



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0526

Corresponding Measures:

De.2. Measure Title: [Timely Initiation of Care](#)

Co.1.1. Measure Steward: [Centers for Medicare & Medicaid Services](#)

De.3. Brief Description of Measure: [Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.](#)

1b.1. Developer Rationale: [Continued reporting of this measure is important for home health care agencies to use to identify the rates at which they provide timely care. While the research findings are complex, there is a trend that more timely provision of care is associated with better clinical outcomes, indicating the value of reporting of this measure.](#)

S.4. Numerator Statement: [Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.](#)

S.6. Denominator Statement: [Number of home health episodes of care ending during the data collection period other than those covered by generic or measure-specific denominator exclusions.](#)

S.8. Denominator Exclusions: [Measure-specific exclusions: None](#)

[Generic exclusions: None, except that HHAs are exempt from reporting OASIS data to CMS on certain categories of patients/clients as described in the next section.](#)

De.1. Measure Type: [Process](#)

S.17. Data Source: [Electronic Health Records](#)

S.20. Level of Analysis: [Facility](#)

IF Endorsement Maintenance – Original Endorsement Date: [Mar 31, 2009](#) **Most Recent Endorsement Date:** [Aug 10, 2012](#)

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? [N/A](#)

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0526_Evidence_MSF5.0_Data.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence

information is needed.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Continued reporting of this measure is important for home health care agencies to use to identify the rates at which they provide timely care. While the research findings are complex, there is a trend that more timely provision of care is associated with better clinical outcomes, indicating the value of reporting of this measure.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

HHA Ave.	StDev	Min	10th	25th	50th	75th	90th	Max
88.3%	11.58	0	75%	85%	91%	96%	99%	1.000

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Date(s): 7/1/2010 – 6/30/2011 Data/Sample: Calculated measure as reported on Home Health Compare. Home Health Compare reports this measure for Medicare certified agencies with at least 20 quality episodes to which the measure applies that have submitted OASIS C assessments for at least 6 months of the 12 month reporting period. Of the 11,236 agencies that are listed on Home Health Compare, 9,853 agencies met the criteria for public reporting (20 episodes and 6 months of data). Information about downloading the Home Health Compare Database is available at:

<http://www.medicare.gov/HomeHealthCompare/Resources/Download-Database.aspx>

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

National Rate (episodes level) = 89.49%

Age	<65	65-74	75-84	85-110
% Timely-Care	88.43	90.37	89.75	89.07

Race	White	Black	Hispanic	Other
% Timely-Care	90.05	86.73	89.27	89.24

Gender	Male	Female
% Timely-Care	90.09	89.14

There appear to be no disparities based on age or gender. Blacks are slightly less likely to have timely initiation of care than other racial groups, albeit their rate of timely initiation is still quite high (nearly 87%).

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Data date(s): 7/1/2010 – 6/30/2011

Data/Sample: OASIS-C data from Medicare certified agencies. The measure is calculated for 99.99% of all quality episodes (only 62 episodes out of 5.78 million episodes had missing data). Outcomes for agencies with at least 20 quality episodes and 6 months of data in a 12-month period for a quality measure are publicly reported.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [OASISQM_data_dictionary-635169279908486918-635477578289679838-635986558439408314.xls](#)

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Number of home health patient episodes of care where at start of episode, OASIS* item M0100 (Reason for Assessment) = 1 (Start of care) AND [M0030 (Start of care date) equals M0102 (Physician-ordered Start of Care Date), OR M0030 (Start of care date) minus M0104 (Date of Referral) is less than 3 days, OR M0030 (Start of care date) minus M1005 (Inpatient Discharge Date) is less than 3 days]

PLUS

Number of home health patient episodes of care where at start of episode: M0100 (Reason for Assessment) = 3 (Resumption of care) AND [M0032 (Resumption of care date) equals M0102 (Physician-ordered Start/Resumption of Care Date), OR M0032 (Resumption of care date) minus M0104 (Date of Referral) is less than 3 days, OR M0032 (Resumption of care date) minus M1005 (Inpatient Discharge Date) is less than 3 days]

*Currently, there are three versions of OASIS assessments on the CMS repository that are used to calculate quality measures for home health agencies. OASIS-C was in use from 1/1/2010 through 12/31/2014. OASIS-C1 / ICD-9 Version was in use from 1/1/2015 through 9/30/2015, and OASIS-C1 / ICD-10 Version is in use from 10/1/2015 onward. All references in this document to OASIS include all three versions of OASIS. Only if item numbers or measure specifications are different among the OASIS versions will a specific OASIS version be referenced.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Number of home health episodes of care ending during the data collection period other than those covered by generic or measure-specific denominator exclusions.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

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

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Measure-specific exclusions: None

Generic exclusions: None, except that HHAs are exempt from reporting OASIS data to CMS on certain categories of patients/clients as described in the next section.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Measure-Specific Exclusions: None

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

has been in operation at least six months.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Not stratified.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

The unit of analysis for patient outcome and process quality measures is an episode of care, defined as starting with an admission to home health care (M0100 (Reason for assessment) = 1 or 2) or resumption of home health care after an inpatient facility stay (M0100 (Reason for assessment) = 3), and ending with a discharge from home health care, including discharge due to death, or admission to inpatient facility for 24 hours or more (M0100 (Reason for assessment) = 6, 7, 8, or 9). In the specifications below, variable names from the CMS data submission specifications are used, with a [1] appended to indicate the data come from the start or resumption of care assessment and a [2] appended to indicate the data come from the discharge or inpatient facility transfer assessment.

IF M0100_ASSMT_REASON[1] = 01 THEN

IF M0102_PHYSN_ORDRD_SOCROC_DT_NA[1] = 1 THEN

IF M0104_PHYSN_RFRL_DT[1] IS BLANK THEN

Timely_Care = MISSING

ELSE

IF DATEVALUE(M0030_START_CARE_DT[1]) <= DATEVALUE(M0104_PHYSN_RFRL_DT[1]) + 2 Days THEN

Timely_Care = 1

ELSE

IF M1000_DC_NONE_14_DA[1] = 1 THEN

Timely_Care = 0

ELSE

IF M1005_INP_DSCHG_UNKNOWN[1] = 1 THEN

Timely_Care = MISSING

ELSE

IF DATEVALUE(M1005_INP_DISCHARGE_DT[1]) > DATEVALUE(M0104_PHYSN_RFRL_DT[1]) THEN

IF DATEVALUE(M0030_START_CARE_DT[1]) <= DATEVALUE(M1005_INP_DISCHARGE_DT[1]) + 2 Days THEN

Timely_Care = 1

ELSE

Timely_Care = 0

ELSE

Timely_Care = 0

ELSE

IF DATEVALUE(M0030_START_CARE_DT[1]) <= DATEVALUE(M0102_PHYSN_ORDRD_SOCROC_DT[1]) THEN

Timely_Care = 1

ELSE

```
Timely_Care = 0
ELSE
IF M0102_PHYSN_ORDRD_SOCROC_DT_NA[1] = 1 THEN
IF M0104_PHYSN_RFRL_DT[1] IS BLANK THEN
Timely_Care = MISSING
ELSE
IF DATEVALUE(M0032_ROC_DATE[1]) <= DATEVALUE(M0104_PHYSN_RFRL_DT[1]) + 2 Days THEN
Timely_Care = 1
ELSE
IF M1000_DC_NONE_14_DA[1] = 1 THEN
Timely_Care = 0
ELSE
IF M1005_INP_DSCHG_UNKNOWN[1] = 1 THEN
Timely_Care = MISSING
ELSE
IF DATEVALUE(M1005_INP_DISCHARGE_DT[1]) > DATEVALUE(M0104_PHYSN_RFRL_DT[1]) THEN
IF DATEVALUE(M0032_ROC_DATE[1]) <= DATEVALUE(M1005_INP_DISCHARGE_DT[1]) + 2 Days THEN
Timely_Care = 1
ELSE
Timely_Care = 0
ELSE
Timely_Care = 0
ELSE
IF M1000_DC_NONE_14_DA[1] = 1 THEN
IF DATEVALUE(M0032_ROC_DATE[1]) <= DATEVALUE(M0102_PHYSN_ORDRD_SOCROC_DT[1]) THEN
Timely_Care = 1
ELSE
Timely_Care = 0
ELSE
IF M1005_INP_DSCHG_UNKNOWN[1] = 1 THEN
Timely_Care = MISSING
ELSE
IF DATEVALUE(M1005_INP_DISCHARGE_DT[1]) > DATEVALUE(M0102_PHYSN_ORDRD_SOCROC_DT[1]) OR
DATEVALUE(M0102_PHYSN_ORDRD_SOCROC_DT[1]) > DATEVALUE(M1005_INP_DISCHARGE_DT[1]) + 2 THEN
IF DATEVALUE(M0032_ROC_DATE[1]) <= DATEVALUE(M1005_INP_DISCHARGE_DT[1]) + 2 Days THEN
Timely_Care = 1
ELSE
Timely_Care = 0
ELSE
IF DATEVALUE(M0032_ROC_DATE[1]) <= DATEVALUE (M0102_PHYSN_ORDRD_SOCROC_DT[1]) THEN
Timely_Care = 1
ELSE
Timely_Care = 0
```

Calculation algorithm published in the Technical Specifications at:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Process-Quality-Measures-Technical-Documentation.pdf>

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable, completion of OASIS-C assessments is mandated by CMS and all completed assessments are used to calculate measure

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and*

guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.17. Data Source (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

[Electronic Health Records](#)

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

[OASIS-C](#)

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

[URL](#)

S.20. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Facility](#)

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

[Home Care](#)

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

[0526_MeasureTesting_MS5.0_Data.doc](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should

be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition
If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in a combination of electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

OASIS data are collected by the home health agency during the care episode as part of the Conditions of Participation, and transmitted electronically to the state and CMS national OASIS repository. No issues regarding availability of data, missing data, timing or frequency of data collection, patient confidentiality, time or cost of data collection, feasibility or implementation have become apparent since OASIS-C was implemented 1/1/2010.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Inaccuracies may result either due to confusion on the part of the clinician completing the OASIS or intentionally, to manipulate scores on quality measures. CMS has created and disseminated manuals and training materials to maximize accurate reporting of this data. Data accuracy could be audited through a review of medical records for evidence of relevant orders and implementation.

All home health agencies serving adult, non-maternity Medicare and/or Medicaid patients must submit their OASIS assessment data to their respective state OASIS repository in a standard format. The repository software passes each incoming OASIS assessment record through an extensive set of quality edits. These include internal range and logic checks that assure that assessment items include only allowable values and that they are consistent with each other. When there are significant errors in an assessment, it is not accepted by the repository and the erroneous data are not available to be included in any published quality information. Data accuracy is also supported by the state survey process. Surveyors use OASIS to characterize each agency's caseload and to select sample patients to be interviewed. They also review and assess the accuracy of the agency's OASIS assessments. In addition, CMS payment contractors assess the accuracy of a sample of the OASIS assessments as part of their medical review processes. We are unable to provide results of these audit activities as we do not currently have access to the findings of the CMS surveyors, the data repository or CMS contractors regarding OASIS data accuracy.

4c.2. Please explain any unexpected benefits from implementation of this measure.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

This measure assesses whether the agency initiated home health care in a timely manner. This process is not currently addressed in the home health or long-term care setting in any other measure.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [Centers for Medicare & Medicaid Services](#)

Co.2 Point of Contact: [Helen, Dollar-Maples](#), Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-

Co.3 Measure Developer if different from Measure Steward: [Acumen LLC](#)

Co.4 Point of Contact: [Keziah, Cook](#), kcook@acumenllc.com, 650-558-8882-247

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role

in measure development.

In December 2010, a Technical Expert Panel (TEP) was convened to review the analysis conducted on the home health measures that received NQF time limited endorsement (including Timely Initiation of Care). The TEP was comprised of individuals selected by CMS for their expertise and perspectives related to the panel objectives, from a pool of individuals who were nominated in response to the September 2010 Call for TEP notice.

2010 HH TLE Measure Review TEP Members:

Mary Carr RN, MPH - Associate Director for Regulatory Affairs, National Association of Home Care and Hospice

Rick Fortinsky, PhD- Professor of Medicine, Physicians Health Services Endowed Chair in Geriatrics and Gerontology, UConn Center for Health Services Research

Barbara Gage, PhD - Deputy Director of Aging, Disability, and Long-term Care, Post-Acute Care Research Lead, Research Triangle Institute

Margherita Labson, R.N., Executive Director for the Home Care Program at The Joint Commission

Steve Landers MD, MPH - Director, Center for Home Care and Community Rehabilitation, Cleveland Clinic

Bruce Leff, MD – Associate Director, Elder House Call Program,

Barbara McCann, MSW - Chief Industry Officer, Interim Health Care

Jennifer S. Mensik PhD, RN, NEA-BC, FACHE - Director, Clinical Practices and Research, Banner Health, Arizona and Western Regions

Dana Mukamel, Professor, Department of Medicine, Division of General Internal Medicine & Primary Care, University of California, Irvine & Senior Fellow, Health Policy Research Institute, Irvine, California

Robert J. Rosati Ph.D - Vice President, Clinical Informatics, Visiting Nurse Service of New York, Center for Home Care Policy and Research

Judy Sangl Sc.D. – Health Scientist Administrator, Agency for Healthcare Research and Quality (AHRQ), Center for Patient Safety and Quality Improvement (CQuIPS), Rockville, MD

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2010

Ad.3 Month and Year of most recent revision: 10, 2008

Ad.4 What is your frequency for review/update of this measure? Annual

Ad.5 When is the next scheduled review/update for this measure? 09, 2012

Ad.6 Copyright statement:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: