



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 subcriterion 1b).

Brief Measure Information

NQF #: 0537

Corresponding Measures:

De.2. Measure Title: Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate

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 patients who can ambulate had a multi-factor fall risk assessment at start/resumption of care.

1b.1. Developer Rationale: As noted above, studies have demonstrated that older people receiving home health care have relatively high rates of falls, which are in turn associated with mortality, injury, and substantial amounts of health care resource use. The current literature indicates there is significant variation in provider behavior on falls risk assessment and thus a need for a more systematic way of assessing and encouraging home health providers to conduct fall risk assessments, in order to prevent the high rates of falls in older individuals. This measure will encourage home health agencies to promote patient safety by conducting fall risk assessments for patients aged 65 or older. It will also provide home health agencies and consumers with information that will enable them to monitor the care received by patients at risk of falls.

TEP Comments:

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. The TEP was asked to rate the measure importance (is the measurement and reporting important for making significant gains in health care quality). Members noted that variation in this measure was not high, and the variation will become even more limited over time. Approximately half of TEP members rated the measure as moderately meeting the criterion for importance.

S.4. Numerator Statement: Number of home health episodes of care in which patients who can ambulate had a multi-factor fall risk assessment at start/resumption of care.

S.7. Denominator Statement: Number of home health episodes of care ending during the reporting period, other than those covered by generic or measure-specific exclusions.

S.10. Denominator Exclusions: Episodes in which the patient was unable to ambulate at the time of assessment.

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Records

S.26. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Dec 14, 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? Not Applicable

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.***

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

[2015_Evidence_Form_0537.docx](#)

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., the benefits or improvements in quality envisioned by use of this measure)

As noted above, studies have demonstrated that older people receiving home health care have relatively high rates of falls, which are in turn associated with mortality, injury, and substantial amounts of health care resource use. The current literature indicates there is significant variation in provider behavior on falls risk assessment and thus a need for a more systematic way of assessing and encouraging home health providers to conduct fall risk assessments, in order to prevent the high rates of falls in older individuals. This measure will encourage home health agencies to promote patient safety by conducting fall risk assessments for patients aged 65 or older. It will also provide home health agencies and consumers with information that will enable them to monitor the care received by patients at risk of falls.

TEP Comments:

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. The TEP was asked to rate the measure importance (is the measurement and reporting important for making significant gains in health care quality). Members noted that variation in this measure was not high, and the variation will become even more limited over time. Approximately half of TEP members rated the measure as moderately meeting the criterion for importance.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
see attachment "Importance to Report" for a tabular presentation of these data

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.
see attachment "Importance to Report" for a tabular presentation of these data

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.*
see attachment "Importance to Report" for a tabular presentation of these data

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.
see attachment "Importance to Report" for a tabular presentation of these data

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Falls among older people are high risk events associated with mortality, injury, and substantial amounts of health care resource use. Rates of falls for American home health care patients are under-studied: the most recent study and only study specific to home health patients' reports an annual rate of 28.5% among home health care patients aged 65 and older in one state in the Midwest. 1 Other studies of community dwelling older people report falls rates ranging from 11% (Canadian home health care patients in Quebec)2 to 25% (community dwelling older adults in three European countries)3 to 49% (very old, age 85 and older, Finnish people).4 A Cochrane review of 159 RCTs reports a 30% fall rate among community dwelling older people with evidence that multifactorial assessment and interventions reduce the rate of falls but not the risk of falls.5

There is variation in provider behavior on falls risk assessment. Prior to implementation of the OASIS-C assessment, Fortinsky et al. reported that nurses and rehabilitation therapists, despite having received in-service training on the benefits of performing falls risk assessment, reported clinician level follow-up on falls risk assessment elements ranging from 51% for medication history to 81% for assessment of postural hypotension.6 Peel et al. reported that among home health physical therapists responding to a survey of their practice, 98% and 100% (respectively) asked about a history of falls and identified risk factors for falling.7 However, this study was limited by response bias, implying that the true rates of falls risk assessment are most likely much lower than those reported in the Peel et al. study. Thus, the current literature illustrates that there is evidence of high rates of falls among home health care patients (28.5% based on the most recent U.S. home health care study) and variation in clinician practice, even following an in-service educational program. This measure will encourage home health agencies to promote patient safety by conducting fall risk assessments for patients aged 65 or older and by providing information to home health agencies and consumers that will enable them to monitor the care received by patients at risk of falls.

1c.4. Citations for data demonstrating high priority provided in 1a.3

- (1) Spoelstra S, Given B, von Eye A, Given C. Falls in the community-dwelling elderly with a history of cancer. *Cancer Nurs* 2010;33:149-155.
- (2) Leclerc BS, Begin C, Cadieux E et al. A classification and regression tree for predicting recurrent falling among community-dwelling seniors using home-care services. *Can J Public Health* 2009;100:263-267.
- (3) Clough-Gorr KM, Erpen T, Gillmann G et al. Preclinical disability as a risk factor for falls in community-dwelling older adults. *J Gerontol A Biol Sci Med Sci* 2008;63:314-320.
- (4) Iinattiemi S, Jokelainen J, Luukinen H. Falls risk among a very old home-dwelling population. *Scand J Prim Health Care* 2009;27:25-30.
- (5) Gillespie LD, Robertson MC, Gillespie WJ et al. Interventions for preventing falls in older people living in the community. *Cochrane Database Syst Rev* 2012;9:CD007146.
- (6) Fortinsky RH, Baker D, Gottschalk M, King M, Trella P, Tinetti ME. Extent of implementation of evidence-based fall prevention practices for older patients in home health care. *J Am Geriatr Soc* 2008;56:737-743.
- (7) Peel C, Brown CJ, Lane A, Milliken E, Patel K. A survey of fall prevention knowledge and practice patterns in home health physical therapists. *J Geriatr Phys Ther* 2008;31:64-70.

1c.5. 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.)

Not Applicable

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 subcriteria 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):

Safety

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.)
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html> <https://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: 2015_Data_Dictionary.xlsx

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

No significant changes

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)

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

Number of home health episodes of care in which patients who can ambulate had a multi-factor fall risk assessment at start/resumption of care.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

All episodes that end within a rolling 12 month period, updated quarterly.

S.6. 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, 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.

Number of home health patient episodes of care where at start of episode:

- (M1910) Has patient had a Multi-factor Fall Risk Assessment = 1 (yes - found no risk) or 2 (yes - found risk)

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

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

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

Number of home health patient episodes of care, defined as:

A start/resumption of care assessment ((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 denominator exclusions.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Episodes in which the patient was unable to ambulate at the time of assessment.

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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:

Number of home health patient episodes of care where at start of episode:

-(M0100) Reason for Assessment = 1 (Start of care) AND

-(M1860) Ambulation/Locomotion = 4, 5, or 6

PLUS

Number of home health patient episodes of care where at start of episode:

-(M0100) Reason for Assessment = 3 (Resumption of care) AND

-(M1860) Ambulation/Locomotion = 4, 5, or 6

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

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

Not Applicable- measure not stratified.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not Applicable- process measure.

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

Provided in response box S.15a

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Not Applicable- process measure.

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

Data from matched pairs of OASIS assessments for each episode of care (start or resumption of care paired with a discharge or transfer to inpatient facility) are used to calculate individual patient outcome and process quality measures.

Target population: All episodes of care ending during a specified time interval (usually a period of twelve months), subject to generic and measure-specific exclusions.

Generic exclusions: None.

Measure specific exclusions: Episodes of care for which the patient was assessed to be chairfast or bedfast (M1860_CUR_AMBLTN[1] = 04 OR M1860_CRNT_AMBLTN[1] = 05 OR M1860_CRNT_AMBLTN[1] = 06)

Cases meeting the target process: Episodes of care during which the patient received a multi-factor fall risk assessment at start/resumption of care (M1910_MLT_FCTR_FALL_RISK_ASMT[1] = 01 OR M1910_MLT_FCTR_FALL_RISK_ASMT[1] = 02)

Aggregating Data: The observed process measure value for each HHA is calculated as the percentage of cases meeting the target population (denominator) criteria that meet the target process (numerator) criteria.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No diagram provided

S.20. 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.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

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

Not Applicable

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

Not Applicable

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

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

The measure is calculated based on the data obtained from the Home Health Outcome and Assessment Information Set (OASIS-C), which is a core standard assessment data set that home health agencies integrate into their own patient-specific, comprehensive assessment to identify each patient's need for home care. The data set is the foundation for valid and reliable information for patient assessment, care planning, and service delivery in the home health setting, as well as for the home health quality

assessment and performance improvement program. Home health agencies are required to collect OASIS data on all non-maternity Medicare/Medicaid patients, 18 or over, receiving skilled services. Data are collected at specific time points (admission, resumption of care after inpatient stay, recertification every 60 days that the patient remains in care, transfer, and at discharge). HH agencies are required to encode and transmit patient OASIS data to the state OASIS repositories. Each HHA has on-line access to outcome and process measure reports based on their own OASIS data to the OASIS repositories. Each HHA has on-line access to outcome and process measure reports based on their own OASIS data submissions, as well as comparative state and national aggregate reports, case mix reports, and potentially avoidable event reports. CMS regularly collects OASIS data for storage in the national OASIS repository, and makes measures based on these data (including the Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate measure) available to consumers and to the general public through the Medicare Home Health Compare website.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Home Care

If other:

S.28. 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.)

Not Applicable

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

2015_Testing_form_0537_V1.docx

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

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)

ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

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.

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.

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. Describe what you have learned/modified 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 PROM data (patients, service recipients, respondents) and those whose performance is being measured.

OASIS data collection and transmission is a requirement for the Medicare Home Health Conditions of Participation. Information used to calculate this measure is recorded in the relevant OASIS items embedded in the agency's clinical assessment as part of normal clinical practice. OASIS data are collected by the home health agency during the care episode and transmitted electronically to the 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).

Not Applicable

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.

Planned	Current Use (for current use provide URL)
	Public Reporting Home Health Compare http://www.cms.gov/HomeHealthCompare/search.aspx

4a.1. For each CURRENT use, checked above, provide:

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

The Home Health Compare website is a federal government website managed by the Centers for Medicare and Medicaid Services (CMS). It provides information to consumers about the quality of care provided by Medicare-certified home health agencies throughout the nation. The measures reported on Home Health Compare includes all Medicare-certified agencies with at least 20 home health quality episodes. In the period ending June 30, 2014, there were 10,499 agencies (87.3 percent of the 12,022 agencies with at least one quality episode) the met the measure denominator criteria for reporting of Multifactor Fall Risk Assessment

Conducted For All Patients Who Can Ambulate. This included 5,195,559 patients nationally.

CMS' Home Health Quality Initiative "Outcome Quality Measure Report" provides all Medicare-certified home health agencies with opportunities to use outcome measures for outcome-based quality improvement. The report allows agencies to benchmark their performance against agencies across the state and nationally, as well as their own performance from prior time periods. All Medicare-certified home health agencies can access their Outcome Quality Measure Reports via CMS' online CASPER system.

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?)

Not Applicable

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.)

Not Applicable

4b. 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.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

Between the July 2010-June 2011 measurement period and the July 2013-June 2014 measurement period,

- At the agency level, average performance on this measure increased from 96.3 percent to 98.4 percent for agencies with at least 20 valid episodes
- At the population level, the performance rate increased from 95.0% to 98.0%

Measured entities for this analysis include 10,499 agencies and 5,195,559 patients. Additional information on the geographic area and number and percentage of accountable entities and patients included in this analysis is shown in the Attachment: Importance to Report.

4b.2. 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.

Not Applicable

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. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

No unintended consequences identified.

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.
Yes

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

0035 : Fall Risk Management (FRM)

0101 : Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls

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

5a. Harmonization

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 completely harmonized?

No

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

Fall Risk Management (NQF #0035) is a process measure that incorporates two rates: discussion of fall risk between patient and provider and patient report that providers managed fall risk. However, this measure is calculated for adults older than 75 or 65-74 with self-reported fall or balance issue within prior 12 months, and is specific to ambulatory care or acute care facilities. Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls (NQF #0101) is a clinical process measure that incorporates screening for fall risk and plan of care for falls. The measure has three rates: patients over 65 screened for future fall risk at least once in prior 12 months (history of falls); patients with a risk assessment for falls within the prior 12 months; and plan of care for falls. The measure has been endorsed for use in ambulatory care and post-acute care settings, including home health care. A new version of this measure is currently under consideration, which will require a multifactorial risk assessment. Data for this measure is calculated from claims data and electronic clinical data. The current measure (#0537) used in home care is not limited to older adult patients.

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.)

A search using the NQF QPS for quality measures addressing fall risk assessment for home health care patients who can ambulate resulted in two conceptually similar measures. Fall Risk Management (NQF #0035) is a process measure that incorporates two rates: discussion of fall risk between patient and provider and patient report that providers managed fall risk. However, this measure is calculated for adults older than 75 or 65-74 with self-reported fall or balance issue within prior 12 months, and is specific to ambulatory care or acute care facilities. Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls (NQF #0101) is a clinical process measure that incorporates screening for fall risk and plan of care for falls. The measure has three rates: patients over 65 screened for future fall risk at least once in prior 12 months (history of falls); patients with a risk assessment for falls within the prior 12 months; and plan of care for falls. The measure has been endorsed for use in ambulatory care and post-acute care settings, including home health care. A new version of this measure is currently under consideration, which will require a multifactorial risk assessment. Data for this measure is calculated from claims data and electronic clinical data. The current measure (#0537) used in

home care is not limited to older adult patients.

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 **Attachment:** [2015_Importance_to_Report_0537_V1.docx](#)

Contact Information

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

Co.2 Point of Contact: [Corette, Byrd, MMSSupport@Battelle.org](#), 202-786-1158-

Co.3 Measure Developer if different from Measure Steward: [Centers for Medicare & Medicaid Services](#)

Co.4 Point of Contact: [Alan, Levitt, Alan.Levitt@CMS.hhs.gov](#), 410-786-6892-

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 PPV Ever Received). 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-termCare, 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, InterimHealth 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 \(CQIPS\), Rockville, MD](#)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2009 Ad.3 Month and Year of most recent revision: 01, 2009 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? 06, 2015
Ad.6 Copyright statement: Not Applicable Ad.7 Disclaimers: Not Applicable
Ad.8 Additional Information/Comments: Not Applicable