



**Outcome and Assessment Information Set (OASIS) Quality Measure
Development and Maintenance
Technical Expert Panel Meeting Notes**

Hilton Garden Inn BWI Airport, 1516 Aero Drive, Linthicum, MD 21090
August 21, 2015 8:00 a.m. – 4:30 p.m.

Technical Expert Panel members:

Ellen Martin, RN, PhD(c), CHPCA, CPHQ (*participated via phone*)

Director of Clinical Practice & Regulatory Affairs
Texas Association for Home Care & Hospice

Misty Kevech, RN, MS

RN Project Coordinator
WVMI /Quality Insights

Judy Fenton, RN

Vice President Clinical Practice & Quality
Kindred at Home

Barbara Dale, RN CWOCN CHHN

Director of Wound Care
Quality Home Health

Michelle Funk, RN, COS-C

Regional Director of Nursing/ Director of Program Quality and Compliance
Aging Well Healthcare

Frances Petrella, RN

Senior Director, Quality
Community Health Accreditation Partner (CHAP)

Ann Olson, RN

Principal and Vice President
Qualidigm

Barbara Huston, RN, BSN COS-C

Director of Home Health Compliance & Performance Improvement
Celtic Healthcare

Rick Greene, MSW

Executive Advisor
National Alliance for Caregiving



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OASIS QMs Team: Betty Fout, Wesley Heeter, Elizabeth Madigan, Gene Nuccio, David Hittle, Linda Krulish, Marian Essey, Tokumbo Oluwole, Megan Shaheen, Donna Hurd, Henry Goldberg, Roopa Akkineni, Alrick Edwards, Sara Galantowicz, Nicole Keane, Anisha Illa

Federal observers: Kelly Vontran, Michelle Brazil, Theresa White, Mary Pratt, Tara McMullen, Stace Mandl

Introduction

The Centers for Medicare & Medicaid Services (CMS) contracted with Abt Associates to develop and maintain quality measures for the Home Health Quality Reporting Program (HHQRP). The contract name is Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002). The purpose of this project is to maintain, evaluate and modify as needed the current HHQRP measure set, which includes measures based on the HH Item Set (OASIS) and claims. CMS also plans to implement additional measures of home health quality addressing gaps in measurement that have been identified by stakeholders.

As part of its measure development process, CMS asked contractors to convene groups of stakeholders and subject matter experts who contribute direction and thoughtful input to the measure contractor during measure development and maintenance. TEP members were asked to review analytics on the current HHQRP outcome, process, and potentially avoidable event measures and evaluate recommendations to modify the measure set. TEP members gave input on two measures under consideration; a falls risk composite process measure and an outcome measure assessing improvement in dyspnea in patients with a primary diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and/or Asthma.

Dr. Fout explained the purpose of the following **measure review documents**:

- Criteria Summary Sheet: Yes/No results of applying criteria to 81 measures
- Individual Measure Profiles: Detailed summary of each measure with specific definition and stratifications by year
- Measure Input Sheet: Measure-by-measure TEP member recommendation sheet – please complete throughout the day and return before you leave
- Prediction Model Summaries: Performance of the current prediction models by measure



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Reevaluation Criteria

1-3. NQF endorsement, public reporting via HHC, inclusion in the star rating

Variability

4. Topped out (national rate > 95%)

5. Topped out (greater than 50% of agencies have perfect scores)

6. No discrimination across agencies (IQR < 5%)

7. Insufficient number of low performers (10th percentile > 70%)

8. Reportability

- Poor reportability (50% of agencies do not have at least 20 episodes)

9. Reliability

- Instability in rankings (greater than 50% of agencies change ranking by 3 or more deciles from year-to-year)

Validity

10. Level of scientific evidence (review of the literature revealed None, Low, Moderate, High)

11. Expert opinion indicates keep/revise/retire (internal experts were asked to make recommendations on each measure)

12. Variability across states (IQR > 5%)

13-14. Gaps in performance (large gaps in performance when stratified by gender, race, age, urban location, CMS regions)

HH QMs Overview

- There are 29 process measures
 - Used to evaluate the rate of home health agency use of specific evidence-based processes of care. They focus on high-risk, high-volume, problem-prone areas for home health care.
 - Most process measures first reported to agencies in 2010.



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- There are 52 outcome measures
 - Used to assess the “outputs” of care by examining health status changes as a result of care. They are risk adjusted to account for changes due to the natural progression of disease and disability to allow for valid comparison.
 - Most outcome measures first reported to agencies in 1999/2000.

Review of current HH Measures – Process Measures

P1-P2: Timely care and care coordination

- P1 – Timely Initiation of Care
- P2 – Physician Notification Guidelines Established

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
|----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| P1 | ✓ | ✓ | ✓ | | | | Y | | | Y | Y | | Y |
| P2 | | | | | | | Y | | | Y | Y | Y | Y |

P1- Timely Initiation of care

This measure is NQF endorsed, reported on Home Health Compare (HHC) and part of the star ratings.

Some of the participants were surprised that this measure is not “topped out”. However, **Ms. Funk** was not surprised since of all the process measures that are easy to “game”, this one is more objective since it is based on actual dates. In her opinion it is one of the most useful measures.

Ms. Olson said that this measure is important to monitor variation observed among small and large agencies.

Ms. Kevech said that this measure helps state surveyors and organizations to identify staffing issues that might give insight into other outcome issues.

Summary: Participants agreed that process measure #1- *Timely Initiation of care* is useful in many scenarios, including monitoring variation among agencies, and identifying staffing issues that could provide insight into outcome issues. This measure is not easily “game-able” because it is based on actual dates; thus making it one of the most objective and useful measure of quality of patient care.



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P2- Physician Notification Guidelines Established

This measure is not endorsed, not on HHC and not part of star ratings. It has an insufficient number of low performers. There is low scientific evidence and in expert's opinion, it should be retired.

Ms. Fenton said this measure is not helpful. Physician orders drive care and each patient has different parameters. Furthermore, it is challenging to operationalize this measure on weekends or weekday evenings as it is difficult to reach the physician during those times.

Summary: A majority of the participants recommended removing process measure #2- *Physician Notification Guidelines Established*, since it is not useful and does not factor the importance of having different parameters of care for each patient. Additionally, it is difficult to reach physicians over the weekend or on weekday evenings and hence difficult to operationalize.

P3-P5: Depression

- P3 – Depression Assessment Conducted
- P4 – Depression Interventions in Plan of Care
- P5 – Depression Interventions Implemented during All Episodes of Care

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
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| P3 | ✓ | ✓ | | Y | | Y | Y | | | | | | |
| P4 | | | | | | | Y | | | | Y | | Y |
| P5 | | | | | | | | | | | Y | | Y |

P3 – Depression Assessment Conducted

Measure is “topped out”- national rate is over 95%, IQR value is low.

Participants were concerned that if this measure does not exist, then this item will no longer be collected during the OASIS assessment.

Ms. Funk said that because the PHQ2 is built into the assessment set, clinicians automatically conduct the depression assessment. It is a best practice and should remain as a best practice but may not be useful as a process measure since that is redundant. **Ms. Dale** stated that if this measure is altered or retired, then agencies and clinicians will not follow through for best practice purposes.



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One participant said that clinicians are often not aware that process measures are not met if *P1- Timely Initiative of Care* is not met; this causes misunderstanding.

Ms. Kevech said that depression affects all of the diseases management cases, especially for underserved populations. She thought that it is currently not conducted on the right populations. **Ms. Kevech** recommends not retiring this measure; increased education about the measure can improve its performance.

Ms. Huston added that this measure is useful for care planning purposes and hence advised against retiring it.

Dr. Hittle suggested a composite measure that indicates that clinician did the assessment and in case of a positive screen followed up might be slightly less “topped out” and still be valuable.

Dr. Nuccio said that perhaps an assessment alone is not robust and that a more robust measure of the depression process from the perspective of delivery of care is not only to assess but create a plan of care and follow up; the three process items are all grouped together- while they are not all “topped out”, they do have similar characteristics to get a holistic understanding of conducting depression assessment and implementation.

Ms. Fenton agreed that the assessment is valuable to ensure best practice. Most clinicians’ hesitation with this measure is having the conversation with the physician when the screening indicates that the patient has depression but that diagnosis is not listed by the physician; the clinicians who identified it have actions listed in the care plan and are unsure how far to progress with the treatment and follow through.

Ms. Fout said to indicate preference to make it a composite measure as “combined and kept”

Summary: Participants agreed that a composite measure of the three depression associated measures: *P3- Depression Assessment Conducted*, *P4- Depression Interventions in Plan of Care*, and *P5- Depression Interventions Implemented during All Episodes of Care* would be valuable. These measures are valuable for care planning and to ensure best practice methods. Increased education about this measure to clinicians may improve its performance.

P6-P8: Falls

- P6 – Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate
- P7 – Falls Prevention Steps in Plan of Care
- P8 – Falls Prevention Steps Implemented for All Episodes of Care



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| P6 | ✓ | ✓ | | Y | Y | Y | Y | | | | Y | | |
| P7 | | | | Y | Y | Y | Y | | | | Y | | |
| P8 | | | | Y | Y | Y | Y | | | | Y | | |

The measures are very topped out; experts felt these measures need to be revised.

One participant said that these should be combined into a composite measure.

Ms. Funk said that 90% of home health patients are at risk for “falls”.

Gene said that the assessment of falls is endorsed by NQF but is not used as part of star rating calculation because it is “topped out”.

Summary: Some participants agreed that a composite measure of the three “falls” measures: P6- *Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate*, P7- *Falls Prevention Steps in Plan of Care*, and P8- *Falls Prevention Steps Implemented for All Episodes of Care* would be valuable.

P9-P11: Pain

- P9 – Pain Assessment Conducted
- P10 – Pain Interventions In Plan of Care
- P11 – Pain Interventions Implemented during All Episodes of Care

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
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| P9 | | ✓ | | Y | | Y | Y | | | | Y | | |
| P10 | | | | Y | Y | Y | Y | | | | Y | | |
| P11 | | ✓ | | Y | | Y | Y | | | | Y | | |

Dr. Fout asked if these measures are used individually or if they would be more useful as a composite measure. Most participants agreed they would use them as a composite.

Ms. Funk asked how a composite measure would be measured.



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Dr. Madigan said that all three measures need a response in order for the agency to get credit for that composite measure.

Ms. Funk said that is very difficult to track and ensure all three were conducted.

Ms. Dale said that plan of care might have interventions in place, but that those are not necessarily always implemented, and so the overall pain interfering with activity does not change.

Ms. Kevech said that since all three measures are topped out, a composite may not be valuable. A lot of interventions on plan of care are generic and do not affect an individual patient's pain. She recommends retiring them. The outcome measure related to pain is better.

Ms. Funk recommended the same. A validated pain assessment tool is necessary; rating pain from 1-10 is not the best pain assessment.

Mr. Greene asked if there should be a related process measure in order to have an outcome measure.

Dr. Madigan said no, that is not a requirement.

Summary: A majority of the participants recommended retiring the three pain measures: P9- *Pain Assessment Conducted*, P10- *Pain Interventions In Plan of Care*, and P11-*Pain Interventions Implemented during All Episodes of Care* since interventions in the plan of care are not always implemented or are far too generic and hence not valuable in reducing pain; it would be valuable to create a validated pain assessment tool different from the 1-10 rating scale that is currently in use. An outcome measure of pain is more useful.

P12-P16: Pressure Ulcer

- P12 – Pressure Ulcer Risk Assessment Conducted
- P13 – Pressure Ulcer Prevention in Plan of Care
- P14 – Pressure Ulcer Prevention Implemented during All Episodes of Care
- P15 – Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care
- P16 – Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented during All Episodes of Care



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| P12 | ✓ | ✓ | | Y | | Y | Y | | | | Y | | |
| P13 | ✓ | ✓ | | Y | | Y | Y | | | | Y | | |
| P14 | ✓ | ✓ | | Y | | | Y | | | | Y | | |
| P15 | | | | | | | | Y | | | Y | Y | Y |
| P16 | | | | | | | | Y | | | Y | Y | Y |

The first three pressure ulcer process measures are currently NQF endorsed and reported on Home Health Compare.

Only around 7-8% of patients in home health care are affected by pressure ulcers. The number of patients who develop new pressure ulcers is even smaller.

Ms. Funk said that P15 and P16 are more useful than P12, P13, and P14 since they are not as “topped out”.

Ms. Dale does not support taking away these measures. Prevention is much better and more cost effective than intervention. **Ms. Funk** agreed.

Ms. Dale said that P13 and P14 are the important ones. She said it would be useful to have P15 and P16 for “all wounds”.

Ms. Funk suggested that P12 is the best candidate for retirement since it is built into all home health agencies’ software and will be conducted regardless.

A majority of participants agreed it would be most beneficial to keep P15 and P16.

Ms. Fout suggested a composite for P12, P13, and P14 and another composite for P15 and P16. Most participants agreed to this approach.

Ms. Petrella said that not every home health agency is on EMR and hence getting rid of P12 completely is a big concern.

Ms. Kevech agreed that it is important to keep in mind that not all small home health agencies are able to afford EMR.

Ms. Olson said that with the movement of patients from long term care to the community, there is an increase in immobile patients and so there is a risk of low numbers changing due to patient centered care and so there are more immobile patients signing a risk document and coming home. That is a big concern.



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Ms. Funk added that the measure should encompass more wound types.

Summary: Participants agreed that a composite of measures P12-*Pressure Ulcer Risk Assessment Conducted*, P13- *Pressure Ulcer Prevention in Plan of Care*, and P14- *Pressure Ulcer Prevention Implemented during All Episodes of Care* and possibly a separate composite measure for P15-*Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care*, and P16- *Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented during All Episodes of Care* would be valuable. This would ensure that all home health agencies, including those that do not have an Electronic Medical Record (EMR) system can comply with best practice methods. Language in measures P15 and P16 should be expanded to include “all wounds”.

P17-18: Diabetes

- P17 – Diabetic Foot Care and Patient Education in Plan of Care
- P18 – Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
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| P17 | | | | Y | | Y | Y | | | Y | Y | | Y |
| P18 | ✓ | ✓ | | | | | Y | | | Y | Y | | |

Both diabetes measures are currently topped out.

Ms. Dale said that P17 is not that useful in the agency where she works. She recently conducted an audit on the “No” items and almost 82 out of the 100 she checked were answered incorrectly. P18 is important because it focuses on prevention; however, implementation is the more important piece.

Ms. Funk agreed that it is a good start but if there is no outcome measure to back it up then it is less useful.

Ms. Huston said that these two could be combined.

Ms. Kevech said that with low income populations as well as baby boomers generation, there is a continuous increase in diabetic incidences; an outcome measures related to this is important.

Ms. Dale said it is surprising that is very little scientific evidence.



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Dr. Madigan said that there is a lot of evidence to support the whole package including filament testing; however, there is not much literature on patient education for diabetic foot care.

P18 should be kept, and if possible both should be combined. There should be an outcome piece as well.

Summary: Participants agreed that it is important to retain P18-*Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care*; however, a composite of measures P17-*Diabetic Foot Care and Patient Education in Plan of Care*, and P18- *Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care* would be valuable. An outcome measure associated with this potential composite measure would be a valuable addition.

P19: Heart Failure

- P19 – Heart Failure Symptoms Addressed during All Episodes of Care

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
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| P19 | ✓ | ✓ | | Y | Y | Y | Y | Y | | | Y | | |

Ms. Funk said this measure is very broad. This measure should be revised to be more valuable; patients with heart failure symptoms should not necessarily have a diagnosis of heart failure to be taken seriously.

Dr. Nuccio asked if the revision must be conducted at an item level in the instrument; there are only one or two items in the OASIS dataset that are related to heart failure.

Ms. Krulish asked if the measure should be expanded to include patients with heart failure symptoms even if there is no diagnosis yet.

Ms. Funk said yes, since often times it is the nurse in the home who finds the orthopnea or early edema and will call the physician to initiate, but it was not at start of care or resumption of care. It is the symptomology that need to be addressed

Ms. Krulish said that if patient has diagnosis by discharge then it is included. If nurse identified the symptoms during the episode then agency gets credit for it.

Ms. Funk said that not all agencies have EMR and some may have staffing issues and in those cases symptoms without diagnosis are not captured.



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Ms. Krulish said that increased education to focus on symptoms can improve this as well as an item change. Some participants agreed that an item change may be sufficient.

Ms. Fenton said increased education on symptom issues and management could be beneficial.

Ms. Funk and some other participants said this measure needs to be revised and expanded.

Summary: Some participants recommended revising measure P19- *Heart Failure Symptoms Addressed during All Episodes of Care* to capture those patients with heart failure symptoms who do not have an existing heart failure diagnosis. Some participants, however, agreed that increased education/ training about this measure and revision of the item set are sufficient.

P20-21: Drug Education

- P20 – Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode
- P21 – Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
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| P20 | | | | Y | | | Y | | | | Y | | |
| P21 | | ✓ | ✓ | | | | Y | | | | Y | | Y |

Ms. Funk said that clinicians educate patients on all high risk medications at the SOC and hence, patients are overwhelmed with information by the time the clinician finishes a two hour SOC. It is not beneficial to rush and educate the patient at SOC only to receive credit for the process measure. The two measures should be combined so there is no pressure to get all of the high risk drug education done at the SOC.

Ms. Kevech said that many hospitalizations are related to high risk drugs, especially warfarin. She agreed that the patient does not retain all the information clinician gives at SOC; however putting the emphasis on high risk drug education early in the episode (maybe within 72 hours) is critical because of the hospitalization rates and potential harm for patients that may be caused in the absence of such education.

Ms. Funk said to narrow down the high risk medications that patients must be made aware of initially according to evidence in literature. Increased guidance on high risk medications is necessary.

A revision of the measure would be ideal.



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Dr. Martin said that it is not realistic to complete patient education at SOC since the visit is long already. It should be extended to around seven days or so. The nurse's judgement in such matters would be useful.

Ms. Petrella agreed that the education period should be extended and added that seven days may not be sufficient because agencies may not be able to send clinicians until the next week.

Ms. Funk said that a seven day timeframe could spur the change for improved patient care delivery since agencies will front load patient visits to ensure they are educated on their high risk medications.

Ms. Krulish asked how long HHAs take to do a comprehensive assessment at SOC?

Clinicians have to complete and record the visit and assessment in the EMR after the first visit before the next visit can be scheduled; they can go back and revise it at a later date.

Ms. Funk said that the EMR at the agency she works at requires the clinician to lock down the interventions conducted at the visit but do not have to lock down the OASIS or plan of care; they have five days to do so. Agency encourages clinicians to take their time for patients with complicated issues.

Some participants agree that P21 is useful and recommended to keep it as is.

Participants agreed that P20 needs revision.

Summary: A majority of participants recommended revising measure P20- *Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode* to increase the initial time frame during which the clinician can educate their patient on high risk medications; a few participants recommended that measure P21-*Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care* remain unchanged since it is valuable. The list of high risk medications should be tightened based on evidence in literature.

P22-24: Influenza Immunization

- P22 – Influenza Immunization Received for Current Flu Season
- P23 – Influenza Immunization Offered and Refused for Current Flu Season*
- P24 – Influenza Immunization Contraindicated*



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| P22 | ✓ | ✓ | ✓ | | | | | | | Y | Y | Y | Y |
| P23 | | | | | | | | | | | Y | | Y |
| P24 | | | | Y | Y | Y | Y | | | Y | Y | | |

A few participants said measure P24- *Influenza Immunization Contraindicated* is useful and encourages best practice methods.

Dr. Nuccio added that this measure has an interesting history with NQF; the original guidelines set by NQF was to report measures separately in such a way that patient was “offered” a influenza vaccine in season was a separate item; “offered but refused” was a separate item; and “contraindicated” was a separate item. Nursing homes were given guidance to collapse all three into a single measure and agencies would get credit for the measure if they gave the vaccine to them or if it was “offered and refused” and if it was “contraindicated”. Home health stakeholders previously recommended that all three measures be collapsed into one.

Ms. Kevech said that the measures need to be separate. The individual measures provide information on problems that help agencies identify best practice methods.

Dr. Hittle said that currently all three measures are reported on CASPER.

Ms. Funk asked if there is any literature or research that links flu to hospitalization. What percentage was hospitalized with influenza symptoms that did or not receive the influenza vaccination? That would be interesting information to know.

Summary: Consensus from the participants was to keep the measures P22-*Influenza Immunization Received for Current Flu Season*, P23-*Influenza Immunization Offered and Refused for Current Flu Season*, and P24- *Influenza Immunization Contraindicated* separate since creating a composite would take away attention from the targets of the intervention. One participant suggested future analysis on the percentage of patients who did not receive the influenza vaccination who went on to be hospitalized with flu symptoms.

P25-27: Pneumococcal Polysaccharide

- P25 – Pneumococcal Polysaccharide Vaccine Ever Received
- P26 – Pneumococcal Polysaccharide Vaccine Offered and Refused*
- P27 – Pneumococcal Polysaccharide Vaccine Contraindicated*



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| | | | | | Variability | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| P25 | ✓ | ✓ | | | | | | | | | | Y | Y |
| P26 | | | | | | | Y | | | Y | Y | | Y |
| P27 | | | | Y | Y | Y | Y | | | Y | Y | | |

Ms. Funk identified many errors while conducting chart reviews on this set of measures. The patient's eligibility itself gives information on whether the patient has been vaccinated; however, often times a patient cannot remember when they were vaccinated because of which the items are marked incorrectly. It is difficult to make sure that the patient can remember that information accurately.

Dr. Madigan added that the Centers for Disease Control recently released guidance about the two pneumococcal vaccines; it is now called Pneumococcal PPV and they need to be completed within a tighter time frame.

Ms. Fenton added that this measure is based on historical information, which can be difficult for patients to recollect.

The pneumonia vaccine is often confused with the influenza vaccine and hence patients incorrectly think they need it every year.

A few participants recommended that this measure must be retired.

Summary: Consensus from the participants was to retire measures P25-*Pneumococcal Polysaccharide Vaccine Ever Received*, P26-*Pneumococcal Polysaccharide Vaccine Offered and Refused*, and P27-*Pneumococcal Polysaccharide Vaccine Contraindicated* since this information is historical and patients often find it challenging to remember when they last received the pneumococcal polysaccharide vaccine, which leads to inaccurate patient data; patients also often confuse the influenza vaccine with the pneumococcal polysaccharide vaccine.

P28-29: Potential Medication Issues

- P28 – Potential Medication Issues Identified and Timely Physician Contact at Start of Episode
- P29 – Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care



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| P28 | | | | | | | | | | Y | | Y | Y |
| P29 | | | | | | | | | | Y | Y | Y | Y |

Ms. Funk agreed that potential medication issues must be identified and timely physician contact must occur; however, the agency should not be graded on whether the physician responded to the agency within a calendar day since that is beyond the agency's control. Often times, agencies have to answer no even if they hear back from the physician the next day, regardless of if the patient was admitted on the weekend.

Ms. Kevech said that this measure has pushed physicians to not refer patients to home care.

Ms. Huston agreed that it is very difficult for agencies to be accountable for something the physician does.

Ms. Fenton said that this measure itself is important and contributes to best practices; however, the time period must be revised to be fair to the agency.

Dr. Hittle said that the IMPACT act requires measures on medication reconciliation to be standardized. A potential revision of this measure is under consideration across post- acute care (PAC) settings.

A majority of the participants agreed that the current time frame stipulated is the biggest issue.

Ms. Huston said that measure P29- *Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care* might be sufficient.

Ms. Funk said that reconciliation, identification of issues and outreach to the physician sufficiently contribute to best practices; however, the fact that the physician did not respond to the home health agency within one day should not negatively impact the home health agencies.

Dr. Martin said that this measure is critical. It should not be completely retired only because a few physicians are not responding on time.

Ms. Funk agreed with **Dr. Martin's** comment; however, to grade home care and an individual agency whether or not that physician responds is not fair or useful.

Ms. Fenton asked if the measure should be revised to give credit to agencies for contacting the physician and not include a guarantee that the physician will respond.



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Ms. Olson said that it is a challenge across all agencies. Nurses are strongly incentivized to keep calling the physician for their response with how the measure is currently written.

Ms. Kevech suggested adding another response to indicate that the agency reached out to the physician and received a response within the allotted timeframe. This was done prior to OASIS-C, but not currently.

Summary: Participants agreed that it is difficult to guarantee physician response in the currently allotted timeframe and that the measures P28- *Potential Medication Issues Identified and Timely Physician Contact at Start of Episode*, P29- *Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care* should be revised to either expand the timeframe within which physician response must be elicited or revise the responses in the OASIS items to indicate that the home health agency reached out to the physician and received their response within the allotted timeframe.



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Are there process measures that do not currently exist that would be useful?

- **Ms. Funk** said that a measure that ties an intervention to the process measure would be useful.
 - For example, if you find a patient with a high fall risk and therapy was not ordered at the SOC, put therapy in the plan of care.
- **Mr. Greene** said that his organization is interested in a caregiver assessment; unsure if it would be a process or outcome measure. Their research indicated that an increased number of nursing tasks are being passed on to the family caregiver in the home, especially for elderly relatives. The caregivers have indicated that they are not adequately trained. This could be an opportunity to educate caregivers so she/he can perform the best care.
 - **Ms. Huston** added that there is a hospice measure that does caregiver assessment.
 - **Dr. Greene** added that caregiver education and an assessment of caregiver capability of performing that care at home is critical. There is literature indicating that over time the caregiver's health declines and in that case the patient is hospitalized or institutionalized.
 - **Dr. Martin** added that knowledge, willingness, and ability are all important, especially for technology dependent care.
 - **Ms. Funk** agreed that a caregiver assessment is valuable. Reviewing the OASIS dataset to see what the patient can do safely with or without a caregiver would have to be clearly delineated.
 - **Dr. Martin** said that it is critical not to lose sight of a patient's abilities.
- **Ms. Huston** said that a measure related to respiratory conditions between COPD/ CHF and best practices would be valuable.
- **Ms. Kevech** said that a measure related to signs and symptoms related to cardiovascular health would be helpful. All the symptom questions and assessment are good; however, we do not yet identify barriers to care, which greatly affects patient outcomes.
 - **Ms. Kevech** said that they have trouble using OASIS data to determine dual eligibility and accurate assessment because when you look at the overall numbers, you can pull that from Medicare and Medicaid numbers; however, in a majority of cases, the clinicians only fill in what the payer is for that source. Hence, we are unable to use that as a data source; that question was previously embedded for all sources in the cardiovascular data registry.
- **Ms. Funk** recommended incorporating a measure or best practice method to maintain a dietary diary. The agency she is a part of implements this best practice at SOC visit and the first visit after the SOC when the nurse goes back; this has been extremely relevant for every major disease process. It is often times overlooked. There is a huge opportunity to educate patients on proper nutrition and when missed contributes to disease state process.



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- If it was a reportable process measure and interventions were implemented in plan of care it would be more valid and have higher performance rates.
- **Ms. Kevech** said that we ask about smoking already, but that should be expanded to include questions on other tobacco use in general, including chewing tobacco and electronic cigarettes that contain nicotine.
- **Ms. Olson** said that access to proper food sources is an important issue. She recommended that an item/ measure be introduced to gather that information since lack of access to a proper food source is often a barrier to care.

Ms. Fout asked if participants are thinking about new measures to examine those processes or are they intended to be guidelines to agencies.

- **Dr. Nuccio** said the cross setting measures in line with the IMPACT Act include dental health. Are dentures an issue? Is health literacy a barrier?
 - **Ms. Kevech** said that health literacy in patients who are 65 years and over is significant. There are scoring systems to determine if a patient is health literate- but that is time consuming. It is part of best practices to make sure they are health literate.
 - **Ms. Fenton** said that she does not see a lot of difference in agencies that do not use the scoring systems to estimate a patient's health literacy rate.
 - **Ms. Kevech** said that increased awareness and education is sufficient to address health literacy in lieu of a new measure.
- There is also issue of language barriers; are patients getting the education they need in the language they understand.
 - **Dr. Martin** conducted an environmental scan to evaluate health literacy and the results were not very robust. The measures do not clearly predict if patients can clearly comprehend the information they are provided.
 - Health literacy evaluation instruments are complicated, but it is not clear if they address what the critical cultural and language issues are.
 - **Ms. Funk** said that narrowing down the social determinants of health issues that could be barriers would be valuable information to possess.

[illegible]



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Participants were asked to review those that they found most useful first.

Ms. Huston said that O5- *Improvement in Toilet Transferring*, O7- *Improvement in Bed Transferring*, and O8- *Improvement in Ambulation/Locomotion* are the most important ones to their agency as it affects patient's ability to stay at home.

O9- *Improvement in Eating*, O10- *Improvement in Light Meal Preparation*, and O11- *Improvement in Phone Use* are not in use as much.

Ms. Petrella questioned if O12- *Improvement in Management of Oral Medications* would be useful for patients with short lengths of stay, especially for managed care patients. Are the agencies going to have an impact in improvement of that process?

Ms. Funk asked if there is any way within the dataset to identify the patients that are in an assisted living facility (ALF); they should be excluded from the measure because they are not expected to improve. Our improvement in management of oral medications has decreased since the demographic has changed from community based to ALF based. The agency did not do a worse job, only their population has changed. She recommended changing the denominator to exclude such patients.

Dr. Nuccio said that there is a care setting item in the OASIS that might be useful. Mr. Goldberg suggested that this may be a risk adjustment issue to resolve. **Dr. Nuccio** said there would have to be exclusions or team should consider creating two separate measures- one for the ALF population and another for the community based population.

Ms. Funk asked if the upper body dressing and lower body dressing measures should be combined.

Dr. Hittle said that addressing those two often requires different skills. Upper body dressing does not involve as much reaching, bending, and balancing as lower body dressing does. However, they are highly correlated.

A composite measure overall for dressing might work better.

Ms. Dale suggested adding new guidance that excludes physician ordered gradient compression for measure O3- *Improvement in Lower Body Dressing* since a majority of their patients know they need caregiver assistance to put them on.

O1- *Improvement in Grooming* is not very important.

O4- *Improvement in Bathing* is more important than O1. O4- *Improvement in Bathing* and O8 have many complicated questions, hence it is difficult to teach clinicians how to conduct the assessment and answer the questions accurately; many errors are identified in these items during chart reviews.



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Ms. Funk said that the responses could be more inclusive. There is a lot of difference between being able to pivot transfer or just to use a device to transfer; it goes from that to bed bound- there is not a lot of grading. Capturing that gradient, especially at SOC, and to be able to show that there was improvement is a missed opportunity. They may not ever be able to get up and pivot but we may have made an impact in that they can now safely use a transfer board. There is not enough in the responses to capture improvement.

One participant said that O6- *Improvement in Toileting Hygiene* is not particularly helpful.

Summary: In order of importance, participants agreed that O5- *Improvement in Toilet Transferring*, O7- *Improvement in Bed Transferring*, and O8- *Improvement in Ambulation/Locomotion* are the most important measures as they affect a patient's ability to stay at home. O2- *Improvement in Upper Body Dressing*, and O3- *Improvement in Lower Body Dressing* could be combined since they are highly correlated, even though they require different skill sets from the clinician. It was recommended to provide additional guidance to exclude physician order compression hose from the denominator of O3- *Improvement in Lower Body Dressing*. It is challenging for home health agency training leadership to teach clinicians how to accurately conduct the assessment and answer related questions for O4- *Improvement in Bathing* and O8- *Improvement in Ambulation/ Locomotion* since they have many complicated questions. O1- *Improvement in Grooming*, O6- *Improvement in Toileting Hygiene*, O9- *Improvement in Eating*, O10- *Improvement in Light Meal Preparation*, and O11- *Improvement in Phone Use* are least important since they are not used frequently. One participant questioned how much impact home health agencies can make for O12- *Improvement in Management of Oral Medications*, especially for patients who have shorter lengths of stay. Participants agreed that there should be a way to delineate those patients who transfer to (or are already in) Assisted Living Facilities (ALFs) rather than in the community since the home health agencies are penalized when patients in ALFs, who are not expected to improve, do not show improvement.

O23-30: Stabilization Functional

- O23 – Stabilization in Grooming
- O24 – Stabilization in Bathing
- O25 – Stabilization in Toilet Transferring
- O26 – Stabilization in Toileting Hygiene
- O27 – Stabilization in Bed Transferring
- O28 – Stabilization in Light Meal Preparation



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- O29 – Stabilization in Phone Use
- O30 – Stabilization in Management of Oral Medications

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| O23 | | | | Y | | | Y | | | Y | Y | | |
| O24 | | | | Y | | | Y | | | | Y | | |
| O25 | | | | Y | | Y | Y | | | Y | Y | | |
| O26 | | | | Y | | Y | Y | | | Y | Y | | |
| O27 | | | | Y | | Y | Y | | | | Y | | |
| O28 | | | | | | | Y | | | | Y | | |
| O29 | | | | Y | | | Y | | | | Y | | |
| O30 | | | | | | | Y | | | | Y | | |

Ms. Funk said to consider that based on her earlier point, you may not get that patient to stand and pivot, but when we first went in and they could not transfer with the transfer board but now showed improvement; that is an improvement and not a stabilization. Having graded responses would be helpful in determining if they really improved or just stabilized.

Some participants agreed that O28- *Stabilization in Light Meal Preparation* and O29- *Stabilization in Phone Use* are lower priority; **Ms. Huston** recommended that they should be combined.

Participants agreed to combine O23- *Stabilization in Grooming*, O24- *Stabilization in Bathing*, and O26- *Stabilization in Toileting Hygiene* as one and combine O25- *Stabilization in Toilet Transferring* and O27- *Stabilization in Bed Transferring* as another.

Ms. Dale said that the bathing and toileting can be home health aide/ occupational therapy and the transfer ones can be nursing or therapy etc. Then agencies can work on improving those with certain disciplines.

Regarding O30- *Stabilization in Management of Oral Medication*, one participant agreed with **Ms. Funk's** earlier point; looking at agencies that have a high Assisted Living Facilities (ALF) population, it is difficult to influence much; however, that population could be part of the stabilization denominator.

Ms. Funk said to have an “N/A” response in a particular question for patients whose medications are managed by the ALF.

Dr. Madigan recommended excluding assisted living facility population.



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Ms. Fenton said that adding an “N/A” option would help since their agency reaches out to some patients in ALF who self-administer and therefore the teaching and measurement is very appropriate. When we see that the patient receives or is administered by facility staff, then that would indicate that that is not an appropriate.

Dr. Madigan asked if the participants would recommend the same thing for improvement items i.e. keeping a composite of ones that are alike. One participant said yes.

Dr. Hittle asked if the low priority items should be eliminated since they do not need to be assessed.

Ms. Funk said that the items should be included in the comprehensive assessment, which may not be included in the measure, but is useful for best practice.

Ms. Kevech would not recommend removing too many of the items from the dataset at this point since there is new research out that ties ADL to acute care hospitalization population; we will probably see more statistics that may set us up for best practices.

Summary: Participants recommended to combine O23- *Stabilization in Grooming*, O24- *Stabilization in Bathing*, and O26- *Stabilization in Toileting Hygiene* as one and to combine O25- *Stabilization in Toilet Transferring* and O27- *Stabilization in Bed Transferring* as another; treatment of the composites can hence be discipline specific since those patients under O23, O24, and O26 can be addressed by home health aide/occupational therapy while those under the O25 and O27 measure composite can be addressed by nursing or therapy visits. One participant recommended adding an “N/A” response option under measure O30- *Stabilization in Management of Oral Medication* to address potential/expected lack of improvement for patients whose medications are managed by an ALF. Participants agreed that measures O28- *Stabilization in Light Meal Preparation* and O29- *Stabilization in Phone Use* are lower priority, and if possible should be combined. Incorporating graded responses would be helpful in determining if patients improved or stabilized. Participants recommended retaining these measures in the comprehensive assessment since they are valuable for best practices.

O13-22: Improvement – Clinical

- O13 – Improvement in Dyspnea
- O14 – Improvement in Pain Interfering with Activity
- O15 – Improvement in Speech and Language
- O16 – Improvement in Status of Surgical Wounds
- O17 – Improvement in Urinary Tract Infection



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- O18 – Improvement in Urinary Incontinence
- O19 – Improvement in Bowel Incontinence
- O20 – Improvement in Confusion Frequency
- O21 – Improvement in Anxiety Level
- O22 – Improvement in Behavior Problem Frequency

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
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| O13 | | ✓ | ✓ | | | | | | | | | | |
| O14 | ✓ | ✓ | ✓ | | | | | | | | | Y | |
| O15 | | | | | | | | | | Y | Y | Y | |
| O16 | ✓ | ✓ | | | | | | Y | | | | | |
| O17 | | | | | | | | Y | | | Y | | |
| O18 | | | | | | | | | | | | Y | |
| O19 | | | | | | | | Y | | Y | Y | Y | |
| O20 | | | | | | | | | | Y | Y | Y | |
| O21 | | | | | | | | | | | Y | Y | |
| O22 | | | | | | | | Y | | Y | Y | Y | |

Most participants said they do not find O15- *Improvement in Speech and Language* useful, although they acknowledged that if there were a speech therapist on the panel there might be a dissenting opinion. Its' importance depends on the population in question. One participant said that agencies do not generally use it to drive therapy referrals.

Participants agreed that O13- *Improvement in Dyspnea* and O14- *Improvement in Pain Interfering with Activity* are valuable.

Ms. Funk said that O16- *Improvement in Status of Surgical Wounds* is important; however, when you look at surgical wounds versus other types of chronic wounds, surgical wounds run their typical course and improve but stasis wounds and diabetic wounds are much more costly and there is a lot more variability on whether they will improve based directly on the interventions. Consider revising this to including other wounds besides surgical wounds.

Ms. Dale said that this really reflects an agency physician's interaction on proper wound care. This indicator reflects a lot about the agency.

Ms. Fenton raised the point that home health agencies have restrictions set by the payer.



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Ms. Funk says that there is an opportunity to clarify that and see where correlation and causation is. We have regional payers that will give us three visits for a brand new stroke or three visits for someone who has been in the hospital for two months for non-healing stasis ulcers. Where can we capture that causation and correlation between payer and outcomes?

Ms. Huston said that there are limitations with managed care. Sometimes we discharge patients early due to the limitations with managed care.

Ms. Kevech suggested looking at statistics for readmissions for patients with surgical wounds. Looking across settings, we know that knee and hip issues will continue to increase in our populations and we are trying to align with the work that hospitals are doing.

O18- Improvement in Urinary Incontinence: **Ms. Funk** said that patients with urinary incontinence pose a huge barrier to their care and hence their outcome; there is very little opportunity for improvement in incontinence. There are such small fractions of interventions that can be put in place that would improve their clinical functioning in their continence. There is more of a decline than improvement often times.

O17- Improvement in Urinary Tract Infection is useful; **Ms. Dale** asked if it can be tied to indwelling catheter since that would drastically decrease number of infections. **Ms. Funk** agreed.

Ms. Huston said that when they look at potentially avoidable events such as UTIs, was able to find discrepancies when they look at OASIS with this one as clinicians were answering it wrong.

Ms. Fenton said that the fine balance between catching and diagnosing UTIs before sepsis is an issue versus that of over diagnosis and use of broad spectrum medications.

Dr. Martin agreed that it is confusing for the nurse to get difference between colonization and real infection.

Participants said that *O19- Improvement in Bowel Incontinence* is a useful measure.

Ms. Dale said that there would be some people who have a sheet that has things that helps them predict skin breakdown and that is one of the questions.

Regarding *O20- Improvement in Confusion Frequency*, *O21-Improvement in Anxiety Level*, and *O22-Improvement in Behavior Problem Frequency*:

Ms. Kevech said to look at increase in Dementia and Alzheimer's patients; it they are appropriate for home care skills needed at that point. Think about that population as it grows.



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Ms. Funk said there is a problem at their agency with accuracy on all three of those measures because they get stuck on behavior problem, which are highly subjective.

Ms. Funk said that there are many patients in memory care units and hence not much potential for improvement. **Ms. Funk** cautions not to take it away because confusion may not be related to the dementia necessarily.

Ms. Kevech said we can have an impact by offering more mental health programs. These are three broad and would be difficult to use these to derive what the real problems are.

Ms. Fenton said that this is where your caregiver must be taught and be involved. Their frustration levels are often impacting the outcome. It's a huge repercussion on the patient.

Summary: In order of importance, participants agreed that measures O13- *Improvement in Dyspnea* and O14- *Improvement in Pain Interfering with Activity* are valuable. Measure O16- *Improvement in Status of Surgical Wounds* is important; however, it must be expanded to include stasis wounds as well. Measure O17- *Improvement in Urinary Tract Infection* is useful, and can be improved if tied to indwelling catheters since that might drastically reduce instances of urinary tract infections. Measure O19- *Improvement in Bowel Incontinence* is valuable; O18- *Improvement in Urinary Incontinence* and O19 should not be combined as caregiver tolerance differs between the two. A few participants said that measures O20- *Improvement in Confusion Frequency*, O21- *Improvement in Anxiety Level*, and O22- *Improvement in Behavior Problem Frequency* should not be removed, even though they do not show much improvement, since they could indicate mental and behavioral issues such as Dementia, and Alzheimer's. Measure O15- *Improvement in Speech and Language* is not valuable. An analysis on payer restrictions could reveal causation between payers and outcomes.

O31-33: Stabilization – Clinical

- O31 – Stabilization in Speech and Language
- O32 – Stabilization in Cognitive Functioning
- O33 – Stabilization in Anxiety Level

| | Variability | | | | | | | Reportability | Reliability | Validity | | | |
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| O31 | | | | | | | Y | | | Y | Y | | |
| O32 | | | | | | | Y | | | | Y | | |
| O33 | | | | | | | Y | | | | Y | | |



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Ms. Funk said that there could be accuracy concerns with these as well. It is important, however, to be able to capture that stabilization, which may have occurred by the caregiver education; increased guidance may help resolve this.

O31- some participants claimed that this is not as useful.

Summary: Participants cited accuracy concerns with these measures, which can be improved by increased guidance/training. Measure O31- *Stabilization in Speech and Language* is not useful.

O34-40: Utilization

- O34 – Acute Care Hospitalization (OASIS-based)*
- O35 – Emergency Department Use with Hospitalization (OASIS-based)*
- O36 – Discharged to Community (OASIS-based)
- O37 – Acute Care Hospitalization (Claims-based)
- O38 – Rehospitalization During the First 30 Days of Home Health (Claims-based)
- O39 – Emergency Department Use without Hospitalization (Claims-based)
- O40 – Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (Claims-based)

| | | | | Variability | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
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| O34 | | | | | | | | | | | Y | | |
| O35 | | | | | | | | | | | Y | | |
| O36 | | | | | | | | | | Y | Y | Y | |
| O37 | ✓ | ✓ | ✓ | | | | Y | | | Y | Y | | |
| O38 | ✓ | ✓ | | | | | Y | Y | | | | | |
| O39 | ✓ | ✓ | | | | | Y | | | | | | |
| O40 | ✓ | ✓ | | | | | Y | Y | | | | | |

We have two kinds of utilization measures: OASIS based and claims based measure. Since the OASIS based measures are self-reported, there is potential for inaccuracies in reporting. Are the OASIS based measures still useful to have?



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Some participants agreed that they do not pay attention to O35- *Emergency Department Use with Hospitalization*.

Ms. Olson said that she was thrilled when she first heard that system is moving to claims based measures since we do find errors in the TIFs (transfer to inpatient facility) being done.

Many participants agreed that O34- *Acute Care Hospitalization* should be deleted.

Ms. Olson said that accuracy issues regarding O36- *Discharged to Community* can be solved with increased education.

Dr. Nuccio said that there is an ongoing effort right now to create claims based Discharge to Community measure.

Mr. Heeter said to think about the claims based measures as O37-*Acute Care Hospitalization* and O39-*Emergency Department Use without Hospitalization*.

O38- *Rehospitalization During the First 30 Days of Home Health* and O40- *Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health* are grouped together; those are rehospitalization measures and require an index acute care hospitalization stay within 30 days of start of home health care.

Ms. Olson said that these groupings are useful from an agency perspective, but it is challenging to explain that to short term acute care hospitals that might confuse them for a 30 day readmission penalty.

Dr. Hittle said that those patients with managed care are not included in this measure.

Ms. Funk said perhaps managed care patients should be included.

Summary: Participants recommended claims- based measures since they are more objective. Accuracy issues regarding O36- *Discharged to Community* may be solved with increased education. Measure O35- *Emergency Department Use with Hospitalization* is a low priority measure according to participants. Measure O34- *Acute Care Hospitalization* should be deleted.

O41-44: Potentially Avoidable Events (Emergent Care)

- O41 – Emergent Care for Injury Caused by Fall
- O42 – Emergent Care for Wound Infections, Deteriorating Wound Status
- O43 – Emergent Care for Improper Medication Administration, Medication Side Effects



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- O44 – Emergent Care for Hypo/Hyperglycemia

| | | | | Variability* | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| O41 | | | | Y | | Y | Y | | | Y | Y | | |
| O42 | | | | Y | | Y | Y | | | Y | Y | | |
| O43 | | | | Y | Y | Y | Y | | | Y | Y | | |
| O44 | | | | Y | Y | Y | Y | | | Y | Y | | |

Ms. Fenton said that the M2310 on the transfer says to “mark all that apply” and so when I try to do some analysis for reason for rehospitalization, those numbers never jive because multiple responses have been marked.

Ms. Funk agreed that claims- based measures would definitely clear up a lot of accuracy problems. The diagnosis for rehospitalization would clearly indicate rather than what is in our notes/ discharge summary.

Ms. Kevech said that 50% of patients have “other” or “unknown” marked and hence its value is unknown unless you break that down. It would be valuable if it was claims based.

Team will have to investigate if this can be made claims based.

This one can be difficult to track since there are multiple issues. They are admitted for symptoms and clinicians are picking what the hospitals will get paid on which causes inconsistencies.

Ms. Huston said that from her experience auditing this information, she does not find this measure to be helpful.

Dr. Martin added that the problem with having these as claims based measures is that frequently diagnosis codes are looked at and so you can imagine a situation where a person has improperly taken their medication and they fainted and fell and were hypoglycemic got there- but the ER doctor’s code will be “unresponsive” since they will get paid more for that workup. Hence ER claims may not have that level of detail.

Ms. Funk said that it would be interesting to see what happens with ICD-10 because they will be forced to have more accuracy in the coding. There would be more opportunities for claims based after October.

Mr. Heeter said that with the Discharge to Community measure and the Potentially Preventable Readmission measures, team is looking into more condition specific items. The numbers are very low for individual conditions, which makes reporting at an agency level difficult.



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Summary: Participants recommended revising the *Emergent Care Potentially Avoidable Events* measures O41-*Emergent Care for Injury Caused by Fall*, O42-*Emergent Care for Wound Infections, Deteriorating Wound Status*, O43-*Emergent Care for Improper Medication Administration, Medication Side Effects*, and O44-*Emergent Care for Hypo/Hyperglycemia* to claims based; recommended OASIS QMs team to conduct feasibility analysis after ICD-10 is introduced since coding will be more accurate.

O45-48: Potentially Avoidable Events (Substantial Decline)

- O45 – Development of Urinary Tract Infection
- O46 – Increase in Number of Pressure Ulcers
- O47 – Substantial Decline in 3 or more Activities of Daily Living
- O48 – Substantial Decline in Management of Oral Medications

| | | | | Variability* | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| O45 | | | | Y | | Y | Y | | | | Y | | |
| O46 | | | | Y | Y | Y | Y | | | | | | |
| O47 | | | | Y | Y | Y | Y | | | Y | | | |
| O48 | | | | Y | Y | Y | Y | | | | Y | | |

Ms. Funk said that they look at them, but if the instance is low and statistically insignificant, then there is potential to eliminate this one.

Ms. Funk said to retain measure O47- *Substantial Decline in 3 or more Activities of Daily Living* because those patients would not be discharged to community, but instead will be discharged to a different level of care.

Ms. Olson said that regarding O45 is that if urinary tract infection is catheter associated? Catheter associated infection should be captured. She recommended retaining and revising this measure to include information about catheter use.

Ms. Dale questioned why agencies would discharge to community unless they are in managed care, are in hospice, or changed their insurance.

Ms. Funk said that it is important to capture information regarding where the patients are discharged to; that might be useful for agencies to identify what did we not have control over. Our agency is largely



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inner city versus our sister agency that is rural; perhaps we cannot find these people since they move around a lot so we must try to identify the underlying cause.

Dr. Martin added that if a patient has Depression, there might be many reasons why they might decline in ADLs so you would check with your staff to see why more patients are getting discharged and identify a trend in the data. Participants agreed that these are rare measures but important

Summary: Participants recommended retaining all the measures since they might help identify underlying trends and causes for patient conditions.

O49-52: Potentially Avoidable Events (Discharged with Risk)

- O49 – Discharged to the Community Needing Wound Care or Medication Assistance
- O50 – Discharged to the Community Needing Toileting Assistance
- O51 – Discharged to the Community with Behavioral Problems
- O52 – Discharged to the Community with an Unhealed Stage II Pressure Ulcer

| | | | | Variability* | | | | Reportability | Reliability | Validity | | | |
|-----|--------|--------|---------|--------------|-----------------------|------------|-------------------|----------------------|-----------------|-----------------------------------|-------------------------------|--------------------|----------|
| | 1. NQF | 2. HHC | 3. Star | 4. High Rate | 5. High Perfect Score | 6. Low IQR | 7. Few Low Scores | 8. Low HHA Reporting | 9. Large Swings | 10. Low or No Scientific Evidence | 11. Expert Say Drop or Change | 12. High State IQR | 13. Gaps |
| O49 | | | | Y | Y | Y | Y | | | Y | Y | | |
| O50 | | | | Y | Y | Y | Y | | | Y | Y | | |
| O51 | | | | Y | Y | Y | Y | | | Y | Y | | |
| O52 | | | | Y | Y | Y | Y | | | Y | Y | | |

Ms. Funk said that at discharge, the M2420 does not accurately capture informal assisted services by the caregiver in the community; hence a revision to include such services would be valuable.

Ms. Fenton agrees with **Ms. Funk** in that it must be revised to identify an informal caregiver that has been taught since it could be appropriate at that point and there is no place to break that out.

Ms. Funk said that in their agency if they discharge due to insurance, most of the time they readmit and just change the payer source. So, they are discharging but with formal assistance.

There is concern that when people are identifying the payer, they are identifying the primary payer and not all the possible payers; dual eligibles would hence not be captured.



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Dr. Fout clarified that for the purpose of this analysis, dual eligibility information is from CMS' Enrollment Database, which is presumably more accurate than the check boxes from the OASIS payer question.

They are rare events but important nonetheless.

Ms. Dale said that she does the record reviews; it is time consuming but she finds issues and about 50% of theirs are for some other reason such as patients going from Medicare to some other company and so they had to discharge him with a pressure ulcer. They went to the hospital for wound infection or something else but the hospital wrote down that he had pressure ulcer. She likes the potentially preventable events; even though they are rare events they are important.

Summary: Participants recommended expanding the response options to include "discharged to community with informal assisted services" to capture caregivers in the community. Measures O49- *Discharged to the Community Needing Wound Care or Medication Assistance*, O50-*Discharged to the Community Needing Toileting Assistance*, O51- *Discharged to the Community with Behavioral Problems*, and O52 – *Discharged to the Community with an Unhealed Stage II Pressure Ulcer* are rare but important to measure.



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Are there other outcomes we should be considering that we are not?

- **Dr. Madigan** asked if it would be useful to have an outcome measure for referrals to hospice, especially in light of palliative care expansion on the provider and home care side due to which transfers to hospice may increase.
 - **Ms. Funk** said that it could be claims based measure; currently if the patient says they are going to hospice but determine in the last minute they do not want to take the benefit, we are capturing it inappropriately based on claims.
 - **Ms. Kevech** said that it might be interesting to look at that from a regional basis; regions in the south are not prone to moving to hospice, which may help create best practices and strategies for home health agencies. Ethnicity differences can also be a factor.
 - **Dr. Madigan** asked others to consider a time period for such a measure: admitting to hospice within 90 days?
 - **Ms. Funk** said that 30 days is reasonable.
- **Dr. Nuccio** said that one of the issues we have talked about is regarding patient and caregiver involvement and the patient's ability to self-manage. Is there a way to measure self-care management in a way that is not onerous?
 - Possibly create an Uber composite of all items that they were independent on and rate the agency on what the maximum discharge ability of a patient might be.
 - Potentially create a composite score across all the functional and improvement items as a numeric value and compare that with their numeric value at the beginning; this would measure any improvement patient's made in being independent.
 - **Ms. Funk** said that assigning weighted numbers to each of the outcome measures would help.
 - **Ms. Fenton** stressed the importance of symptom management and added that if that can aid in self-management.
 - **Dr. Ellen** said that it would be interesting to compare a patient's perception of improvement in self-management versus analytics that shows their ability to self-manage.
 - **Ms. Kevech** added that QIN QIOs can now apply for a certain amount of PAMS (Patient Activation Measured) assessments, which are usually very expensive; this might help agencies gather patient assessment data.
- **Ms. Kevech** said that an outcome measure to align the shingles vaccination would be relevant. It is part of the comprehensive assessment at home health agencies and is included in the best practices package, but could benefit from increased focus.
 - A participant clarified that shingles vaccination is part of the pay for performance.



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Prediction models and risk adjustment

Dr. Nuccio provided some background information on the risk adjusted prediction models. He used five criteria to evaluate information on the spreadsheets that follow.

Terminology:

Step 1- Prediction Model is created using

- a. Multiple risk factors that are items and elements from dataset (around 500 potential that can be used for outcome measures)
- b. Statistical and clinical evaluation

Step 2- Risk adjustment

- a. Application of information from prediction model (for each episode we create a predicted value)
- Risk adjustment value (R_a) for publicly-reported measures is based on the agency's observed score plus the difference between the national predicted and the agency predicted score.
 - Prediction models were based on 2010 data. The difference between observed and predicted values has increased over time.
 - One of the first criteria is how national versus predicted value has changed over time. If it has diverged too much, that implies predictive model must be revised since they are no longer predictive.
 - The C-statistic is a number that goes between zero to one. It reveals how well the prediction is. Look for C-statistic values that are higher than 0.5.
 - C-statistic values greater than 0.7 indicates a strong prediction model and are in the high category; C-statistic values between 0.65 and 0.7 are in the moderate range; anything less than 0.65 is low. Prediction models in home health are stronger than any other healthcare provider type's.

Other criteria are sensitivity and specificity:

Sensitivity: % of 'true' positives

Specificity: % of 'true' negatives



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Prediction Models and Risk Adjustment

- To allow for valid comparison, outcome measures are risk adjusted to account for an agency's case mix.
- Prediction models were developed for each outcome measure to "predict" measure values conditional on patient characteristics from the OASIS (OASIS-based measures) or claims (claims-based measures).
- The HHA's observed and predicted values, as well as the national predicted value, for each measure are combined to create the HHA's risk-adjusted (publicly reported) value.
- Question: Do the prediction models need to be revised?

Prediction Model Evaluation Criteria

| Criteria | Performance Standards |
|--|---|
| The national predicted and observed values diverge: | <ul style="list-style-type: none">• Substantially ($\geq 3\%$)• Moderately (1.5% to $<3\%$)• Not meaningfully ($<1.5\%$) |
| The strength of the relationship between the predicted and observed values is: (based on the C-statistic) | <ul style="list-style-type: none">• Strong (≥ 0.700)• Moderate (≥ 0.650 & < 0.700)• Low (<0.650) |
| The predictive power of the prediction model worsens over time (CY11 to CY13): (based on the C-statistic over time) | <ul style="list-style-type: none">• Yes• Yes, but not substantially• No meaningful difference |
| The sensitivity of the prediction model indicates that the model is: | <ul style="list-style-type: none">• Useful ($\geq 75\%$)• Somewhat useful ($\geq 66.67\%$ & $< 75\%$)• Marginally useful ($<66.67\%$) |
| The specificity of the prediction model indicate that the model is: | <ul style="list-style-type: none">• Useful ($\geq 66.67\%$)• Somewhat useful ($\geq 55\%$ but $< 66.67\%$)• Marginally useful ($< 55\%$) |



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Summary of HHC and Functional Prediction Models:

| Metric | Predicted/Observed Divergence | c-Statistic Value | c-Statistic Trend | Sensitivity | Specificity |
|--|-------------------------------|-------------------|-------------------|-------------|-------------|
| O8. Imprv. Ambulation | Not meaningfully | Strong | No | Useful | Somewhat |
| O4. Imprv. Bathing | Not meaningfully | Strong | No | Useful | Marginal |
| O7. Imprv. Bed Transferring | Not meaningfully | Strong | No | Somewhat | Somewhat |
| O13. Imprv. Dyspnea | Not meaningfully | Moderate | No | Useful | Marginal |
| O14. Imprv. Pain Interfering with Activity | Not meaningfully | Low | No | Useful | Marginal |
| O12. Imprv. Medication Management | Not meaningfully | Strong | No | Somewhat | Useful |
| O16. Imprv. Status Surgical Wounds | Not meaningfully | Low | Not substantial | Useful | Marginal |
| | | | | | |
| O1. Imprv. Grooming | Not meaningfully | Strong | No | Useful | Marginal |
| O2. Imprv. Upper Body Dressing | Not meaningfully | Strong | No | Useful | Marginal |
| O3. Imprv. Lower Body Dressing | Not meaningfully | Strong | No | Useful | Marginal |
| O5. Imprv. Toileting Transfer | Not meaningfully | Strong | No | Useful | Marginal |
| O5. Imprv. Toileting Hygiene | Not meaningfully | Strong | No | Useful | Marginal |
| O9. Imprv. Eating | Moderate | Strong | No | Useful | Somewhat |
| O10. Imprv. Light Meal Prep | Not meaningfully | Strong | No | Useful | Somewhat |
| O11. Imprv. Phone Use | Not meaningfully | Moderate | No | Somewhat | Somewhat |

Summary of Selected Other OASIS Prediction Models

| Metric | Predicted/Observed Divergence | c-Statistic Value | c-Statistic Trend | Sensitivity | Specificity |
|---|-------------------------------|-------------------|-------------------|-------------|-------------|
| O15. Imprv. Speech & Language | Not meaningfully | Moderate | No | Marginal | Useful |
| O20. Imprv. Confusion Frequency | Not meaningfully | Moderate | No | Marginal | Useful |
| O21. Imprv. Anxiety Level | Not meaningfully | Low | No | Somewhat | Marginal |
| O22. Imprv. Behavior Problem Frequency | Moderate | Low | No | Useful | Marginal |
| O17. Imprv. Urinary Tract Infection | Substantially | Moderate | No | Useful | Marginal |
| O18. Imprv. Urinary Incontinence | Not meaningfully | Low | No | Marginal | Useful |
| O19. Imprv. Bowel Incontinence | Not meaningfully | Moderate | No | Useful | Marginal |
| | | | | | |
| O24. Stabiliz. Bathing | Not meaningfully | Strong | No | Useful | Marginal |
| O28. Stabiliz. Light Meal Prep | Not meaningfully | Strong | No | Useful | Marginal |
| O31. Stabiliz. Speech & Language | Not meaningfully | Strong | No | Useful | Marginal |
| O32. Stabiliz. Cognitive Functioning | Not meaningfully | Strong | No | Useful | Marginal |
| | | | | | |
| O41. PAE: Emergent Care for Injury Caused by Fall | Not meaningfully | Moderate | No | Useful | Marginal |
| O47. PAE: Substantial Decline in 3+ ADLs | Not meaningfully | Moderate | Not substantial | Marginal | Useful |



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Analyses are based on data from 2011, 2012, and 2013. The measures are organized based on improvement items on Home Health Compare. The next group is functional improvement measures (O1-O11).

Improvement model for bathing is in one model while the stabilization bathing is in a different model; there are different predictors because they have different outcomes.

Dr. Madigan explained that the TEP member's task is to identify based on these findings, which models should be analyzed further and which ones do not need any changes.

Dr. Nuccio added that if we create a new outcome measure then we will create a new model.

Group #1:

| |
|---|
| O8. Improvement in Ambulation |
| O4. Improvement in Bathing |
| O7. Improvement in Bed Transferring |
| O13. Improvement in Dyspnea |
| O14. Improvement in Pain Interfering with Activity |
| O12. Improvement in Medication Management |
| O16. Improvement in Status Surgical Wounds |

- The difference between observed and predicted values nationally in 2011 was 0.004, which means that the difference between our observed national value and predicted national value was about 5/10ths of 1%. In 2012; the difference was about 9/10th of 1%. In 2013 the difference is slightly more than 1%.
- In our criteria we said that if the difference between the observed and the predicted was less than 1.5% over the three year period then it would not be meaningful. If it is between 1.5%- 3% then we can say it is a moderate amount of change. If it changed by more than 3% a year between what we observed and predicted then it has substantially changed.
- Next category is the c-statistic value; from 2011- 2013, the c-statistic values are 0.76, 0.769 and 0.773 respectively. They each met criteria to be over 0.7; they also improved over time. Hence we rated it as strong.
- Last two criteria are sensitivity and specificity. From 2011 to 2013, the sensitivity values are 74.7, 77.6, and 80.1%. The percentage of true positives that we currently identified increased and is above our criteria for 75%. Hence it is rated as useful.



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- Specificity percentages were 62%, 60%, and 57.1%; it falls within our criteria since it is between 55% and 66%. Hence it is somewhat useful.
- On this model we are able to better identify who improved but not those who did not improve.
- O8- *Improvement in Ambulation* and O4- *Improvement in Bathing* are acceptable.
- O7- *Improvement in Bed Transferring* is mostly acceptable although the sensitivity is not useful; this measure may need further analysis.
- O13- *Improvement in Dyspnea* has a moderate c-statistic and may need some changes.
- O14- *Improvement in Pain Interfering with Activity* is of most concern because c-statistic is low; this measure may need further analysis. Participants agreed.
- O12- *Improvement in Medication Management* is reasonable.
- There was discussion previously of broadening the measure O16- *Improvement in Status of Surgical Wounds*; but if we keep the current measure, it has a low c-statistic and trends to go down. Need to look at that one.

Summary: Participants said that the publically reported measures are acceptable, with room to improve O7- *Improvement in Bed Transferring*, O13- *Improvement in Dyspnea*, and O16- *Improvement in Status of Surgical Wounds*.

Group #2:

| |
|---|
| O1. Improvement in Grooming |
| O2. Improvement in Upper Body Dressing |
| O3. Improvement in Lower Body Dressing |
| O5. Improvement in Toileting Transfer |
| O5. Improvement in Toileting Hygiene |
| O9. Improvement in Eating |
| O10. Improvement in Light Meal Prep |
| O11. Improvement in Phone Use |

Dr. Nuccio said that if the quality measure is retired, the prediction model will be retired (not be revised).

There was not much support for measure O11- *Improvement in Phone Use*; team will consider removing it.

Participants recommended retaining the item associated with measures O15- *Improvement in Speech and Language* but not report it as an outcome.



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The c-statistic is moderate and sensitivity is marginal at 49.6% for measure O20- *Improvement in Confusion Frequency*.

Measure O21- *Improvement in Anxiety Level* has an even lower c-statistic value than O20.

Summary: This model needs some additional improvements including removal of measure O11- *Improvement in Phone Use*.

Group #3:

| |
|--|
| O15. Improvement in Speech & Language |
| O20. Improvement in Confusion Frequency |
| O21. Improvement in Anxiety Level |
| O22. Improvement in Behavior Problem Frequency |
| O17. Improvement in Urinary Tract Infection |
| O18. Improvement in Urinary Incontinence |
| O19. Improvement in Bowel Incontinence |

There is substantial diversion for measure O17- *Improvement in Urinary Tract Infections*; in 2011, 2012, and 2013, the difference between observed and predicted was 3%. **Dr. Madigan** suggested that further analysis should be conducted on this measure. **Dr. Nuccio** said this might be a candidate for modification.

O18- *Improvement in Urinary Incontinence* and O19- *Improvement in Bowel Incontinence* need to be reviewed again.

Summary: Participants agreed that measures in this model are difficult to predict.

Group #4:

| |
|---|
| O24. Stabilization in Bathing |
| O28. Stabilization in Light Meal Prep |
| O31. Stabilization in Speech & Language |
| O32. Stabilization in Cognitive Functioning |



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Summary: Participants agreed that the measures in this model are reasonable, even though the specificity is not optimal.

Group #5:

| |
|--|
| O41. PAE: Emergent Care for Injury Caused by Fall |
|--|

| |
|---|
| O47. PAE: Substantial Decline in 3+ ADLs |
|---|

Summary: Participants agreed that measures O41-PAE: *Emergent Care for Injury Caused by Fall* and O47- PAE: *Substantial Decline in 3+ ADLs* need further analysis. These are rare events.



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Summary of Claims-Based Prediction Models

Background

- Based on Part A and Part B claims data
(Medicare Fee-for-Service only)

Keep in mind we are looking at home health claims and Medicare claims. Models were recalibrated almost annually. These measures are paired together in that they are mutually exclusive, hence we use a multinomial logistic regression model, which means that the same potential risk factors can affect both outcomes. Likelihood of an outcome measures adds to a 100%.

Measures

- Measure 37 (NQF #0171)
 - Acute Care Hospitalization (ACH) During the First 60 Days of Home Health
- Measure 34 (NQF #0173)
 - Emergency Department (ED) Use without Hospitalization During the First 60 Days of Home Health
- Measure 38 (NQF #2380)
 - Rehospitalization During the First 30 Days of Home Health
- Measure 39 (NQF #2505)
 - Emergency Department (ED) Use without Hospital Readmission During the First 30 Days of Home Health

Risk Factors

- Prior Care Received
- Demographics
- Pre-existing Health Conditions
- Enrollment Status

Model Performance

- The models were rigorously tested and performed well on both the development data and validation samples
 - Measure Rate Distributions
 - Provider Movement
 - Predictive Power

C-statistic all would fall in moderate relationship. After we risk adjust- difference between 90th and 10th percentile has reduced for all four measures, which indicates that after adjusting for patient case mix, agencies will perform similarly.

Ms. Fenton said that regarding the 5 day window, any patient leaving short term acute care and go into skilled nursing care are automatically excluded. Mr. Heeter confirmed that is true. The thought process



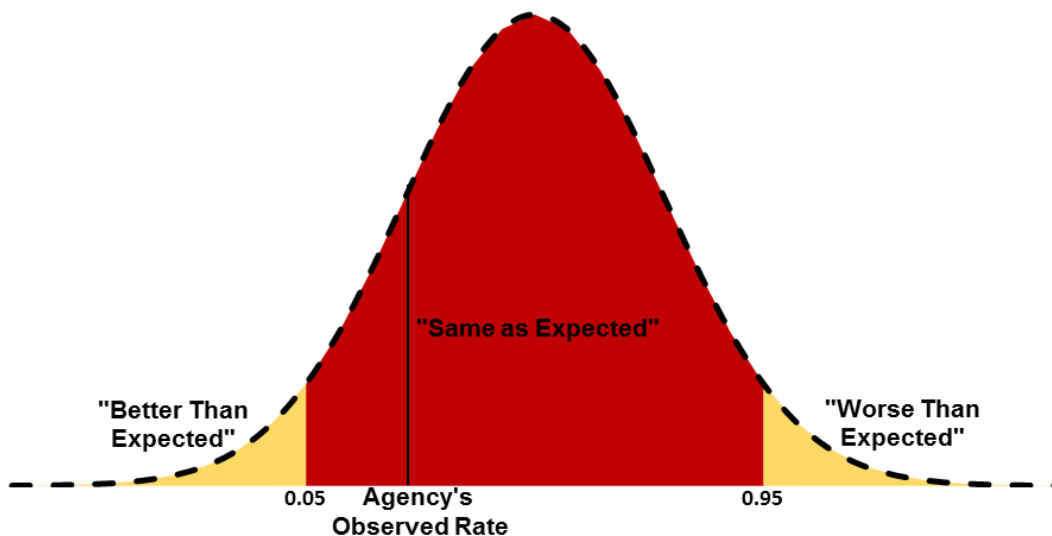
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is to capture those who come directly to home health; we run into issues intervening care. Generally when patients have acute care hospitalization, they come into home health almost right away.

- Publicly Reported on Home Health Compare
- Rehospitalization and ED Use without Readmission
- Categorization Method
 - “Better than Expected,” “Same as Expected,” or “Worse than Expected”

Distribution of Agency's Predicted Values



These measures are reported on Home Health Compare which uses three years of data. Rather than reporting a specific rate for each agency- we report into a category; the categories are “better than expected”, “same as expected”, and “worse than expected”. Almost all agencies fall under “same as expected” those that are exceptional will be better than expected.

Ms. Funk recommended adding a hyperlink to the data behind the category the agencies fall under.

Dr. Hittle said that Hospital Compare shows where the point estimate is.

Dr. Nuccio asked if it possible to break out the information per year for agencies that have more than 110,000 episodes in a year. Maybe make it available in CASPER reports for agencies who have episodes more than 500 a year or so- a cutoff must be determined.

Ms. Funk said that could be part of the inclusion or exclusions in search criteria.

Mr. Heeter said that risk adjustments are done to make demographics of variable sizes measurable.



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Ms. Fenton said that it would be useful to outline a frame of reference for providers to better understand since claims- based grouping is new.

Mr. Heeter said that the cut offs are based off of agency's case mix weights and are different for each agency.



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NQF sociodemographic variables

Background

- NQF Directive based on 10 TEP recommendations including:

“When there is a conceptual relationship (i.e., logical rationale or theory) between sociodemographic factors and outcomes or processes of care and empirical evidence (e.g., statistical analysis) that sociodemographic factors affect an outcome or process of care reflected in a performance measure:

- those sociodemographic factors should be included in risk adjustment of the performance score (using accepted guidelines for selecting risk factors) unless there are conceptual reasons or empirical evidence indicating that adjustment is unnecessary or inappropriate;

AND

- the performance measure specifications must also include specifications for stratification of a clinically-adjusted version of the measure based on the sociodemographic factors used in risk adjustment.”

Claims-based utilization measures are part of NQF Transition activity

- Proposed sociodemographic variables include:
 - Age, gender, race/ethnicity, Medicaid status
 - Rurality & neighborhood characteristics (incl. income, employment rate, crime rate)

What other sociodemographic variables might be useful and readily available for inclusion in the prediction model?

- **Dr. Madigan** said that it would be interesting to know how many local short term care hospitals are near patients in rural areas.
- Number of Primary Care Physicians available
- Availability of therapists
 - **Ms. Funk** noted that when she practiced in rural Missouri she had to learn how to cardiac rehabilitation.
- Availability of social workers
- Marital status or whether there is a caregiver
- Neighborhood density (neighborhoods with high rises versus rural areas that have great distance between home health agencies and patients)
- Neighborhood density combined with zip code is important to distinguish density due to high rise buildings (high income living) versus due to low income families since that has an impact on the number of visits



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- Number of home health agencies available
- **Dr. Martin** asked if there is anything in the claims data for qualified Medicare beneficiaries who are getting their Medicaid premiums paid because they do not qualify for Medicaid but are very close to the qualification. **Dr. Hittle** said that information is in the enrollment database rather than in the claims database (spend-down Medicaid?).
- A lot of senior housing is over 30 years old and hence there is less opportunities to stay in affordable housing.
- Language from the census bureau
- Address changes
 - **Dr. Martin** said that in Texas there are many cases of people who move around a lot due to unstable housing
- Transportation including in urban areas, especially food desserts
- Education levels
- Number of beds in Assisted Living Facilities
- Population of private duty agencies available
- Availability of community based long term care services; some of them are based on block grants and others are based in municipal/ state
- Distribution of veterans
 - There is a disproportionate number of veterans living in rural areas, which is a barrier
 - Availability of VA services
- Access to urgent care and primary care physicians in urban areas
 - Availability of specialists in such areas
- Infant mortality rate is an indicator as it tells you something about the neighborhood
- Health literacy rates
- Disability rates
- Mental health providers
- Drug/ substance treatment
- Houses of worship; churches represent stability in some neighborhoods
 - Could increase access to caregivers
 - Churches often distribute food through food pantries and provide transportation to those who need it
- Availability of hospice centers
- Birth rate
- Race/ ethnicity mix and cultural diversity first generation versus later generations
- Generational mobility: transplanted couples with no family; such families have a good income but feel isolated due to the move and need help associated with mental health



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Falls Risk Composite (Process Measure)

- Currently, three separate measures related to falls:
 - P6: Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate
 - P7: Falls Prevention Steps in Plan of Care
 - P8: Falls Prevention Steps Implemented for All Episodes of Care
- Falls Risk Composite proposal:
 - Denominator: all episodes
 - Numerator: number of episodes where the risk assessment is conducted; if risk is indicated, then prevention steps in plan of care AND prevention steps implemented
 - Exclude patients who are chairfast or bedfast (M1860 = 4, 5, 6)

Falls Risk Composite Components

| Ambulation/Locomotion (M1860) | CY2011 | CY2012 | CY2013 |
|--------------------------------|--------|--------|--------|
| Can ambulate (0, 1, 2, 3) | 88.7% | 88.4% | 88.3% |
| Chairfast or bedfast (4, 5, 6) | 11.3% | 11.6% | 11.7% |

| Multi-factor Risk Assessment Conducted (M1910)? | CY2011 | CY2012 | CY2013 |
|--|--------|--------|--------|
| 0. No | 4.3% | 4.0% | 2.5% |
| 1. Yes, and it does <u>not</u> indicate a risk for falls | 16.1% | 14.1% | 11.8% |
| 2. Yes, and it does indicate a risk for falls | 79.7% | 81.9% | 85.7% |

| Falls Prevention Steps | CY2011 | CY2012 | CY2013 |
|--|--------|--------|--------|
| Yes, falls prevention steps in plan of care (M2250) | 89.3% | 91.0% | 92.8% |
| Yes, falls prevention steps implemented for all episodes of care (M2400) | 89.4% | 91.2% | 92.7% |

Falls Risk Composite Results



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| Falls Composite | CY2011 | CY2012 | CY2013 |
|--|-----------|-----------|-----------|
| Falls risk assessed for patients who can ambulate; if risk indicated, prevention steps included in care plan and implemented | 90.0% | 91.3% | 93.4 |
| Number of Episodes | 5,246,782 | 5,134,570 | 5,229,363 |
| Percent of all Episodes | 88.4% | 88.1% | 88.0% |

- Pros: can continue to motivate/incentivize good practices with one measure compared to three separate measures.
- Cons: the composite also exhibits low variability, though it is not as topped out as the individual measures.

Discussion:

- **Ms. Funk** asked if these three measures can be tied together with an outcome measure.
- **Ms. Fenton** asked if the type of assessment is still up to the agency; **Dr. Madigan** confirmed.
- **Ms. Olson** supported the decision to combine.
- **Dr. Nuccio** said that the ambulation piece might be interesting to measure.
- **Ms. Galantowicz** asked it is important for agencies to know which of the three components caused the failure since if we replace existing measure with the combined the agency would lose the individual measure reporting on CASPER.
 - **Dr. Martin** said that it would be important to know which individual component the team failed on.
 - **Dr. Nuccio** suggested that the composite gets publically reported but the CASPER contains all three at an individual level. All agreed.
- Is there a way to tie this measure to the cost; it would be beneficial for agencies to know if they are saving Medicare any money.
- **Ms. Kevech** said that it would be interesting to see data on patients who fell, had an outcome and went the hospital; where did they end up after the hospital episode?
- **Ms. Funk** said that it would be valuable to have a question on discharge as: Did they sustain a fall during an episode of care? Whether they got emergent care or not?
- A clearer definition of injuries would be useful to have.



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Improvement in Dyspnea with Selected Medical Conditions (Outcome Measure)

- Current Improvement in Dyspnea (O-13) is calculated for all patients who are short of breath (M1400) regardless of diagnosis codes
- NQF review committee suggested adjusting measure to apply only to patients with conditions related to breathing
- Explored calculating the Improvement in Dyspnea measure for only those patients with diagnosis codes for:
 - Congestive Heart Failure (CHF)
 - Chronic Obstructive Pulmonary Disorder (COPD)
 - Asthma
- Explored using the OASIS primary diagnosis field (M1020) and any diagnosis field (M1020, M1022, M1024)

Improvement in Dyspnea with Selected Medical Conditions, Episodes Included in Measure

| Eligible Population is Patients with: | Three Year Weighted Average | | |
|--|-----------------------------|--------------------------|-----------------------------|
| | % All Episodes | % Episodes w/ Dyspnea QM | % all Episodes w/ Condition |
| Primary diagnosis of CHF, COPD, Asthma | 6.2% | 3.1% | 50.8% |
| Any diagnosis of CHF, COPD, Asthma | 18.3% | 9.2% | 50.1% |
| All diagnosis (current measure) | 100.0% | 47.8% | 47.8% |

- Substantial decline in the number of patients measured (47.8% to 3.1% using primary diagnosis)
- Small improvement in patients measured as a percent of eligible population (47.8% to 50.8% using primary diagnosis)



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Improvement in Dyspnea with Selected Medical Conditions, Measure Scores

| Condition Subgroups | <u>Three Year Weighted Average Improvement in Dyspnea = Yes</u> |
|---|---|
| All episodes current measure (O-13) | 63.5% |
| Episodes with primary diagnosis of CHF, COPD, Asthma | 61.8% |
| Episodes with any diagnosis of CHF, COPD, Asthma | 61.2% |
| Episodes where primary diagnosis is not CHF, COPD, Asthma | 63.7% |
| Episodes where no diagnosis include CHF, COPD, Asthma | 64.1% |

- Improvement rate is not significantly better for those with just the diagnosis versus without diagnosis.
- By restricting the measure to only those patients with either a primary diagnosis of CHF/ COPD, or asthma, number of patients who can be included in the measure is heavily reduced, which will result in a problem with report ability.
 - There is no tangible difference with conducting this measure with the subgroup when compared with conducting it for everyone.
 - **Dr. Madigan** said that the etiology of dyspnea is not important for this measure; not necessarily worth it to look at a specific diagnosis.
- **Dr. Martin** asked if the group included lung and bronchial cancers in this. **Dr. Nuccio** said that he did not.
- All participants agreed to leave the measure as is.



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IMPACT Act of 2014

Tara McMullen, is the measures technical lead for the Division of Chronic and Post-Acute Care. Her comments are below:

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014:

- Bi-partisan bill introduced in March, U.S. House & Senate, passed on September 18, 2014, and signed into law by President Obama October 6, 2014.
- The Act requires the submission of standardized data by:
 - Long-Term Care Hospitals (LTCHs): LCDS
 - Skilled Nursing Facilities (SNFs): MDS
 - Home Health Agencies (HHAs): OASIS
 - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

Post-Acute Care Requirements

Requires PAC providers to report standardize assessment data:

- **Assessment Instrument Domains:**
 - Functional status, cognitive function and mental status;
 - Special services, treatments, and interventions;
 - Medical conditions and co-morbidities;
 - Impairments; and
 - Other categories.
- **Quality Measure Domains:**
 - Functional status, cognitive function, and changes in function and cognitive function;
 - Skin integrity and changes in skin integrity;
 - Medication reconciliation;
 - Incidence of major falls;
 - Transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings.

The measure domains provided in the Act are not exhaustive

- **Must submit data for measures: Resource use, and other measures to include:**
 - Total estimated Medicare spending per beneficiary;
 - Discharge to the community;
 - All condition risk adjusted potentially presentable hospital readmission rates.
- **Development of the Skilled Nursing Facility Quality Reporting Program (SNF QRP):**
 - Amends section 1888(e) of the SSA;
 - Reduction in Update for Failure to Report;



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- Failure to submit the data as required results in a penalty of 2% of the annual payment update (APU).
- **Measure Implementation is phased:**
 - QM Reporting begins 10/1/16 for SNFs, IRFs, and LTCHs, and 1/1/17-1/1/19 for HHAs.
 - QMs will first be specified/implemented via rulemaking, collected, providers must receive private feedback reports, and followed by public reporting of performance.

Includes the pre-rulemaking process: Measures Application Partnership (MAP)

Additional Requirements under the IMPACT Act of 2014

- **Discharge Planning:**
 - Applicable to PAC providers, hospitals, and critical access hospitals to assist providers and patients/families with the discharge planning process.
 - To aid in discharge planning, requires providers to take into account quality, resource use, and other measures; and include procedures to address patient preferences and goals of care.
- **Studies Include:**
 - **Medicare Payment Advisory Commission (MedPAC)**
 - PAC payment systems or a unified PAC payment system based on patient characteristics rather than the PAC setting.
 - **Studies of Alternative PAC Payment Models & PAC Payment Recommendations**
 - The Secretary must submit a report to Congress
 - **Study using existing Medicare Data:**
 - The Secretary, through the Assistant Secretary for Planning and Evaluation, must examine the effect of individuals' socioeconomic status on all measure types
 - **Study using other data:**
 - The Secretary must examine the impact of risk factors, race, health literacy, limited English proficiency, and Medicare beneficiary activation, on all measure types.
 - **Assistant Secretary for Planning and Evaluation (ASPE)**
 - Study and report to Congress on the effect of individuals' socioeconomic status on all measure types and for improving PAC and other Medicare payment systems
- **Hospice Services:**
 - Establishes several hospice requirements including: all certified hospices be subject to standard survey at least once every 36 months; medical review in certain instances where care exceeds 180 days; and a cap on payment updates.



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Why IMPACT? Why now?

- The lack of comparable information across PAC settings undermines the ability to evaluate appropriate care settings for patients/residents/individual- to differentiate between the settings.
- Standardized PAC assessment data will allow for continued beneficiary access to the most appropriate setting of care.
- Standardized PAC assessment data allows CMS to compare quality across PAC settings (longitudinal data).
- Standardized PAC assessment data allows CMS to improve hospital and PAC discharge planning.
- Standardized PAC assessment data will allow for PAC payment reform (site neutral or bundled payments).

One participant asked if items will be added to the existing tool to address changes due to standardization efforts.

Tara said that there would be changes made to assessment tools across the PAC settings; however, these additional items will undergo field testing before they are added to the tools. For example, with the functional outcome measure, we are adopting new items which come from the CARE Tool. Field testing of the items could result in removal of some items, addition of new items, or addition of entire new sections of the assessment instrument. All of these changes would be supplemented with appropriate training and manuals.

One participant added that given the recent history, major changes in legislation, and also in care delivery, that there will be increased training at the onset to ensure smoother transitions to the changes.

Tara said that the lesson learned from previous implementations is to provide increased trainings at the frontline of the changes.

One participant asked what checks are in place to monitor data.

Tara said that the IMPACT Act allowed CMS to initiate contracts that include increased monitoring and evaluation of data. We can now extensively validate our data sources. As made apparent by the latest home health rules, we are moving into matching claims and assessment data, within which validation is embedded. The standardization as a result of the IMPACT Act allowed CMS to validate the appropriateness and accuracy of past, present, and future data. We are going to rollout efforts to train providers and increase monitoring activities, which will help from a data standpoint.



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Ms. Dale asked how data might be accurately transferred across PAC settings during transfers.

Tara said that the CARE tool is currently being updated to capture time points for when an individual transitions from one PAC setting to the next. Contractors are attempting to understand how to make appropriate assessments so the information does follow through during transitions from one setting of care to the next. The *Transfer of Health Information* measure, which is expected to be standardized by Calendar Year 2019 will help tremendously with the transfer of patient information.

One participant observed that it is not always appropriate to group home care with other PAC settings. There are barriers at home that are not taken into account in other settings; for instance a functional status item may indicate that the patient can walk 200 feet with mild assistance but we fail to realize that is in a very controlled environment in settings other than home health, since homes may have stairs, which makes it challenging for the patient to move with “mild assistance”. Another participant pointed out that there are difficulties receiving discharge information at transfer, which causes issues as well since the clinician is often starting fresh with the patient.

Tara recognized this disconnect between home care and other PAC settings is a major hurdle to standardization and that they will have to find a way to resolve it in the future.

What would be good measures to standardize?

- Medication Reconciliation would be a good measure to standardize since variables are more controllable. One participant asked to clarify “high risk medications”.
- Coordination challenges among different physicians across PAC settings are important to keep in mind; broadening the provider spectrum to nurse practitioners and non-physician practitioners would be beneficial.
 - Tara asked if it would help to include coding from the assessment by nurse practitioners as guidance for function measure. One participant agreed that would be beneficial.
- Tara asked how relevant it would be to introduce new items into the OASIS dataset that assesses falls with no injury, minor injury, and major injury.
 - Participants said that definitions for major and minor injuries must be clarified. Reporting is a major barrier for falls.



Home Health Quality Reporting Panel Technical Expert Panel Virtual Follow-up

Virtual Technical Expert Panel Meeting Notes

October 2, 2015 10:30 a.m.

Virtual Technical Expert Panel members:

Ellen Martin, RN, PhD(c), CHPCA, CPHQ

Director of Clinical Practice & Regulatory Affairs
Texas Association for Home Care & Hospice

Misty Kevech, RN, MS

RN Project Coordinator
WVMI /Quality Insights

Judy Fenton, RN

Vice President Clinical Practice & Quality
Kindred at Home

Barbara Dale, RN CWOCN CHHN

Director of Wound Care
Quality Home Health

Michelle Funk, RN, COS-C

Regional Director of Nursing/ Director of Program Quality and Compliance
Aging Well Healthcare

Frances Petrella, RN

Senior Director, Quality
Community Health Accreditation Partner (CHAP)

Ann Olson, RN

Principal and Vice President
Qualidigm

OASIS QMs Team:

- **Abt Associates:** Betty Fout, Sara Galantowicz, Anisha Illa, Nicole Keane, Alrick Edwards, Jennifer Riggs, Donna Hurd, Roopa Akkineni, Tokunbo Oluwole
- **Lantana:** Robin Williams, Zabrina Gonzaga
- **Atlas:** Jason Ormsby
- **Acumen:** Wes Heeter
- **OASIS Answers:** Marian Essey, Linda Krulish
- **University of Colorado Denver:** David Hittle, Gene Nuccio

Federal observers: Theresa White, Stacey Cole



Home Health Quality Reporting Panel Technical Expert Panel Virtual Follow-up Virtual Technical Expert Panel Meeting Notes

October 2, 2015 10:30 a.m.

Introduction

The Centers for Medicare & Medicaid Services (CMS) contracted with Abt Associates to develop and maintain quality measures for the Home Health Quality Reporting Program (HHQRP). The contract name is Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002). The purpose of this project is to maintain, evaluate and modify as needed the current HHQRP measure set, which includes measures based on the HH Item Set (OASIS) and claims. CMS also plans to implement additional measures of home health quality addressing gaps in measurement that have been identified by stakeholders.

As part of its measure development process, CMS asked contractors to convene groups of stakeholders and subject matter experts who contribute direction and thoughtful input to the measure contractor during measure development and maintenance. TEP members were asked to review analytics on the current HHQRP outcome, process, and potentially avoidable event measures and evaluate recommendations to modify the measure set. Following that meeting, under the guidance of CMS, the TEP members met again in a virtual meeting to finalize their recommendations.

The follow-up webinar provided TEP members the opportunity to review the input sheet results and re-visit decisions as a group. We also obtained additional information on suggested measure revisions and reasons for retirement. Key points or themes included:

- Recommendations made during the follow-up webinar generally reflected the TEP input sheets. We made an effort to obtain consensus on measures that had mixed recommendations from the TEP input sheets, but tied measures did indeed reflect varied opinions.
- The TEP emphasized the importance of maintaining the ability to view individual measures, even if they recommended a composite of those measures.
- For some measures, TEP members suggested additions to the guidance or clarifications of the wording of an item. In some instances, this information was already present in the manual, suggesting the need for greater education on manual use and content.



Home Health Quality Reporting Panel Technical Expert Panel Virtual Follow-up

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HH Quality Reporting Program Measures

- There are 29 process measures
 - Used to evaluate the rate of home health agency use of specific evidence-based processes of care. They focus on high-risk, high-volume, problem-prone areas for home health care.
 - Most process measures first reported to agencies in 2010.
- There are 52 outcome measures
 - Used to assess the “outputs” of care by examining health status changes as a result of care. They are risk adjusted to account for changes due to the natural progression of disease and disability to allow for valid comparison.
 - Most outcome measures first reported to agencies in 1999/2000.

Review of Process Measure Recommendations

| Depression Process Measures 3- 5: |
|---|
| 3. Depression Assessment Conducted |
| 4. Depression Interventions in Plan of Care |
| 5. Depression Interventions Implemented during All Episodes of Care |

Ms. Kevech recommended keeping Process Measure 3: Depression Assessment Conducted as is; it could be revised to be part of a composite measure.

Dr. Fout reminded the workgroup that removing the individual measures to create a composite could prevent agencies from seeing data from individual measures in CASPER reports.

Most workgroup members agreed that from a performance improvement perspective, it is invaluable to see the data from individual measures.

Process Measure 9: Pain Assessment Conducted

During the on-site Technical Expert Panel, workgroup members recommended the use of a validated pain assessment tool in place of the 1-10 pain scale. **Ms. Krulish** clarified that the process measure 9 only suggests the use of a standardized pain assessment, allowing agencies to select a validated standardized pain assessment tool of their choice.



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At least five participants agreed that outcome measure 14: Improvement in Pain Interfering with Activity is more important than the process measures that give insight into whether the assessment was done.

Ms. Fenton recommended retiring all three process measures related to pain assessment (P9-11).

Ms. Funk and **Ms. Huston** requested that the measure contain recommended standardized pain assessment tools (such as the Edmonton and Brief Pain Inventory).

| Pressure Ulcer Process Measures: P12-26 |
|---|
| 12. Pressure Ulcer Risk Assessment Conducted |
| 13. Pressure Ulcer Prevention in Plan of Care |
| 14. Pressure Ulcer Prevention Implemented during All Episodes of Care |
| 15. Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care |
| 16. Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented during All Episodes of Care |

Ms. Dale recommended that the pressure ulcer process measures are important to keep as is along with the current guidance. **Ms. Fenton** and **Ms. Petrella** agreed that the process measures could be revised to include all wounds, but should remain in the measure set.

| Diabetes Process Measures: P17-18 |
|--|
| 17. Diabetic Foot Care and Patient Education in Plan of Care |
| 18. Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care |

A workgroup member recommended creating a composite of the diabetes process measures.

One participant suggested adding guidance on what “diabetic foot care” includes. **Ms. Fenton** agreed with the approach of creating a composite with additional guidance.

Process Measure 19: Heart Failure Process Measure

The current guidance indicates that the purpose of the health failure measure is to report when a home health agency has taken action for a patient diagnosed with heart failure in response to a symptom they have had.



Home Health Quality Reporting Panel Technical Expert Panel Virtual Follow-up

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Ms. Fenton said that the measure should expand regardless of a formal diagnosis of heart failure. The item should be broadened to read “heart failure symptoms assessed” and not “heart failure symptom addressed”.

Ms. Funk recommended removing the requirement that patient has to have a diagnosis of heart failure in order to encourage heart failure symptom assessment.

Ms. Dale agreed and recommended rewording guidance for this measure to “heart failure with or without diagnosis”.

Ms. Funk and **Ms. Martin** agreed that such a revision could lead to best practices as it encourages heart failure assessments and could improve patient care and outcomes.

Ms. Krulish said that in that case, to include symptoms of heart failure in the measure, including weight gain, edema, dyspnea, etc. should we then ask, “did the home health agency take action after the patient gained weight, had dyspnea etc.”? Would that lead to best practices as described by workgroup members?

Ms. Fenton said that a holistic assessment including a combination of symptoms would be helpful to make a case for early interventions. **Ms. Olson** said that a single symptom would not necessarily be sufficient to make a case for early intervention with the physician.

Ms. Kevech said that adding another response that shows that patient has exhibited symptoms would be helpful.

| Drug Education Process Measures: P20-21 |
|---|
| 20. Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode |
| 21. Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care |

The workgroup members previously recommended that drug education to patients should be allowed up to three to seven plus days after start of care (SOC) starts since patient may be overwhelmed with all the information/ education that are made available to them. **Ms. Krulish** clarified that an agency currently has up to five days after the SOC visit to complete the SOC assessment, and thus they can provide the drug education to patients within those 5 days.

Ms. Funk and **Ms. Fenton** said that their EMRs do not allow them to schedule follow-up visits until the SOC is locked down. They suggested that the item wording is revised to make the explicit the additional time available for providing drug education.



Home Health Quality Reporting Panel Technical Expert Panel Virtual Follow-up

Virtual Technical Expert Panel Meeting Notes

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A workgroup member asked how the pneumococcal vaccination measure retirement is impacted if it is in line to be part of the value based purchasing?

Ms. Galantowicz said that the group's recommendation will be put together in a consensus document that will be presented to CMS; however, the ultimate decision regarding measure revision and retirement and their interaction with other programs will be made later.

Summary of Process Measure changes resulting from Virtual TEP:

Table 1 summarizes the recommendations for process measure from the TEP input sheets and after clarifications from the follow-up webinar. Overall, the final recommendations for process measures consisted of 5 measures kept, as is, 17 measures to be revised and 7 measures to be retired. Specific recommendation changes/updates resulting from the follow-up webinar are described below and shown in the appendix.

Table 1. Process Measures: Summary of TEP Member Recommendations, Input Sheets and Post Follow-Up Results

| Recommendation | TEP Input Sheets | Post Follow-Up |
|-------------------------------|------------------|----------------|
| Keep, as is | 7 | 5 |
| Revise | 14 | 17 |
| Retire | 6 | 7 |
| Tie: keep as is/revise | 1 | - |
| Tie: Revise/retire | 1 | - |
| Tie: keep as is/revise/retire | 0 | - |
| Total | 29 | 29 |

From *Keep, as is* to *Revise*:

- P15. Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care
- P16. Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented during All Episodes of Care

TEP members felt these measures were important, but wanted them to be expanded to apply to all wounds, not just pressure ulcers. Some TEP members suggested making a composite of these two measures.

From *Tie* to *Revise*:

- P18. Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care



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The TEP input sheets had indicated a tie between *keep, as is* and *revise* for this measure. During the follow-up TEP, members confirmed suggestions to combine this measure with P17 (Diabetic Foot Care and Patient Education in Plan of Care) into one composite. The TEP stated that these measures are important though emphasized the importance of an outcome measure. They also suggested including guidance in the manual on diabetic foot care best practices.

From *Tie* to *Retire*:

- P9. Pain Assessment Conducted

From the input sheets, this measure was tied (4 revise, 4 retire). Discussion from the August 21, 2015 TEP demonstrated some confusion on this item- TEP members expressed concern with the pain assessment tool they believed was specified on the OASIS. During the follow-up webinar, our team clarified that the OASIS item only requires that the patient be assessed using “a standardized pain assessment tool (appropriate to the patient’s ability to communicate the severity of pain).” TEP members suggested that the guidance could be updated to include the Edmonton and Brief Pain Inventory as examples of standardized pain assessments. However, members also reemphasized the recommendation to retire this measure. The other pain process measures, P10.Pain Interventions In Plan of Care and P11.Pain Interventions Implemented during All Episodes of Care were already recommended to be retired.

Review of Outcome Measure Recommendations

Outcome Measure 3: Improvement in Lower Body dressing

Ms. Dale, Ms. Funk and Ms. Kevech noted that over 80% of the patients cannot get the compression hose on by themselves and hence there is no way for an agency to improve that measure. However, there are not many issues with using prosthetics; hence prosthetics can remain in the improvement measure.

Ms. Krulish said that overall guidance in the measure currently is that if the patient can don a majority of the lower body items, then the patient would be considered independent. Ms. Fenton said that it would be problematic if the compression hose is the only piece of equipment that the physician orders for the patient.

Ms. Olson asked to emphasize the wording “majority” this in the guidance.



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Outcome Measure 12: Improvement in Management of Oral Medications

Workgroup members previously discussed either excluding Assisted Living Facility (ALF) population or differentiating the measure based on whether they were in an ALF since self-medication management is not common in ALFs. **Dr. Fout** asked do the members have further recommendations?

Ms. Kevech said that most of the patients in ALF are long term patients and clinicians find little value in assessing this piece since it is more impactful to spend resources educating these patients on falls or other high priority issues. This is especially the case of the facility does not allow them to self-medicate.

Ms. Funk added that if the clinician cannot assess the patient's capability for self-medication, then the clinician should answer negative on the OASIS tool rather than make an educated guess. However, if the patient will return home and manage their medication, then there would be a significant change in assessment.

Dr. Nuccio added that the measure currently includes language describing "congregate living situations", which includes ALFs. Does the workgroup recommend calling out the ALFs further?

Ms. Fenton recommended the following response option: a patient resides in an ALF where medications are handled. **Ms. Kevech** supported **Ms. Fenton's** recommendation since some ALFs allow self-medication.

Outcome Measure 26: Stabilization in Toileting Hygiene

The workgroup is interested in combining stabilization measures for outcome measure 25: Stabilization in Toilet Transferring and 27: Stabilization in Bed Transferring; and separately combining outcome measures 23: Stabilization in Grooming, 24: Stabilization in Bathing, and 26: Stabilization in Toileting Hygiene.

Outcome Measures 18 and 19: Incontinence

18. Improvement in Urinary Incontinence

19. Improvement in Bowel Incontinence

Ms. Dale said that there are ways to improve urinary and bowel incontinence, and hence recommended retaining them, though she recommended revising O18 to be tied to the presence of an indwelling catheter.



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| Outcome Measures 20-22: Mental Status |
|---|
| 20. Improvement in Confusion Frequency |
| 21. Improvement in Anxiety Level |
| 22. Improvement in Behavior Problem Frequency |

Ms. Funk added that stabilization is more practical for outcome measures 20, 21, and 22 than improvement. Hence, she recommended adding stabilization measures for confusion frequency, anxiety level, and behavior problem frequency. **Ms. Fenton** agreed and added that improvement in these patients is very difficult. Stabilization is possible through increased education to family members etc.

Ms. Martin added that confusion frequency is extremely variable. Confusion may be because of pulmonary anoxia, but there is also confusion triggered by dementia or basic understanding of their drug regimen. The dementia cases are very different since many are not adhering to their medications.

Typical agencies have such a wide variety of populations, and this may not be valuable to most agencies.

| Outcome Measure 36: Discharged to Community (OASIS-based) |
|--|
|--|

There is ongoing work to create a claims based version of this measure, and TEP members felt the claims version of this measure should replace this measure.

Summary of Outcome Measure changes resulting from Virtual TEP:

Table 2 summarizes the recommendations for outcome measures. The final recommendations for outcome measures consisted of 14 measures to be kept, 24 measures to be revised and 14 measures to be retired. Specific recommendation changes/updates resulting from the follow-up webinar are described below.

**Table 2. Outcome Measures: Summary of TEP Member
Recommendations, Input Sheets and Post Follow-Up Results**

| Recommendation | TEP Input Sheets | Post Follow-Up |
|-------------------------------|------------------|----------------|
| Keep, as is | 13 | 14 |
| Revise | 21 | 24 |
| Retire | 13 | 14 |
| Tie: keep as is/revise | 2 | - |
| Tie: Revise/retire | 2 | - |
| Tie: keep as is/revise/retire | 1 | - |
| Total | 52 | 52 |



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From *Tie to Keep, As Is*:

- O19. Improvement in Bowel Incontinence

From the TEP input sheets, this measure was tied for keep as is/revise/retire. TEP opinion on the usefulness of this measure was varied, but some TEP members at the follow-up webinar indicated the desire to keep this measure. We changed the final recommendation to *keep, as is*, but note that this was a difficult measure to assess, and there was variation in opinions.

From *Tie to Revise*:

- O26. Stabilization in Toileting Hygiene
- O18. Improvement in Urinary Incontinence
- O45. Development of Urinary Tract Infection

Recommendations for these 3 measures from the TEP input sheets were mixed. O26. Stabilization in Toileting Hygiene was tied for revise and retire, but during the follow-up webinar, some members expressed interest in combining O26 into a composite with O23 Stabilization in Grooming and O24 Stabilization in Bathing. TEP members reemphasized recommendations regarding measures O18 Improvement in Urinary Incontinence and O45 Development of Urinary Tract Infection to tie to the use of an indwelling catheter.

From *Tie to Retire*:

- O36. Discharged to Community (OASIS-based)

TEP members stated that O36 should be retired because a claims-based measure would be preferred.

Appendix Tables A and B provides the detailed measure level information on TEP member recommendations. Measures indicated for retirement are listed here:

Process Measures

P2. Physician Notification Guidelines Established
P9. Pain Assessment Conducted
P10. Pain Interventions In Plan of Care
P11. Pain Interventions Implemented during All Episodes of Care
P25. Pneumococcal Polysaccharide Vaccine Ever Received
P26. Pneumococcal Polysaccharide Vaccine Offered and Refused
P27. Pneumococcal Polysaccharide Vaccine Contraindicated

Outcome Measures

O1. Improvement in Grooming
O6. Improvement in Toileting Hygiene
O9. Improvement in Eating
O10. Improvement in Light Meal Preparation
O11. Improvement in Phone Use
O15. Improvement in Speech and Language
O28. Stabilization in Light Meal Preparation
O29. Stabilization in Phone Use
O31. Stabilization in Speech and Language
O32. Stabilization in Cognitive Functioning
O33. Stabilization in Anxiety Level
O34. Acute Care Hospitalization (OASIS based)



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O35. Emergency Department Use with Hospitalization (OASIS-Based)
O36. Discharged to Community (OASIS-based)

Table 3 shows the potential composition of a new HH measure set based on TEP recommendations. Five process measures and 14 outcome measures would remain unchanged. Five process measure composites and 4 outcome measure composites would replace individual measures (assuming that the component measures do not remain as official HH QMs in the measure set). The remaining 4 process measures and 14 outcome measures would be potentially revised. This would result in a measure set consisting of 14 process measures and 32 outcome measures, or 46 total measures (35 fewer than the current 81 measures).

Table 3. Potential New Home Health Measure Set Based Off Recommendations Updated

| | Process Measures | Outcome Measures |
|---------------------------------------|------------------|------------------|
| Unchanged measures | 5 | 14 |
| New composite measures* | 5 | 4 |
| Potentially revised (not a composite) | 4 | 14 |
| Total number of measures | 14 | 32 |

*Assuming that the component measures of a composite would not be counted as an official home health quality measure.

Next Steps

We will need to categorize and further examine recommended revisions to determine which measure could be readily revised (e.g., composites of existing measures) and which would require longer term consideration (e.g., OASIS item-level changes). In addition, we recommend consideration and mapping of all measures proposed for revision or retirement to use in other initiatives, including star ratings, PPS and home health value-based purchasing. Further discussion regarding whether component measures of potential composites would remain in the measure set is needed. The new list of HH QMs (comprised of existing measures kept as is, revised measures, and new measures currently not supported by the OASIS instrument or claims data) will need to be reviewed from a clinical and quality performance perspective as well as assessed for any obvious gaps in QM coverage. We recommend that revised and retired measures would be listed in the 2016-2017 Home Health rule-making to obtain broader community input.

We note that a significant challenge in this process is to review recommendations that are self-contradictory, e.g., measures are not important but assessment is. CMS has taken the position that the purpose of having a mandated assessment is for quality measurement (including risk adjustment) and payment adjustment. Unless CMS has adopted a policy of including items in the post-acute care



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assessment that are useful for care planning but will not be used for risk-adjusted quality measurement or payment determination, TEP recommendations to include such items would be contrary to CMS policy. Looking down the road, it would also be useful to convene a TEP to review the more extensive revisions to OASIS planned in response to IMPACT Act mandates, in conjunction with reliability and validity testing. This may be a topic for the 2017 TEP, which will be after field testing of the OASIS is mostly completed.



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Appendix A. Summary of Recommended Changes for Process Measures

| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|--|--|---|
| Timely Care and Care Coordination | | | | |
| 2. Physician Notification Guidelines Established | Retire | | <ul style="list-style-type: none">• Measure is not useful• Difficult to operationalize because it is difficult to reach physicians on weekends/evenings. | |
| Depression | | | | |
| 3. Depression Assessment Conducted | Revise | <ul style="list-style-type: none">• Composite (assess, plan of care, implement) | <ul style="list-style-type: none">• Individual measures are topped out | <ul style="list-style-type: none">• TEP emphasized the need to keep the individual measures for their own quality improvement, though they would not need to be publically reported |
| 4. Depression Interventions in Plan of Care | Revise | | | |
| 5. Depression Interventions Implemented during All Episodes of Care | Revise | | | |
| Falls | | | | |
| 6. Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate | Revise | <ul style="list-style-type: none">• Composite (assess, plan of care, implement) | <ul style="list-style-type: none">• Individual measures are topped out• Recommendation to see Minnesota Validated Risk Assessment | |
| 7. Falls Prevention Steps in Plan of Care | Revise | | | |
| 8. Falls Prevention Steps Implemented for All Episodes of Care | Revise | | | |
| Pain | | | | |
| 9. Pain Assessment Conducted | Retire** | <ul style="list-style-type: none">• Expand list of examples of standardized pain assessment tools in Ch 3 to include Edmonton and Brief Pain Inventory | <ul style="list-style-type: none">• All 3 are topped out• Outcome measure for pain is more useful than a process measure.• Pain interventions in the plan of care are not always implemented and may be too generic (and not affect the patients' pain). | <ul style="list-style-type: none">• TEP recommended retirement. But, if measure were kept, suggested adding guidance on which pain assessments to use to the manual. |
| 10. Pain Interventions In Plan of Care | Retire | | | |
| 11. Pain Interventions Implemented during All Episodes of Care | Retire | | | |
| Pressure Ulcer | | | | |



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| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|---|---|--|
| 12. Pressure Ulcer Risk Assessment Conducted | Revise | • Composite (assess, plan of care, implement) | • Measures are topped out, but prevention is better and more cost effective than treatment (so useful to keep measures in some way). | |
| 13. Pressure Ulcer Prevention in Plan of Care | Revise | | | |
| 14. Pressure Ulcer Prevention Implemented during All Episodes of Care | Revise | | | |
| 15. Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care | Revise** | • Possible composite • Expand measure to include "all wounds" | • Pressure ulcers affect a small percentage of the HH patient population - expand to include all wounds | • TEP reiterated recommendation to exapnd measure to include all wounds. |
| 16. Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented during All Episodes of Care | Revise** | | | |
| Diabetes | | | | |
| 17. Diabetic Foot Care and Patient Education in Plan of Care | Revise | • Composite (plan of care, implement) | • Topped out, but the measures remain important as diabetic incidence grows. • An associated outcome measure would make these measures more useful/valuable. | • TEP felt that an outcome measure would be more important, but these process measures do help drill down for quality improvement. |
| 18. Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care | Revise** | | | • Recommendation to add guidance on resources for best practices in diabetic foot care |
| Heart Failure | | | | |
| 19. Heart Failure Symptoms Addressed during All Episodes of Care | Revise | • Recommend revising item, guidance and measure to include actions taken in response to one or more symptoms that the clinician feels are indicative of heart failure, with or without a formal HF diagnosis. | • Nurse may find discern failure symptoms during a home visit, even though its not an official diagnosis. | |
| Drug Education | | | | |



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| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|--|---|--|
| 20. Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode | Revise | <ul style="list-style-type: none">• Suggested item wording changed to explicitly allow 5 days from SOC for the drug education• Provide list of applicable high risk medications | <ul style="list-style-type: none">• Patients may not retain all information from SOC, but high risk drug education is critical. Although the rules state that the SOC can be completed within 5 days, HHAs appear to believe that the drug education must all occur during the first visit. | <ul style="list-style-type: none">•Evaluation Team clarified that the agencies have up to 5 days after the SOC to complete it, so drug education does not have to be done the same day as the SOC visit. TEP members stated that their EMR does not allow them to schedule follow up visits without have a completed SOC assessment, forcing them to complete the drug education in one visit. |
| Pneumococcal Polysaccharide | | | | |
| 25. Pneumococcal Polysaccharide Vaccine Ever Received | Retire | | <ul style="list-style-type: none">• Measure requires historical information that patients may not accurately remember• CDC guidelines on this vaccine have changed | <ul style="list-style-type: none">•Suggestion to update measure with new CDC guidelines |
| 26. Pneumococcal Polysaccharide Vaccine Offered and Refused | Retire | | | |
| 27. Pneumococcal Polysaccharide Vaccine Contraindicated | Retire | | | |
| Potential Medication Issues | | | | |
| 28. Potential Medication Issues Identified and Timely Physician Contact at Start of Episode | Revise | <ul style="list-style-type: none">• Allow for more time for physician contact or• Add response that indicates attempt to contact physician | <ul style="list-style-type: none">• Agency cannot control if the physician responds within a calendar day | |
| 29. Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care | Revise | <ul style="list-style-type: none">• Allow for more time for physician contact or• Add response that indicates attempt to contact physician | <ul style="list-style-type: none">• Agency cannot control if the physician responds within a calendar day | |



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Appendix B. Summary of Recommended Changes for Outcome Measures

| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|--|---|---|
| Improvement - Functional | | | | |
| 1. Improvement in Grooming | Retire | | • Not helpful | |
| 2. Improvement in Upper Body Dressing | Revise | • Composite (upper and lower body dressing) • Exclude TED hose as an included lower body dressing task | • Skills for each are different but correlated • Most patients need assistance with compression hose; limited potential to achieve improvement | • Emphasize/Educate re: "majority of the tasks" guidance |
| 3. Improvement in Lower Body Dressing | Revise | | | |
| 6. Improvement in Toileting Hygiene | Retire | | • Not helpful | |
| 9. Improvement in Eating | Retire | | • Not used frequently | |
| 10. Improvement in Light Meal Preparation | Retire | | • Not used frequently | |
| 11. Improvement in Phone Use | Retire | | • Not used frequently | |
| 12. Improvement in Management of Oral Medications | Revise | • Add a response option to M2020 to indicate that the patient resides in an ALF where the facility controls management of medications, then modify the measure to exclude those patients from the Improvement QM | • Patients in ALF are not expected to improve | • Emphasize/educate re: "ability vs performance" guidance |
| Stabilization - Functional | | | | |
| 23. Stabilization in Grooming | Revise | • Composite (grooming, bathing, and toileting hygiene) | • Would enable HHA to target improvement within discipline (HH aide/occupational therapy for this measure) | |
| 24. Stabilization in Bathing | Revise | | | |
| 26. Stabilization in Toileting Hygiene | Revise** | | | |
| 25. Stabilization in Toilet Transferring | Revise | • Composite (toilet and bed transferring) | • Would enable HHA to target improvement within discipline (nursing or therapy for this measure) | |
| 27. Stabilization in Bed Transferring | Revise | | | |
| 28. Stabilization in Light Meal Preparation | Retire | | • Measures are low priority, but could also be combined in one measure | |
| 29. Stabilization in Phone Use | Retire | | | |



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| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|---|--|---------------------|
| 30. Stabilization in Management of Oral Medications | Revise | • Differentiate patients in Assisted Living Facilities from community-based patients; consider a "N/A" option for ALF | • Patients in ALF are not expected to improve | |
| Improvement - Clinical | | | | |
| 15. Improvement in Speech and Language | Retire | | • Utility depends on the population, not broadly useful | |
| 16. Improvement in Status of Surgical Wounds | Revise | • Include all wounds | • Stasis wounds and diabetic wounds are more costly than surgical wounds, and there is more variability in their improvement based on interventions | |
| 17. Improvement in Urinary Tract Infection | Revise | • Tie to indwelling catheter | • Tying to indwelling catheter would decrease the number of UTIs | |
| 18. Improvement in Urinary Incontinence | Revise** | • Tie to indwelling catheter | • Little opportunity to improve incontinence; usually a decline not an improvement | |
| 20. Improvement in Confusion Frequency | Revise | • Possibly a composite of O20-22 | • May be too broad | |
| 21. Improvement in Anxiety Level | Revise | | • May be too broad | |
| 22. Improvement in Behavior Problem Frequency | Revise | | • May be too broad | |
| Stabilization - Clinical | | | | |
| 31. Stabilization in Speech and Language | Retire | | • Not useful • Accuracy concerns • Not relevant for most agencies (perhaps useful for the small number of agencies focused on dementia patients) | |
| 32. Stabilization in Cognitive Functioning | Retire | | | |
| 33. Stabilization in Anxiety Level | Retire | | | |
| Utilization | | | | |



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| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|---|-------------------|---|--|---------------------|
| 34. Acute Care Hospitalization (OASIS based) | Retire | | <ul style="list-style-type: none"> Potentially inaccurate; not useful; claims measure preferred | |
| 35. Emergency Department Use with Hospitalization (OASIS-Based)* | Retire | | <ul style="list-style-type: none"> Potentially inaccurate; not useful; claims measure preferred | |
| 36. Discharged to Community (OASIS-based) | Retire** | <ul style="list-style-type: none"> Create a claims-based version of this measure | <ul style="list-style-type: none"> Potentially inaccurate Accuracy issues may be resolved with increased education | |
| Potentially Avoidable Events (Emergent Care)* | | | | |
| 41. Emergent Care for Injury Caused by Fall | Revise | <ul style="list-style-type: none"> Make claims-based; use ICD10 | <ul style="list-style-type: none"> Claims-based measure would be more accurate and helpful | |
| 42. Emergent Care for Wound Infections, Deteriorating Wound Status | Revise | <ul style="list-style-type: none"> Make claims-based; use ICD10 | <ul style="list-style-type: none"> Claims-based measure would be more accurate and helpful | |
| 43. Emergent Care for Improper Medication Administration, Medication Side Effects | Revise | <ul style="list-style-type: none"> Make claims-based; use ICD10 | <ul style="list-style-type: none"> Claims-based measure would be more accurate and helpful | |
| 44. Emergent Care for Hypo/Hyperglycemia | Revise | <ul style="list-style-type: none"> Make claims-based; use ICD10 | <ul style="list-style-type: none"> Claims-based measure would be more accurate and helpful | |
| Potentially Avoidable Events (Substantial Decline)* | | | | |
| 45. Development of Urinary Tract Infection | Revise** | <ul style="list-style-type: none"> Tie to catheter use | <ul style="list-style-type: none"> Valuable to capture catheter associated infection | |
| Potentially Avoidable Events (Discharged with Risk)* | | | | |
| 49. Discharged to the Community Needing Wound Care or Medication Assistance | Revise | <ul style="list-style-type: none"> Add response option "discharged to community with informal assisted services" | <ul style="list-style-type: none"> Capture care provided by informal caregivers | |
| 50. Discharged to the Community Needing Toileting Assistance | Revise | <ul style="list-style-type: none"> Add response option "discharged to community with informal assisted services" | <ul style="list-style-type: none"> Capture care provided by informal caregivers | |
| 51. Discharged to the Community with Behavioral Problems | Revise | <ul style="list-style-type: none"> Add response option "discharged to community with informal assisted services" | <ul style="list-style-type: none"> Capture care provided by informal caregivers | |



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| Measure | Majority Response | Revision Recommended | Reason for Revision or Retirement | Follow-Up TEP Notes |
|--|-------------------|---|--|---------------------|
| 52. Discharged to the Community with an Unhealed Stage II Pressure Ulcer | Revise | <ul style="list-style-type: none">• Add response option “discharged to community with informal assisted services” | <ul style="list-style-type: none">• Capture care provided by informal caregivers | |

**Indicates a change or update to the majority response resulting from the follow-up webinar.