressed to facilitate optimal quality of life, recovery, and rehabilitation.

AHH-029-08 Pain assessment conducted (Centers for Medicare & Medicaid Services)
This process measure is contingent on approval of the OASIS-C items required for its calculation and measures the percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care. The Committee required that a standardized pain assessment tool be defined as an assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to, Multidimensional Pain Score and McGill Pain Questionnaire.

AHH-030-08 Pain interventions implemented (Centers for Medicare & Medicaid Services)
This process measure is contingent on approval of the OASIS-C items required for its calculation and measures the percent of patients with pain for who steps to monitor and mitigate pain were implemented during their episode of care. The Committee felt this was a very important concept for public reporting since the level of pain must be assessed and treated effectively to maximize the patient’s recovery.

0177 Improvement in pain interfering with activity (Centers for Medicare & Medicaid Services)
This outcome measures the percentage of patients who have less pain when conducting daily activities. This measure replaces the existing NQF endorsed Home Health measure “Improvement in Pain Interfering with Activity”. The updated measure includes an additional level of detail by which improvement can be measured. The original category of “Patient has no pain or pain does not interfere with activity or movement” is being replaced with two new categories: “Patient has no pain” and “Patient has pain that does not interfere with activity or movement.” These categories allow for more precise measurement of improvement in pain interfering with activity. In addition, the measure is now risk adjusted using multiple factors found in the accompanying reference document.
Clinical Symptoms Addressed

0179 Improvement in dyspnea (Centers for Medicare & Medicaid Services)
This outcome measures the percentage of patients whose shortness of breath occurs less often. Shortness of breath is a big problem for many home care patients with heart or lung problems.\textsuperscript{11} For OASIS-C, minor changes were made to item(s) contributing to the measure: Item M0490 (Short of Breath) on OASIS B-1-number changed to M0492 on OASIS-C. Response (0) on M0492 was reworded to remove the word “never”.

AHH-025-08 Heart failure symptoms addressed (Centers for Medicare & Medicaid Services)
This process measure reports the percentage of patients exhibiting symptoms of heart failure for which appropriate actions were taken. The quality of life and life expectancy of persons with heart failure can be improved with early diagnosis and treatment. The AHA/ACC guideline\textsuperscript{8} provides guidance as to monitoring symptoms and appropriate treatments. The Committee felt the measure should present interventions that contribute to best practices and an intervention to “call physician”.

0178 Improvement in status of surgical wounds (Centers for Medicare & Medicaid Services)
This outcome measures the percentage of patients whose wounds improved or healed after an operation. Wound infections and other complications that prevent or slow healing create additional pain and discomfort. Furthermore, recovery costs increase due to additional supplies and skilled visits. Appropriate treatment with subsequent wound healing will improve the patient's safety and health.\textsuperscript{12} This measure replaces the existing NQF endorsed Home Health measure entitled “Improvement in Status of Surgical Wounds.” An additional category has been added to the determination of presence of a surgical wound: “Surgical wound known or likely but not observable due to non removable dressing”. The Committee noted that an additional category has been added to the status of the most problematic observable surgical wound: “Re-epithelialized or healed”. These categories allow for more precise measurement of improvement in status of surgical wounds. In addition, the measure is now risk adjusted using multiple factors found in the accompanying reference document.

0181 Increase in the number of pressure ulcers (Centers for Medicare & Medicaid Services)
This outcome measure has been revised to measure the percentage of patients who had an increase in the number of unhealed pressure ulcers. Pressure ulcers are a complex clinical problem with a variety of causes including an adverse outcome of admission to a health care facility and are one of the five most
common causes of harm to patients. In addition, pressure ulcers are key clinical indicators of the standard and effectiveness of care. Even though they are largely preventable and major technical advances have been made in prevention, pressure ulcers still occur at unacceptable rates within healthcare facilities. The measure revisions reflect an attempt to harmonize with the National Pressure Ulcer Advisory Panel (NPUAP) guidance and with other CMS instruments such as the Minimum Data Set (MDS) and Continuity Assessment Record and Evaluation (CARE) tool. The Committee felt that this measure was important despite being documentation of how many pressure ulcers versus more a clinically detailed measure.

**Functional Status**
The ability to be as independent as possible in performing activities of daily life (ADL) or instrumental activities of daily living (IADL) is extremely important to the patient’s quality of life. Arbaje et al. (2008) identify that, among community dwelling Medicare patients, having unmet functional needs increases the likelihood of early hospital re-admission by 1.5 times, even when controlling for living alone.

**Improvement in ambulation/locomotion** (Centers for Medicare & Medicaid Services)
This outcome measures patients who get better at walking or moving around in a wheelchair safely. The ability to ambulate or move about independently is an important activity of daily living and enhances the patient’s quality of life. This measure replaces the existing NQF endorsed Home Health measure “Improvement in Ambulation/Locomotion”. The revise measure includes an additional level of detail by which improvement can be measured --the original category of “Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces” is being replaced with two new categories: “With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings” and “Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.” These categories allow for more precise measurement of improvement in mobility. The Committee felt this was an evidence-based functional status measure.

**Improvement in bathing** (Centers for Medicare & Medicaid Services)
This outcome measures the patient’s current ability to wash their entire body safely. This does not include grooming (washing hands and face only). Among community dwelling older people, Gill et al. (2006) found that disability in bathing was independently associated with long term (> 3 month) nursing home
stays (hazard ratio 1.77), thus interventions directed at the prevention and remediation of bathing
disability have the potential to reduce the burden and expense of long-term care services. This measure replaces the existing NQF endorsed Home Health measure “Improvement in Bathing”. It now includes an additional level of detail by which improvement can be measured--the original category of “Unable to use the shower or tub and is bathed in bed or bedside chair” is being replaced with two new categories: “Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode” and “Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, bedside chair, or on commode, but requires presence of another person throughout the bath for assistance or supervision.” These categories allow for more precise measurement of improvement in ability to bathe.

0175 Improvement in bed transferring (Centers for Medicare & Medicaid Services)

This outcome measures the percentage of patients who get better at getting in and out of bed. Transferring is a basic activity of daily living and a critical self-care skill with a strong relationship to community safety at home and quality of life. In the older adult literature, physical performance measures of impairment and function such as transferring are identified as valuable predictors of future morbidity, mortality and nursing home placement, even among older adults who self-report no disability. This measure replaces the existing NQF endorsed Home Health measure “Improvement in Transferring” and focuses on transferring to/from bed and ability to turn/position self in bed, whereas the former measure included not only these but also the ability to move on and off toilet or commode, and into and out of tub or shower. The ability to transfer independently is a basic functional capacity, which is required to carry out many tasks subsumed under other activities of daily living

Emergent Care and Acute Hospitalization

While not all emergent care can be eradicated, good monitoring and treatment by the home health staff can prevent or reduce the need for emergency room visits. While measure 0173 Emergent Care is risk adjusted, the other emergent care condition specific (Measures 0168, 0169, 0170) are not currently not risk adjusted since they are rare occurrences and it is difficult to calculate the risk adjustment with any statistically soundness. The Committee was concerned that the measure was not risk adjusted and recommended only if the developer would agree to add risk adjustment. The developer agreed to investigate risk adjustment for the condition specific emergent care measures.

Measure 0173 Emergent care (risk adjusted) (Centers for Medicare & Medicaid Services)
This outcome measure assesses the percentage of patients who went to a hospital emergency department. The Committee notes that emergent care is under-reported since patients may seek emergent care without the knowledge of their home health care agency. The Committee felt that emergency department visits resulting in a hospital admission should be excluded since they are already captured in the acute care hospitalization measure. This measure is a revision to the original endorsed measure and requires items for risk adjustment found on the OASIS-C. Providers had difficulty with the previous definition that included “last-minute” MD office or clinic visits that were not for emergent care. The OASIS-C has been modified so that the measure can now be calculated as emergency department care only or emergency care resulting in hospitalization.

Measure 0171 **Acute care hospitalization** (Centers for Medicare & Medicaid Services)
This outcome measure measures the percentage of patients who were admitted to the hospital as reported on the OASIS instrument. Admission to the hospital is an important indicator of an acute decline in health status. The national demonstration of the Outcomes Based Quality Improvement (OBQI) found that the implementation of OBQI in home health agencies decreased hospitalization rates by 22-26 percent (from 32.5 percent to 25.3 percent).²¹

**Patient Experience of Care**

**PEC-001-08 Home Health CAHPS®** (Centers for Medicare & Medicaid Services)
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, also referred as the "CAHPS Home Health Care Survey" or "Home Health CAHPS" is a standardized survey instrument and data collection methodology for measuring home health patients' perspectives on their home health care in Medicare-certified home health care agencies. The Committee had concerns with a negative, leading question even though it was followed by a positive one. There were specific requests to standardize the medication questions to reflect all meds instead of some questions being specific to prescription meds. The developer made wording revisions requested by the TAP and Committee that did not impact the psychometrics of the instrument. The Committee agreed to move other concerns that impacted the psychometric testing to their recommendations list for further review and testing.

**Measures Not Recommended**

**0172 Discharge to community** (Centers for Medicare & Medicaid Services)
The Committee did not recommend this measure since it does not reflect whether a patient met treatment
goals, but only that they were discharged from services, which may have been because the benefits ended. They also felt that the acute hospitalization measure captures many of these patients.

AHH-032-08 **Physician notification guidelines established** (Centers for Medicare & Medicaid Services)
The Committee felt this is an important concept but the specific parameters and instructions for notifying the physician would have to be present to accurately note if the measure was adequately met. Needs more clarity-- A member of the Steering Committee noted that they are currently being cited for a blood pressure reading of 140/92 (standard 140/90) if there are not specific parameters documented by the physician.

AHH-022-08 **Drug education on high risk medications provided to patients/caregiver at start of episode** (Centers for Medicare & Medicaid Services)
The Committee questioned which medications are not high risks in the elderly? The Steering Committee recommended the measure for drug education for all medications. They also were concerned that the original submission excluded maternity patients. There was a concern that patients may not remember all their medications and that it is complicated to reconcile medications on the first visit, although CMS allows five days from start of care.

AHH-034-08 **Potential medication issues identified and timely physician contact at start of episode** (Centers for Medicare & Medicaid Services)
AHH-035-08 **Potential medication issues identified and timely physician contact during episode** (Centers for Medicare & Medicaid Services)
The Committee was concerned that only one calendar day is allowed. Accepted modes of contact should include voice mail, and the office nurse. Definitions are lacking for “clinically significant issues” and “significant alert”. Medication reconciliation is usually done at the start of care but hospitals do not always send medication lists home with patient. There was also a concern regarding too much variation in how medication reconciliation is completed and reported back to the physician.

0180 **Improvement in urinary incontinence** (Centers for Medicare & Medicaid Services)
The Committee noted that this is difficult to capture reliably, as patients may be embarrassed and reluctant to admit to incontinence. A urinary catheter may be in place for reasons other than urinary incontinence as noted in the second value choice for documentation.
AHH-002-08 Development of urinary tract infection (Centers for Medicare & Medicaid Services)
The Committee felt this is an important clinical topic but not as a publicly reported measure since the urinary tract infection may go undetected and questioned whether this was truly measurable.

AHH-004-08 Improvement in anxiety level (Centers for Medicare & Medicaid Services)
While interventions in home care can reduce anxiety for some patients (e.g., patients with cancer), anxiety may be related to dementia or anxiety disorders and it is unclear if home care can make a difference. Anxiety is difficult to measure adequately and is a broad term with many causative factors.

AHH-005-08 Improvement in behavior problem frequency (Centers for Medicare & Medicaid Services)
While the Committee felt this is an important topic, it is unlikely that home care will be able to improve behavior problems. If publicly reported, it may create a disincentive for home health agencies to identify behavior problems since they will not be able to improve them.

AHH-006-08 Improvement in cognitive functioning (Centers for Medicare & Medicaid Services)
The Committee felt that the identification of cognitive impairment is more important than improvement because delirium and dementia are often missed. Home care is unlikely to improve cognition. If this measure were publicly reported it may create a disincentive for home health agencies to identify cognitive impairment since they will often not be able to improve it.

AHH-007-08 Improvement in confusion frequency (Centers for Medicare & Medicaid Services)
The Committee felt that it was unlikely that home health agencies would be able to reduce confusion. If this measure was publicly reported, it could create a disincentive for home health agencies to identify confusion because they will be unlikely to reduce it.

AHH-016-08 Depression interventions implemented (Centers for Medicare & Medicaid Services)
The Committee recommended the measure for depression screening. The Committee agreed that assessment is easier than interventions since it may be difficult to put interventions in place (e.g., the physician may not agree with the assessment; often difficult for the agency to convince physician depression exists).
AHH-036-08 Pressure ulcers treated with moisture-retentive dressings (Centers for Medicare & Medicaid Services) AHH-036-08
The Committee questioned the definition of moisture retentive dressings and why the measure was limited to this one treatment.

AHH-026-08 Improvement in toileting hygiene (Centers for Medicare & Medicaid Services)
AHH-013-08 Improvement in toilet transferring (Centers for Medicare & Medicaid Services)
AHH-014-08 Improvement in upper body dressing (Centers for Medicare & Medicaid Services)
AHH-008-08 Improvement in eating (Centers for Medicare & Medicaid Services)
AHH-009-08 Improvement in grooming (Centers for Medicare & Medicaid Services)
AHH-011-08 Improvement in lower body dressing (Centers for Medicare & Medicaid Services)
The Committee felt that these functional status measures would be more appropriate in a functional status composite along with the improvement measures for ambulation/locomotion, bathing, and bed transferring. A suggestion was made to weight the upper and lower body dressing as a single measure so as not to disproportionately weight dressing. They have proposed this as a research recommendation. The developer agreed to consider. The Committee did feel it was appropriate to use these measures in quality improvement reports such as the CMS OBQI reports.

AHH-010-08 Improvement in light meal preparation (Centers for Medicare & Medicaid Services)
The Committee felt this was not important for public reporting.

AHH-012-08 Improvement in speech and language (Centers for Medicare & Medicaid Services)
The Committee felt the measure is better suited for quality improvement.

AHH-003-08 Emergent care for injury caused by fall or accident at home (Centers for Medicare & Medicaid Services)
The Committee felt that falls with injury are infrequent and are not appropriate for public reporting but should be kept in the CMS OBQI reports for quality improvement.

Emergent Care for specific clinical areas
The Steering Committee initially recommended these three measures if the measure could be risk adjusted and if those cases resulting in hospitalizations could be removed. The developer provided additional
information stating the risk adjustment could be done however if hospitalizations were removed the case numbers would be so small that many home health agencies would not have enough cases to report. Based on this additional information, the Steering Committee felt it could no longer recommend the measures.

0169 **Emergent care for improper medication administration or medication side effects** (Centers for Medicare & Medicaid Services)

This outcome measures emergent care received for improper medication administration or medication side effects. The Committee noted there was a concern about under-reporting because adverse events do not always occur when the agency is in the home and many times are unaware that emergent care was sought. There was also a concern about attribution of symptoms to a cause. It was noted that adverse medication events are already reported in the acute care setting. This previously endorsed measure has not been used for public reporting to date.

0170 **Emergent care for hypo/hyperglycemia** (Centers for Medicare & Medicaid Services)

This revised outcome measures the percentage of patients who need hospital emergency department care for hypo/hyperglycemia. The underlying OASIS-C item was revised to collect information only on hospital emergency department care. Providers had difficulty with the previous specification that included “last-minute” MD office of clinic visits that were not for emergent care.

0168 **Emergent care for wound infections, deteriorating wound status** (Centers for Medicare & Medicaid Services)

This outcome measures the percentage of patients who need hospital emergency department care related to a wound that is new, is worse, or has become infected. For OASIS-C, minor changes were made to item(s) contributing to the measure: Item M0830 (Emergent Care) on OASIS B-1 – number is changed to M0831 on OASIS-C. Responses to M0831 were modified to eliminate options referencing doctor’s office visit and outpatient department/clinic visit. Item M0840 (Emergent Care Reason) on OASIS B-1 – number is changed to M0845 on OASIS-C. Additional responses to M0845 address a greater number of reasons for emergent care, changing the numbering of the responses; however the response category used for this measure did not change. It was also noted that this might be under-reported because the patient or caregiver may seek care that the Agency is not aware of.

AHH-023-08 **Falls prevention steps implemented** (Centers for Medicare & Medicaid Services)

The Committee felt this was a quality improvement measure but not for public reporting.
The Committee agrees the concept of care planning is important but felt that implementation of interventions and the eventual outcome was more appropriate for public reporting. After discussion, the developer is looking into revising the measure to make it be more in line with coordination of care and will likely submit it to the NQF Care Coordination project.

Measures Moved to Other Concurrent NQF Projects

AHH-039-08 Pressure ulcer prevention plans implemented (Centers for Medicare & Medicaid Services)
0181 Improvement in number of pressure ulcers (Centers for Medicare & Medicaid Services)

The pressure ulcer measures will be revisited in the Pressure Ulcer Framework project that began in December 2008. Although the improvement in number of pressure ulcers measure was approved, harmonization may be needed pending the outcome of the Framework project.

Relationship to Other NQF-Endorsed Consensus Standards

This report does not represent the entire scope of NQF work relevant to the quality of home health care. NQF has endorsed several disease specific topics that could be applied to home health but research has not been done specifically in patients within this setting. Some of the endorsed measures are the same topic area but have a different focus such as the endorsed fall measure that
looks to prevent future falls (instead of the submitted falls assessment which does not require a fall having occurred). The measures in Table 2 are appropriate for home health but are not captured on the OASIS instrument, but their data is collected by other tools including Focus on Therapeutic Outcomes (FOTO), Boston University Activity Measurement-Post Acute Care (AM-PAC), and the American Speech Language Hearing Association (ASHA) National Outcomes Measurement System (NOMS).

Table 2. NQF endorsed measures that directly related to the home health measures submitted

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>NQF Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>0423</td>
<td>Functional status change for patients with hip impairments (FOTO)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0425</td>
<td>Functional status change for patients with lumbar spine impairments (FOTO)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0426</td>
<td>Functional status change for patients with shoulder impairments (FOTO)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0427</td>
<td>Functional status change for patients with elbow, wrist or hand impairments (FOTO)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0429</td>
<td>Change in Basic Mobility (AM-PAC)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0430</td>
<td>Change in Daily Activity Function (AM-PAC)</td>
<td>Non-Physician Professional</td>
</tr>
<tr>
<td>0442</td>
<td>Functional Communication Measure: Writing (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0443</td>
<td>Functional Communication Measure: Swallowing (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0444</td>
<td>Functional Communication Measure: Spoken Language Expression (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0445</td>
<td>Functional Communication Measure: Spoken Language Comprehension (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0446</td>
<td>Functional Communication Measure: Reading (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0447</td>
<td>Functional Communication Measure: Motor Speech (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0448</td>
<td>Functional Communication Measure: Memory (NOMS)</td>
<td>Stroke</td>
</tr>
<tr>
<td>0449</td>
<td>Functional Communication Measure: Attention (NOMS)</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

The full constellation of consensus standards, along with those presented in this report, provide a growing number of NQF-endorsed® voluntary consensus standards that directly and indirectly reflect the importance of measuring and improving quality of care. Organizations that adopted these consensus standards will promote the development of safer and higher quality-care for patients throughout the nation.

Recommendations to Accompany the Measures

The following recommendations were put forward by the Steering Committee to accompany the measures:
THE NATIONAL QUALITY FORUM

- **Stratify some of the populations.** The Committee felt the measures would be more meaningful if there were subsets of the population such as acute versus chronic or long-term care reported. This could lead to incentives for caring for vulnerable populations.

- **Reimbursement for pharmacists.** Medication management requires a multidisciplinary team that includes a pharmacist but there is currently no reimbursement by Medicare for the pharmacist. The nurse has the sole responsibility of medications in the home at present.

- **Need for evidence.** Promote formal research in the home care field and publication in recognized peer reviewed journals.

- **Risk adjustment.** All measures (except process measures) should be risk adjusted for use in public reporting.

- **Consider augmenting quality measures from the OASIS instrument with CAHPS and claims data.** CAHPS captures concepts of patient and caregiver engagement in planning care. Emergent care visits as well as admissions could be derived from claims data and would take care of the under-reporting of these areas on OASIS.

- **Develop a measure to assess whether the home health agency has incorporated findings about a patient’s cognitive status and level of confusion from the OASIS into its plan of care and interventions for other important aspects of the patient’s care.** These aspects of care include (from OASIS items) patient/caregiver drug education; management of all medications; assessment and management of pain; ability to communicate and understand communication; patient education about diabetic foot care; patient education about symptoms and management of heart failure; management of incontinence; assessment of ability to perform all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and need for help with all ADLs and IADLs; fall interventions; patient management of equipment; and decision-making capacity.

- **Develop a functional status composite.** The composite could include:
  - AHH-026-08 Improvement in toileting hygiene
  - AHH-013-08 Improvement in toilet transferring
  - AHH-014-08 Improvement in upper body dressing

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NQF MEMBER VOTES DUE TO NQF BY TUESDAY, FEBRUARY 26, 2009 AT 6:00PM ET
The Committee felt that the improvement in lower body dressing and improvement in upper body dressing should be counted as one measure for weighting purposes in order not skew the measure. They also realize that the proposed individual measures may change based on additional required analyses for the composite.

- Develop a falls assessment measure specific to those patients 65 and older since guidelines and literature are based primarily in this population.
  - Specific instruments should be recommended that are reliable and valid for homecare geriatric patients and that the instrument should be brief and easy to administer by various disciplines. Some examples in discussion: Morse Scale, Timed up and go, Tinetti, Berg, Missouri Alliance Project.
  - A multi-factorial fall risk assessment must take into consideration cognitive impairment and be risk adjusted for this item in particular.
  - Identify population attributes for determining which Falls Assessment Tools specifically recommended.
  - Conduct research for sub-group analysis: post-surgical, post-acute hospital or rehab medical versus chronic / maintenance.

- Investigate the impact of removing the death exclusion from the process measures. Minimal data elements are currently collected at the patient’s death and therefore do not support the calculations of the quality measures.

- Recommendations specific to the Home Health CAHPS instrument:
  - Explore the use of proxy and how well it works.
  - Research the patient/discipline mix and its impact.
• Use positively stated questions. Surveys should not included loaded negative questions that are leading to the person completing the survey and could be misleading to the public when reported.
• Investigate the use of removing the limitation to “new or changed prescription meds” to be “new or changed medications”.
• Investigate the use of the 2-month time period.

References

1 U.S. Census Bureau, 2002 Economic Census (www.census.gov) (October 2004)
2 Centers for Medicare & Medicaid Services, Office of the Actuary (January 2008)
3 Center for Medicare & Medicaid Services, OSCAR data (February 2008)
4 Nuccio E and Richard A, Do delays in initiation of home health care services affect outcomes. (2008 pre-publication)
5 http://www.nlm.nih.gov/medlineplus/diabeticfoot.html last accessed 12/10/08
6 http://www.nfid.org/factsheets/pneumofacts.html last accessed 12/10/08
7 http://www.dbsalliance.org/site/PageServer?pagename=about_statistics_depression last accessed 12/11/08
8 http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm
11 http://www.medicare.gov/HHCompare/Home.asp?dest=NAV|Home|DataDetails#TabTop last accessed 12/10/08
13 Elliot R, McKinley S, Fox V, Quality improvement program to reduce the prevalence of pressure ulcers in an intensive care unit, Am J Crit Care, 2008.17(4):338-334
Acknowledgement
This work was funded by the Centers for Medicare & Medicaid Services.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure#0167</td>
<td>Number of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.</td>
<td>All home health episodes except those where either of the following conditions applies:</td>
<td>All home health episodes where either of the following conditions applies:</td>
</tr>
<tr>
<td>Title: Improvement in Ambulation/locomotion</td>
<td>Improvement in Ambulation/Locomotion is coded as follows:</td>
<td>1 (YES) IF: The value recorded for the OASIS item M0702 on the discharge assessment is</td>
<td>(1) The value recorded for the OASIS item M0702 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. OR (2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.</td>
</tr>
</tbody>
</table>

1 CMS GENERIC EXCLUSIONS for all measures except CAHPS –
- Non-Medicare/non-Medicaid Patients - Medicare-certified home health agencies are currently required to collect and submit OASIS data only on Medicare and Medicaid patients who are receiving skilled home health care excluding maternity patients. The OASIS-C items were tested on this population only, and the existing risk adjustment models used in CMS systems such as the Home Health Compare website, are based on data for this population only. However, the OASIS items and related measures could be used for other adult, non-maternity home health care patients, ideally with further testing and possible recalibration of the risk adjustment models.

- Small and new agencies and rare conditions - The publicly reported data on CMS’ Home Health Compare web site also repless cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.

- Very long stay patients - Please note that CMS is removing the generic exclusion for very long stay patients. Currently, reports in CMS’ Home Health Quality Initiative systems (such as agency OBQI reports and the publicly-reported Home Health Compare) are based on a rolling 12-month period, and an episode of care must start AND end within the specific twelve-month period to be included in agency-level reporting of the measure. For this reason, home health care patients who are on service for an extremely long period of time are excluded from an agency’s report unless they are admitted to an inpatient facility. CMS is relaxing this restriction, such that long-stay patients would no longer be excluded from the reports, and other data providers could choose a different time window.
<table>
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<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.</td>
<td>death at home, and those covered by the CMS generic exclusions (see footnote).</td>
<td></td>
</tr>
<tr>
<td>0 (NO) IF: The value recorded for the OASIS item M0702 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care.</td>
<td>Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.</td>
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</table>

OASIS C item:

(M0702) Ambulation/Locomotion: Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

-0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
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</thead>
<tbody>
<tr>
<td>1 -</td>
<td>With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 -</td>
<td>Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 -</td>
<td>Able to walk only with the supervision or assistance of another person at all times.</td>
<td></td>
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<tr>
<td>4 -</td>
<td>Chairfast, unable to ambulate but is able to wheel self independently.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 -</td>
<td>Chairfast, unable to ambulate and is unable to wheel self.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 -</td>
<td>Bedfast, unable to ambulate or be up in a chair.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure#0168</td>
<td>Title: Emergent care for wound infections, deteriorating wound status</td>
<td>IP Owner: Centers for Medicare &amp; Medicaid Services</td>
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<td></td>
<td>WITHDRAWN FROM SUBMISSION</td>
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<table>
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<tr>
<th>Measure#0169</th>
<th>Title: Emergent care for improper medication administration, medication side effects</th>
<th>IP Owner: Centers for Medicare &amp; Medicaid Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WITHDRAWN FROM SUBMISSION</td>
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</table>

<table>
<thead>
<tr>
<th>Measure#0170</th>
<th>Title: Emergent care for hypo/ hyperglycemia</th>
<th>IP Owner: Centers for Medicare &amp; Medicaid Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WITHDRAWN FROM SUBMISSION</td>
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</tr>
<tr>
<td>Measure#0171</td>
<td>Number of home health episodes where the assessment completed at the conclusion of the episode of care is a transfer to inpatient facility assessment (M0100 has a value of six or seven), AND the value recorded for the OASIS item M0855 on that assessment is one, indicating the patient was admitted to a hospital.</td>
<td>All episodes except those where the patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home, and those covered by the CMS generic exclusions (see footnote)</td>
</tr>
<tr>
<td>Title: Acute care hospitalization (risk-adjusted)</td>
<td>Acute Care Hospitalization is coded as follows: 1 (YES) IF: The assessment completed at the conclusion of the episode of care is a transfer to inpatient facility assessment (M0100 has a value of six or seven), AND the value recorded for the OASIS item M0855 on that assessment is one, indicating the patient was admitted to a hospital. 0 (NO) IF: The assessment completed at the conclusion of the episode of care is a discharge assessment (M0100 has a value of nine), OR The value recorded for the OASIS item M0855 on the transfer to inpatient facility assessment is two, three, or four, indicating that the patient was admitted to an inpatient facility other than a hospital.</td>
<td>Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.</td>
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<tr>
<td>IP Owner: Centers for Medicare &amp; Medicaid Services</td>
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</table>
Quarterly, CMS proposes to drop the requirement that episodes start during the 12-month period.

OASIS C item:

(M0100) This Assessment is Currently Being Completed for the Following Reason: Start/Resumption of Care

- 1 – Start of care—further visits planned
- 3 – Resumption of care (after inpatient stay)
- Follow-Up
- 4 – Recertification (follow-up) reassessment
- 5 – Other follow-up
- Transfer to an Inpatient Facility
- 6 – Transferred to an inpatient facility—patient not discharged from agency
- 7 – Transferred to an inpatient facility—patient discharged from agency
- Discharge from Agency — Not to an Inpatient Facility
- 8 – Death at home
- 9 – Discharge from agency

(M0855) To which Inpatient Facility has the
<table>
<thead>
<tr>
<th>patient been admitted?</th>
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<tbody>
<tr>
<td>• 1 - Hospital</td>
</tr>
<tr>
<td>• 2 - Rehabilitation facility</td>
</tr>
<tr>
<td>• 3 - Nursing home</td>
</tr>
<tr>
<td>• 4 - Hospice</td>
</tr>
<tr>
<td>• NA - No inpatient facility admission</td>
</tr>
<tr>
<td>Measure#0173</td>
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</tbody>
</table>

**Percent** of home health episodes where the value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is 1 (one), indicating the patient required emergency medical treatment from a hospital emergency department, reported separately for cases with and without subsequent hospitalization.

(a) **Emergency Department Use without Hospitalization** is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is one, indicating the patient required emergency medical treatment from a hospital emergency department without hospitalization.

0 (NO) IF: The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is zero or 2, indicating that no emergency department care was received or emergency department care was received followed by hospitalization.

(b) **Emergency Department Use with Hospitalization** is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is one, indicating the patient required emergency medical treatment from a hospital emergency department.

All episodes except those where:

1. The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is "UK." OR

2. The patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

Il episodes where:

1. The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is "UK." OR

2. The patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

- **Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

- **Deleted:** Number

- **Deleted:** Emergent care (risk adjusted)

- **Deleted:** Any Emergency Department Use

- **Deleted:** medical treatment
for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is 2 (two), indicating the patient required emergency medical treatment from a hospital emergency department with subsequent hospitalization.

0 (NO) IF: The value recorded for the OASIS item M0831 on the discharge or transfer to inpatient facility assessment is zero or 1, indicating that no emergency department care was received OR emergency department care was received without subsequent hospitalization.

Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

OASIS C item:

(M0831) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation with or without hospital admission)?

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<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes, used hospital emergency department WITHOUT hospital admission</td>
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</table>

Deleted: Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation with or without hospital admission)?

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<tr>
<th>2 - Yes, used hospital emergency department WITH hospital admission</th>
<th>UK - Unknown</th>
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<tr>
<td>• 0 - No ¶</td>
<td>• 1 - Yes</td>
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</table>
| Measure#0174 | Number of home health episodes where the value recorded for the OASIS item M0672 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care. Improvement in Bathing is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0672 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.

0 (NO) IF: The value recorded for the OASIS item M0672 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care.

All home health episodes except those where:

1. The value recorded for the OASIS item M0672 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. OR
2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home; OR
3. Those covered by the CMS generic exclusions (see footnote).

Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

All home health episodes except those where:

1. The value recorded for the OASIS item M0672 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement. OR
2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home; OR
3. Those covered by the CMS generic exclusions (see footnote).
### OASIS C item:
(M0672) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face and hands only).

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bath self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub.
tub, but able to participate in bathing self in bed, at the sink, bedside chair, or on commode with assistance or supervision from another person throughout the bath.

• 6 - Unable to participate effectively in bathing and is bathed totally by another person.
<table>
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<tr>
<th>Measure#0175</th>
<th>Title: Improvement in bed transferring</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP Owner: Centers for Medicare &amp; Medicaid Services</td>
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</tbody>
</table>

Number of home health episodes where the value recorded for the OASIS item M0692 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.

Improvement in Transferring is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0692 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.

0 (NO) IF: The value recorded for the OASIS item M0692 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or more impairment at discharge compared to start of care.

All episodes except those where either of the following conditions applies:

1. The value recorded for the OASIS item M0692 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.

2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

3. Those covered by the CMS generic exclusions (see footnote).

Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.
the requirement that episodes start during the 12-month period.

<table>
<thead>
<tr>
<th>OASIS C item:</th>
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</thead>
<tbody>
<tr>
<td>(M0692) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.</td>
</tr>
<tr>
<td>• 0 - Able to independently transfer.</td>
</tr>
<tr>
<td>• 1 - Able to transfer with minimal human assistance or with use of an assistive device.</td>
</tr>
<tr>
<td>• 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.</td>
</tr>
<tr>
<td>• 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</td>
</tr>
<tr>
<td>• 4 - Bedfast, unable to transfer but is able to turn and position self in bed.</td>
</tr>
<tr>
<td>• 5 - Bedfast, unable to transfer and is unable to turn and position self.</td>
</tr>
</tbody>
</table>
| Measure#0176 | **Title:** Improvement in Management of Oral Medications  
**IP Owner:** Centers for Medicare & Medicaid Services |
|-------------|---------------------------------------------------------------|
| **Number of home health episodes**
Number of home health episodes where the value recorded for the OASIS-C item M0782 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.

Improvement in Management of Oral Medications is coded as follows:

- **= 1 (YES) IF:** The value recorded for the OASIS-C item M0782 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment.
- **= 0 (NO) IF:** The value recorded for the OASIS-C item M0782 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment.

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. |
| **All home health episodes except those where any of the following conditions apply:**
All home health episodes except those where any of the following conditions apply:

1a) The value "NA" is recorded for the OASIS-C item M0782 on either the start (or resumption) of care assessment or the discharge assessment.

1b) The value recorded for the OASIS-C item M0782 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement.

2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

3) Those covered by the CMS generic exclusions (see footnote). |
| **All home health episodes where any of the following conditions apply:**
All home health episodes where any of the following conditions apply:

1a) The value "NA" is recorded for the OASIS-C item M0782 on either the start (or resumption) of care assessment or the discharge assessment.

1b) The value recorded for the OASIS-C item M0782 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement.

2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

3) Those covered by the CMS generic exclusions (see footnote). |
**OASIS C item:**

(M0782) Management of Oral Medications: Patient’s current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

- **0** - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- **1** - Able to take medication(s) at the correct times if:
  - (a) individual dosages are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- **2** - Able to take medication(s) at the correct times if given daily reminders by another person.
- **3** - Unable to take medication unless administered by another person.
- **NA** - No oral medications prescribed.
<table>
<thead>
<tr>
<th><strong>Measure#0177</strong></th>
<th><strong>Title:</strong> Improvement in pain interfering with activity</th>
<th><strong>IP Owner:</strong> Centers for Medicare &amp; Medicaid Services</th>
</tr>
</thead>
</table>

Number of home health episodes where the value recorded for the OASIS item M0422 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent pain interfering with activity at discharge compared to start of care.

**Improvement in Pain Interfering with Activity** is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0422 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less frequent pain interfering with activity at discharge compared to start of care.

0 (NO) IF: The value recorded for the OASIS item M0422 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating that pain interfering with activity occurs with the same or greater frequency at discharge compared to start of care.

---

All home health episodes except where either of the following conditions applies:

1. The value recorded for the OASIS item M0422 on the start (or resumption) of care assessment is zero, indicating there is no pain. These patients are excluded because it would be impossible for them to show measurable improvement. OR

2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

---

All home health episodes where either of the following conditions applies:

1. The value recorded for the OASIS item M0422 on the start (or resumption) of care assessment is zero, indicating there is no pain. These patients are excluded because it would be impossible for them to show measurable improvement. OR

2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

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**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

**Time Window:** All home health episodes except where either of the following conditions apply:

1. The value recorded for the OASIS item M0422 on the start (or resumption) of care assessment is zero, indicating there is no pain. These patients are excluded because it would be impossible for them to show measurable improvement. OR

2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.
systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

OASIS C item:

(M0422) Frequency of Pain interfering with patient's activity or movement:

- 0 - Patient has no pain
- 1 - Patient has pain that does not interfere with activity or movement
- 2 - Less often than daily
- 3 - Daily, but not constantly
- 4 - All of the time
Measure#0178

Title: Improvement in status of surgical wounds

IP Owner: Centers for Medicare & Medicaid Services

Number of home health episodes where the value recorded for the OASIS item M0487 on the discharge assessment is less than the value recorded on the start (or resumption) of care assessment, indicating more healing at discharge compared to start of care, OR the response to M0483 at start/resumption of care is one (YES) and the response to M0483 at discharge is zero (No), indicating that there are no current surgical wounds remaining.

Improvement in Status of Surgical Wounds is coded as follows:

1 (YES) IF: The value recorded for the OASIS item M0487 on the discharge assessment is less than the value recorded on the start (or resumption) of care assessment, indicating more healing at discharge compared to start of care, OR the response to M0483 at start/resumption of care is one (YES) and the response to M0483 at discharge is zero (No), indicating that there are no current surgical wounds remaining.

0 (NO) IF: The value recorded for the OASIS item M0487 on the discharge assessment is greater than or equal to the value.

All home health episodes where either of the following conditions applies:

(1a) The value recorded for the OASIS item M0487 on the start (or resumption) of care assessment or on the discharge assessment is NA, indicating no observable surgical wound, or

(1b) the value recorded for the OASIS item M0483 on the start (or resumption) of care assessment or on the discharge assessment is zero (No) or two, indicating either no surgical wound or no observable surgical wound. These patients are excluded because it would be impossible to show measurable improvement. OR

(2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home

(3) Those covered by the CMS generic exclusions (see footnote).
recorded on the start (or resumption) of care assessment, indicating the same or worse surgical wound healing at discharge compared to start of care.

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

OASIS C item:
(M0483) Does this patient have a Surgical Wound?
- 0 - No
- 1 - Yes, patient has at least one (observable) surgical wound
- 2 - Surgical wound known or likely but not observable due to non-removable dressing (M0487)

Status of Most Problematic (Observable) Surgical Wound (ask if M0483=1):
- 0 - Re-epithelialized or healed
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable surgical wound
Number of home health episodes where the value recorded for the OASIS-C item M0492 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less serious condition at discharge compared to start of care.

Improvement in Dyspnea is coded as follows:
1 (YES) IF: The value recorded for the OASIS-C item M0492 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less serious condition at discharge compared to start of care.
0 (NO) IF: The value recorded for the OASIS-C item M0492 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or worse condition at discharge compared to start of care.

All home health episodes where either of the following conditions applies:
1 The value recorded for the OASIS-C item M0492 on the start (or resumption) of care assessment is zero, indicating patient is not short of breath. These patients are excluded because it would be impossible for them to show measurable improvement. OR
2 The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

(3) Those covered by the CMS generic exclusions (see footnote).

Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.
<table>
<thead>
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<th>OASIS C item:</th>
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<tbody>
<tr>
<td>(M0492) When is the patient dyspneic or noticeably Short of Breath?</td>
</tr>
<tr>
<td>• 0 - Patient is not short of breath</td>
</tr>
<tr>
<td>• 1 - When walking more than 20 feet, climbing stairs</td>
</tr>
<tr>
<td>• 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)</td>
</tr>
<tr>
<td>• 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation</td>
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<tr>
<td>• 4 - At rest (during day or night)</td>
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<tr>
<td>Measure#0181</td>
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</tbody>
</table>

**Number of home health episodes**

Number of home health episodes where [(a) the value recorded for the total number of stageable pressure ulcers \((M0462 - \text{number at stage 1}) + (M0452 - \text{number at stage 2}) + (M0452 - \text{number at stage 3}) + (M0452 - \text{number at stage 4})\) or (b) "0" if \(M0448=0\) and \(M0462=0\)] on the discharge assessment is numerically greater than the value resulting from the same calculation using the responses on the start (or resumption) of care assessment - indicating an increase in the number of pressure ulcers.

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

**OASIS C items:**

- \((M0448)\) Does this patient have at least one unhealed (non-epithelialized) Pressure Ulcer at Stage II or higher or designated as "not stageable"?
  - 0-No
  - 1-Yes
- \((M0452)\) Current Number of Unhealed

**All home health episodes except those where:**

1. The total number of pressure ulcers reported on the start (or resumption) of care assessment is 16. These patients are excluded because it would be impossible for them to show increase in the number of pressure ulcers.

2. The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home.

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

**Deleted:**

- generic exclusions (see below)
(non-epithelialized) Pressure Ulcers at Each Stage:
(Enter "0" if none; enter "4" if "4 or more"; enter "UK" for rows d.1 – d.3 if "Unknown")

a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

d.1 Unstageable: Known or likely but not stageable due to non-removable dressing or device
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<tbody>
<tr>
<td>d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar.</td>
<td></td>
</tr>
<tr>
<td>d.3 Unstageable: Suspected deep tissue injury in evolution.</td>
<td></td>
</tr>
<tr>
<td>(M0462) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.</td>
<td>0, 1, 2, 3, 4 or more</td>
</tr>
<tr>
<td>Measure#</td>
<td>AHH-001-08</td>
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<tr>
<td></td>
<td>Number of home health episodes where at start of episode, patient was screened for depression, using a standardized depression screening tool.</td>
</tr>
<tr>
<td></td>
<td>Number of patient episodes where at start of episode:</td>
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<tr>
<td></td>
<td>-Where (M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care) AND</td>
</tr>
<tr>
<td></td>
<td>-(M1120) Depression Screening conducted = 1 (yes) or 2 (yes)</td>
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Deleted: | Number of patient episodes where at start of episode:
-Where (M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care) AND
-(M1120) Depression Screening conducted = 1 (yes) or 2 (yes)
<table>
<thead>
<tr>
<th>Measure#</th>
<th>AHH-018-08</th>
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<tbody>
<tr>
<td><strong>Title:</strong></td>
<td>Diabetic Foot Care and Patient Education Implemented during Short-term Episodes of Care</td>
</tr>
<tr>
<td><strong>IP Owner:</strong></td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
</tbody>
</table>

Number of **short-term** home health episodes where at end of episode, diabetic foot care and education specified in the care plan had been implemented. **Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

Details: Number of patient episodes less than 60 days long where at end of episode:
- (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge); AND
- no assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; AND
- (M1095) Diabetic Foot Care Plan implemented = 1 (yes)

Number of **short-term** home health episodes where diabetic foot care had been specified in the care plan and episode is not covered by CMS generic exclusions (see footnote).

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

All episodes where:
- the patient is not diabetic OR
- the patient is a bilateral amputee (M1095=NA) OR
- diabetic foot care was not included in the care plan (M1095=NA); OR
- an assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; OR
- the episode did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.
| Measure#AHH-021-08 | Number of short-term home health episodes where by the end of the episode, patient/caregiver was instructed to monitor the effectiveness of drug therapy and potential adverse effects, and how and when to report problems. **Time Window**: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. **Details**: Number of patient episodes where at end of episode: 

- (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND 
  - no assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; AND 
  - (M1185) Patient/Caregiver Drug Education provided since last OASIS assessment = 1 (yes) | All short-term home health episodes - OTHER THAN episodes covered by CMS generic exclusions (see footnote). **Time Window**: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. All episodes where the patient did not have any drug therapy (M1185 = NA); OR
- an assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; OR
- the episode did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home |
<table>
<thead>
<tr>
<th>Measure#AHH-025-08</th>
<th>Number of short-term home health episodes where by the end of episode, when patients with diagnosis of heart failure had exhibited symptoms, the provider had responded appropriately in each instance.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> Heart Failure Symptoms Addressed during Short-term Episodes</td>
<td></td>
</tr>
<tr>
<td><strong>IP Owner:</strong> Centers for Medicare &amp; Medicaid Services</td>
<td></td>
</tr>
<tr>
<td><strong>Time Window:</strong> Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.</td>
<td></td>
</tr>
<tr>
<td><strong>Details:</strong> Number of patient episodes where at end of episode:</td>
<td></td>
</tr>
<tr>
<td>-(M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND</td>
<td></td>
</tr>
<tr>
<td>-(M1105) Symptoms of Heart Failure = 1 (yes) AND</td>
<td></td>
</tr>
<tr>
<td>-no assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; AND</td>
<td></td>
</tr>
<tr>
<td>-(M1110) Heart Failure Follow-up = 1,2,3,4 or 5 (appropriate actions taken)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of short-term home health episodes where by the end of episode, patients with diagnosis of heart failure had exhibited symptoms (M1105 = 1 (yes) - OTHER THAN those covered by CMS generic exclusions (see footnote).)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Time Window:</strong> Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.</td>
<td></td>
</tr>
<tr>
<td><strong>Details:</strong> Number of patient episodes where at end of episode:</td>
<td></td>
</tr>
<tr>
<td>-(M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND</td>
<td></td>
</tr>
<tr>
<td>-(M1105) Symptoms of Heart Failure = 1 (yes) AND</td>
<td></td>
</tr>
<tr>
<td>-no assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; AND</td>
<td></td>
</tr>
<tr>
<td>-(M1110) Heart Failure Follow-up = 1,2,3,4 or 5 (appropriate actions taken)</td>
<td></td>
</tr>
<tr>
<td><strong>All episodes where:</strong></td>
<td></td>
</tr>
<tr>
<td>-the patient does not have diagnosis of heart failure (M1105=NA) OR</td>
<td></td>
</tr>
<tr>
<td>-an assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; OR</td>
<td></td>
</tr>
<tr>
<td>-the episode did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home</td>
<td></td>
</tr>
<tr>
<td><strong>Deleted:</strong> numerator denominator exclusions (Q6)</td>
<td></td>
</tr>
<tr>
<td><strong>Deleted:</strong> Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.</td>
<td></td>
</tr>
</tbody>
</table>
| **Deleted:** Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.
**Measure**#AHH-027-08

**Title:** Influenza Immunization Received for Current Flu Season

**IP Owner:** Centers for Medicare & Medicaid Services

<table>
<thead>
<tr>
<th>Number of home health episodes specified in the denominator where patients received the influenza vaccine from the home health provider OR patient or responsible party reported receipt from another provider (computed separately); OR</th>
<th>Number of home health episodes with an OASIS Transfer or Discharge assessment in which any part of the patient episode occurred between October 1 - March 31; AND in which the patient age is 50 and older or 6 mo. – 18 yrs; OR in which the patient resides in a long-term care facility (including nursing homes and skilled nursing facilities); OR is age 19-49 with high-risk conditions of pregnancy, diabetes, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), or human immunodeficiency virus (HIV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) Were determined to have medical contraindication(s) of anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplant within 6 months prior to encounters between October 1 and March 31 (computed separately) between October 1 (or whenever the vaccine became available) through March 31.</td>
<td>Episodes in which (M0100) Reason for Assessment = 8, Death (limited data is collected at time of death and does not capture the data required for measure calculation)</td>
</tr>
</tbody>
</table>

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. Patients with home health episodes in which:

- Deleted: Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.
Details: Number of home health patient episodes in which the patient:

a) Received the influenza vaccine between October 1 (or whenever the vaccine became available) through March 31 [M1021 Flu Vaccination given = 1]

b) Was offered and refused vaccine [M1025 Reason Influenza Vaccine not received = 1]

c) Was medically ineligible due to medical contraindications [M1025 Reason Influenza Vaccination not received = 2]

NOTE: The OASIS-C instrument has been further revised since our previous submission. Here is the current formulation of the relevant items (as of 12/12/2008) which is still subject to further change during OMB review.

(M1021) Influenza Vaccine: Did the patient receive the influenza vaccine for this year's flu season?
- 0 - No
- 1 - Yes [Go to M1031]
- NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge)

- (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge)
- the period between the related Start of Care (M0030) or Resumption of Care (M0032) AND
- (M0906) Date of Transfer, Discharge or Death includes dates between October 1 through March 31; AND
- (M0066) Date of Birth indicates the patient is age 50 or older or age 6 mo. to 18 years; OR
- (M0066) Date of Birth indicates the patients is age 19 - 49 AND has a high-risk condition(s)

- (M1025) Reason Influenza Vaccine not received = 1, 2, 4 or 5

NOTE: Data regarding immunization status will be collected at time of transfer or discharge. Patients with home health episodes in which the Start of Care/Resumption of Care date and the Transfer/Discharge date includes the time period between October 1 through March 31 will be included in the measure for the period that includes the date of Transfer/Discharge.
is outside the period October 1 – March 31. [Go to M1031] -- UK - Unknown [Go to M1031]

NOTE: Guidance for #1 will indicate that vaccine given may be given by HH provider or another provider between October 1 (or whenever the vaccine became available) through March 31.

(M1025) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine for this year's flu season, state reason:

1. Offered and declined
2. Assessed and determined to have medical contraindication(s)
3. Not indicated; patient does not meet age/condition guidelines for influenza vaccine
4. Inability to obtain vaccine due to declared shortage
5. None of the above

NOTE: Guidance will identify medical contraindications (anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplant within past 6 months [< 6 months prior to encounter between October 1 and March 31]).

Because home health diagnoses reported in the OASIS assessment are not all-inclusive, identification of high risk conditions will rely on clinician response to M1025 (i.e. clinician will choose #3 if influenza vaccine is not indicated because the patient does not meet age/condition guidelines. Guidance defining high-risk conditions will be provided. Also, as stated above, although children under the age of 18 and patients in skilled nursing facilities are included in this definition of high-risk, these patient groups will not be included in the measure as reported by CMS, since OASIS is not collected on those populations.
Guidance will also define age/condition guidelines (influenza vaccine recommended for all patients without medical contraindications who are: age 6 mo. – 18 yr, OR age 50 and older, OR are age 19-49 with high-risk conditions such as pregnancy, diabetes, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus (HIV), OR reside in a skilled nursing or long-term care facility). Also note that although children under the age of 18 and patients in skilled nursing facilities are included in this definition of high-risk, these patient groups will not be included in the measure as reported by CMS since OASIS is not collected on those populations.
<table>
<thead>
<tr>
<th>Measure#</th>
<th>Title</th>
<th>IP Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHH-029-08</td>
<td>Pain Assessment Conducted</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
</tbody>
</table>

**Details:**

- **Number of home health episodes where the patient had any pain at start of episode and was assessed using a standardized pain assessment tool.**

  - **Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

  - **Details:**
    - Number of patient episodes where at start of episode:
      - (M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care) AND
      - (M0422) Frequency of Pain = 1, 2, 3, or 4 (some pain present) AND
      - (M1050) Has this patient had a formal Pain Assessment = 1 (Yes, doesn't indicate severe pain) OR = 2 (Yes, indicates severe pain)

- **Number of home health episodes where the patient had any pain at start of episode (M0422 > 0) OTHER THAN those covered by CMS generic exclusions (see footnote).**

  - **Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

- **All episodes where the patient had no pain (M0422=0).**

  - **Time Window:** Number of home health episodes where the patient had any pain at start of episode (M0422 > 0) OTHER THAN those covered by denominator exclusions (Q6).
<table>
<thead>
<tr>
<th>Measure#</th>
<th>Title: Pain Interventions Implemented during Short-term Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP Owner: Centers for Medicare &amp; Medicaid Services</td>
<td></td>
</tr>
</tbody>
</table>

Number of short-term home health episodes where the patient had pain interventions included in the care plan and these pain management steps had been implemented by the end of the episode.

- **Details:** Number of patient episodes where at end of episode:
  - (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND
  - no assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; AND
  - (M1065) Pain Management Steps Implemented = 1 (Yes)

- **Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

All episodes where:
- the patient did not have pain interventions in the care plan (M01065=NA) OR
- an assessment with (M0100) Reason for Assessment = 4 or 5 (recertification or other followup) was conducted; OR
- the patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

- **Deleted:** denominator exclusions (Q6)
- **Deleted:** Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.
Measure#AHH-033-08

Title: Pneumococcal Polysaccharide Vaccine (PPV) Ever Received

IP Owner: Centers for Medicare & Medicaid Services

Number of home health episodes specified in the denominator where the patient:

a) ever received the PPV23 (pneumococcal polysaccharide) vaccine (documented administration by the provider or patient/responsible party reported receipt from another provider (computed & reported separately); OR

(b) patient was assessed and offered but declined the vaccination (computed & reported separately); OR

(c) patient was assessed and determined to have medical contraindication(s) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (< 12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (< 2 weeks prior to encounters during the measurement year)(computed & reported separately).

Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

Details:
- (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge) AND
- (M0066) Date of Birth indicates the patient is age 65 or older; OR
- (M0066) Date of Birth indicates the patient is age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, or asplenia.

Episodes in which (M0100) Reason for Assessment = 8, Death (limited data is collected at time of death and does not capture the data required for measure calculation)

NOTE: Data regarding immunization status will be collected at time of transfer or discharge, so immunization rates as reported by CMS will only include persons with transfer or discharge during the measurement year. Also, the measure as reported by CMS will include all patients for whom the relevant OASIS data are collected. Currently, Medicare-certified home health agencies are required to collect and submit OASIS data only on adult non-maternity patients receiving skilled services for whom Medicare and/or Medicaid are primary payers. Therefore the measure as reported by CMS will cover those populations only.

Deleted: persons

Deleted: Time Window: Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly.
Details: a) Number of patient episodes where:
- (M1031) Patient Received Pneumococcal Vaccine from your agency this episode = 1 (yes) OR
- (M1035) Reason PPV not received = 1 (Patient has received PPV in the past)

(b) Number of patient episodes where:
- (M1035) Reason PPV not received = 2 (Offered and declined)

(c) Number of patient episodes where:
- (M1035) Reason PPV not received = 3 (Assessed and determined to have medical contraindication(s))

NOTE: The OASIS-C instrument has NOT been further revised since our previous submission. Here is the current formulation of the relevant items (as of 12/14/2008) which is still subject to further change during OMB review. Guidance will identify medical contraindications for PPV (anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (< 12 months prior to encounters during the measurement year), or receiving course of chemotherapy or

Deleted: Time Window: CMS systems will report data on episodes that end within a rolling 12 month period, updated quarterly.
radiation therapy (< 2 weeks prior to encounters during the measurement year). Guidance will also define age/condition guidelines (PPV vaccine recommended for all patients without medical contraindications who are 5-64 with prevalent high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, asplenia. Note that although children under the age of 18 are included in the age/condition guidelines they will not be included in the measure as reported by CMS since OASIS is not collected on this population.

(M1031) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

| 0 - No | 1 - Yes [Go to M1040] |

(M1035) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

<p>| 1 - Patient has received PPV in the past |
| 2 - Offered and declined |
| 3 - Assessed and determined to have medical contraindication(s) |</p>
<table>
<thead>
<tr>
<th></th>
<th>4 - Not indicated; patient does not meet age/condition guidelines for PPV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 - None of the above</td>
</tr>
<tr>
<td></td>
<td>s received PPV in the past</td>
</tr>
<tr>
<td>Measure#AHH-041-08</td>
<td>Timely Initiation of Care</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>Timely Initiation of Care</td>
</tr>
<tr>
<td><strong>IP Owner:</strong></td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
</tbody>
</table>

Number of home health episodes where the start or resumption of care date was on the physician-specified date or within 2 days of the referral date.

**Details:** Number of start-of-care patient episodes where at start of episode:
- (M0100) Reason for Assessment = 1 (Start of care) AND
- [(M0030) Start of care date] minus [(M0102) Date of Referral] < 3 OR
  - [(M0030) Start of care date] equals (M0104) Physician-ordered Start of Care Date

PLUS those resumption-of-care patient episodes where at start of episode:
- (M0100) Reason for Assessment = 3 (Resumption of care) AND
  - [(M0032) Resumption of care date] minus (M0102) Date of Referral < 3

All home health episodes other than those covered by denominator exclusions: OR
the CMS generic exclusions (see footnote).

**Time Window:** Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period.

None

Deleted: All episodes where:
- the patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home;

Deleted: (Q6).
<p>| (M0032) Resumption of care date equals (M0104) Physician-ordered Resumption of Care Date |  |  |
| Measure#AHH-028-08 | Number of home health episodes where at start of episode, patients 65 and older had a standardized and validated multifactor fall risk assessment. <strong>Time Window:</strong> Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. <strong>Details:</strong> Number of home health episodes with an OASIS assessment in which: 1. (M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care) AND 2. (M1140) Has patient had a Multi-factor Fall Risk Assessment = 1 (yes - found no risk) or 2 (yes - found risk) AND 3. (M0066) Date of Birth indicates the patient is age 65 or older. | Number of home health episodes ending in transfer, discharge or death during the measurement year for patients who are age 65 or older OTHER THAN those covered by the CMS generic exclusions (see footnote). <strong>Time Window:</strong> Current CMS systems report data on episodes that start and end within a rolling 12 month period, updated quarterly. CMS proposes to drop the requirement that episodes start during the 12-month period. <strong>Details:</strong> 1. (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient), 8 (death at home) or 9 (discharge) AND 2. (M0066) Date of Birth on associated Start of Care or Resumption of Care indicates the patient is age 65 or older. | Patients under age 65 at start of episode |</p>
<table>
<thead>
<tr>
<th>Measure#</th>
<th>Title</th>
<th>IP Owner</th>
<th>Numerator and Denominator Exclusions</th>
</tr>
</thead>
</table>
| PEC-001-08 | CAHPS® Home Health Care Survey | Centers for Medicare & Medicaid Services | - Patients under 18 years of age at any time during their stay are excluded.  
- Patients who died during the sample month are excluded.  
- Patients who received fewer than 2 visits from home health agency personnel during a 60-day look-back period are excluded. (Note that the 60 day look-back period is defined as the 60-day period prior to and including the last day in the sample month.)  
- Patients have been previously selected for the HHCAHPS sample during any month in the current quarter, or during the last 5 months, are excluded.  
- Patients who are currently receiving hospice, or are discharged to hospice, are excluded.  
- Maternity patients are excluded.  
- "No publicity" status patients are excluded.  
- Patients receiving only non-skilled (aide) care are excluded. |
Appendix B

Background: Overview of 2005 Home Health Consensus Project and Current OASIS

In order to better understand the current submitted measures, we are providing details on the current use and data collection of home health quality measures. Beginning in 2003, the Centers for Medicare & Medicaid Services have used their Home Health Compare web site (www.medicare.gov/hhcompare) to report data on the quality measures. The current portfolio reported is:

Three measures related to improvement in getting around:
- Percentage of patients who get better at walking or moving around
- Percentage of patients who get better at getting in and out of bed
- Percentage of patients who have less pain when moving around

Four measures related to meeting the patient's activities of daily living:
- Percentage of patients whose bladder control improves
- Percentage of patients who get better at bathing
- Percentage of patients who get better at taking their medicines correctly (by mouth)
- Percentage of patients who are short of breath less often

Two measures about how home health care ends:
- Percentage of patients who stay at home after an episode of home health care ends
- Percentage of patients whose wounds improved or healed after an operation

Three measures related to patient medical emergencies:
- Percentage of patients who had to be admitted to the hospital
- Percentage of patients who need urgent, unplanned medical care
- Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected

The quality measures reported on Home Health Compare are limited because results are based on data collected about home health patients whose care is covered by Medicare (both fee for service and managed care) or Medicaid and provided by a Medicare-approved Home Health Agency. The following patients who receive services are not required to have data submitted to the federal government:
- Medicaid-only certified agency
- Patients who pay privately for their care
- Patients under the age of 18
- Patients receiving maternity services
- Patients receiving only personal care/supportive services

1 http://www.medicare.gov/HHCompare/Home.asp?dest=NAV|Home|DataDetails#TabTop
last accessed 12/5/08
The data is collected using their OASIS instrument. The current version, OASIS-B, has been revised and the proposed version, OASIS-C, is currently in the federal approval process. This is important to this project since many of the newly submitted measures and revised endorsed measures are comprised of OASIS-C items and requires the measure to be recommended as time-limited (due to need for additional testing), conditional (pending approval of the OASIS-C instrument). The OASIS instrument is in the public domain and could be utilized by other stakeholders.

The 2005 project Steering Committee proposed eight research areas be addressed.

1. Measures that address all home health care populations including but not limited to the following subpopulations: post acute and chronic care, pediatric, mentally retarded/developmentally disabled, and mentally ill/substance use disorder patients.

2. Cross cutting measures that are not unique to any particular population (e.g., perception of care, pain, patient safety).

3. Measures that address all home health care provider organizations that serve patients in their homes such as skilled nursing services, home health aide services, palliative and end of life care, therapies (physical, speech-language, and occupational), homemaker services/personal care, social services, infusion/pharmacy services, medical supplies and equipment provision services, and in-home physician services.

4. Measures that address all of the NQF aims with specific attention to measures that address the degree to which home health services are patient centered, timely, efficient, and equitable.

5. Develop measures that address all measurement framework areas with specific attention to developing measures that address all process of care domains (referral/intake, education/consultation) and structural elements, including system, organizational (e.g., costs), workforce, and human resources (e.g., staffing, staff turnover) characteristics.

6. Measures that address all 13 Medicare identified high risk, high volume, high cost conditions and treatments that comprehensively address all priority areas: heart failure, hypertension, cerebrovascular disease, fracture of the neck of the femur, osteoarthritis, diabetes mellitus, pressure ulcer/decubitus ulcer, pneumonia, chronic airway obstruction, neoplasms, pain (chronic and acute), cognitive impairment/dementia, and depression. Research should also be undertaken to identify similar conditions for pediatrics and develop performance measurements.

7. Care coordination and system-level coordination measures suitable for public reporting should be developed.


As previously discussed, this submission includes maintenance of the measures endorsed in 2005 during the original project, as well as new measures of process, outcomes, and patient experience of care. Many of the current measures in this current submission are an outcome of the recommendation.
It is important to note that the consensus development process has evolved since the original project and now only endorses measures for public reporting. Endorsement now requires meeting more stringent criterion of importance, usability, feasibility and scientific acceptability (to now include citations for the clinical guideline or evidenced based literature to support the measure).

All NQF-endorsed measures are fully disclosed and available for any interested parties. The home health consensus standards are intended for use at the agency level. The Home Health Steering Committee noted that practice comparisons that fail standard tests of statistical significance are inappropriate and urged those adopting and utilizing these measures to address issues such as appropriate sample size responsibly.
<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure</th>
<th>Submission Status</th>
<th>Steering Committee Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0171</td>
<td>Acute Care Hospitalization (risk-adjusted)</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td>0172</td>
<td>Discharge to community</td>
<td>Currently Endorsed</td>
<td>No</td>
</tr>
<tr>
<td>0170</td>
<td>Emergent Care for Hypo/Hyperglycemia</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td>0169</td>
<td>Emergent Care for Improper Medication Administration, Medication Side Effects</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td>0168</td>
<td>Emergent Care for Wound Infections, Deteriorating Wound Status</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td>0179</td>
<td>Improvement in Dyspnea</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td>0176</td>
<td>Improvement in Management of Oral Medications</td>
<td>Currently Endorsed</td>
<td>No</td>
</tr>
<tr>
<td>0181</td>
<td>Increase in Number of Pressure Ulcers</td>
<td>Currently Endorsed</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Improvement in Status of Surgical Wounds</td>
<td>Currently Endorsed but refined</td>
<td>Yes</td>
</tr>
<tr>
<td>0178</td>
<td>Improvement in Urinary Incontinence</td>
<td>Currently Endorsed but refined</td>
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<td>0173</td>
<td>Emergency Department Use (replaces Emergent care - risk adjusted)</td>
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<td>0167</td>
<td>Improvement in Ambulation/Locomotion</td>
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<td>0174</td>
<td>Improvement in Bathing</td>
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<td>0175</td>
<td>Improvement in Bed Transferring</td>
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<td>0177</td>
<td>Improvement in Pain Interfering with Activity</td>
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<td>AHH-002-08</td>
<td>Development of Urinary Tract Infection</td>
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<td>AHH-003-08</td>
<td>Emergent Care for Injury Caused by Fall or Accident at Home</td>
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<td>AHH-004-08</td>
<td>Improvement in Anxiety Level</td>
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<td>AHH-005-08</td>
<td>Improvement in Behavior Problem Frequency</td>
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<td>AHH-006-08</td>
<td>Improvement in Cognitive Functioning</td>
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<td>AHH-007-08</td>
<td>Improvement in Confusion Frequency</td>
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<td>AHH-007-08</td>
<td>Improvement in Eating</td>
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<td>AHH-009-08</td>
<td>Improvement in Grooming</td>
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<td>AHH-011-08</td>
<td>Improvement in Lower Body Dressing</td>
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<td>AHH-013-08</td>
<td>Improvement in Toilet Transferring</td>
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<td>AHH-014-08</td>
<td>Improvement in Upper Body Dressing</td>
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<td>AHH-026-08</td>
<td>Improvement in Toilet Hygiene</td>
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<td>AHH-012-08</td>
<td>Improvement in Speech and Language</td>
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<td>AHH-010-08</td>
<td>Improvement in Light Meal Preparation</td>
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<td>AHH-015-08</td>
<td>Improvement in Urinary Tract Infection</td>
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<td>AHH-001-08</td>
<td>Depression Assessment Conducted</td>
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<td>AHH-016-08</td>
<td>Depression Interventions Implemented</td>
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<td>AHH-017-08</td>
<td>Depression Interventions in Plan of Care</td>
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<td>AHH-018-08</td>
<td>Diabetic Foot Care and Patient Education Implemented</td>
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<td>Diabetic Foot Care and Patient Education in Plan of Care</td>
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1 Pressure Ulcer measures will be revisited in the NQF Pressure Ulcer Framework project
2 Steering Committee recommends these functional status measures be combined into composite
3 Care plan measures including composite will be revised and likely resubmitted under the NQF Care Coordination project
<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure</th>
<th>Submission Status</th>
<th>Steering Committee Recommendation</th>
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<tr>
<td>AHH-021-08</td>
<td>Drug Education on All Medications Provided to Patient/Caregiver During Episode</td>
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<td>AHH-022-08</td>
<td>Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode</td>
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<td>AHH-023-08</td>
<td>Falls Prevention Steps Implemented</td>
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<td>AHH-024-08</td>
<td>Falls Prevention Steps in Plan of Care</td>
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<td>AHH-025-08</td>
<td>Heart Failure Symptoms Addressed</td>
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<td>AHH-026-08</td>
<td>Improvement in Toileting Hygiene</td>
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<td>AHH-027-08</td>
<td>Influenza Immunization Received for Current Flu Season</td>
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<td>AHH-028-08</td>
<td>Multifactor Fall Risk Assessment Conducted</td>
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<td>AHH-029-08</td>
<td>Pain Assessment Conducted</td>
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<td>AHH-031-08</td>
<td>Pain Interventions in Plan of Care</td>
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<td>AHH-032-08</td>
<td>Physician Notification Guidelines Established</td>
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<td>AHH-033-08</td>
<td>Pneumococcal Polysaccharide Vaccine Ever Received</td>
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<td>AHH-034-08</td>
<td>Potential Medication Issues Identified and Timely Physician Contact at Start of Episode</td>
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<td>AHH-036-08</td>
<td>Pressure Ulcer treated with moisture retentive dressings</td>
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<td>AHH-037-08</td>
<td>Pressure Ulcer Plan of Care includes moisture retentive dressings</td>
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<td>AHH-038-08</td>
<td>Pressure Ulcer Prevention Included in Plan of Care</td>
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<td>Pressure Ulcer Prevention Plans Implemented</td>
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<td>Pressure Ulcer Risk Assessment Conducted</td>
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<td>Timely Initiation of Care</td>
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<td>AHH-042-08</td>
<td>Proactive Plan of Care Composite</td>
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<td>PEC-001-08</td>
<td>Home Health CAHPS®</td>
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</table>
Engage patients and families in managing their health and making decisions about their care

We envision care that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages and social backgrounds.

The Partners will work together to ensure that:

1.1 All patients will be asked for feedback on their experience of care, which healthcare organizations and their staff will then use to improve care.

1.2 All patients will have access to tools and support systems that enable them to effectively navigate and manage their care.

1.3 All patients will have access to information and assistance that enables them to make informed decisions about their treatment options.

Improve the health of the population

We envision communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability – reliable, effective, and proactive in helping all people reduce the risk and burden of disease.

The Partners will work together to ensure that:

2.1 All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force.

2.2 All Americans will adopt the most important healthy lifestyle behaviors known to promote health.

2.3 The health of American communities will be improved according to a national index of health.
NATIONAL PRIORITIES PARTNERSHIP
National Priorities and Goals

Improve the safety and reliability of America’s healthcare system

We envision a healthcare system that is relentless in continually reducing the risks of injury from care, aiming for “zero” harm wherever and whenever possible – a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. We envision healthcare leaders and healthcare professionals intolerant of defects or errors in care, and who constantly seek to improve, regardless of their current levels of safety and reliability.

The Partners will work together to ensure that:

3.1 All healthcare organizations and their staff will strive to ensure a culture of safety while driving to lower the incidence of healthcare-induced harm, disability or death toward zero. They will focus relentlessly on continually reducing and seeking to eliminate all healthcare-associated infections (HAIs) and serious adverse events.

**HAIs include but are not limited to:**
- Catheter-associated blood stream infections
- Surgical site infections
- Catheter-associated urinary tract infections
- Ventilator-associated pneumonia

(See CDC’s *Infectious Diseases in Healthcare Settings* at [www.cdc.gov/ncidod/dhqp/id.htm](http://www.cdc.gov/ncidod/dhqp/id.htm) for a more inclusive list.)

**Serious adverse events include but are not limited to:**
- Pressure ulcers
- Falls
- Blood product injuries
- Adverse drug events associated with high alert medications
- Wrong site surgeries
- Air embolisms
- Foreign objects retained after surgery

(See NQF’s *Serious Reportable Events* at [www.qualityforum.org/projects/completed/sre/fact-sheet.asp](http://www.qualityforum.org/projects/completed/sre/fact-sheet.asp) for a more inclusive list.)

3.2 All hospitals will reduce preventable and premature hospital-level mortality rates to best-in-class.*

3.3 All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, pneumonia) to best-in-class.

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* “Best-in-class” may be determined by using an accepted methodology, such as Achievable Benchmarks in Care (ABC)™, available at [http://main.uab.edu/show.asp?durki=14527](http://main.uab.edu/show.asp?durki=14527).
Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care

We envision a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professionals accountable for their care.

The Partners will work together to ensure that:

4.1 Healthcare organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families, when appropriate) regarding coordination of their care during transitions.

4.2 Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.

4.3 All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates.

4.4 All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits.

Guarantee appropriate and compassionate care for patients with life-limiting illnesses

We envision healthcare capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life.

The Partners will work together to ensure that:

5.1 All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.

5.2 All patients with life-limiting illnesses and their families will have access to help with psychological, social, and spiritual needs.

5.3 All patients with life-limiting illnesses will receive effective communication from healthcare professionals about their options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness.

5.4 All patients with life-limiting illnesses will receive high-quality palliative care and hospice services.
Eliminate overuse while ensuring the delivery of appropriate care

We envision healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

The Partners will work together to ensure that:

6.1 All healthcare organizations will continually strive to improve the delivery of appropriate patient care, and substantially and measurably reduce extraneous service(s) and/or treatment(s).

The recommended areas of concentration are as follows:

- Inappropriate medication use, targeting:
  - Antibiotic use
  - Polypharmacy (for multiple chronic conditions; of antipsychotics)
- Unnecessary laboratory tests, targeting:
  - Panels (e.g., thyroid, SMA 20)
  - Special testing (e.g., Lyme Disease with regional considerations)
- Unwarranted maternity care interventions, targeting:
  - Cesarean section
- Unwarranted diagnostic procedures, targeting:
  - Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring)
  - Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags
  - Uncomplicated chest/thorax CT screening
  - Bone or joint x-ray prior to conservative therapy, without red flags
  - Chest x-ray, preoperative, on admission, or routine monitoring
  - Endoscopy
- Inappropriate nonpalliative services at end of life, targeting:
  - Chemotherapy in the last 14 days of life
  - Aggressive interventional procedures
  - More than one emergency department visit in the last 30 days of life
- Unwarranted procedures, targeting:
  - Spine surgery
  - Percutaneous transluminal coronary angioplasty (PTCA)/Stent
  - Knee/hip replacement
  - Coronary artery bypass graft (CABG)
  - Hysterectomy
  - Prostatectomy
- Unnecessary consultations
- Preventable emergency department visits and hospitalizations, targeting:
  - Potentially preventable emergency department visits
  - Hospital admissions lasting less than 24 hours
  - Ambulatory care-sensitive conditions
- Potentially harmful preventive services with no benefit, targeting:
  - BRCA mutation testing for breast and ovarian cancer - female, low risk
  - Coronary heard disease screening using electrocardiography (ECG), exercise treadmill test (ETT), electron-beam computed tomography (EBCT) - adults, low risk
  - Carotid artery stenosis screening – general adult population
  - Cervical cancer screening – female over 65, average risk and female, post-hysterectomy
  - Prostate cancer screening – male over 75 (See U.S. Preventive Services Task Force D Recommendations List at www.ahrq.gov/clinic/prevenix.htm.)