NQF

NATIONAL QUALITY FORUM

HOME HEALTH CARE

National Voluntary Consensus Standards for Home Health Care—Additional Performance Measures 2008

A CONSENSUS REPORT

National Quality Forum

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

This work was conducted under a contract with the Centers for Medicare & Medicaid Services (**www.cms.hhs.gov**).

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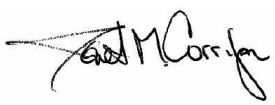
Foreword

HOME HEALTH IS A CRITICAL PART of the continuum of care, especially for people with more than one chronic illness. Approximately 9,024 agencies deliver home health care services to a variety of patients—those recently released from hospitals or nursing homes, patients who are disabled, the frail elderly, and chronically or terminally ill people in need of medical, nursing, or therapeutic treatment to help them with their daily activities. Approximately 7.2 million people currently receive care from 17,666 providers for acute or terminal illness, long-term health conditions, or permanent disability. As in all areas of healthcare, a diverse mix of stakeholders—including consumers, purchasers, and providers—are concerned about the quality of care patients receive.

In 2005, the National Quality Forum (NQF) endorsed 15 performance measures specific to home health quality, which are described in the report *National Voluntary Consensus Standards for Home Health Care.* As part of NQF's ongoing measures maintenance process, these endorsed measures were reconsidered alongside the newly submitted candidate standards. Seven of those 15 measures were substantially revised based on user feedback over the years and were considered as new measures. Topic areas include patient experience of care, immunization, medication management, pain management, fall prevention, depression screening/intervention, care coordination, risk assessment, heart failure, and diabetes. 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, and 24 were endorsed and are presented in this report.

NQF thanks the Home Health Care Steering Committee, the Patient Experience of Care Technical Advisory Panel, and NQF Members for their efforts in helping to improve the quality of home health care for all Americans.



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Executive Summary

RECOGNITION OF THE IMPORTANCE OF HOME HEALTH CARE in the continuum of care has been growing, especially among those with chronic, comorbid illnesses. Home health care services are delivered by approximately 9,024 agencies to patients at home who are recovering after care provided 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. Currently 7.2 million individuals receive care from 17,666 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 $59 billion. As in all areas of healthcare, the quality of the home health care provided is a vital concern.

In 2005, the National Quality Forum (NQF) endorsed 15 performance measures specific to home health quality as described in the report *National Voluntary Consensus Standards for Home Health Care*. As part of NQF's ongoing measure 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 user feedback over the years and were considered as new measures. Topic areas include patient experience of care, immunization, medication management, pain management, fall prevention, depression screening/intervention, care coordination, risk assessment, heart failure, and diabetes. A total of 58 consensus standards ultimately were identified and evaluated by the Home Health Steering Committee for appropriateness as voluntary consensus standards for accountability and public reporting, and 24 were endorsed.

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- Timely initiation of care
- Improvement in management of oral medications
- Diabetic foot care and patient education implemented
- Drug education on medications provided to patient/caregiver during short-term episode of care
- Influenza immunization received for current flu season
- Pneumococcal polysaccharide vaccine (PPV) ever received
- Depression assessment conducted
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- Improvement in bathing
- Improvement in bed transferring
- Multifactor fall risk assessment conducted for patients 65 and over
- Emergency department use: with and without hospitalization
- Acute care hospitalization (risk adjusted)
- CAHPS® home health care survey

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Background

RECOGNITION OF THE IMPORTANCE OF HOME HEALTH CARE in the continuum of care has been growing, especially among those with chronic, comorbid illnesses. Home health care services are delivered by approximately 9,024 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 well as assistance with the essential activities of daily living. Approximately 7.2 million individuals currently receive care from 17,666 providers because of acute illness, long-term health conditions, permanent disability, or terminal illness.[2] In 2007, annual expenditures for home health care were about $59 billion.[3] As in all areas of healthcare, the quality of care provided is of concern to consumers, purchasers, providers, and other stakeholders.

To date, the National Quality Forum (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. 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.

Appendix D 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.[4]

Strategic Directions for NQF

NQF's mission includes three parts: 1) setting national priorities and goals for performance improvement; 2) endorsing national consensus standards for measuring and publicly reporting on performance; and 3) promoting the attainment of national goals through education and outreach programs. As greater numbers of quality measures are developed and brought to NQF for consideration, NQF must assist stakeholders in measuring "what makes a difference" and addressing 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 and patient engagement in decisionmaking, coupled with measures of the healthcare process and cost/resource use. For more information, see **www.qualityforum.org**. Several strategic issues have been identified to guide the consideration of candidate consensus standards:

DRIVE TOWARD HIGH PERFORMANCE. Over time, the bar of performance expectations should be raised to encourage the achievement of higher levels of system performance.

EMPHASIZE COMPOSITE MEASURES. Composite measures provide much-needed summary information pertaining to multiple dimensions of performance and are more comprehensible to patients and consumers.

MOVE TOWARD OUTCOME MEASUREMENT. Outcome measures provide information of keen interest to consumers and purchasers, and, when coupled with healthcare process measures, they provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.

FOCUS ON DISPARITIES IN ALL THAT WE DO. Some of the greatest performance gaps relate to care of minority populations. Particular attention should be focused on the most relevant race/ethnicity/language/socioeconomic strata to identify relevant measures for reporting.

NQF's Consensus Development Process

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. For this project, candidate standards were solicited though 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.

In addition, as a part of NQF's ongoing measure 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 user feedback 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 58 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 (see list in Appendix E). In addition, the Pressure Ulcer Steering Committee reviewed the pressure ulcer measures at the request of the Home Health Care Steering Committee. The Steering Committees evaluated the candidate standards using the standard criteria of importance, scientific acceptability, usability, and feasibility. See **www.qualityforum.org/uploadedFiles/Quality_Forum/Measuring_Performance/Consensus_Development_Process's_Principle/EvalCriteria2008-08-28Final.pdf?n=4701**.

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 in the same topic area but have a different focus, such as the endorsed falls measure that looks to prevent future falls (instead of the submitted falls assessment, which does not require a fall having occurred). The measures in Appendix A are appropriate for home health but are not captured on the OASIS instrument. Their data are collected using 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).

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 adopt these consensus standards will promote the development of safer and higher-quality care for patients throughout the nation.

National Voluntary Consensus Standards for Home Health Care: Additional Performance Measures 2008

NQF offers some global issues and concerns regarding home health care:

- Home health care does not take place in a constant, round-the-clock healthcare setting. The home care staff may not be aware of all the medical care their patients are receiving. Frequently families or patients seek medical care without notifying their home health providers. This may mean visiting an emergency department or seeking additional medications (prescription or over the counter). Patients or family members also might make changes to the patient's physical environment, such as rearranging furniture in the home, that might make it unsafe.
- There is limited formal research regarding quality in the home health field, especially around specific disease topics. Although there is focused literature, it often is not found in recognized peer-reviewed journals. Also, guidelines in this setting are often only consensus driven.

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

- The Committee noted that many of the measures have received time-limited endorsement. It requested that there be time allowed to collect adequate data that can be accrued for analyses to ensure content validity before these measures are used for public reporting.
- Although the Committee did not recommend continued endorsement of some of the previously endorsed measures for public reporting, it believed strongly that the measures were still important for quality improvement and should remain in the Centers for Medicare & Medicaid Services (CMS) Outcome-Based Quality Improvement (OBQI) reports.
- The process and outcome measures were submitted with the typical CMS exclusions, for example, patients under 18, maternity cases, and long-stay patients. CMS currently reports through 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, during which an episode of care must start AND end within a specific 12-month period for the measure to be included in agency-level reporting. For this reason, home health care patients who 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 already was 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 believed 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, nonmaternity 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).

Overview of the Endorsed Measures

This report presents 24 endorsed performance measures for home health care (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 reported almost exclusively by CMS using its OASIS data collection tool, the specifications are in the public domain and are written so that other measurement programs can use the measures (see Appendix A for the measure specifications). All NQF-endorsed measures are fully open source and are intended for use at the clinician or agency level of analysis as indicated for each measure in the following sections of this report. Implementing organizations should decide the rules of attribution, sample size requirements, and statistical significance based on the characteristics and goals of the measurement program.

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 an NPP Goal assess a high-impact area of care, such as functional status, or specific clinical topics, such as heart failure and diabetes.

Table 1: National Voluntary Consensus Standards for Home Health Care—Additional Performance Measures 2008

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION	LEVEL OF ANALYSIS	MEASURE STEWARD[b]
Timely initiation of care*	0526	The percentage of patients with timely start of care of resumption of home health care	Home health agency	CMS
Improvement in management of oral medications	0176	The percentage of patients who get better at taking their medicines correctly	Home health agency	CMS
Diabetic foot care and patient education implemented*	0519	The percentage of diabetic patients for whom physician ordered monitoring discovered the presence of skin lesions on the lower extremities and patient education on proper foot care were implemented during their episode of care	Home health agency	CMS
Drug education on medications provided to patients/ caregiver during episode*	0520	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	Home health agency	CMS
Influenza immunization received for current flu season*	0522	The percentage of patients who received influenza immunization for the current flu season from this home health agency	Home health agency	CMS
Pneumococcal polysaccharide vaccine (PPV) ever received*	0525	The percentage of patients who have ever received Pneumococcal Polysaccharide Vaccine (PPV)	Home health agency	CMS

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[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Measure steward—intellectual property owner and copyright holder. For the most current specifications and supporting information, please refer to the measure steward:

CMS—Centers for Medicare & Medicaid Services **(www.cms.hhs.gov)**

*Time-limited endorsement.

Table 1: National Voluntary Consensus Standards for Home Health Care—Additional Performance Measures 2008

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION	LEVEL OF ANALYSIS	MEASURE STEWARD[b]
Depression assessment conducted*	0518	The percentage of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care	Home health agency	CMS
Pain assessment conducted*	0523	The percentage of patients who were assessed for pain, using a standardized pain assessment tool, at start/ resumption of home health care	Home health agency	CMS
Pain interventions implemented during short-term episode*	0524	The percentage of patients with pain for whom steps to monitor and mitigate pain were implemented during their episode of care	Home health agency	CMS
Improvement in pain interfering with activity	0177	The percentage of patients who have less pain when moving around	Home health agency	CMS
Improvement in dyspnea	0179	The percentage of patients who are short of breath less often	Home health agency	CMS
Heart failure symptoms addressed during short-term episode*	0521	The percentage of patients exhibiting symptoms of heart failure for which appropriate actions were taken	Home health agency	CMS
Improvement in status of surgical wounds	0178	The percentage of patients whose wounds improved or healed after an operation	Home health agency	CMS
Increase in the number of pressure ulcers	0181	The percentage of patients who had an increase in the number of unhealed pressure ulcers	Home health agency	CMS
Pressure ulcer prevention included in plan of care*	0538	The number of home health episodes in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care at the start of care/resumption of care for patients assessed to be at risk for pressure ulcers	Home health agency	CMS

more

Table 1: National Voluntary Consensus Standards for Home Health Care—Additional Performance Measures 2008

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION	LEVEL OF ANALYSIS	MEASURE STEWARD[b]
Pressure ulcer prevention plans implemented*	0539	The number of home health episodes in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented since the previous OASIS assessment	Home health agency	CMS
Pressure ulcer risk assessment conducted*	0540	The number of home health episodes in which the patient was assessed for risk of developing pressure ulcers at start of care/resumption of care	Home health agency	CMS
Improvement in ambulation/ locomotion	0167	The percentage of patients who get better at walking or moving around in a wheelchair safely	Home health agency	CMS
Improvement in bathing	0174	The percentage of patients who get better at washing their entire body safely	Home health agency	CMS
Improvement in bed transferring	0175	The percentage of patients who get better at getting in and out of bed	Home health agency	CMS
Multifactor fall risk assessment conducted for patients 65 and over*	0537	The percentage of home health episodes in which the patient was 65 or older and was assessed for risk of falls (using a standardized and validated multi-factor Fall Risk Assessment) at start or resumption of home health care	Home health agency	CMS
Emergency department use: with and without hospitalization	0173	The percentage of patients who had to use a hospital emergency department	Home health agency	CMS
Acute care hospitalization (risk-adjusted)	0171	The percentage of patients who had to be admitted to the hospital	Home health agency	CMS
CAHPS® home health care survey*	0517	Measures home health patients' perspectives on their home health care	Home health agency	CMS

Endorsed Measures

0526[5] **Timely initiation of care**
(CMS) *AHH-041-08*[6]

This outcome measure assesses the percentage of patients with timely start of home health care. Preliminary findings from an upcoming study[7] note very small differences in outcomes for patients with start of care within 24 hours versus 48 hours following hospital discharge. However, the outcomes for patients whose care started more than 48 hours after hospital discharge were significantly worse than the group who started within 24 to 28 hours. The Committee agreed it is important to have care begin in a timely fashion. The start of care is defined as the later of the original referral date, physician order date, or discharge from the hospital.

Patient/Caregiver Education

0176 **Improvement in management of oral medications**
(CMS)

This outcome measure indicates less impairment of oral medications at discharge compared to start of care. It reports the 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. A patient may take his or her medications independently or take individual dosages that are prepared in advance by another person. Additionally, another person may develop a drug diary or chart or give the patient daily reminders. The Steering Committee initially was concerned because there can be variability in documentation of this measure. It also noted that some patients will not improve in their ability to take their medications. The measure may reflect being better at answering the questions but not necessarily improving patient outcomes. It may also have the unintended consequence of negatively affecting those agencies that care for many cognitively impaired patients. Based on additional information regarding past performance and improvement efforts, the Committee agreed to recommend the measure.

0519 **Diabetic foot care and patient education implemented**
(CMS) *AHH-018-08*

This process measure reports the percentage of diabetic patients for whom the 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. The Steering Committee agreed that this is an important part of care but noted that home care agencies also need to demonstrate that they are making a difference in the disease process.

0520 **Drug education on medications provided to patient/caregiver during short-term episode**

(CMS) *AHH-21-08*

This process 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 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 Steering Committee to take out the word "all." The Committee believed 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, continue throughout the home health care episode, and conclude with a review of the medication at the end of the episode. The Steering Committee decided it would not be appropriate, nor would it likely be practical, for all medication education to occur immediately at the time of transfer.

Preventive Services

0522 **Influenza immunization received for current flu season**

(CMS) *AHH-027-08*

This outcome measure utilizes the NQF-endorsed harmonized, standard measure specifications for influenza immunizations.[8] According to the Centers for Disease Control and Prevention (CDC), "Every year in the United States, on average 5 percent to 20 percent of the population gets the flu; more than 200,000 people are hospitalized from flu-related complications, and about 36,000 people die from flu-related causes. Some people, such as older people, young children, and people with certain health conditions, are at increased risk for serious influenza complications."[9] The Committee noted this measure allows for immunizations given by the agency or received at another setting.

0525 **Pneumococcal polysaccharide vaccine (PPV) ever received**

(CMS) *AHH-033-08*

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 are responsible for the highest rates of death among the elderly and patients who have underlying medical conditions. According to the CDC, invasive pneumococcal disease causes more than 6,000 deaths annually, and the National Foundation for Infectious Diseases states, "More than half of these cases involve adults for whom vaccination against pneumococcal disease is recommended."[10] The Steering Committee noted this measure allows for immunizations given by the agency or received at another setting.

0518 **Depression assessment conducted**

(CMS) *AHH-001-08*

This process measure reports the percentage of patients who were screened for depression (using a standardized depression screening tool) at the 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 percent to 9 percent among adults, and up to 50 percent of depressed patients are not recognized. The Steering Committee believed this was an important aspect of care because it directly affects the patient's ability to improve.

Pain

More than one-quarter of Americans (26 percent) age 20 years and over—or an estimated 76.5 million Americans—report having had a problem with pain of any sort that persisted for more than 24 hours.[11] The annual cost of chronic pain in the United States, including healthcare expenses, lost income, and lost productivity, is estimated to be $100 billion.[12] The Steering Committee agreed that pain must be assessed and effectively addressed to facilitate optimal quality of life, recovery, and rehabilitation.

0523 **Pain assessment conducted**

(CMS) *AHH-029-08*

This process measure reports the percentage of patients who were assessed for pain, using a standardized pain assessment tool, at the start or resumption of home health care. The Steering 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, the Multi-dimensional Pain Score and the McGill Pain Questionnaire.

0524 **Pain interventions implemented during short-term episodes**

(CMS) *AHH-030-08*

This process measure reports the percentage of patients with pain for whom steps to monitor and mitigate pain were implemented during their episode of care. The Steering Committee believed this was a very important concept for public reporting because the level of pain must be assessed and treated effectively to maximize the patient's recovery.

0177 **Improvement in pain interfering with activity**

(CMS)

This outcome measures the percentage of patients who have decreased 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 Appendix A.

Clinical Symptoms Addressed

0179 **Improvement in dyspnea**
(CMS)

This outcome measure identifies the percentage of patients whose shortness of breath occurs less often than before. Shortness of breath is a serious problem for many home care patients with heart or lung problems.[13] The OASIS-C item required was reworded to remove the word "never."

0521 **Heart failure symptoms addressed**
(CMS)

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 American Heart Association/American College of Cardiologists (AHA/ACC) guideline[14] provides guidance in monitoring symptoms and providing appropriate treatments. The Steering Committee thought the measure should present interventions that contribute to best practices and an intervention to "call physician."

0178 **Improvement in status of surgical wounds**
(CMS)

This outcome measure captures 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 because of additional supplies and skilled visits. Appropriate treatment and wound healing will improve the patient's safety and health. This measure replaces the existing NQF-endorsed home health measure 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 Steering 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 the 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**

(CMS)

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 healthcare 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 the Continuity Assessment Record and Evaluation (CARE) tool. The Committee believed this measure was important despite the fact that it documented the number of pressure ulcers rather than a more clinically detailed measure.

The Home Health Steering Committee originally reviewed the following pressure ulcer measures during the November 2008 meeting but decided to refer them to the Pressure Ulcer Framework project, which began in December 2008. The Pressure Ulcer Steering Committee recommended these measures for time-limited endorsement but expressed concern about the validity of self-reporting because they have not been tested. They also believed additional testing of the validity of self-reporting was recommended to determine the correlation between what is said to be done and what is actually being done. It is noted that the measures will have to be harmonized with the Pressure Ulcer Framework once it is endorsed.

0538 **Pressure ulcer prevention included in plan of care**

(CMS) *AHH-038-08*

0539 **Pressure ulcer prevention plans implemented**

(CMS) *AHH-039-08*

0540 **Pressure ulcer risk assessment conducted**

(CMS) *AHH-040-08*

Steering Committee members believed requiring documentation of the plan of care was a step toward compliance. They also noted that research has been done in this area and that patient involvement in the plan of care is important.

Steering Committee members noted it was important not only to document a plan of care but also to see that the plan was actually implemented.

Functional Status

The ability to be as independent as possible in performing activities of daily living (ADL) or instrumental activities of daily living (IADL) is extremely important to the patient's quality of life. Arbaje et al. 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.[15]

0167 **Improvement in ambulation/ locomotion**
(CMS)

This outcome measure identifies 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 revised 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.

0174 **Improvement in bathing**
(CMS)

This measures patients' current ability to wash the entire body safely. This does not include grooming (washing hands and face only). Gill et al. found that among community-dwelling older people, 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.[16]

This measure replaces the existing NQF-endorsed home health measure Improvement in bathing. It now includes an additional level of detail for measuring improvement—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 the ability to bathe.

0175 **Improvement in bed transferring**

(CMS)

This outcome measure reports the percentage of patients who improve 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 literature about older adults, 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.[17,18,19,20,21] This measure replaces the existing NQF-endorsed home health measure Improvement in Transferring and focuses on transferring to and from bed and the ability to turn and position oneself in bed, whereas the former measure included not only these but also the ability to move on and off the toilet or commode and into and out of a 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.

0537 **Multifactor fall risk assessment conducted for patients 65 and older**

(CMS) *AHH-028-08*

The original falls assessment measure presented to the Home Health Steering Committee in November 2008 included ages 18 and older, which was not supported by evidence. The developer refined the falls assessment measure to be specific to those patients ages 65 and older based on the guidelines and evidence.

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.

0173 **Emergency department use: with and without hospitalization**

(CMS)

This outcome measure assesses the percentage of patients who went to a hospital emergency department. The Steering Committee noted that emergent care is under-reported because patients may seek emergent care without the knowledge of their home health care agency. The Committee decided that emergency department visits resulting in a hospital admission should be excluded because they are already captured in the acute care hospitalization measure. Providers had difficulty with the original endorsed measure definition that included "last-minute" visits to a physician's office or clinic that were not for emergent care. Modifications have been made so that the measure can now be calculated as emergency department care only or emergency care resulting in hospitalization.

0171 **Acute care hospitalization (risk-adjusted)**
(CMS)

This outcome measure estimates 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 OBQI found that implementing it in home health agencies decreased hospitalization rates by 22 percent to 26 percent (from 32.5 percent to 25.3 percent).[22]

Patient Experience of Care

0517 **Home Health CAHPS®**
(CMS) *PEC-001-08*

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, also referred to 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 Steering Committee's discussion focused on the negative, leading tone of some of the questions in the survey and the limitation, in some questions, to a consideration of prescription medications only, rather than all medications. The measure developer made the wording revisions requested by the Technical Advisory Panel (TAP) and the Committee that did not affect the psychometrics of the instrument. The Committee agreed to move other concerns that affected the psychometric testing to its recommendation list for further review and testing (see "Recommendations," p. 20). There also was discussion regarding the proposed sample size of 195 surveys per home health agency. The developer noted that one of the primary purposes of CAHPS instruments is to be able to detect differences across units (agencies, practices, hospitals, etc.), and the recommendation of 195 surveys per agency was made with that purpose in mind. If survey users have other analytic goals, they need to make the appropriate design decisions to achieve those goals, including using power analyses to determine the number of completed surveys that will be sufficient for achieving those goals.

Measures Not Endorsed

Previously Endorsed Measures

0180 **IMPROVEMENT IN URINARY INCONTINENCE (CMS)**

This previously endorsed measure was not recommended because the Steering Committee noted that this information 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.

0172 **DISCHARGE TO COMMUNITY (CMS)**

The Committee did not recommend this previously endorsed measure because it does not reflect whether patients met their treatment goals, only that they were discharged from services, which may have been because their insurance benefits ended. The Committee also believed that the acute hospitalization measure captures many of these patients.

Emergent Care for Specific Clinical Areas

The Steering Committee initially recommended these three previously endorsed measures if the measures 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 decided it could no longer recommend the measures. Although measure 0173 (Emergency department use; with and without hospitalization) is risk adjusted, the other emergent care condition-specific measures (0168, 0169, and 0170) are not currently risk adjusted because they occur rarely, and calculating a statistically sound risk adjustment is difficult.

The Steering Committee noted there was a concern about underreporting because adverse events do not always occur when someone from the agency is in the home, and many times these care providers are unaware that emergent care was sought. There also was a concern about attribution of symptoms to a cause.

0169 EMERGENT CARE FOR IMPROPER MEDICATION ADMINISTRATION OR MEDICATION SIDE EFFECTS (CMS)

This outcome measure analyzes emergent care received for improper medication administration or medication side effects. 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 (CMS)

This revised outcome measure reports the percentage of patients who need hospital emergency department care for hypo/hyperglycemia.

0168 EMERGENT CARE FOR WOUND INFECTIONS, DETERIORATING WOUND STATUS (CMS)

This outcome measure reports the percentage of patients who need hospital emergency department care related to a wound that is new, worse, or has become infected.

Other Measures Not Endorsed

PHYSICIAN NOTIFICATION GUIDELINES ESTABLISHED (CMS) *AHH-032-08*

The Steering Committee believed 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. A Steering Committee member noted patients 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.

DRUG EDUCATION ON HIGH RISK MEDICATIONS PROVIDED TO PATIENTS/CAREGIVER AT START OF EPISODE (CMS) *AHH-022-08*

The Steering Committee questioned which medications do not pose a high risk in the elderly. There was a concern that patients may not remember all their medications and that reconciling medications is complicated on the first visit, although CMS allows five days from start of care.

POTENTIAL MEDICATION ISSUES IDENTIFIED AND TIMELY PHYSICIAN CONTACT AT START OF EPISODE (CMS) *AHH-034-08*

POTENTIAL MEDICATION ISSUES IDENTIFIED AND TIMELY PHYSICIAN CONTACT DURING EPISODE (CMS) *AHH-035-08*

The Steering Committee was concerned that only one calendar day is allowed, and modes of contact should include voice mail and communication with the office nurse. Definitions were lacking for "clinically significant issues" and "significant alert." Medication reconciliation is usually performed at the start of care, but hospitals do not always send medication lists home with patients. There also was a concern that there is too much variation in how medication reconciliation is completed and reported to the physician.

DEVELOPMENT OF URINARY TRACT INFECTION (CMS) *AHH-002-08*

IMPROVEMENT OF URINARY TRACT INFECTION (CMS) *AHH-015-08*

The Committee believed this is an important clinical topic but should not be publicly reported because urinary tract infections may go undetected. It questioned whether this parameter can truly be measured.

IMPROVEMENT IN ANXIETY LEVEL (CMS) *AHH-004-08*

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 in those situations. Anxiety is difficult to measure adequately and is a broad term with many causative factors.

IMPROVEMENT IN BEHAVIOR PROBLEM FREQUENCY (CMS) *AHH-005-08*

Although the Steering Committee believed this is an important topic, it is unlikely that home care will be able to improve behavior problems. If the behavior were publicly reported, it might create a disincentive for home health agencies to identify behavior problems because they would be unable to improve them.

IMPROVEMENT IN COGNITIVE FUNCTIONING (CMS) *AHH-006-08*

The Steering Committee believed the identification of cognitive impairment is more important than improvement because delirium and dementia are often missed. Home care is unlikely to improve cognition. Publicly reporting this measure might create a disincentive for home health agencies to identify cognitive impairment because they seldom would be able to improve it.

IMPROVEMENT IN CONFUSION FREQUENCY (CMS) *AHH-007-08*

The Steering Committee believed it was unlikely that home health agencies would be able to reduce confusion. Publicly reporting this measure could create a disincentive for home health agencies to identify confusion because they would be unlikely to alleviate it.

DEPRESSION INTERVENTIONS IMPLEMENTED (CMS) *AHH-016-08*

The Steering Committee recommended this measure for depression screening. It agreed that assessment is easier than intervention because putting interventions in place may

be difficult (e.g., the physician may not agree with the assessment; it is often difficult for the agency to convince a physician depression exists).

IMPROVEMENT IN TOILETING HYGIENE (CMS) *AHH-026-08*

IMPROVEMENT IN TOILET TRANSFERRING (CMS) *AHH-013-08*

IMPROVEMENT IN UPPER BODY DRESSING (CMS) *AHH-014-08*

IMPROVEMENT IN EATING (CMS) *AHH-008-08*

IMPROVEMENT IN GROOMING (CMS) *AHH-009-08*

IMPROVEMENT IN LOWER BODY DRESSING (CMS) *AHH-011-08*

The Steering Committee believed 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 research recommendation was made to develop a composite measure to weight the upper and lower body dressing as a single measure to avoid disproportionately weighting dressing. The developer agreed to consider the recommendation. The Committee believed it was appropriate to use these measures in quality improvement reports such as the CMS OBQI reports.

IMPROVEMENT IN LIGHT MEAL PREPARATION (CMS) *AHH-010-08*

The Steering Committee believed this was not important for public reporting.

IMPROVEMENT IN SPEECH AND LANGUAGE (CMS) *AHH-012-08*

The Steering Committee believed the measure would be better suited for quality improvement.

EMERGENT CARE FOR INJURY CAUSED BY FALL OR ACCIDENT AT HOME (CMS) *AHH-003-08*

The Steering Committee decided that falls with injury are infrequent and not appropriate for public reporting but should be kept in the CMS OBQI reports for quality improvement.

FALLS PREVENTION STEPS IMPLEMENTED (CMS) *AHH-023-08*

The Steering Committee believed this was a quality improvement measure but not for public reporting.

DEPRESSION INTERVENTIONS IN PLAN OF CARE (CMS) *AHH-017-08*

DIABETIC FOOT AND CARE AND PATIENT EDUCATION IN PLAN OF CARE (CMS) *AHH-019-08*

PAIN INTERVENTIONS IN PLAN OF CARE (CMS) *AHH-031-08*

FALLS PREVENTION STEPS IN PLAN OF CARE (CMS) *AHH-024-08*

PROACTIVE PLAN OF CARE COMPOSITE (CMS) *AHH-042-08 (includes the six individual plan of care measures listed previously)*

The Steering Committee agreed the concept of care planning is important but believed that implementation of interventions and the eventual outcome were more appropriate for public reporting.

PRESSURE ULCERS TREATED WITH MOISTURE-RETENTIVE DRESSINGS *(CMS) AHH-036-08*

PRESSURE ULCER PLAN OF CARE INCLUDES MOISTURE-RETENTIVE DRESSINGS (CMS) *AHH-037-08*

The Home Health Steering Committee reviewed these measures at its November 2008 meeting and did not recommend them for several reasons. It believed there was no clear definition of "moisture-retentive" dressing and that the concept of moist dressing is not clear to the general public. The Committee was concerned with the period of measurement; the pressure ulcer may have healed during an episode. It also questioned why the measure included only moisture-retentive dressings. The Pressure Ulcer Steering Committee agreed that a definition of moisture-retentive dressings was lacking. It discussed the concepts of moisture-retention therapy (the wound bed must be kept moist, so the packing material must be moist at the time of dressing change), which can be achieved with a variety of dressings. Some wounds need to be assessed frequently, and gauze is used; wet-to-dry dressings can be appropriate, but only for short-term use, and they may be difficult to measure. More important, moisture-retention of the wound bed is not under the control of the home health agency because the treatment requires a physician order.

Recommendations

NQF offers the following recommendations to accompany the measures:

- Stratify some of the populations. The Steering Committee thought the measures would be more meaningful if there were subsets of the population reported, such as acute versus chronic or long-term care. This detail could lead to incentives for caring for vulnerable populations.
- Reimburse pharmacists. Medication management requires a multidisciplinary team that includes a pharmacist, but there is currently no Medicare reimbursement for the pharmacist. The nurse has the sole responsibility for medications in the home at present.
- Develop evidence. Promote formal research in the home care field and publication in recognized peer-reviewed journals.
- Provide 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 in 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 decisionmaking 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
  - AHH-008-08 Improvement in eating
  - AHH-009-08 Improvement in grooming
  - AHH-011-08 Improvement in lower body dressing
  - 0167 Improvement in ambulation/ locomotion
  - 0174 Improvement in bathing
  - 0175 Improvement in bed transferring

The Steering Committee believed the improvements in lower body and upper body dressing should be counted as one measure for weighting purposes in order not to skew the measure. It also realized the proposed individual measures might change based on additional required analyses for the composite.

- 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.
- Continue to develop and refine a multifactorial falls risk assessment:
  - Ensure that a multifactorial falls risk assessment takes into consideration cognitive impairment and is risk adjusted for this item in particular.
  - Identify population attributes for determining which falls assessment tools should be specifically recommended.
  - Conduct research for sub-group analysis: post-surgical, post-acute hospital, or rehabilitation medical versus chronic/ maintenance.
- Recommendations specific to the home health CAHPS® instrument:
  - Explore the use of a proxy and how well it works.
  - Research the patient/discipline mix and its impact.
  - Use positively stated questions. Surveys should not include 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 two-month time period.

Notes

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Appendix A
Specifications of the National Voluntary Consensus Standards for Home Health Care—Additional Performance Measures 2008

THE FOLLOWING TABLE PRESENTS the detailed specifications for the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards for Home Health Care: Additional Performance Measures 2008*. All information presented has been derived directly from measure sources/developers.

MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in ambulation/ locomotion	Measure ID #: 0167	CMS	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. Improvement in ambulation/locomotion is coded as follows: 1 (YES) IF: 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 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,	All home health episodes except those where either of the following conditions applies: (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, and 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 where either of the following conditions applies: (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.

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[a] Measure steward—intellectual property owner and copyright holder. ALL RIGHTS RESERVED. For the most current specifications and supporting information, please refer to the IP owner:
CMS—Centers for Medicare & Medicaid Services (**www.cms.gov**)

[b] 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, nonmaternity 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's Home Health Compare website also repress 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's 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 12-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.

MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in ambulation/ locomotion *(continued)*			indicating the same or more impairment 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: (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) ▌ 1 - 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 ▌ 2 - 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		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in ambulation/ locomotion *(continued)*			▪ 3 - Able to walk only with the supervision or assistance of another person at all times ▪ 4 - Chairfast, unable to ambulate but is able to wheel self independently ▪ 5 - Chairfast, unable to ambulate and is unable to wheel self ▪ 6 - Bedfast, unable to ambulate or be up in a chair.		
Acute care hospitalization (risk-adjusted)	Measure ID #: 0171	CMS	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 6 or 7), *AND* the value recorded for the OASIS item M0855 on that assessment is 1, indicating the patient was admitted to a hospital *AND* the value recorded on the OASIS item M0896 is 1-18, 20, or UK, indicating the patient was admitted for a reason other than a scheduled treatment or procedure. 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 6 or 7), *AND* the value recorded for the OASIS item M0855 on that assessment is 1,	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). 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 a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Acute care hospitalization (risk-adjusted) *(continued)*			indicating the patient was admitted to a hospital *AND* the value recorded for the OASIS item M0896 is 1-18, 20, or UK, indicating the patient was admitted for a reason other than a scheduled treatment or procedure 0 (NO) IF: The assessment completed at the conclusion of the episode of care is a discharge assessment (M0100 has a value of 9), *OR* the value recorded for the OASIS item M0855 on the transfer to inpatient facility assessment is 2, 3, or 4, indicating that the patient was admitted to an inpatient facility other than a hospital *OR* the value recorded for item M0896=19, indicating the hospitalization was for a scheduled treatment or procedure. 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: (M0100) This assessment is currently being completed for the following reason: Start/Resumption of Care ▌1 - Start of care—further visits planned		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Acute care hospitalization (risk-adjusted) *(continued)*			▌ 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 patient been admitted? ▌ 1 - Hospital ▌ 2 - Rehabilitation facility ▌ 3 - Nursing home ▌ 4 - Hospice ▌ NA - No inpatient facility admission (M0896) Reason for hospitalization ▌ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Acute care hospitalization (risk-adjusted) *(continued)*			▌2 - Injury caused by fall ▌3 - Respiratory infection (e.g., pneumonia, bronchitis) ▌4 - Other respiratory problem ▌5 - Heart failure (e.g., fluid overload) ▌6 - Cardiac dysrhythmia (irregular heartbeat) ▌7 - Myocardial infarction or chest pain ▌8 - Other heart disease ▌9 - Stroke (CVA) or TIA ▌10 - Hypo/hyperglycemia, diabetes out of control ▌11 - GI bleeding, obstruction, constipation, impaction ▌12 - Dehydration, malnutrition ▌13 - Urinary tract infection ▌14 - IV catheter-related infection or complication ▌15 - Wound infection or deterioration ▌16 - Uncontrolled pain ▌17 - Acute mental/behavioral health problem ▌18 - Deep vein thrombosis, pulmonary embolus ▌19 - Scheduled treatment or procedure ▌20 - Other than above reasons ▌UK - Reason unknown.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Emergency department use: with and without hospitalization	Measure ID #: 0173	CMS	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 1, 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. (a) 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	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 *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 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Emergency department use: with and without hospitalization *(continued)*			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) ☐ 0 - NO ☐ 1 - YES, used hospital emergency department WITHOUT hospital admission ☐ 2 - YES, used hospital emergency department WITH hospital admission ☐ UK - Unknown.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in bathing	Measure ID #: 0174	CMS	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. 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). 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in bathing *(continued)*			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		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in bathing *(continued)*			▌5 - Unable to use the shower or 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.		
Improvement in bed transferring	Measure ID #: 0175	CMS	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	All episodes except those where any of the following conditions apply: (1) The value recorded for the OASIS item M0692 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 episodes where either of the following conditions applies: (1) The value recorded for the OASIS item M0692 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in bed transferring *(continued)*			(or resumption) of care assessment, indicating the same or more impairment 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: (M0692) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. ▌ 0 - Able to independently transfer ▌ 1 - Able to transfer with minimal human assistance or with use of an assistive device ▌ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process ▌ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person ▌ 4 - Bedfast, unable to transfer but is able to turn and position self in bed ▌ 5 - Bedfast, unable to transfer and is unable to turn and position self.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in management of oral medications	Measure ID #: 0176	CMS	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, indicating less impairment at discharge compared to start of care 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, indicating the same or more impairment 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.	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 *OR* (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 *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 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 *OR* (1b) The value recorded for the OASIS item M0782-C 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 generic exclusions (see footnote).

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in management of oral medications *(continued)*			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.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in pain interfering with activity	Measure ID #: 0177	CMS	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. Time Window: Current CMS systems report data on episodes that start and end within a rolling 12-month period,	All home health episodes except where any 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 *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 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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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in pain interfering with activity *(continued)*			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.		
Improvement in status of surgical wounds	Measure ID #: 0178	CMS	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 1 (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:	All home health episodes except where any of the following conditions apply: (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 2, indicating either no surgical wound or no observable surgical wound. These patients are excluded because it would	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 2, indicating either no surgical wound or no observable surgical wound. These patients are excluded because it would

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in status of surgical wounds *(continued)*			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 1 (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 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?	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 *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.	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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in status of surgical wounds *(continued)*			▌ 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 Post 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.		
Improvement in dyspnea	Measure ID #: 0179	CMS	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	All home health episodes except those where any of the following conditions apply: (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 *OR*	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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Improvement in dyspnea *(continued)*			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. 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: (M0492) When is the patient dyspneic or noticeably short of breath? ▌ 0 - Patient is not short of breath ▌ 1 - When walking more than 20 feet, climbing stairs ▌ 2 - With moderate exertion (e.g., while dressing, using commode or bed-pan, walking distances less than 20 feet) ▌ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation ▌ 4 - At rest (during day or night).	(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.	

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Increase in number of pressure ulcers	Measure ID #: 0181	CMS	Number of home health episodes where (a) the value recorded for the total number of stageable pressure ulcers (M0462 - number at stage 1) + (M0452 - number at stage 2) + (M0452 - number at stage 3) + (M0452 - 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 (non-epithelialized) pressure ulcers at each stage:	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 *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 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 *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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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Increase in number of pressure ulcers *(continued)*			(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. d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar. d.3 Unstageable: Suspected deep tissue injury in evolution.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Increase in number of pressure ulcers *(continued)*			(M0462) Current number of stage 1 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. 1, 2, 3, 4 or more.		
Depression assessment conducted	Measure ID #: 0518 Review #: AHH-001-08	CMS	Number of home health episodes where at start of episode, patient was screened for depression, using a standardized depression screening tool. 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-screened, no symptoms displayed) or 2 (YES-screened, symptoms displayed). 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 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.	None

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Diabetic foot care and patient education implemented during short-term episodes of care	Measure ID #: 0519 Review #: AHH-018-08	CMS	Number of short-term home health episodes where at end of episode, diabetic foot care and education specified in the care plan was implemented for patients with diabetes. 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 follow-up) was conducted *AND* ▌ (M1365) Diabetic Foot Care Plan Follow-up=1 (YES).	Number of short-term home health episodes where patient is diabetic and is not bilateral amputee (M2250b=0 or 1) at start of episode, 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* is a bilateral amputee (M2250b=NA) *OR* ▌ an assessment with (M0100) Reason for Assessment=4 or 5 (recertification or other follow-up) 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
CAHPS® home health care survey	Measure ID #: 0517 Review #: PEC-001-08	CMS	Please see attachment for Questions 8-16, on "Composite Measures Specifications."	Please see attachment for Questions 8-16, on "Composite Measures Specifications."	Numerator and Denominator Exclusions: ▌ 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 lookback period are excluded. *(Note that the 60-day lookback period is defined as the 60-day period prior to and including the last day in the sample month.)* ▌ Patients who have been previously selected for the Home Health Care CAHPS (HH-CAHPS) 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Drug education on medications provided to patient/caregiver during short-term episodes	Measure ID #: 0520 Review #: AHH-021-08	CMS	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 follow-up) 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 follow-up) 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Heart failure symptoms addressed during short-term episodes	Measure ID #: 0521 Review #: AHH-025-08	CMS	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. 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* ▌ (M1105) Symptoms of Heart Failure=1 (YES) *AND* ▌ no assessment with (M0100) Reason for Assessment=4 or 5 (recertification or other follow-up) was conducted *AND* ▌ (M1110) Heart Failure Follow-up= 1, 2, 3, 4, or 5 (appropriate actions taken).	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). 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 does not have diagnosis of heart failure (M1105=NA) *OR* ▌ an assessment with (M0100) Reason for Assessment=4 or 5 (recertification or other follow-up) 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.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Influenza immunization received for current flu season	Measure ID #: 0522 Review #: AHH-027-08	CMS	Number of home health episodes specified in the denominator where patients: a) Received the influenza vaccine from the home health provider OR patient or responsible party reported receipt from another provider (computed separately) *OR* b) Were offered and refused vaccine (computed separately) *OR* c) Were determined to have medical contraindication(s) of anaphylactic hypersensitivity to eggs *or* other component(s) of the vaccine, OR history of Guillain-Barré syndrome within 6 weeks after a previous influenza vaccination, OR bone marrow transplant within 6 months prior to encounters between October 1 and March 31 (computed 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 the12-month period. Details: Number of home health patient episodes in which in which the patient:	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 yr. *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). 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: ▌ (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient) or 9 (discharge)	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: The influenza immunization 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 nonmaternity patients receiving skilled services for whom Medicare and/or Medicaid are primary payers. Therefore, the data reported by CMS will cover those populations only and only for those patients for which a transfer or discharge OASIS is collected during the time period.*

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Influenza immunization received for current flu season *(continued)*			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) is outside the period October 1-March 31. [Go to M1031]. ▌ UK - Unknown [Go to M1031].	▌ the period between the related Start of Care (M0030) or Resumption of Care (M0032) *AND* ▌ (M0906) Date of Transfer, Discharge or Death includes dates 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 October 1 through March 31 will be included in the measure for the period that includes the date of Transfer/Discharge.* 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	

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Influenza immunization received for current flu season *(continued)*			*Note: Guidance for #1 will indicate that vaccine given may be given by HH provider or another provider 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-Barré 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]).*	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.	

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Influenza immunization received for current flu season *(continued)*			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.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pain assessment conducted	Measure ID #: 0523 Review #: AHH-029-08	CMS	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, does not 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 the12-month period.	All episodes where: ▌ patient had no pain (M0422=0).

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pain interventions implemented during short-term episodes	Measure ID #: 0524 Review #: AHH-030-08	CMS	Number of short-term home health episodes where the patient had pain and pain interventions were included in the care plan and implemented by the end of the episode. 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 follow-up) was conducted *AND* ▌ (M1246) Pain Management Steps Implemented=1 (YES).	Number of short-term home health episodes where the patient had pain (M1242=1, 2, 3, or 4) at Start of episode [(M0100) Reason for Assessment=1 (start of care) or 3 (resumption of care)] *OR* at end of episode [(M0100) Reason for Assessment=6 or 7 (transfer to inpatient) or 9 (discharge)] 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: ▌ an assessment with (M0100) Reason for Assessment=4 or 5 (recertification or other follow-up) was conducted *OR* ▌ the patient had no pain (M1242=0) at both start of episode [(M0100) Reason for Assessment=1 (start of care) or 3 (resumption of care)] *AND* at end of episode [(M0100) Reason for Assessment=6 or 7 (transfer to inpatient) or 9 (discharge)] *OR* ▌ the patient did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home.

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pneumococcal polysaccharide vaccine (PPV) ever received	Measure ID #: 0525 Review #: AHH-033-08	CMS	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 and 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.	Number of home health episodes in an agency with transfer or discharge assessment during the measurement year who: ▌ are age 65 or older *OR* ▌ reside in a long-term care facility (including nursing homes and skilled nursing facilities) *OR* ▌ are age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, asplenia. 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 *AND* M1035= 1, 2, 3, or 5, indicating the patient has high-risk condition(s) of 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 nonmaternity 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.*

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pneumococcal polysaccharide vaccine (PPV) ever received *(continued)*			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 radiation therapy (<2 weeks prior to encounters during the measurement year).*		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pneumococcal polysaccharide vaccine (PPV) ever received *(continued)*			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: ▌ 1 - Patient has received PPV in the past. ▌ 2 - Offered and declined. ▌ 3 - Assessed and determined to have medical contraindication(s). ▌ 4 - Not indicated; patient does not meet age/condition guidelines for PPV. ▌ 5 - None of the above.		

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Timely initiation of care	Measure ID #: 0526 Review #: AHH-041-08	CMS	Number of home health episodes where the start or resumption of care date was on the physician-specified date or within two days of the referral date. 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 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] *OR* ▌ [(M0032) Resumption of Care Date equals [(M0104) Physician-ordered Resumption of Care Date].	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

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Multifactor fall risk assessment conducted for patients 65 and over	Measure ID #: 0537 Review #: AHH-028-08	CMS	Number of home health episodes in which patients 65 and older had a multifactor fall risk assessment at the start of care/resumption 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. Details: Number of home health episodes with an OASIS assessment in which: ▌(M0100) Reason for Assessment:=1 (Start of care) or 3 (Resumption of care) *AND* ▌(M1910) Has patient had a Multi-factor Fall Risk Assessment=1 (YES - found no risk) or 2 (YES - found risk) *AND* ▌(M0066) Date of Birth indicates the patient is age 65 or older at the start of care/resumption of care date OASIS-C item M0030 and M0032.	All episodes in which the patient is age 65 or older at the start of care/resumption of care OTHER THAN 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.	Home health episodes where any of the following conditions apply: (1) Patient is under age 65 at the start of care/resumption of care *OR* (2) Episodes covered by CMS generic exclusions (see footnote).

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pressure ulcer risk assessment conducted	Measure ID #: 0540 Review #: AHH-040-08	CMS	Number of home health episodes in which the patient was assessed for risk of developing pressure ulcers at start of care/resumption 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. Details: Number of home health episodes with an OASIS assessment in which: (M0100) Reason for Assessment=1 (Start of care) or 3 (Resumption of care) *AND* the value recorded for OASIS-C item M1300=1 or 2, indicating the patient was assessed for pressure ulcer risk either via an evaluation of clinical factors or using a standardized tool, such as Braden or Norton scale.	All episodes except 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.	Home health episodes covered by CMS generic exclusions (see footnote).

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pressure ulcer prevention included in plan of care	Measure ID #: 0538 Review #: AHH-038-08	CMS	Number of home health episodes in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care at the start of care/resumption of care for patients assessed to be at risk for 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. Details: Number of home health episodes in which (M0100) Reason for Assessment=1 (Start of care) or 3 (Resumption of care) *AND* the value recorded for OASIS-C item M2250f=1 (YES), indicating interventions to prevent pressure ulcers were included in the physician-ordered plan of care.	All home health episodes except those in which a formal assessment was done and the patient was determined not to have a risk of developing pressure ulcers at the start of care/resumption of care (OASIS item M2250f=NA) on the OASIS-C start or resumption 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.	Home health episodes where any of the following conditions apply: (1) The value recorded for the OASIS item M2250f=NA on the OASIS-C start or resumption of care, indicating a formal assessment was done and the patient was not at risk for pressure ulcers *OR* (2) Episodes covered by CMS generic exclusions (see footnote).

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MEASURE TITLE	MEASURE NUMBERS	MEASURE STEWARD[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS[b]
Pressure ulcer prevention plans implemented	Measure ID #: 0539 Review #: AHH-039-08	CMS	Number of home health episodes in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented since the previous OASIS 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. Details: Number of home health episodes in which at end of episode: ▌(M0100) Reason for Assessment= 6 or 7 (transfer to inpatient) or 9 (discharge) *AND* the value recorded for OASIS-C item ▌M2400e=1 (YES), indicating interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented during the episode ending in transfer or discharge.	All episodes except those where the patient was not assessed to be at risk for pressure ulcers since the previous OASIS assessment (OASIS-C item M2400e =NA) *OR* did not have a discharge or transfer to inpatient facility assessment because the episode of care ended in death at home *OR* 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.	Home health episodes where any of the following conditions apply: (1) The value recorded for the OASIS item M2400e on the OASIS-C transfer or discharge is NA, indicating a formal assessment was done and the patient was not at risk of pressure ulcers since the last OASIS assessment *OR* (2) The patient did not have a transfer or discharge assessment because the episode of care ended in death at home *OR* (3) Episodes covered by CMS generic exclusions (see footnote).

Appendix B
Home Health Care and Pressure Ulcers Steering Committees and Project Staff

HOME HEALTH CARE—ADDITIONAL PERFORMANCE MEASURES 2008 STEERING COMMITTEE

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Appendix D
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 (CMS) have used its Home Health Compare website (**www.medicare.gov/hhcompare**) to report data on the quality measures. The current portfolio reported is as follows:

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:[1]

- 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

The data are collected using the CMS OASIS (Outcome and Assessment Information Set) 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 because many of the newly submitted measures and revised endorsed measures are composed of OASIS-C items and require the measures to be recommended as time limited (because of the need for additional testing) or 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 that eight research areas be addressed and that new measures should be developed that:

1. cover 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. are not unique to any particular population (e.g., perception of care, pain, patient safety);
3. focus on 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. address all of the NQF aims with specific attention to measures that take note of the degree to which home health services are patient centered, timely, efficient, and equitable;
5. involve all measurement framework areas with specific attention to developing measures that include 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;

[1]See **www.medicare.gov/HHCompare/Home.asp?dest=NAV|Home|DataDetails#TabTop**. Last accessed December 2008.

6. address all 13 Medicare-identified high-risk, high-volume, high-cost conditions and treatments and comprehensively cover 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. focus on care coordination and system-level coordination, and would be suitable for public reporting; and
8. deal with existing gaps in consensus, as noted in the 2005 NQF report *National Voluntary Consensus Standards for Home Health Care.*

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 the more stringent criteria of importance, usability, feasibility, and scientific acceptability (and should 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.

Appendix E
Candidate Home Health Care Quality Consensus Standards Recommendation Summary

MEASURE NUMBER	MEASURE	SUBMISSION STATUS	ENDORSED
0171	Acute care hospitalization (risk-adjusted)	Currently endorsed	Yes
0179	Improvement in dyspnea	Currently endorsed	Yes
0176	Improvement in management of oral medications	Currently endorsed	Yes
0181	Increase in number of pressure ulcers	Currently endorsed	Yes
0178	Improvement in status of surgical wounds	Currently endorsed but refined	Yes
0173	Emergency department use: with and without hospitalization (replaces Emergent care—risk adjusted)	Currently endorsed but refined	Yes
0167	Improvement in ambulation/locomotion	Currently endorsed but refined	Yes
0174	Improvement in bathing	Currently endorsed but refined	Yes
0175	Improvement in bed transferring	Currently endorsed but refined	Yes
0177	Improvement in pain interfering with activity	Currently endorsed but refined	Yes
0518	Depression assessment conducted	New	Yes
0519	Diabetic foot care and patient education implemented	New	Yes
0522	Influenza immunization received for current flu season	New	Yes
0521	Heart failure symptoms addressed	New	Yes
0523	Pain assessment conducted	New	Yes
0524	Pain interventions implemented	New	Yes
0525	Pneumococcal polysaccharide vaccine (PPV) ever received	New	Yes
0526	Timely initiation of care	New	Yes

more

MEASURE NUMBER	MEASURE	SUBMISSION STATUS	ENDORSED
0520	Drug education on medications provided to patient/caregiver during short-term episode	New	Yes
0537	Multifactor fall risk assessment conducted for patients 65 and over	New	Yes
0538	Pressure ulcer prevention included in plan of care	New	Yes
0539	Pressure ulcer prevention plans implemented	New	Yes
0540	Pressure ulcer risk assessment conducted	New	Yes
0517	CAHPS® home health care survey	New	Yes
0180	Improvement in urinary incontinence	Currently endorsed but refined	No
0172	Discharge to community	Currently endorsed	No
0170	Emergent care for hypo/hyperglycemia	Currently endorsed	No
0169	Emergent care for improper medication administration, medication side effects	Currently endorsed	No
0168	Emergent care for wound infections, deteriorating wound status	Currently endorsed	No
AHH-012-08	Improvement in speech and language	New	No
AHH-010-08	Improvement in light meal preparation	New	No
AHH-015-08	Improvement of urinary tract infection	New	No
AHH-016-08	Depression interventions implemented	New	No
AHH-017-08	Depression interventions in plan of care	New	No
AHH-019-08	Diabetic foot care and patient education in plan of care	New	No
AHH-022-08	Drug education on high risk medications provided to patient/ caregiver at start of episode	New	No
AHH-023-08	Falls prevention steps implemented	New	No
AHH-024-08	Falls prevention steps in plan of care	New	No
AHH-026-08	Improvement in toileting hygiene	New	No
AHH-031-08	Pain interventions in plan of care	New	No
AHH-032-08	Physician notification guidelines established	New	No
AHH-034-08	Potential medication issues identified and timely physician contact at start of episode	New	No
AHH-035-08	Potential medication issues identified and timely physician contact during episode	New	No

more

MEASURE NUMBER	MEASURE	SUBMISSION STATUS	ENDORSED
AHH-036-08	Pressure ulcer treated with moisture-retentive dressings	New	No
AHH-037-08	Pressure ulcer plan of care includes moisture-retentive dressings	New	No
AHH-042-08	Proactive plan of care composite	New	No
AHH-002-08	Development of urinary tract infection	New	No
AHH-003-08	Emergent care for injury caused by fall or accident at home	New	No
AHH-004-08	Improvement in anxiety level	New	No
AHH-005-08	Improvement in behavior problem frequency	New	No
AHH-006-08	Improvement in cognitive functioning	New	No
AHH-007-08	Improvement in confusion frequency	New	No
AHH-008-08	Improvement in eating	New	No
AHH-009-08	Improvement in grooming	New	No
AHH-011-08	Improvement in lower body dressing	New	No
AHH-013-08	Improvement in toilet transferring	New	No
AHH-014-08	Improvement in upper body dressing	New	No

THE NATIONAL QUALITY FORUM (NQF) is a private, nonprofit, open membership, public benefit corporation whose mission is to improve the American healthcare system so that it can be counted on to provide safe, timely, compassionate, and accountable care using the best current knowledge. Established in 1999, NQF is a unique public-private partnership having broad participation from all parts of the healthcare industry. As a voluntary consensus standard-setting organization, NQF seeks to develop a common vision for healthcare quality improvement, create a foundation for standardized healthcare performance data collection and reporting, and identify a national strategy for healthcare quality improvement. NQF provides an equitable mechanism for addressing the disparate priorities of healthcare's many stakeholders.

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