

## Attachment X — CMS Quality Measures for Home Health Agencies

<b>Summary Measures</b>	
<b>Quality of patient care Star Rating</b>	Summary of quality of care measures (process of care and outcomes measures)
<b>Patient survey summary Star Rating</b>	Summary of patient survey/patient experience measures

<b>Process of Care Measures</b>	
<b>Timely initiation of care</b>	How often the home health team began their patients' care in a timely manner
<b>Influenza immunization received for current flu season</b>	How often the home health team made sure that their patients have received a flu shot for the current flu season
<b>Pneumococcal polysaccharide vaccine ever received</b>	How often the home health team made sure that their patients have received a pneumococcal vaccine (pneumonia shot).
<b>Diabetic foot care and patient education implemented</b>	For patients with diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care
<b>Depression assessment conducted</b>	How often the home health team checked patients for depression
<b>Drug education on all medications provided to patient/caregiver</b>	How often the home health team taught patients (or their family caregivers) about their drugs
<b>Multifactor fall risk assessment conducted for all patients who can ambulate</b>	How often the home health team checked patients' risk of falling

<b>Outcome Measures</b>	
<b>Improvement in ambulation</b>	How often patients got better at walking or moving around
<b>Improvement in bed transfer</b>	How often patients got better at getting in and out of bed
<b>Improvement in pain interfering with activity</b>	How often patients had less pain when moving around
<b>Improvement in bathing</b>	How often patients got better at bathing
<b>Improvement in management of oral medications</b>	How often patients got better at taking their drugs correctly by mouth
<b>Improvement in dyspnea</b>	How often patients' breathing improved
<b>Improvement in status of surgical wounds</b>	How often patients' wounds improved or healed after an operation
<b>Acute care hospitalizations</b>	How often home health patients had to be admitted to the hospital
<b>Emergency department use without hospitalization</b>	How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital

<b><i>Outcome Measures</i></b>	
<b>Rehospitalization during the first 30 days of home health</b>	How often home health patients who have had a recent hospital stay had to be readmitted to the hospital.
<b>Emergency department use without hospital readmission during the first 30 days of home health</b>	How often home health patients who have had a recent hospital stay received care in the hospital emergency room without being readmitted to the hospital.

<b><i>Patient Experience Measures</i></b>
HHCAHPS Star Rating (Summary measure)
How often the home health team gave care in a professional way?
How well did the home health team communicate with patients?
Did the home health team discuss medicines, pain, and home safety with patients?
How do patients rate the overall care from the home health agency?
Would patients recommend the home health agency to friends and family?

## KEY TERMS

**CMS quality measures:** CMS home health quality measures include measures of clinical processes and outcomes, patient experience with care, patient safety, resource use or cost of care, and structural measures (such as a home health agency's use of EHRs). These measures are reported by home health agencies to the Centers for Medicare & Medicaid Services (CMS) and can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Measures.html>. Measures come from patient assessment data that home health agencies routinely collect on the patients at specified time intervals during their stay as well as Medicare claims data.

**Accountable Care Organizations (ACO):** ACOs are networks of healthcare providers and organizations (usually hospitals and ambulatory care physician groups, and possibly including nursing homes, home health agencies, and hospice organizations) that agree to take some financial responsibility for reducing the costs and improving the quality of care for a defined patient population.

**Clinical decision support (CDS):** CDS encompasses a variety of tools to enhance decision-making in the clinical workflow. These tools include computerized alerts and reminders to care providers and patients; clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant reference information, among other tools.

**Culture of safety:** Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. The Agency for Healthcare Research and Quality notes the following key features: acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations; a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment; and encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems; organizational commitment of resources to address safety concerns.

**Integrated Delivery System (IDS):** An IDS is an integrated network of healthcare providers and organizations such as nursing homes, primary and specialty care, hospitals, rehabilitation centers, home health care agencies, and hospice services that provides or arranges to provide a coordinated continuum of services to a defined population. It may own or be closely aligned with an insurance product, usually a form of managed care.

**Lean/Six Sigma Engineering:** Redesign or re-engineering concepts that were originally developed to increase the efficiency of production and reduction of errors within manufacturing companies. Lean/Six Sigma has been adopted by healthcare organizations to identify problems or inefficiencies and take actions to address these issues. "Lean" and "Six Sigma" emphasize focusing on customer satisfaction, problem solving, and elimination of waste and involving employees in identifying and resolving the problem.

**Learning Organization:** An organization that encourages and supports continuous employee learning, critical thinking, and risk-taking with new ideas.

**Plan, Do, Study, Act Improvement Cycles (PDSA):** PDSA is a tool that is used for accelerating quality improvement that involves developing a plan to test the change (Plan),

carrying out the test (**Do**), observing and learning from the consequences (**Study**), and determining what modifications should be made to the test (**Act**).

**Situation Background Assessment Recommendation (SBAR):** SBAR is a standardized way of communicating that promotes patient safety by helping individuals communicate with each other with a shared set of expectations. Staff and physicians can use SBAR to share patient information in a concise and structured format.