NATIONAL QUALITY FORUM

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 #: 0538
Corresponding Measures:
De.2. **Measure Title:** Pressure Ulcer Prevention and Care
Co.1.1. **Measure Steward:** Centers for Medicare & Medicaid Services
De.3. **Brief Description of Measure:** Pressure Ulcer Risk Assessment Conducted: Percentage of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers at start/resumption of care.

Pressure Ulcer Prevention Included in Plan of Care: Percentage of home health episodes of care in which the physician-ordered plan of care included interventions to prevent pressure ulcers.

Pressure Ulcer Prevention Implemented: Percentage of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented.
1b.1. **Developer Rationale:** As noted above, studies have demonstrated that while pressure ulcers may be relatively rare, they have a substantial adverse impact on patient quality of life and have a predictive risk with mortality. They are a national focus because they are widely seen as preventable with sufficient risk assessment and quality care provision. These measures are envisioned to encourage agencies to conduct a risk assessment, include pressure ulcer prevention in the plan of care, and implement pressure ulcer prevention during short term episodes of care, which could significantly reduce the incidence of pressure ulcers in the home health care patient population. Additionally, these measures would provide home health agencies and consumers with information that will enable them to monitor the quality of care received by all patients at risk of developing pressure ulcers.

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 these measures was not high, but they also indicated that these measures should continue to be included in the OASIS-C assessment to encourage agencies to reduce the racial/ethnic disparities in pressure ulcer prevention. The majority of TEP members rated the measure as partially or completely meeting the criterion for importance.

S.4. **Numerator Statement:** Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers either via an evaluation of clinical factors or using a standardized tool, at start/resumption of care.

Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care in which the physician-ordered plan of care included interventions to prevent pressure ulcers.

Pressure Ulcer Prevention Implemented: Number of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented.
S.7. **Denominator Statement:** Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.

Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.

Pressure Ulcer Prevention Implemented: 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:** Pressure Ulcer Risk Assessment Conducted: No measure-specific exclusions.

Pressure Ulcer Prevention Included in Plan of Care: Episodes in which the patient is not assessed to be at risk for pressure ulcers.

Pressure Ulcer Prevention Implemented: Number of home health episodes in which the patient was not assessed to be at risk for pressure ulcers, or the home health episode ended in transfer to an inpatient facility or death.

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_0538.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 while pressure ulcers may be relatively rare, they have a substantial adverse impact on patient quality of life and have a predictive risk with mortality. They are a national focus because they are widely seen as preventable with sufficient risk assessment and quality care provision. These measures are envisioned to encourage agencies to conduct a risk assessment, include pressure ulcer prevention in the plan of care, and implement pressure ulcer prevention during short term episodes of care, which could significantly reduce the incidence of pressure ulcers in the home health care patient population. Additionally, these measures would provide home health agencies and consumers with information that will enable them to monitor the quality of care received by all patients at risk of developing pressure ulcers.

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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 the 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 the 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 the 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 the 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**
Patient/societal consequences of poor quality, Severity of illness
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.**
According to unpublished data from the national population of home health care patients, pressure ulcers are relatively rare with a 5% or lower prevalence, although other studies identify a 9% prevalence rate (1). Bergquist & Frantz (2) report a 6.3% incidence rate during home health care stays. Ferrell et al. (1) identified 30% of home health care patients as being at risk for pressure ulcer development based on use of the Braden scale to predict risk. (These latter two studies are dated but are the most recent to report prevalence.)
One study focused on pressure ulcer prevention in home health care identifies evidence of potentially poor quality of care: Bergquist identified that only one third of the 128 agencies surveyed in four Midwestern states had agency policies for prediction and/or prevention and fewer than 20% of agencies identified prevention recommendations in a protocol to be used by clinical staff (3). However, pressure ulcers are a national focus, are widely seen as preventable with sufficient risk assessment and quality care provision, and there is interest in linking the processes of care with payment (4). A large multi-country systematic review of the literature identified that pressure ulcers have substantial adverse impact on patient quality of life (5) and have a predictive risk with mortality (6). Westra et al (7) report that the majority (88.5%) of home health care agencies have access to a wound, ostomy, continence nurse and the expertise associated with these providers in identifying and caring for home health care patients with pressure ulcers. Thus, pressure ulcer prevention and care is important for measurement and public reporting.

1c.4. **Citations for data demonstrating high priority provided in 1a.3**
(1) Ferrell BA, Josephson K, Norvid P, Alcorn H. Pressure ulcers among patients admitted to home care. J Am Geriatr Soc 2000; 48(9):1042-1047.
(2) Bergquist S. Subscales, subscores, or summative score: evaluating the contribution of Braden Scale items for predicting pressure ulcer risk in older adults receiving home health care. J Wound Ostomy Continence Nurs 2001; 28(6):279-289.
(3) Bergquist S. The quality of pressure ulcer prediction and prevention in home health care. Appl Nurs Res 2005; 18(3):148-154.
(4) Baharestani MM, Black JM, Carville K, Clark M, Cuddigan JE, Dealey C et al. Dilemmas in measuring and using pressure ulcer prevalence and incidence: an international consensus. Int Wound J 2009; 6(2):97-104.
(5) Gorecki C, Brown JM, Nelson EA, Briggs M, Schoonhoven L, Dealey C et al. Impact of pressure ulcers on quality of life in older

patients: a systematic review. J Am Geriatr Soc 2009; 57(7):1175-1183.
(6) Landi F, Onder G, Russo A, Bernabei R. Pressure ulcer and mortality in frail elderly people living in community. Arch Gerontol Geriatr 2007; 44 Suppl 1:217-223.
(7) Westra BL, Bliss DZ, Savik K, Hou Y, Borchert A. Effectiveness of wound, ostomy, and continence nurses on agency-level wound and incontinence outcomes in home care. J Wound Ostomy Continence Nurs 2013;40:25-53.

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

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-635638474121315509.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.
Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers either via an evaluation of clinical factors or using a standardized tool, at start/resumption of care.

Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care in which the physician-ordered plan of care included interventions to prevent pressure ulcers.

Pressure Ulcer Prevention Implemented: Number of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented.

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.)*
CMS systems report data on 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.
Pressure Ulcer Risk Assessment Conducted: Number of home health patient episodes of care where at start of episode: (M1300) Pressure Ulcer Risk Assessment conducted = 1 (yes-clinical factors) or 2 (yes-standardized tool)

Pressure Ulcer Prevention Included in Plan of Care: Number of home health patient episodes of care where at start of episode: (M2250f) Pressure Ulcer Prevention in Care Plan = 1 (yes)

Pressure Ulcer Prevention Implemented: Number of home health patient episodes of care where at end of episode: (M2400e) Pressure Ulcer Prevention Plan implemented = 1 (yes)

S.7. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Pressure Ulcer Risk Assessment Conducted: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.

Pressure Ulcer Prevention Included in Plan of Care: Number of home health episodes of care ending during the reporting period, other than those covered by generic exclusions.

Pressure Ulcer Prevention Implemented: 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, Populations at Risk

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)*
Denominator for each measure: 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)*
Pressure Ulcer Risk Assessment Conducted: No measure-specific exclusions.

Pressure Ulcer Prevention Included in Plan of Care: Episodes in which the patient is not assessed to be at risk for pressure ulcers.

Pressure Ulcer Prevention Implemented: Number of home health episodes in which the patient was not assessed to be at risk for pressure ulcers, or the home health episode ended in transfer to an inpatient facility or death.

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)*

Pressure Ulcer Risk Assessment Conducted:
Measure Specific Exclusions: None

Pressure Ulcer Prevention Included in Plan of Care:
Measure Specific Exclusions: Number of patient episodes where at start of episode: (M2250f) Pressure Ulcer Prevention in Care Plan = NA – Patient is not assessed to be at risk for pressure ulcers

Pressure Ulcer Prevention Implemented:
Measure-specific Exclusions:
Number of home health patient episodes of care where at end of episode: (M0100) Reason for Assessment = 8 (death at home) PLUS
Number of home health patient episodes of care where at end of episode: (M0100) Reason for Assessment = 6 or 7 (transfer to inpatient facility) or 9 (discharge) AND (M2400e) Pressure Ulcer Prevention Plan implemented = NA (Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment)

Generic exclusions for all three measures: 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 - 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:
Pressure Ulcer Risk Assessment Conducted: None.
Pressure Ulcer Prevention Included in Plan of Care: Episodes of care for which pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers (M2250_PLAN_SMRY_PRSULC_PRVNT[1] = NA).
Pressure Ulcer Prevention Implemented: Episodes of care ending with the death of the patient of for which pressure ulcer risk assessment indicates the patient is not at risk of developing pressure ulcers (M2400_INTRVTN_SMRY_PRSULC_PRVN[2] = NA OR M0100_ASSMT_REASON[2] = 08).

Cases meeting the target process:
Pressure Ulcer Risk Assessment Conducted: Episodes of care during which the patient was assessed for risk of developing pressure ulcers at start/resumption of care (M1300_PRSR_ULCR_RISK_ASMT[1] = 01 OR M1300_PRSR_ULCR_RISK_ASMT[1] = 02).
Pressure Ulcer Prevention Included in Plan of Care: Episodes of care during which the physician-ordered plan of care included intervention(s) to prevent pressure ulcers (M2250_PLAN_SMRY_PRSULC_PRVNT[1] = 01).
Pressure Ulcer Prevention Implemented: Episodes of care ending with the death of the patient of for which pressure ulcer risk assessment indicates the patient is not at risk of developing pressure ulcers (M2400_INTRVTN_SMRY_PRSULC_PRVN[2] = NA OR M0100_ASSMT_REASON[2] = 08).
Pressure Ulcer Prevention Implemented: Episodes of care during which intervention(s) to prevent pressure ulcers were BOTH included in the physician-ordered plan of care AND implemented (M2400_INTRVTN_SMRY_PRSULC_PRVN[2] = 01).
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 OASIS repository. Each HHA has on-line access to outcome and process measure reports based on their own OASIS data to the OASIS repository. 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 this 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_0538_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 is 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 10,747 agencies (88.6 percent of the 12,126 agencies with at least one quality episode) the met the measure denominator criteria for reporting of Pressure Ulcer Risk Assessment; 9,149 agencies (76.9 percent of the 11,904 agencies with at least one quality episode) for Prevention in Plan of Care measure; and 8,927 agencies (75.3 percent of the 11850 agencies with at least one quality episode) in Prevention Implemented measure. This included 5,894,698 patients nationally for the Pressure Ulcer Risk Assessment measure; 2,586,874 patients nationally for the Prevention in Plan of Care measure; and 2,491,704 patients nationally for the Prevention Implemented measure.

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 increased from 93.4 percent to 96.9 percent for the Pressure Ulcer Risk Assessment measure; from 92.1 percent to 96.4 percent for the Prevention in Plan of Care measure; from 90.9 to 95.2 percent for the Prevention Implementation measure for agencies with at least 20 valid episodes
- At the population level, the performance rate increased by several percentage points across all population groups

Measured entities for this analysis include 10,747 agencies and 5,894,698 patients for the Pressure Ulcer Risk Assessment measure; 9,149 agencies and 2,586,874 patients for the Prevention in Plan of Care measure; and 8,927 agencies and 2,491,704 patients for the Prevention Implemented measure. 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.

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.
No

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

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?
Yes

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.)
A search using the NQF QPS for quality measures addressing pressure ulcer prevention and care for home health patients found no other endorsed measures for a home health population. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678) is an outcome measure that reports the percent of short-stay residents (residing in nursing home, LTCH, or inpatient rehabilitation facilities) with Stage 2 – 4 pressure ulcers that were new or worsened when compared with the previous assessment. The measure is calculated using MDS data. A new version of this measure is under consideration. However, this measure does not address processes of care implemented in home settings to prevent pressure ulcers.

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_0538_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 Programat 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 (CQuIPS), 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:** 07, 2010
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:**