

6

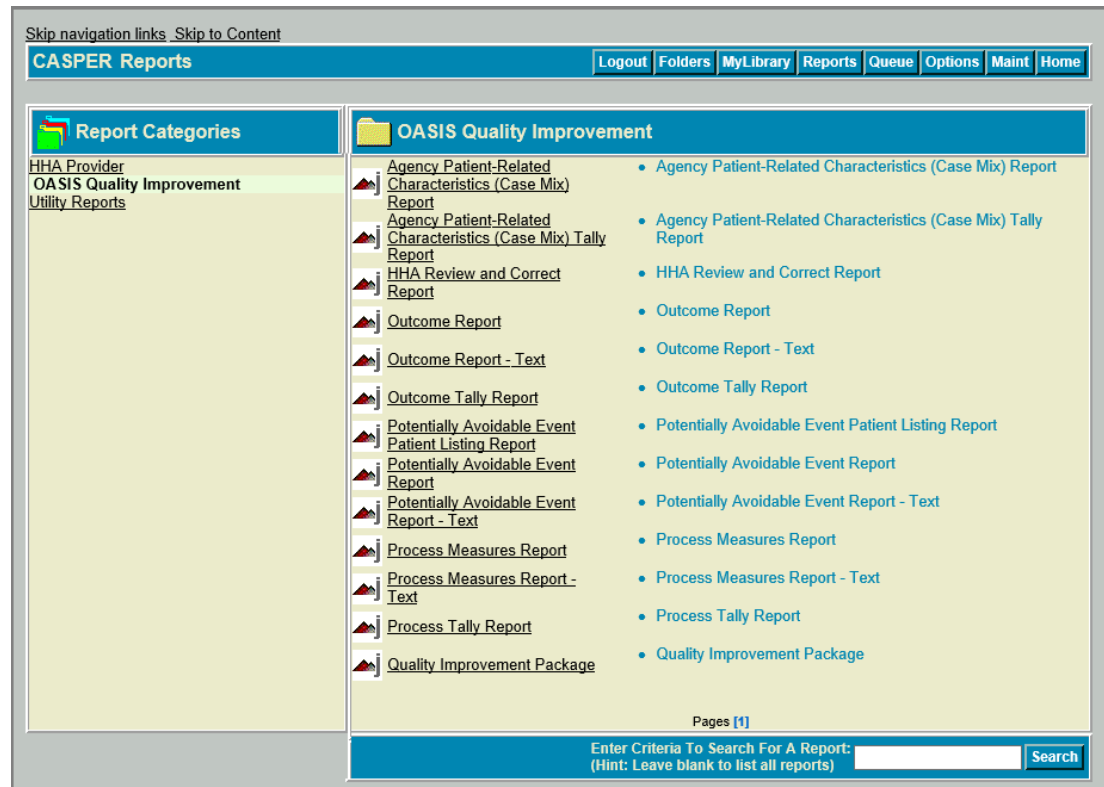
OASIS QUALITY IMPROVEMENT REPORTS

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GENERAL INFORMATION

OASIS Quality Improvement reports are requested on the **CASPER Reports** page (Figure 6-1).

Figure 6-1. CASPER Reports Page – OASIS Quality Improvement Category



1. Select the OASIS Quality Improvement link from the *Report Categories* frame on the left. A list of the individual OASIS Quality Improvement reports you may request displays in the right-hand frame.

NOTE: Only those report categories to which you have access are listed in the *Report Categories* frame.

2. Select the desired underlined report name link from the right-hand frame. One or more **CASPER Reports Submit** pages are presented providing criteria options with which you specify the information to include in your report. These options may differ for each report.

3. Choose the desired criteria and select the **Submit** or **Next** button.

NOTE: OASIS Quality Improvement reports access detailed information and may require a significant amount of time to process. Once you submit your report request(s), you may consider exiting the CASPER Reporting application, and viewing the completed report(s) at a later time.

4. Refer to Section 2, Functionality, of the CASPER Reporting HHA Provider User's Guide for assistance in viewing, printing, saving, and exporting the reports you request.

The episodes of care represented in the OASIS Quality Improvement reports are the same as all other reports based on OASIS data. Each episode of care must have a beginning (i.e., a Start of Care [SOC] or Resumption of Care [ROC] assessment) and a conclusion (i.e., a transfer or discharge assessment) to be considered a complete case. A patient who is admitted to your agency, then is transferred to an inpatient facility WITHOUT discharge, then resumes care, and is subsequently discharged, is represented as two episodes of care. One episode goes from SOC to transfer to inpatient facility, while the second goes from resumption of care to discharge. This episode of care is not the same as a payment episode under PPS.

The number of cases for an agency includes all patients with complete episodes of care (defined as having a SOC/ROC assessment matched with a transfer/discharge assessment) during the selected reporting period. The reference cases - the patients to whom agency patients are being compared - are composed of a random sample of all patients served by home health agencies that are subject to the OASIS reporting requirements and subject to data quality screening criteria.

AGENCY PATIENT-RELATED CHARACTERISTICS (CASE MIX) REPORT

The Agency Patient-Related Characteristics (Case Mix) Report provides the mean value of each OASIS patient-related characteristics (patient attributes or circumstances) measure for episodes of care that ended during two specified periods (current and prior) for the agency, along with national reference mean values for the current period.

The criteria selection page (Figure 6-2) for the Agency Patient-Related Characteristics (Case Mix) Report presents *Prior Begin Date*, *Prior End Date*, *Current Begin Date*, *Current End Date*, and *Report By Branch* options.

Figure 6-2. CASPER Reports Submit Page – Agency Patient-Related Characteristics (Case Mix) Report

The screenshot shows the 'CASPER Reports Submit' page. At the top, there are navigation links: 'Skip navigation links', 'CASPER Reports Submit', 'Logout', 'Folders', 'MyLibrary', 'Reports', 'Queue', 'Options', 'Maint', and 'Home'. Below this is a section titled 'Report: Agency Patient-Related Characteristics (Case Mix) Report'. Inside this section, there are five date pickers: 'Prior Begin Date' (03/2012), 'Prior End Date' (02/2013), 'Current Begin Date' (03/2013), 'Current End Date' (07/2017), and 'Report By Branch' (a checkbox). At the bottom, there are two dropdown menus: 'Template Folder' (My Favorite Reports) and 'Template Name' (Agency Patient-Related Characteristics (Case Mix) Report). To the right of these are four buttons: 'Submit', 'Back', 'Save & Submit', and 'Save'.

Current Begin Date defaults to the month and year of the most recent data available that begins a full 12-month reporting period. *Prior Begin Date* defaults to the month and year 12 months earlier than the *Current Begin Date*.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

Current End Date defaults to the most recent date available for reporting. *Prior End Date* defaults to the month and year 12 months earlier than the *Current End Date*.

You can select an alternate *Current End Date*, *Prior End Date*, *Current Begin Date*, and/or *Prior Begin Date* from the drop-down lists provided. The *Current Begin Date* must be earlier than the *Current End Date*, and the *Prior Begin Date* must be earlier than the *Prior End Date*. The *Prior End Date* must be earlier or the same as the *Current Begin Date*.

To view data for branches along with the overall agency report, select the *Report By Branch* checkbox.

NOTE: Branch information is available only for patients with episodes of care where the SOC/ROC and Discharge/Transfer assessments indicate the same Branch ID (M0016).

The Agency Patient-Related Characteristics (Case Mix) Report (Figure 6-3) compares the agency's mean values of approximately 250 patient-related characteristic items in the following categories to those in the national reference sample for the specified current period and the agency's prior period:

- Patient History
 - Demographics
 - Payment Source
 - Episode Start
 - Inpatient Discharge
 - Therapies
- General Health Status
 - Hospitalization Risks
 - Body Mass Index
- Living Arrangement/Assistance
 - Current Situation
 - Availability
- Care Management
 - Supervision/Safety
- Sensory Status
 - Sensory Status
- Integumentary Status
 - Pressure Ulcers/Injuries
 - Stasis Ulcers
 - Surgical Wounds
- Physiological Status
 - Respiratory
 - Elimination Status
- Neuro/Emotional/Behavioral
 - Cognition
 - Emotional
 - Behavioral
- Activities of Daily Living
 - SOC/ROC Status

- Functional Abilities
 - Prior Functioning: Everyday Activities
 - Prior Device Use
 - Self Care
 - Mobility
- Medications, Other
 - Falls Risk
 - Medication Status
- Therapy/Plan of Care
 - Therapy Visits
- Patient Diagnostic Information
 - Chronic Conditions
 - Home Care Diagnoses
 - Active Diagnoses
- Patient Discharge Information
 - Length of Stay
 - Reason for Emergent Care
 - Falls

The heading of the report provides the following information on each page:


- Agency Name
- Agency ID
- Location
- CMS Certification Number (CCN)
- Branch
- Medicaid Number
- Report Run Date
- Requested Current Period
- Request Prior Period
- Actual Current Period
- Actual Prior Period
- Number of Cases:
 - Current
 - Prior
 - National

Definitions of the following terms are provided:

- HHA Obs – Home Health Agency's Observed Rate/Value is the agency's actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.
- HHA Prior Obs – Home Health Agency's Observed Rate/Value from the Prior Period is the agency's actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.
- Nat'l Obs – National Observed Rate/Value is the actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for all patients served by home health agencies nationally during the reporting period.
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
 - * The probability is 1% or less that this difference is due to chance, and 99% or more that the difference is real.
 - ** The probability is 0.1% or less that this difference is due to chance, and 99.9% or more that the difference is real.

NOTE: The Agency Patient-Related Characteristics (Case Mix) Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-3. Agency Patient-Related Characteristics (Case Mix) Report*



CASPER Report
Agency Patient-Related Characteristics (Case Mix) Report

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Agency Name: [REDACTED]

Agency ID: [REDACTED]

Location: [REDACTED]

CCN: [REDACTED] **Branch:** All

Medicaid Number: [REDACTED]

Report Run Date: 11/14/2018

Requested Current Period: 09/2016 - 01/2019

Request Prior Period: 09/2015 - 08/2016

Actual Current Period: 09/2016 - 07/2017

Actual Prior Period: 09/2015 - 08/2016

Cases: Curr 302 **Prior** 319

Number of Cases (National): 6,404,479

Definitions:

HHA Obs - Home Health Agency's Observed Rate/Value is the agency's actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.

HHA Prior Obs¹ - Home Health Agency's Observed Rate/Value from the Prior Period is the agency's actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for patients served during the reporting period. These rates/values are not risk adjusted.

Nat'l Obs - National Observed Rate/Value is the actual rate (e.g., xx.yy% of patients were Female) or average value (average age was xx.yy years) for all patients served by home health agencies nationally during the reporting period.

Asterisks - Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.

* The probability is 1% or less that this difference is due to chance, and 99% or more that the difference is real.

** The probability is 0.1% or less that this difference is due to chance, and 99.9% or more that the difference is real.

	HHA Obs	HHA Prior Obs ¹	Nat'l Obs		HHA Obs	HHA Prior Obs ¹	Nat'l Obs
PATIENT HISTORY							
Demographics							
Age (years)	72.31	72.45	74.88 **	Current Situation			
Gender: Female (%)	56.95%	57.68%	60.87%	Lives alone (%)	31.79%	29.15%	23.66% **
Race: Black (%)	1.66%	0.94%	13.65% **	Lives with others (%)	63.25%	63.95%	65.23%
Race: White (%)	97.68%	98.12%	76.24% **	Lives in congregate situation (%)	4.97%	6.90%	11.10% **
Race: Other (%)	0.66%	0.94%	10.47% **	Availability			
Payment Source				Around the clock (%)	64.57%	80.25%	74.21% **
Any Medicare (%)	74.50%	84.64%	93.41% **	Regular daytime (%)	4.97%	2.51%	4.28%
Any Medicaid (%)	25.50%	15.99%	9.12% **	Regular nighttime (%)	7.28%	4.70%	5.39%
Any HMO (%)	33.44%	13.79%	30.41%	Occasional (%)	20.86%	12.54%	15.21% *
Medicare HMO (%)	12.91%	10.34%	25.77% **	None (%)	2.32%	0.00%	0.91%
Other (%)	0.00%	0.00%	3.94% **	CARE MANAGEMENT			
Episode Start				Supervision / Safety			
Episode timing: Early (%)	98.41%	98.55%	88.62% **	None needed (%)	16.56%	21.94%	21.52%
Episode timing: Later (%)	1.20%	1.45%	6.72% **	Caregiver provides (%)	32.12%	54.23%	49.51% **
Episode timing: Unknown (%)	0.40%	0.00%	4.66% **	Caregiver training needed (%)	39.07%	18.50%	25.36% **
Inpatient Discharge				Uncertain/Unlikely to be provided (%)	7.62%	1.57%	2.19% **
Long-term nursing facility (%)	1.32%	0.63%	0.69%	Needed, but not available (%)	4.64%	3.76%	1.43% **
Skilled nursing facility (%)	12.91%	16.30%	14.80%	SENSORY STATUS			
Short-stay acute hospital (%)	61.59%	67.08%	51.28% **	Sensory Status			
Long-term care hospital (%)	0.00%	0.00%	0.57%	Vision impairment (0-2)	0.25	0.14	0.31
Inpatient rehab hospital/unit (%)	13.91%	7.84%	5.92% **	Pain interfering with activity (0-4)	2.47	2.30	2.46
Psychiatric hospital/unit (%)	0.99%	0.00%	0.40%	INTEGUMENTARY STATUS			
Therapies				Pressure Ulcers/Injuries			
IV/infusion therapy (%)	9.60%	8.46%	3.42% **	Pressure ulcer/injury present (%)	7.28%	9.09%	5.13%
Parenteral nutrition (%)	0.66%	0.94%	0.23%	Stage II pressure ulcer count (#)	0.05	0.05	0.04
Enteral nutrition (%)	2.65%	2.82%	1.57%	Stage III pressure ulcer count (#)	0.03	0.03	0.01
				Stage IV pressure ulcer count (#)	0.01	0.00	0.01
				Unstageable PU: Non-remove. dsq. count (#)	---	---	6.86
				Unstageable PU: Slough/eschar count (#)	---	---	2.61
				Unstageable PU: Deep tissue inj. count (#)	---	---	2.64
GENERAL HEALTH STATUS				Stage I pressure injuries count (0-4)	0.02	0.01	0.02
Hospitalization Risks				Stage most problematic PU/injury (1-4)	2.40	2.38	2.11
Recent decline mental/emot/behav (%)	23.51%	17.87%	16.90% *	Stasis Ulcers			
Multiple hospitalizations (%)	43.05%	42.63%	32.11% **	Stasis ulcer indicator (%)	2.32%	4.08%	1.80%
History of falls (%)	38.08%	37.62%	32.39%	Stasis ulcer count (0-4)	0.07	0.11	0.03
5 or more medications (%)	93.71%	90.91%	90.81%	Status most problematic stasis (0-3)	0.07	2.12	0.05
Frailty factors (%)	58.28%	55.80%	40.95% **	Surgical Wounds			
Other (%)	84.44%	68.65%	48.88% **	Surgical wound indicator (%)	28.15%	30.72%	26.21%
None (%)	0.99%	0.94%	1.96%	Status most problematic surg. (0-3)	0.57	1.96	0.39 *
Body Mass Index							
Low Body Mass Index (%)	5.22%	---	6.24%				
LIVING ARRANGEMENT / ASSISTANCE							

¹ Home Health Agencies that are newly certified will not have available data in the "HHA Prior Obs" column until they have 12 months of data.

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

AGENCY PATIENT-RELATED CHARACTERISTICS (CASE MIX) TALLY REPORT

The Agency Patient-Related Characteristics (Case Mix) Tally Report details the patient-related characteristics associated with each episode of care that ended during a specified period.

The criteria selection page (Figure 6-4) for the Agency Patient-Related Characteristics (Case Mix) Tally Report presents *Begin Date*, and *End Date* options.

Figure 6-4. CASPER Reports Submit Page – Agency Patient-Related Characteristics (Case Mix) Tally Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: Agency Patient-Related Characteristics (Case Mix) Tally Report

Begin Date: 03/2013
End Date: 07/2017

Template Folder: My Favorite Reports
Template Name: Agency Patient-Related Characteristics (Case Mix) Tally Report

Submit Save & Submit Back Save

Begin Date defaults to the month and year of the most recent data available that begins a full 12-month reporting period.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

End Date defaults to the most recent date available for reporting.

You can select an alternate *End Date* and/or *Begin Date* from the drop-down list provided. The *Begin Date* must be earlier than the *End Date*.

NOTE: The number of episodes of care is limited to 5,000 for this report. If the timeframe you request includes more than 5,000 episodes of care, the report is not run. You are instructed to select the **Back** button to return to the criteria selection page and select a shorter timeframe that includes fewer episodes of care.

The Agency Patient-Related Characteristics (Case Mix) Tally Report (Figure 6-5) lists each episode, including the Patient Name, Start of Care/Resumption of Care (SOC/ROC) date, and Start of Care/End of Care (SOC/EOC) Branch ID, and indicates the value for each patient-related characteristic in the following categories:

- Patient History
 - Demographics

- Payment Source
- Episode Start
- Inpatient Discharge
- Therapies
- General Health Status
 - Hospitalization Risks
 - BMI
- Living Arrangement/Assistance
 - Current Situation
 - Availability
- Care Management
 - Supervision/Safety
- Sensory Status
 - Sensory Status
- Integumentary Status
 - Pressure Ulcers/Injuries
 - Stasis Ulcers
 - Surgical Wounds
- Physiological Status
 - Respiratory
 - Elimination Status
- Neuro/Emotional/Behavioral
 - Cognition
 - Emotional
 - Behavioral
- Activities of Daily Living
 - SOC/ROC Status
- Functional Abilities
 - Prior Functioning: Everyday Activities
 - Prior Device Use
 - Self Care
 - Mobility
- Medications, Other
 - Falls Risk
 - Medication Status
- Therapy
 - Therapy Visits
- Patient Diagnostic Information
 - Chronic Conditions

- Home Care Diagnoses
- Active Diagnoses
- Patient Discharge Information
 - Length of Stay
 - Reason for Emergent Care
 - Falls

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CMS Certification Number (CCN)
- Medicaid Number
- Report Run Date

NOTE: The Agency Patient-Related Characteristics (Case Mix) Tally Report contains protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-5. Agency Patient-Related Characteristics Tally Report*

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CASPER Report

Agency Patient-Related Characteristics (Case Mix) Tally Report

Agency Name: ██████████
 Agency ID: ██████████
 Location: ██████████

CCN: ██████████
 Medicaid Number: ██████████
 Report Run Date: 11/14/2018

Report Period: 09/01/2016 - 01/31/2019			Patient History																					
			Demographics				Payment Source					Episode Start			Inpatient Discharge				Therapies					
Patient Name	SOC/ROC Date	SOC/EOC Branch ID	Age (years)	Gender: Female (%)	Race: Black (%)	Race: White (%)	Race: Other (%)	Any Medicare (%)	Any Medicaid (%)	Any HMO (%)	Medicare HMO (%)	Other (%)	Episode timing: Early (%)	Episode timing: Later (%)	Episode timing: Unknown (%)	Long-term nursing facility (%)	Skilled nursing facility (%)	Short-stay acute hospital (%)	Long-term care hospital (%)	Inpatient rehab hospital/unit (%)	Psychiatric hospital/unit (%)	IV/infusion therapy (%)	Parenteral nutrition (%)	Enteral nutrition (%)
██████████	03/21/17	N/N	77	n	n	y	n	y	n	n	n	n	y	n	n	n	n	n	n	y	n	n	n	
██████████	03/01/17	N/N	59	n	n	y	n	n	y	y	n	n	y	n	n	n	n	n	n	n	n	n	n	
██████████	03/23/17	N/N	59	n	n	y	n	n	y	y	n	n	-	-	-	n	n	y	n	n	n	n	n	
██████████	03/30/17	N/N	59	n	n	y	n	n	y	y	n	n	-	-	-	n	n	y	n	n	n	n	n	
██████████	05/01/17	N/N	60	n	n	y	n	n	y	y	n	n	-	-	-	n	n	n	n	n	n	n	n	
██████████	01/18/17	N/N	74	n	n	y	n	y	n	y	y	n	y	n	n	n	n	n	n	n	n	n	n	
██████████	02/24/17	N/N	74	n	n	y	n	y	n	y	y	n	y	n	n	n	n	y	n	n	n	n	n	
██████████	08/27/16	N/N	86	n	n	y	n	y	n	n	n	n	y	n	n	n	n	y	n	n	n	n	n	
██████████	01/23/17	N/N	86	n	n	y	n	y	n	n	n	n	y	n	n	n	n	y	n	n	n	n	n	
██████████	09/06/16	N/N	87	y	n	y	n	n	y	y	n	n	-	-	-	n	n	n	n	n	n	n	n	
██████████	10/13/16	N/N	87	y	n	y	n	n	y	y	n	n	-	-	-	n	n	y	n	n	n	n	n	
██████████	08/01/13	N/N	32	y	n	y	n	n	y	n	n	n	-	-	-	n	n	n	n	n	n	n	n	
██████████	06/17/17	N/N	71	n	n	y	n	y	n	n	n	n	y	n	n	n	n	n	n	n	n	n	n	
██████████	12/07/16	N/N	71	n	n	y	n	y	n	n	n	n	y	n	n	n	n	n	n	n	n	n	n	
██████████	01/30/17	N/N	83	n	n	y	n	y	n	n	n	n	y	n	n	n	y	y	n	n	n	n	n	
██████████	11/12/16	N/N	74	y	n	n	y	y	n	n	n	n	y	n	n	n	n	y	n	n	n	n	n	

This report may contain privacy protected data and should not be released to the public.
 Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

Patient characteristics with a percent sign (%) included in the characteristic description are those characteristics for which there are non-numeric values. Values are presented in the report as:

"y" if the attribute was present

"n" if the attribute was not present

"-" if data were not available

Patient characteristics that are measured using integer (numeric) scales include the possible range of values in parentheses in the characteristic description. The patient's score for a characteristic is shown as either a number within the range indicated or "-" if no data were collected for the characteristic.

Pressure ulcer count characteristics include a pound sign (#) in the characteristic description. Possible values include the numbers 0 through 9.

The Age characteristic value is displayed as a whole number of years.

HHA REVIEW AND CORRECT REPORT

The HHA Review and Correct Report allows home health agencies to review their quality measure (QM) results to identify if corrections or changes are necessary prior to the quarter's data submission deadline, which is 4.5 months after the end of the quarter.

NOTE: Correction periods for each quarter end as follows:

Q1 (1/1-3/31) – August 15

Q2 (4/1-6/30) – November 15

Q3 (7/1-9/30) – February 15

Q4 (10/1-12/31) – May 15

The HHA Review and Correct Report provides a breakdown, by measure and by quarter, of the agency's QM results for four rolling quarters. The report also identifies the open/closed status of each quarter's data correction period as of the report run date.

NOTE: Quality Measure calculations are performed weekly and on the first day of each quarter.

The **CASPER Reports Submit** criteria page (Figure 6-6) for the HHA Review and Correct Report presents *Begin Date*, *End Date*, *Quality Measures*, and *Include Patient-Level Data* criteria options.

Figure 6-6. HHA Review and Correct Report CASPER Reports Submit Page

The screenshot shows a web application interface for submitting CASPER reports. At the top, there is a navigation bar with links: Skip navigation links, CASPER Reports Submit, Logout, Folders, MyLibrary, Reports, Queue, Options, Maint, and Home. Below this, the page title is "Report: HHA Review and Correct Report". The main content area includes a "Begin Date" field set to "Q1 2019" and an "End Date" dropdown menu currently showing "Q4 2019". A section titled "*Quality Measures:" contains a "Select All" button and a list of 18 quality measures, all of which are highlighted in blue. These measures include: Pressure Ulcer Injury, Pressure Ulcers, Drug Regimen Review Conducted with Follow-Up, Improvement in Ambulation/Locomotion, Improvement in Bed Transferring, Improvement in Bathing, Improvement in Pain Interfering with Activity, Improvement in Dyspnea, Improvement in Status of Surgical Wounds, Improvement in Management of Oral Meds, Timely Initiation of Care, Depression Assessment Conducted, Multifactor Fall Risk Assessment Conducted, Diabetic Foot Care and Patient Education, Drug Education on All Medications, Influenza Immunization for Current Flu Season, Pneumococcal Vaccine Ever Received, Application of Functional Assessment, and Application of Falls. Below the list is an unchecked checkbox labeled "Include Patient-Level Data". A small asterisked note states: "* To select multiple items, hold down the Ctrl key and click the desired items". At the bottom, there are two dropdown menus for "Template Folder:" (set to "My Favorite Reports") and "Template Name:" (set to "HHA Review and Correct Report"). To the right of these are four buttons: "Submit", "Back", "Save & Submit", and "Save".

Begin Date and *End Date* values define the date range of the QM calculations to select for the report. A drop-down list associated with the *End Date* field provides the calendar quarters for which calculated quality measure data is available. The default value is the most recently completed calculated quarter. You may select a different quarter from the list. *Begin Date* is a read-only field that displays the first quarter of the 4-quarter period ending with the specified *End Date*.

NOTE: Only qualifying stays with a discharge record containing a Discharge Date between the Begin Date and End Date are included in the QM calculations for the report.

The *Quality Measures* list box presents the measures that are available for the period associated with the selected *End Date*. All measures are selected by default. Alternately you may select only those measures of interest. Press and hold the Ctrl and/or Shift keys on the keyboard as you click to select/highlight multiple measures. If all measures are no longer selected, use the **Select All** button to reselect all measures if necessary. You must select at least one measure.

The *Include Patient-Level Data* checkbox, when selected, adds criteria options to the **CASPER Reports Submit** criteria page (Figure 6-7) for the inclusion of patient-level information in the report output.

The patient-level data criteria options presented are *Create Patient-Level .csv File*, *Status*, *Reporting Quarter*, *Data Correction Status*, *Primary Sort By*, and *Reverse Default Sort Order*.

Figure 6-7. HHA Review and Correct Report CASPER Reports Submit Page with Patient-Level Criteria

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: HHA Review and Correct Report

Begin Date: Q1 2019
End Date: Q4 2019

*Quality Measures: [Select All](#)

- Pressure Ulcer Injury
- Pressure Ulcers
- Drug Regimen Review Conducted with Follow-Up
- Improvement in Ambulation/Locomotion
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Pain Interfering with Activity
- Improvement in Dyspnea
- Improvement in Status of Surgical Wounds
- Improvement in Management of Oral Meds
- Timely Initiation of Care
- Depression Assessment Conducted
- Multifactor Fall Risk Assessment Conducted
- Diabetic Foot Care and Patient Education
- Drug Education on All Medications
- Influenza Immunization for Current Flu Season
- Pneumococcal Vaccine Ever Received
- Application of Functional Assessment
- Application of Falls

☒ Include Patient-Level Data
☐ Create Patient-Level .csv File

*Status: Triggered
Not Triggered
Excluded
Dash

*Reporting Quarter: Q4 2019
Q3 2019
Q2 2019
Q1 2019

Data Correction Status: ☒ Both ☐ Open ☐ Closed

Primary Sort By: Discharge Date ☐ Reverse Default Sort Order

* To select multiple items, hold down the Ctrl key and click the desired items

Template Folder: My Favorite Reports
Template Name: HHA Review and Correct Report

Submit Back
Save & Submit Save

Select the *Create Patient-Level .csv File* checkbox to create a separate patient-level data CSV file that is placed in *My Inbox* on the **CASPER Folders** page.

Status options include *Triggered*, *Not Triggered*, *Excluded*, and *Dash*. All are selected by default. Press and hold the Ctrl key on the keyboard as you click to select/highlight only the status option(s) of interest. You must select at least one status.

The *Reporting Quarter* list box presents the quarters for which measure data are available for the specified *End Date*. Press and hold the Ctrl key on the keyboard as you click to select/highlight only the reporting quarter option(s) of interest. You must select at least one reporting quarter.

Data Correction Status options include *Both* (the default), *Open*, and *Closed* radio buttons.

Primary Sort By drop-down options include *Discharge Date* (the default), *Admission Date*, *Last Name/First Name*, and *Status*. You may select only one primary sort-by option.

The default sort order for the patient-level measure results is as follows:

- Discharge Date (descending)
- Admission Date (descending)
- Lastname, Firstname (ascending)
- Status
 - Triggered
 - Not Triggered
 - Excluded
 - Dash

The *Reverse Default Sort Order* checkbox, when selected, reverses the order of each of the sort elements as follows:

- Discharge Date (ascending)
- Admission Date (ascending)
- Lastname, Firstname (descending)
- Status
 - Dash
 - Excluded
 - Not Triggered
 - Triggered

The header of the Home Health Review and Correct Report (Figure 6-8) presents the following for each selected measure:

- Agency ID
- CMS Certification Number (CCN)
- Agency Name
- City/State
- Requested Quarter End Date
- Report Release Date
- Report Run Date
- Data Calculation Date
- Report Version Number

The next section of the report identifies additional user-selected criteria with which the report was generated:

- Quality Measures
- Status
- Reporting Quarter
- Data Correction Status

The remainder of the report details the results for the selected quality measures.

- HH Quality Measure Name
 - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
 - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

NOTE: Measure results for the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened measure will be frozen as of the October 2019 Home Health Compare refresh and will include quality episodes ending Jan 2018-Dec 2018. This information is included as a footnote on the report for this measure.

- Percent of Patients with Drug Regimen Review Conducted with Follow-Up for Identified Issues
- Improvement in Ambulation-Locomotion (NQF #0167)
- Improvement in Bed Transferring (NQF #0175)
- Improvement in Bathing (NQF #0174)
- Improvement in Pain Interfering with Activity (NQF #0177)
- Improvement in Dyspnea
- Improvement in Status of Surgical Wounds (NQF #0178)
- Improvement in Management of Oral Medications (NQF #0176)
- Timely Initiation of Care (NQF #0526)
- Depression Assessment Conducted (NQF #0518)
- Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate (NQF #0537)
- Diabetic Foot Care and Patient Education Implemented during All Episodes of Care (NQF #0519)
- Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care
- Influenza Immunization Received for Current Flu Season
- Pneumococcal Polysaccharide Vaccine Ever Received
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

- o Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
- Table Legend:
 - o * Episode: A quality episode begins with a start or resumption of care (SOC/ROC) and ends with a death, discharge or transfer. Additional measure-specific exclusions may apply.
 - o Dash (-): Data not available or not applicable
 - o X: Triggered (when patient-level data selected)
 - o NT: Not Triggered (when patient-level data selected)
 - o E: Excluded from analysis based on quality measure exclusion criteria (when patient-level data selected)

The *Agency-Level Data* section of the report details the following for the selected measure:


- Reporting Quarter: The quarter and calendar year for which the data were collected
- Start Date: Beginning date of the reporting quarter
- End Date: Ending date of the reporting quarter
- Data Correction Deadline: The date after which the data for the reporting quarter are frozen

NOTE: Corrections of the data for a reporting quarter made after the Data Correction Deadline will not affect QM results.

- Data Correction Period as of Report Run Date:
 - o Open = As of the Report Run Date, the data correction deadline of the reporting quarter is either today or in the future; data may still be corrected
 - o Closed = As of the Report Run Date, the data correction deadline is in the past; data can no longer be corrected and affect the QM results
- Number of HH Episodes Included in the Numerator for this Quality Measure
- Number of HH Episodes Included in the Denominator
- Your Agency's Observed Performance Rate

NOTE: The HHA Review and Correct Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-8. Home Health Review and Correct Report – Agency-Level Data*



CASPER Report
Home Health Review and Correct Report

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Agency ID: [REDACTED]
 CCN: [REDACTED]
 Agency Name: [REDACTED]
 City/State: [REDACTED]

Requested Quarter End Date: Q1 2019
 Report Release Date: 04/01/2019
 Report Run Date: 04/19/2019
 Data Calculation Date: 01/29/2019
 Report Version Number: 2.0

Quality Measures: Pressure Ulcer Injury, Pressure Ulcers, Drug Regimen Review Conducted with Follow-Up, Improvement in Ambulation/Locomotion, Improvement in Bed Transferring, Improvement in Bathing, Improvement in Pain Interfering with Activity, Improvement in Dyspnea, Improvement in Status of Surgical Wounds, Improvement in Management of Oral Meds, Timely Initiation of Care, Depression Assessment Conducted, Multifactor Fall Risk Assessment Conducted, Diabetic Foot Care and Patient Education, Drug Education on All Medications, Influenza Immunization for Current Flu Season, Pneumococcal Vaccine Ever Received, Application of Functional Assessment, Application of Falls

Status: Triggered, Not Triggered, Excluded, Dash
Reporting Quarter: Q1 2019, Q4 2018, Q3 2018, Q2 2018
Data Correction Status: Both

HH Quality Measure: Improvement in Ambulation/Locomotion (NQF #0167)

Table Legend
***Episode:** A quality episode begins with a start or resumption of care (SOC/ROC) and ends with a death, discharge, or transfer. Additional measure-specific exclusions may apply.
Dash (-): Data not available or not applicable
X: Triggered
NT: Not Triggered
E: Excluded from analysis based on quality measure exclusion criteria

Agency-Level Data							
Reporting Quarter	Start Date	End Date	Data Correction Deadline	Data Correction Period as of Report Run Date	Number of HH Episodes Included in the Numerator for this Quality Measure*	Number of HH Episodes Included in the Denominator*	Your Agency's Observed Performance Rate
Q1 2019	01/01/2019	03/31/2019	08/15/2019	Open	357	359	99.4%
Q4 2018	10/01/2018	12/31/2018	05/15/2019	Open	19	19	100.0%
Q3 2018	07/01/2018	09/30/2018	02/15/2019	Closed	-	-	-
Q2 2018	04/01/2018	06/30/2018	11/15/2018	Closed	-	-	-
Cumulative	04/01/2018	03/31/2019	-	-	376	378	99.5%

This report may contain privacy protected data and should not be released to the public.
 Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

The report records are sorted by State Code, CCN (or agency name), Start Date (descending), and End Date (ascending).

When selected, a *Patient-Level Data* section of the report (Figure 6-9) immediately follows the *Agency-Level Data* section for each selected measure and presents the following for the related patient records:

- Reporting Quarter
- Patient Name
- Patient ID
- SOC/ROC Date
- Transfer, Discharge, or Death Date
- Data Correction Deadline
- Data Correction Period as of Report Run Date
- Status

Figure 6-9. Home Health Review and Correct Report – Patient-Level Data*

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CASPER Report

Home Health Review and Correct Report

Patient-Level Data (continued)

Reporting Quarter	Patient Name	Patient ID	SOC/ROC Date*	Transfer, Discharge, or Death Date*	Data Correction Deadline	Data Correction Period as of Report Run Date	Status
Q1 2019	[REDACTED]	44743072	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743518	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44742933	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743766	01/01/2019	01/02/2019	08/15/2019	Open	E
Q1 2019	[REDACTED]	44743300	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44742930	01/01/2019	01/02/2019	08/15/2019	Open	NT
Q1 2019	[REDACTED]	44743271	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743226	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743065	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743318	01/01/2019	01/02/2019	08/15/2019	Open	E
Q1 2019	[REDACTED]	44743070	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44742936	01/01/2019	01/02/2019	08/15/2019	Open	X
Q1 2019	[REDACTED]	44743521	01/01/2019	01/02/2019	08/15/2019	Open	NT
Q1 2019	[REDACTED]	44685161	01/01/2019	01/02/2019	08/15/2019	Open	X

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

The patient records are sorted, as user-specified, by:

- Transfer, Discharge, or Death Date
- SOC/ROC Date
- Lastname, Firstname
- Status
- Patient ID

OUTCOME REPORT

The Outcome Report provides agency observed, national observed and, where available, risk-adjusted prior and Home Health Compare risk-adjusted measure performance comparisons.

End Results Outcomes are computed only for episodes of care ending with a discharge to the community (RFA = 09).

Utilization Outcomes are computed for episodes of care ending with a transfer to an inpatient facility (RFA = 06 or 07) or a discharge to the community (RFA = 09).

Claims Based Outcomes are calculated based upon the Episode Begin Date.

The Medicare Spending per Beneficiary – Post-Acute Care Home Health Outcome is calculated based upon the treatment period and/or associated services period.

A bar graph containing up to 4 bars provides the following for each outcome measure:

- The actual observed (not risk-adjusted) percentage of agency patients that attained the outcome in the requested reporting period.
- The percentage of agency patients that attained the outcome in the prior reporting period, risk-adjusted where appropriate.
- The Home Health Compare (HHC) risk-adjusted percentage of agency patients that attained the outcome in the requested reporting period. If the requested reporting period does not align with the HHC reporting period or if the measure is not displayed on HHC, the percentage for the measure is not included on the report.
- The national observed reference value, which is the mean performance of all home health agencies with a quality episode of care for the selected period for the quality measure.

You may select a text-only version of the report for use with electronic screen-reading technology.

<p>NOTE: The non-text version of this report contains bar graphics and is incompatible with the CSV output format. PDF is the recommended output format for the non-text version of this report. If you desire the report output in CSV format, please request the text version of this report.</p>
--

The criteria selection page (Figure 6-10) for the Outcome Report presents *Prior Begin Date*, *Prior End Date*, *Current Begin Date*, *Current End Date*, *Prior Claims Begin Date*, *Prior Claims End Date*, *Current Claims Begin Date*, *Current Claims End Date*, and *Report By Branch* options.

Figure 6-10. CASPER Reports Submit Page – Outcome Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: Outcome Report

Prior Begin Date: 09/2015 ▼
Prior End Date: 08/2016 ▼
Current Begin Date: 09/2016 ▼
Current End Date: 01/2019 ▼
Prior Claims Begin Date: 01/2016 ▼
Prior Claims End Date: 12/2016 ▼
Current Claims Begin Date: 01/2017 ▼
Current Claims End Date: 12/2017 ▼
Report By Branch: ☐

Template Folder: My Favorite Reports ▼
Template Name: Outcome Report ▼

Submit Back
Save & Submit Save

Prior Begin Date, *Prior End Date*, *Current Begin Date*, and *Current End Date* allow you to specify the dates between which episodes of care ended for the end-result and utilization outcomes.

Prior Begin Date and *Prior End Date* default to the 12-month period prior to the most recent 12 months of data available for reporting. You can select alternate dates from the drop-down lists provided. The *Prior End Date* must not be earlier than the *Prior Begin Date*.

Current Begin Date and *Current End Date* default to a 12-month period that begins 11 months prior to the most recent date of the data available for reporting. You can select alternate dates from the drop-down lists provided. The *Current End Date* must not be earlier than the *Current Begin Date* and the *Current Begin Date* must be later than the *Prior End Date*.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

Prior Claims Begin Date, *Prior Claims End Date*, *Current Claims Begin Date*, and *Current Claims End Date* allow you to specify the dates between which episodes of care began for the claims-based outcomes.

Prior Claims Begin Date and *Prior Claims End Date* default to the 12-month period prior to the most recent 12 months of data available for reporting. You can select alternate dates from the drop-down lists provided. The *Prior Claims End Date* must not be earlier than the *Prior Claims Begin Date*.

Current Claims Begin Date and *Current Claims End Date* also default to a 12-month period that begins 11 months prior to the most recent date of the data available for reporting. You can select alternate dates from the drop-down lists provided. The *Current Claims End Date* must not be earlier than the *Current Claims Begin Date*, and the *Current Claims Begin Date* must be later than the *Prior Claims End Date*.

To view data for branches along with the overall agency report, select the *Report By Branch* checkbox.

NOTE: Branch information includes only those patients with episodes of care where both the start and end dates of care are associated with the same branch or parent agency. Branch level calculations are not available for the claims-based outcome measures.

NOTE: The Outcome Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

The Outcome Report presents risk-adjusted End Result (Figure 6-11), non-risk-adjusted End Result (Figure 6-12), risk-adjusted Utilization (Figure 6-13), risk-adjusted Claims Based (Figure 6-14), and Medicare Spending per Beneficiary Outcomes (Figures 6-15 and 6-16) separately.

The heading of the report provides the following information on each page, unless otherwise noted:

- Agency Name
- Agency ID (for End Result, Utilization, and Claims-based Outcomes only)
- Location
- CCN
- Branch (for End Result, Utilization, and Claims Based Outcomes only)
- Medicaid Number (for End Result, Utilization, and Claims Based Outcomes only)
- Report Run Date
- Requested Current Period (for End Result and Utilization Outcomes)
- Requested Current Period (Claims) (for Claims Based Outcomes)
- Requested Current Period (MSPB) (for the Medicare Spending per Beneficiary Outcome)
- Requested Prior Period (for End Result and Utilization Outcomes)
- Requested Prior Period (Claims) (for Claims Based Outcomes)
- Actual Current Period (for End Result and Utilization Outcomes)
- Actual Current Period (Claims) (for Claims Based Outcomes)

- Actual Current Period (MSPB) (for the Medicare Spending per Beneficiary Outcome)
- Actual Prior Period (for End Result and Utilization Outcomes)
- Actual Prior Period (Claims) (for Claims Based Outcomes)
- Number of Cases Current Period (for End Result and Utilization Outcomes)
- Number of Cases Current Period (Claims) (for Claims Based Outcomes)
- Number of Cases Prior Period (for End Result and Utilization Outcomes)
- Number of Cases Prior Period (Claims) (for Claims Based Outcomes)
- Number of cases (National) (for End Result and Utilization Outcomes)
- Number of cases (National) (Claims) (for Claims Based Outcomes)

The body of the report provides the following data and supporting bar graphs for each outcome measure, except for the pages for the Medicare Spending per Beneficiary – PAC HH measure:

- Measure name
- Number of eligible cases
- Statistical significance level

NOTE: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level is not displayed on the report.

The data are depicted in a bar graph with bars labeled as follows, as appropriate:

- HHA Obs
- HHA Prior Obs
- HHA Adj Prior
- HHA HHC RA
- Nat'l Obs

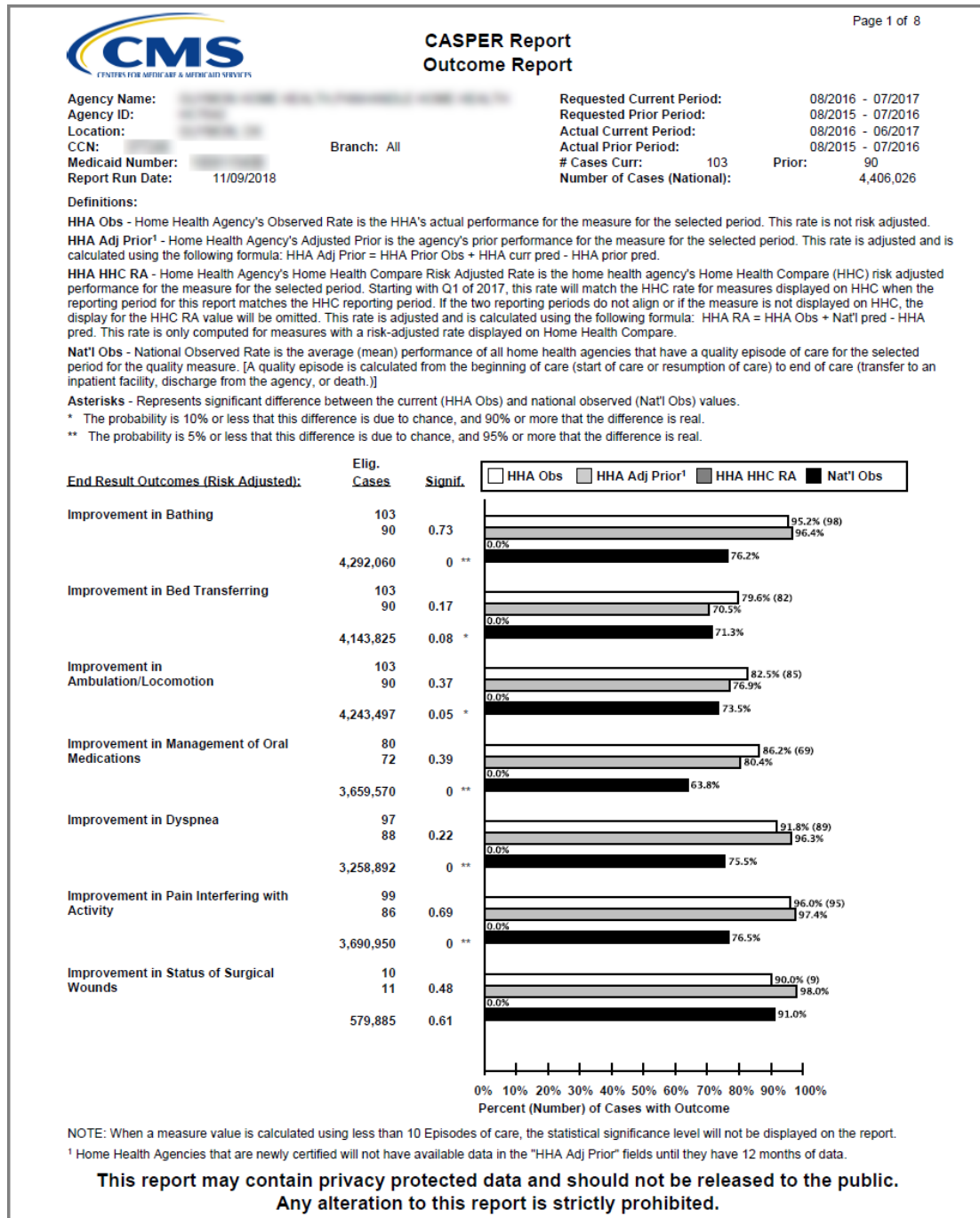
The actual number of agency cases for which the event occurred is presented in parentheses at the end of the HHA Obs(erved) bar of the graph.

Definitions of the following terms are provided for risk-adjusted End Result Outcomes (Figure 6-11) unless otherwise noted below:

- HHA Obs – Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected period. This rate is not risk adjusted.

- HHA Adj Prior – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected period. This rate is adjusted and is calculated using the following formula: $\text{HHA Adj Prior} = \text{HHA Prior Obs} + \text{HHA curr pred} - \text{HHA prior pred}$.
 - Home Health Agencies that are newly certified will not have available data in the HHA Adj Prior fields until they have 12 months of data.
- HHA HHC RA – Home Health Agency's Home Health Compare Risk Adjusted Rate is the home health agency's Home Health Compare (HHC) risk adjusted performance for the measure for the selected period. Starting with Q1 of 2017, this rate will match the HHC rate for measures displayed on HHC when the reporting period for this report matches the HHC reporting period. If the two reporting periods do not align or if the measure is not displayed on HHC, the display for the HHC RA value will be omitted. This rate is adjusted and is calculated using the following formula: $\text{HHA RA} = \text{HHA Obs} + \text{Nat'l pred} - \text{HHA pred}$. This rate is only computed for measures with a risk-adjusted rate displayed on Home Health Compare.
- Nat'l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

Figure 6-11. Outcome Report – End Result Outcomes (Risk Adjusted)*

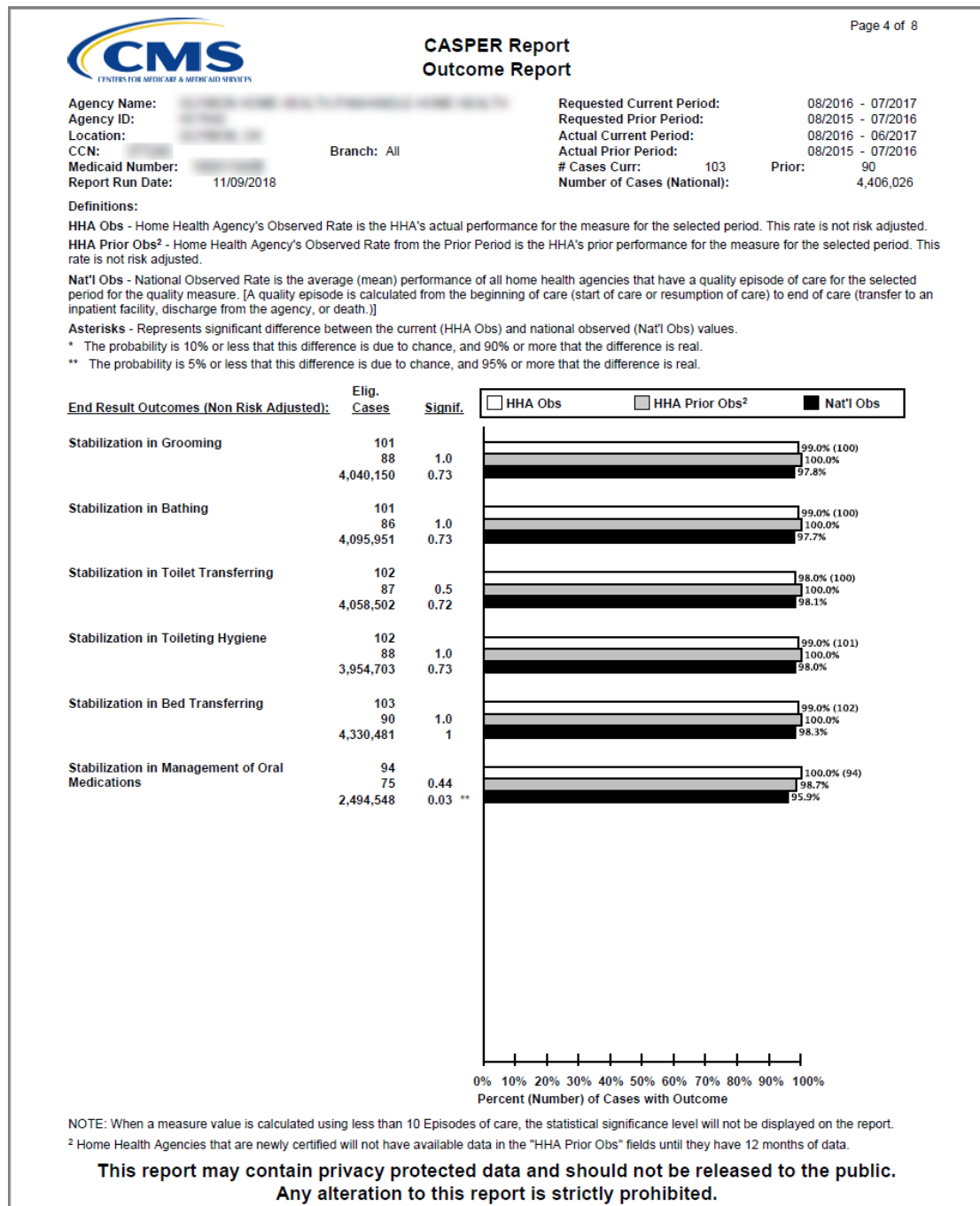


* Fictitious, sample data are depicted.

Definitions of the following terms are provided for non-risk-adjusted End Result Outcomes (Figure 6-12):

- HHA Obs – Home Health Agency’s Observed Rate is the HHA’s actual performance for the measure for the selected period. This rate is not risk adjusted.
- HHA Prior Obs – Home Health Agency’s Observed Rate from the Prior Period period is the HHA’s prior performance for the measure for the selected period. This rate is not risk adjusted.
 - Home Health Agencies that are newly certified will not have available data in the “HHA Prior Obs” fields until they have 12 months of data.
- Nat’l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat’l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

Figure 6-12. Outcome Report – End Result Outcomes (Non Risk Adjusted)*

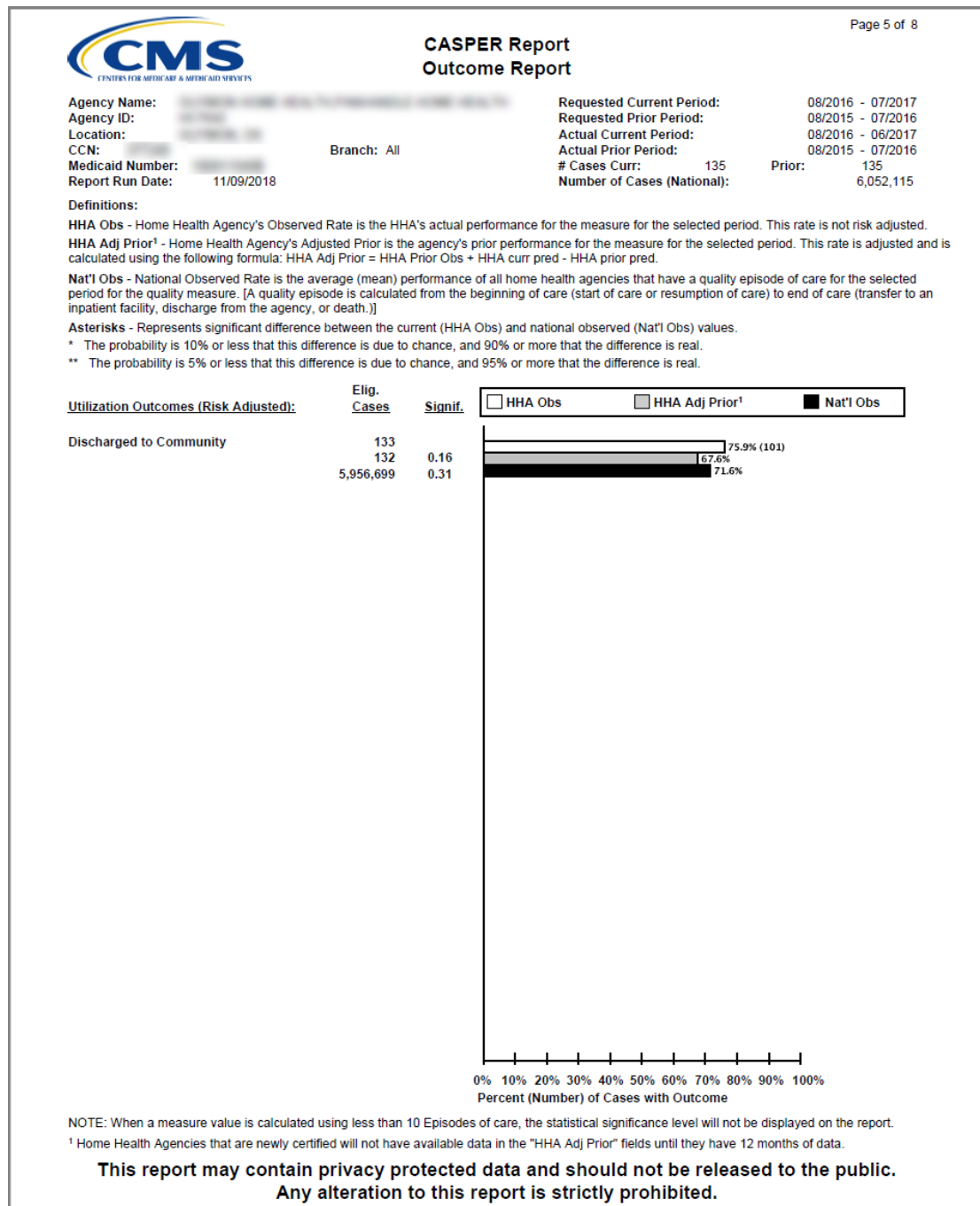


* Fictitious, sample data are depicted.

Definitions of the following terms are provided for risk-adjusted Utilization Outcomes (Figure 6-13):

- HHA Obs – Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected period. This rate is not risk adjusted.
- HHA Adj Prior – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected period. This rate is adjusted and is calculated using the following formula: $\text{HHA Adj Prior} = \text{HHA Prior Obs} + \text{HHA curr pred} - \text{HHA prior pred}$.
 - Home Health Agencies that are newly certified will not have available data in the HHA Adj Prior fields until they have 12 months of data.
- Nat'l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

Figure 6-13. Outcome Report – Utilization Outcomes (Risk Adjusted)*

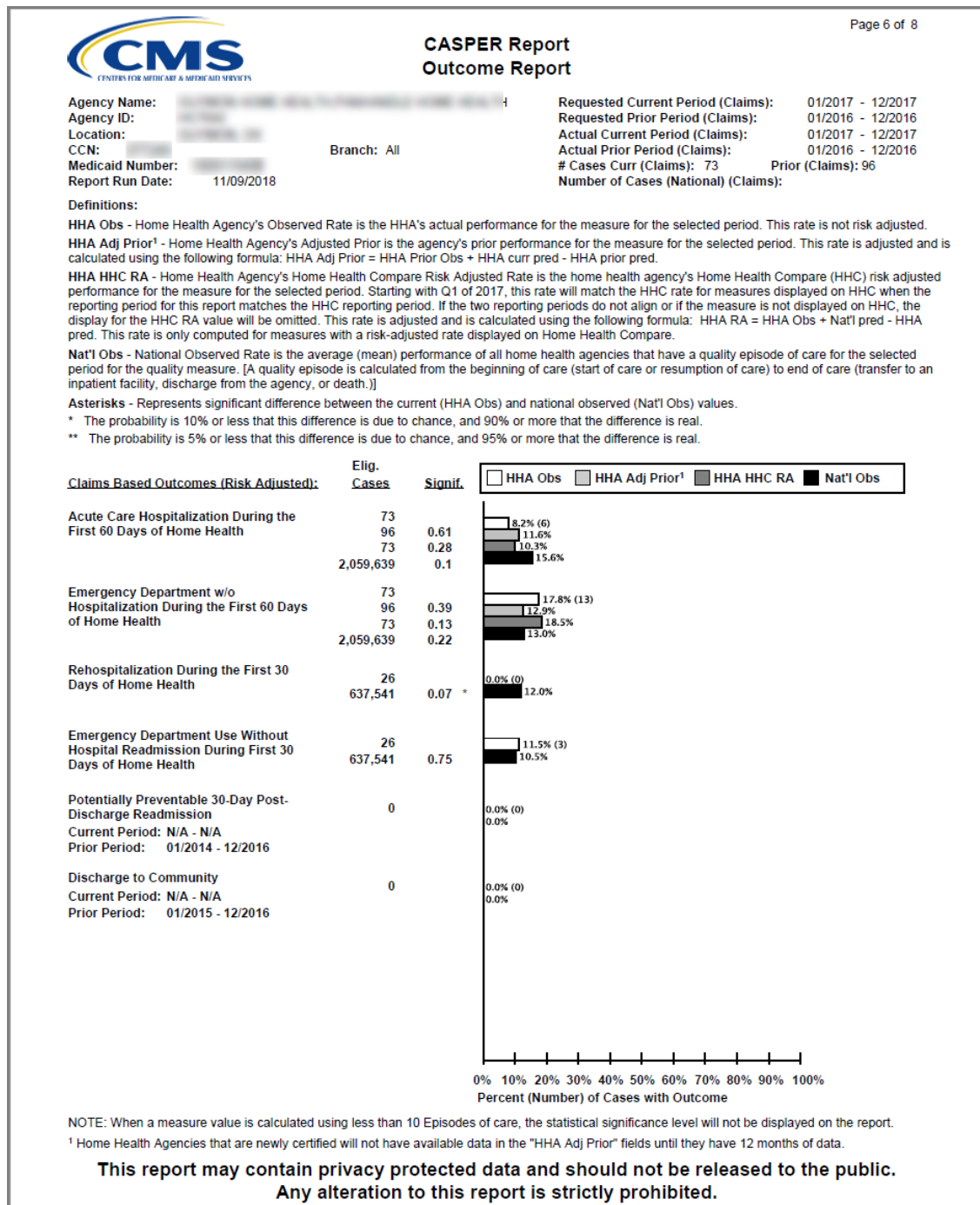


* Fictitious, sample data are depicted.

Definitions of the following terms are provided for risk-adjusted Claims Based Outcomes (Figure 6-14):

- HHA Obs – Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected period. This rate is not risk adjusted.
- HHA Adj Prior – Home Health Agency's Adjusted Prior is the agency's prior performance for the measure for the selected period. This rate is adjusted and is calculated using the following formula: $HHA\ Adj\ Prior = HHA\ Prior\ Obs + HHA\ curr\ pred - HHA\ prior\ pred$.
 - Home Health Agencies that are newly certified will not have available data in the HHA Adj Prior fields until they have 12 months of data.
- HHA HHC RA – Home Health Agency's Home Health Compare Risk Adjusted Rate is the home health agency's Home Health Compare (HHC) risk adjusted performance for the measure for the selected period. Starting with Q1 of 2017, this rate will match the HHC rate for measures displayed on HHC when the reporting period for this report matches the HHC reporting period. If the two reporting periods do not align or if the measure is not displayed on HHC, the display for the HHC RA value will be omitted. This rate is adjusted and is calculated using the following formula: $HHA\ RA = HHA\ Obs + Nat'l\ pred - HHA\ pred$. This rate is only computed for measures with a risk-adjusted rate displayed on Home Health Compare.
- Nat'l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

Figure 6-14. Outcome Report – Claims Based Outcomes (Risk Adjusted)*



* Fictitious, sample data are depicted.

NOTE: Patient-level data for claims-based measures are not included in CASPER patient-level quality measure reports.

The Medicare Spending per Beneficiary (MSPB) – Post-Acute Care Home Health (PAC HH) measure results page of the report (Figure 6-15) presents the following agency-level and national-level information:

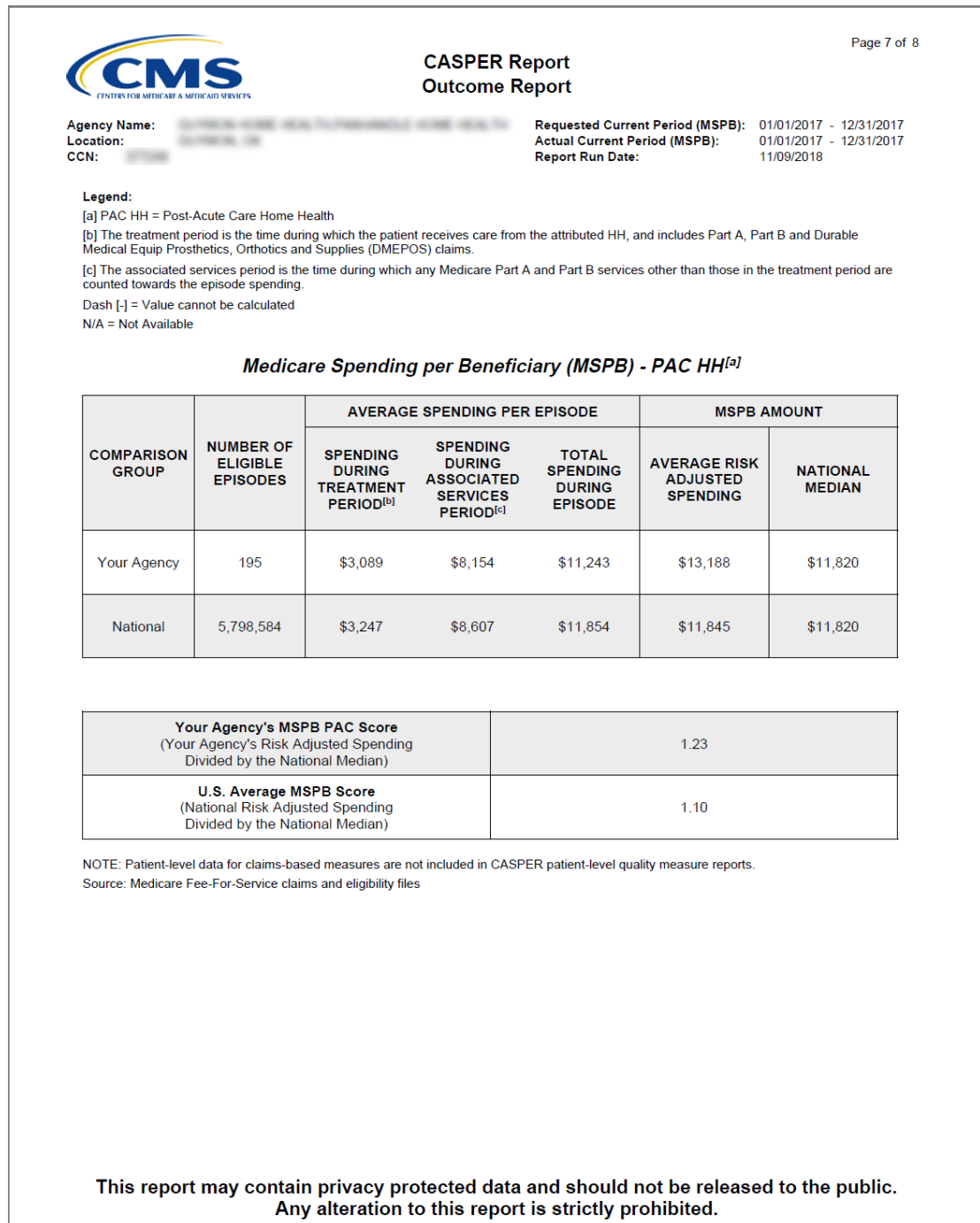
- Comparison Group (Your Agency vs. National)
- Number of Eligible Episodes
- Average Spending Per Episode
 - Spending During Treatment Period
 - Spending during Associated Services Period
 - Total Spending During Episode
- MSPB Amount
 - Average Risk Adjusted Spending
 - National Median
- Your Agency's MSPB PAC Score – Your Agency's Risk Adjusted Spending Divided by the National Median)
- U.S. Average MSPB Score – National Risk Adjusted Spending Divided by the National Median

Source: Medicare Fee-For-Service claims and eligibility files

A legend provides the following definitions:

- [a] PAC HH = Post-Acute Care Home Health
- [b] The treatment period is the time during which the patient receives care from the attributed HH, and include Part A, Part B and Durable Medical Equip Prosthetics, Orthotics and Supplies (DMEOPS) claims.
- [c] The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.
- Dash [-] = Value cannot be calculated
- N/A = Not Available

Figure 6-15. Outcome Report – Medicare Spending per Beneficiary – Post-Acute Care Home Health Measure*



* Fictitious, sample data are depicted.

The Explanation of Medicare Spending per Beneficiary (MSPB) Post-Acute Care (PAC) HHA Measure page of the report (Figure 6-16) provides the following:

“The purpose of the MSPB-PAC measures are to support public reporting of resource use in PAC provider settings as well as provide actionable, transparent information to support PAC providers’ efforts to promote care coordination and improve the efficiency of care provided to their patients.

The measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB-PAC Amount for each agency divided by the episode-weighted median MSPB-PAC Amount across all agencies of the same type. For home health agencies, episodes are categorized as Partial Episode Payment (PEP), Low Utilization Payment Adjustment (LUPA), and all others (Standard) and agencies’ episodes are compared only within each category. The figure below illustrates the episode window for calculating this measure. Beneficiary spending during the episode window is categorized as related to “Treatment” or “Associated Services.” The episode window begins on the first day of the home health claim and ends 30 days after the Treatment Period ends (which is either 60 days or at discharge for PEP episodes). Spending is standardized, bottom-coded when necessary, and risk-adjusted.”

The diagram provided shows a 90-day Associated Services Period, the first 60 days of which is the Treatment Period and the last 30 days of which completes the Associated Services Period.

For Partial Episode Payment (PEP) episodes, it is noted that the Treatment Period may be less than 60 days since a PEP episode ends at discharge from the HHA.

Treatment Period spending includes Medicare Part A/B services directly related to the beneficiary’s home health care that are provided directly or reasonably managed by the HHA.

Associated Services Period spending includes non-treatment Medicare Part A/B services provided during the full episode window. Settings include: inpatient, outpatient, SNF, HHA, IRF, LTCH, Part B, DMEPOS, Hospice.

Episode Exclusions include:

- Episodes from a RAP
- Episodes outside the 50 states, D.C., Puerto Rico and U.S. territories
- Episodes with the standard allowed amount equal to zero or where the standard allowed amount cannot be calculated
- Episodes in which the beneficiary is not enrolled in Medicare FFS for the 90 days prior to the first day of the home health claim through the episode window, or is enrolled in Part C
- Episodes not paid through prospective payment system

Service Exclusions include:

- Planned hospital admissions
- Routine management of certain preexisting chronic conditions
- Some routine screening and health care maintenance
- Immune modulating medications

Specific exclusions subject to change; please refer to links under Resources for most current information.

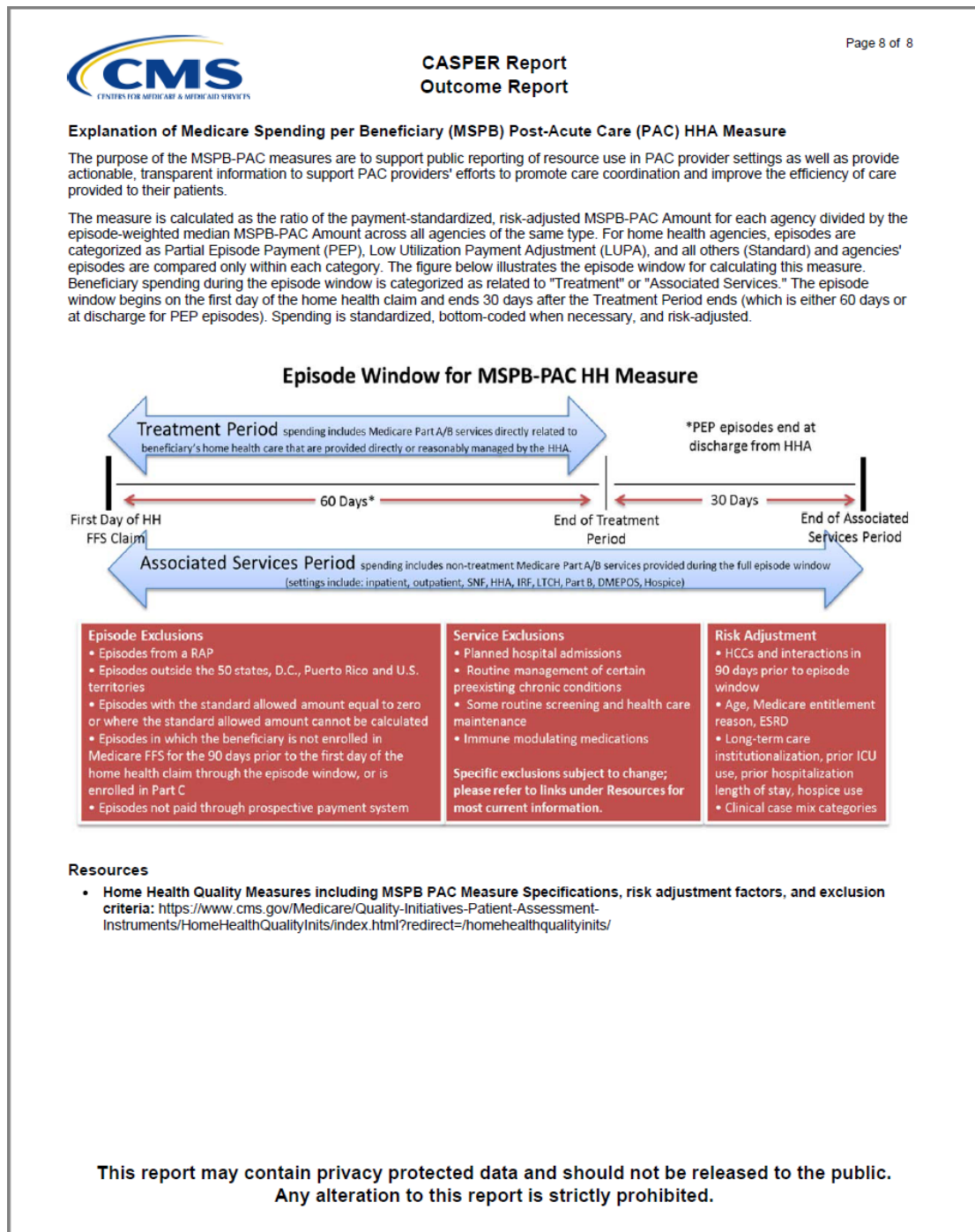
Risk Adjustment factors include:

- HCCs and interactions in 90 days prior to episode window
- Age, Medicare entitlement reason, ESRD
- Long-term care institutionalization, prior ICU use, prior hospitalization length of stay, hospice use
- Clinical case mix categories

Resources:

- Home Health Quality Measures including MSPB PAC Measure Specifications, risk adjustment factors, and exclusion criteria:
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=homehealthqualityinits/>

Figure 6-16. Outcome Report – MSPB-PAC HH Measure Explanation



OUTCOME TALLY REPORT

The Outcome Tally Report details the episodes of care that ended during a specified period and were used to calculate the Outcome Report for that period.

The criteria selection page (Figure 6-17) for the Outcome Tally Report presents *Begin Date*, and *End Date* options.

Figure 6-17. CASPER Reports Submit Page – Outcome Tally Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: Outcome Tally Report

Begin Date: 03/2013
End Date: 07/2017

Template Folder: My Favorite Reports
Template Name: Outcome Tally Report

Submit Save & Submit Back Save

Begin Date defaults to the month and year of the most recent data available that begins a full 12-month reporting period.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

End Date defaults to the most recent date available for reporting.

You can select an alternate *End Date* and/or *Begin Date* from the drop-down list provided. The *Begin Date* must be earlier than the *End Date*.

NOTE: The number of episodes of care is limited to 25,000 for this report unless the reporting period is one month. If the timeframe you request is greater than one month and includes more than 25,000 episodes of care, the report is not run. You are instructed to select the **Back** button to return to the criteria selection page and select a shorter timeframe that includes fewer episodes of care.

The Outcome Tally Report (Figure 6-18) lists each episode of care that ended during the specified period, including the Patient Name, SOC/ROC Date, and SOC/EOC Branch ID, and indicates the value for each Outcome measure in the following categories:

- Functional Outcomes
 - Activities of Daily Living
 - IADLs

- Health Status Outcomes
- Utilization Outcomes (OASIS-Based)

For each episode and Outcome measure one of the following is noted:


- “y” indicates the outcome was achieved
- “n” indicates the outcome was not achieved
- “-” indicates no data were available
- “/” indicates the patient was excluded from this measure

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CMS Certification Number (CCN)
- Medicaid Number
- Report Run Date

NOTE: The Outcome Tally Report contains protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-18. Outcome Tally Report*



CASPER Report
Outcome Tally Report

Page 1 of 21 - A

Agency Name: [REDACTED]
 Agency ID: [REDACTED]
 Location: [REDACTED]

CCN: [REDACTED]
 Medicaid Number: [REDACTED]
 Report Run Date: 11/14/2018

Report Period: 09/2016 - 01/2019			Functional Outcomes															
			Activities of Daily Living													IADLs		
Legend:			Improvement in Grooming ¹	Stabilization in Grooming	Improvement in Upper Body Dressing	Improvement in Lower Body Dressing	Improvement in Bathing	Stabilization in Bathing	Improvement in Toilet Transferring	Stabilization in Toilet Transferring	Improvement in Toileting Hygiene ¹	Stabilization in Toileting Hygiene	Improvement in Bed Transferring	Stabilization in Bed Transferring	Improvement in Ambulation/Locomotion	Improvement in Eating ¹	Improvement in Management of Oral Medications	Stabilization in Management of Oral Medications
Patient Name	SOC/ROC Date	SOC/EOC Branch ID																
[REDACTED]	05/01/17	N/N	y	y	y	y	y	y	-	y	-	y	-	y	y	-	-	y
[REDACTED]	01/18/17	N/N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
[REDACTED]	02/24/17	N/N	n	y	n	n	n	y	n	y	y	y	y	y	y	n	y	-
[REDACTED]	08/27/16	N/N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
[REDACTED]	01/23/17	N/N	y	y	y	y	y	y	y	y	y	y	y	y	y	-	y	-
[REDACTED]	09/06/16	N/N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
[REDACTED]	10/13/16	N/N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
[REDACTED]	08/01/13	N/N	-	y	-	-	-	y	-	y	-	y	-	y	-	n	y	-
[REDACTED]	06/17/17	N/N	y	y	y	y	y	y	y	y	y	y	y	y	y	-	y	y
[REDACTED]	12/07/16	N/N	y	y	y	y	y	y	y	y	y	-	y	y	y	y	y	-
[REDACTED]	01/30/17	N/N	y	y	y	y	y	y	n	y	-	y	n	y	y	y	y	y

Footnote Legend

¹ This measure has been removed from the CMS Home Health Quality Initiative. Data are provided here for agencies' internal quality monitoring and improvement efforts.

² Measure results for "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" will be frozen as of the October 2019 Home Health Compare refresh and will include quality episodes ending January 2018-December 2018.

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

Report Footnote Legend:

¹ This measure has been removed from the CMS Home Health Quality Initiative. Data are provided here for agencies' internal quality monitoring and improvement efforts.

² Measure results for "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" will be frozen as of the October 2019 Home Health Compare refresh and will include quality episodes ending January 2018-December 2018.

POTENTIALLY AVOIDABLE EVENT PATIENT LISTING REPORT

The Potentially Avoidable Event Patient Listing Report lists each of the Potentially Avoidable Event Measures, statistics for each, and the patients who experienced those events for the agency during a specified period.

The criteria selection page (Figure 6-19) for the Potentially Avoidable Event Patient Listing Report presents *Begin Date*, and *End Date* options.

Figure 6-19. CASPER Reports Submit Page – Potentially Avoidable Event Patient Listing Report

The screenshot shows a web interface for submitting a report. At the top, there is a navigation bar with links: Logout, Folders, MyLibrary, Reports, Queue, Options, Maint, and Home. Below this, the page title is "Report: Potentially Avoidable Event Patient Listing Report". Underneath the title, there are two date selection fields: "Begin Date" with a dropdown menu showing "03/2013" and "End Date" with a dropdown menu showing "07/2017". At the bottom, there are two input fields: "Template Folder" with a dropdown menu showing "My Favorite Reports" and "Template Name" with a dropdown menu showing "Potentially Avoidable Event Patient Listing Report". To the right of these fields are four buttons: "Submit", "Back", "Save & Submit", and "Save".

Begin Date and *End Date* default to the most recent 12 months of data available for reporting. You can select alternate dates from the drop-down lists provided. The *End Date* must not be earlier than the *Begin Date*.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

The Potentially Avoidable Event Patient Listing Report (Figure 6-20) lists each of the Potentially Avoidable Event measures and provides the following information about the occurrence of each event for the agency during a specified period:

- Complete Data Cases
- Number of Events
- Agency Incidence
- National Observed Rate
- Patient ID
- Last Name
- First Name
- Gender
- Birth Date
- SOC/ROC Date
- Discharge/Transfer Date


- SOC/EOC Branch ID

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CCN
- Medicaid Number
- Requested Current Period
- Actual Current Period
- Number of Cases in Current Period
- Number of Cases (National)
- Report Run Date

NOTE: The Potentially Avoidable Event Patient Listing Report contains protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-20. Potentially Avoidable Event Patient Listing*



CASPER Report
Potentially Avoidable Event:
Patient Listing Report

Page 1 of 2

Agency Name: [REDACTED]
 Agency ID: [REDACTED]
 Location: [REDACTED]
 CCN: [REDACTED]
 Medicaid Number: [REDACTED]

Requested Current Period: 09/2016 - 01/2019
 Actual Current Period: 09/2016 - 07/2017
 Number of Cases in Current Period: 302
 Number of Cases (National): 6,404,479
 Report Run Date: 11/14/2018

Emergent Care for Improper Medication Administration, Medication Side Effects

Complete Data Cases : 299 Number of Events : 2 Agency Incidence : 0.67% Nat'l Obs : 0.18%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N

Emergent Care for Hypo/Hyperglycemia

Complete Data Cases : 299 Number of Events : 0 Agency Incidence : 0.00% Nat'l Obs : 0.34%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Development of Urinary Tract Infection

Complete Data Cases : 172 Number of Events : 3 Agency Incidence : 1.74% Nat'l Obs : 1.01%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N

Increase in Number of Pressure Ulcers

Complete Data Cases : 203 Number of Events : 2 Agency Incidence : 0.99% Nat'l Obs : 0.44%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	N/N

Substantial Decline in 3 or More Activities of Daily Living

Complete Data Cases : 201 Number of Events : 0 Agency Incidence : 0.00% Nat'l Obs : 0.29%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Substantial Decline in Management of Oral Medications

Complete Data Cases : 37 Number of Events : 0 Agency Incidence : 0.00% Nat'l Obs : 0.39%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Discharged to the Community Needing Wound Care or Medication Assistance

Complete Data Cases : 203 Number of Events : 0 Agency Incidence : 0.00% Nat'l Obs : 0.05%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Discharged to the Community Needing Toileting Assistance

Complete Data Cases : 203 Number of Events : 0 Agency Incidence : 0.00% Nat'l Obs : 0.03%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

POTENTIALLY AVOIDABLE EVENT REPORT

The Potentially Avoidable Event Report provides risk-adjusted Potentially Avoidable Event mean measure rates for episodes of care that ended during two specified periods (current and prior) and compares these findings to a national reference.

A separate bar graph containing three bars is provided for each measure. The first of the three bars reflects the actual percentage of agency patients that experienced the event in the requested reporting period. The second bar reflects the risk-adjusted percentage of agency patients that experienced the event in the prior reporting period. The third bar reflects the average (mean) performance of all home health agencies with a quality episode of care for the selected period for the event.

You may select a text-only version of the report for use with electronic screen-reading technology.

NOTE: The non-text version of this report contains bar graphics and is incompatible with the CSV output format. PDF is the recommended output format for the non-text version of this report. If you desire the report output in CSV format, please request the text version of this report.

The criteria selection page (Figure 6-21) for the Potentially Avoidable Event Report presents *Prior Begin Date*, *Prior End Date*, *Current Begin Date*, *Current End Date*, and *Report By Branch* options.

Figure 6-21. CASPER Reports Submit Page – Potentially Avoidable Event Report

The screenshot shows the 'CASPER Reports Submit' page. At the top, there are navigation links: Skip navigation links, CASPER Reports Submit, Logout, Folders, MyLibrary, Reports, Queue, Options, Maint, and Home. Below this is a section titled 'Report: Potentially Avoidable Event Report'. Inside this section, there are four date pickers: 'Prior Begin Date' (09/2015), 'Prior End Date' (08/2016), 'Current Begin Date' (09/2016), and 'Current End Date' (01/2019). There is also a checkbox for 'Report By Branch'. At the bottom, there are two dropdown menus: 'Template Folder' (My Favorite Reports) and 'Template Name' (Potentially Avoidable Event Report). To the right of these are four buttons: Submit, Back, Save & Submit, and Save.

Prior Begin Date and *Prior End Date* default to the 12-month period prior to the most recent 12 months of data available for reporting. You can select alternate dates from the drop-down lists provided. The *Prior End Date* must not be earlier than the *Prior Begin Date*.

Current Begin Date and *Current End Date* default to the most recent 12 months of data available for reporting. You can select alternate dates from the drop-down lists provided. The *Current End Date* must not be earlier than the *Current Begin Date* and the *Current Begin Date* must be later than the *Prior End Date*.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

To view data for branches along with the overall agency report, select the *Report By Branch* checkbox.

NOTE: Branch information includes only those patients with episodes of care where both the start and end dates of care are associated with the same branch or parent agency.

The Potentially Avoidable Event Report (Figure 6-22) compares, for the specified “current” period, the agency’s measure values and numbers of eligible cases of the Potentially Avoidable Event measures to those in the national reference sample as well as the specified “prior” period.

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CCN
- Branch
- Medicaid Number
- Report Run Date
- Requested Current Period
- Requested Prior Period
- Actual Current Period
- Actual Prior Period
- Number of Cases
 - Current Period
 - Prior Period
 - National

Definitions of the following terms are provided:

- HHA Obs – Home Health Agency’s Observed Rate is the HHA’s actual performance for the measure for the selected period. This rate is not risk adjusted.

- HHA Prior Obs – Home Health Agency’s Observed Rate from the Prior Period is the HHA’s prior performance for the measure for the selected period. This rate is not risk adjusted.
 - Home Health Agencies that are newly certified will not have available data in the HHA Prior Obs fields until they have 12 months of data.
- Nat’l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat’l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

The data are depicted in a bar graph with bars labeled as follows:

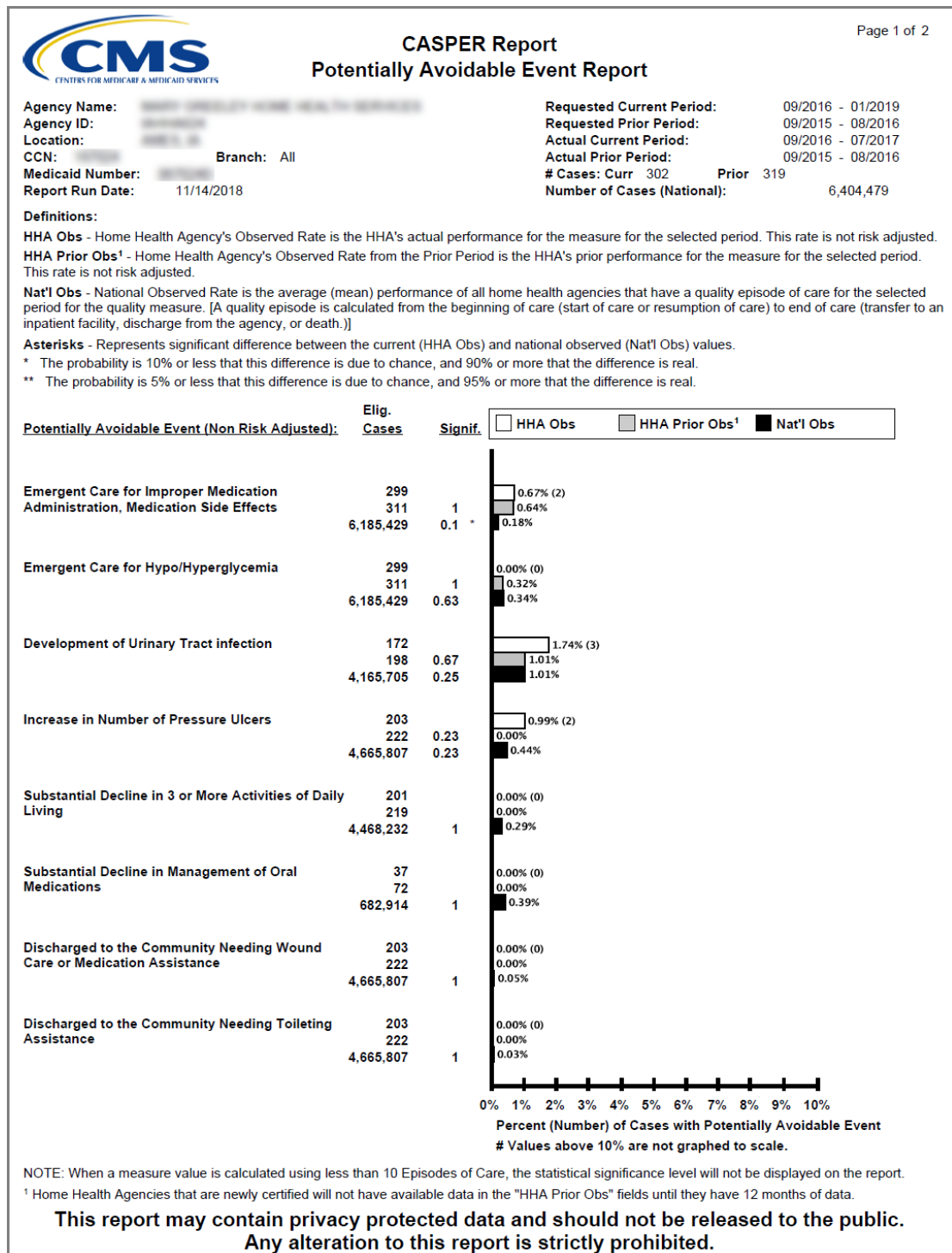
- HHA Obs
- HHA Prior Obs
- Natl Obs

The actual number of agency cases for which the event occurred is presented in parentheses at the end of the HHA Obs(erved) bar of the graph.

NOTE: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level is not displayed on the report.

NOTE: The Potentially Avoidable Event Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-22. Potentially Avoidable Event Report*



* Fictitious, sample data are depicted.

PROCESS MEASURES REPORT

The Process Measures Report identifies the agency's performance for each process measure for episodes of care that ended during two specified periods (current and prior), along with national reference rates for the current period.

You may select a text-only version of the report for use with electronic screen-reading technology.

NOTE: The non-text version of this report contains bar graphics and is incompatible with the CSV output format. PDF is the recommended output format for the non-text version of this report. If you desire the report output in CSV format, please request the text version of this report.

The criteria selection page (Figure 6-23) for the Process Measures Report presents *Prior Begin Date*, *Prior End Date*, *Current Begin Date*, *Current End Date*, and *Report By Branch* options.

Figure 6-23. CASPER Reports Submit Page – Process Measures Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: Process Measures Report

Prior Begin Date: 03/2012
Prior End Date: 02/2013
Current Begin Date: 03/2013
Current End Date: 07/2017
Report By Branch: ☐

Template Folder: My Favorite Reports
Template Name: Process Measures Report

Submit Save & Submit Back Save

Current Begin Date defaults to the month and year of the most recent data available that begins a full 12-month reporting period. *Prior Begin Date* defaults to the month and year 12 months earlier than the *Current Begin Date*.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

Current End Date defaults to the most recent date available for reporting. *Prior End Date* defaults to the month and year 12 months earlier than the *Current End Date*.

You can select an alternate *Current End Date*, *Prior End Date*, *Current Begin Date*, and/or *Prior Begin Date* from the drop-down list provided. The *Current Begin Date* must be earlier than the *Current End Date*, and the *Prior Begin Date* must be earlier than the *Prior End Date*. The *Prior End Date* must be earlier or the same as the *Current Begin Date*.

To view data for branches along with the overall agency report, select the *Report By Branch* checkbox.

NOTE: Branch information is available only for patients with episodes of care where the SOC/ROC and Discharge/Transfer assessments indicate the same Branch ID (M0016).

The Process Measures Report (Figure 6-24) compares in a 3-bar graph the agency's percentage for each of the Process measures in the categories listed below for the specified current and prior periods to those in the national reference sample.

- Timely Care
- Assessment
- Care Plan Implementation
- Education
- Prevention

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CMS Certification Number (CCN)
- Branch
- Medicaid Number
- Report Run Date
- Requested Current Period
- Requested Prior Period
- Actual Current Period
- Actual Prior Period
- Number of Cases
 - Current Period
 - Prior Period
 - National

The data are depicted in a bar graph with bars labeled as follows, as appropriate:

- HHA Obs
- HHA Prior Obs
- Nat'l Obs

The number of cases during the current period for which each process was followed is presented in parentheses at the end of the HHA Obs(erved) bar of the graph.

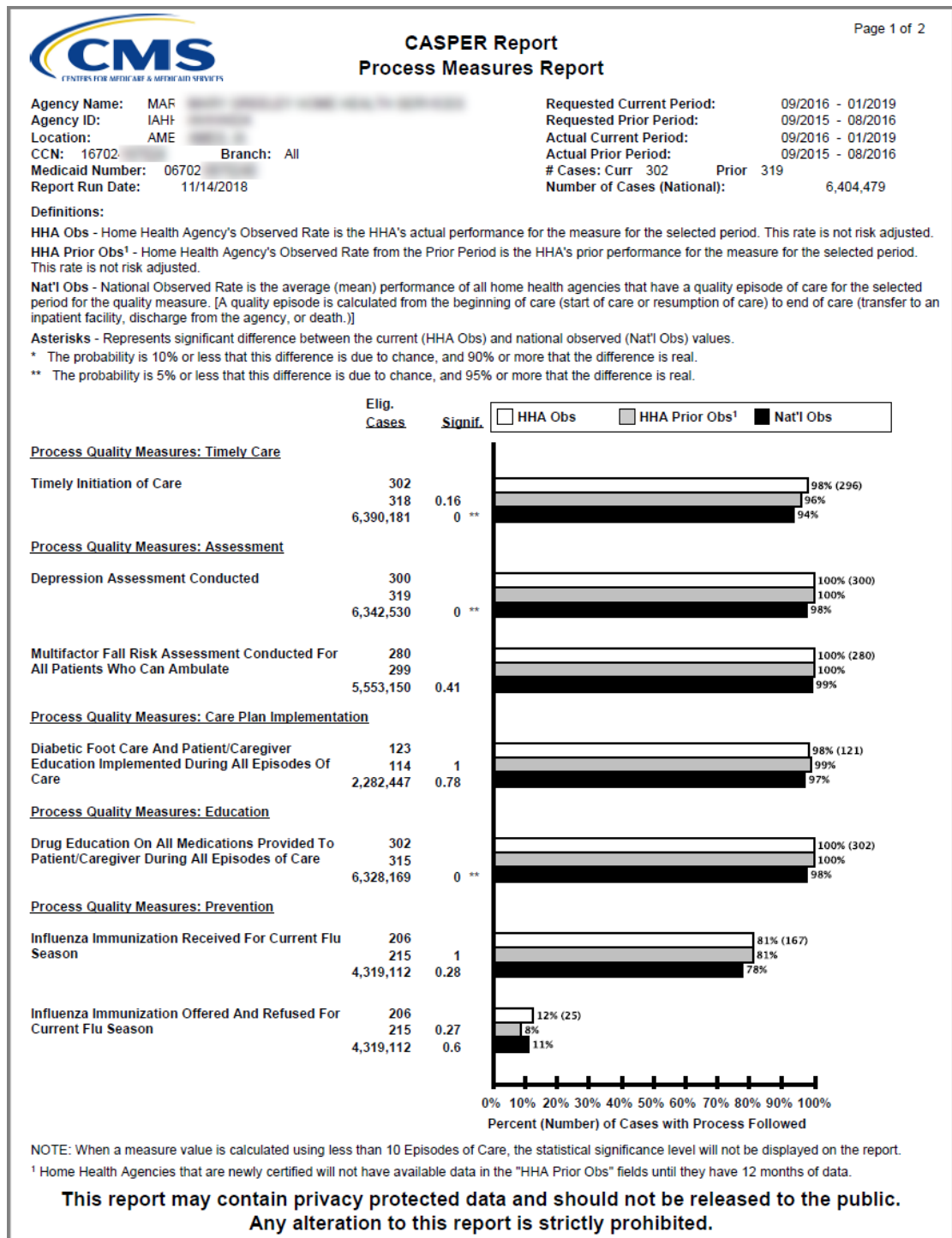
Definitions of the following terms are provided:

- HHA Obs – Home Health Agency's Observed Rate is the HHA's actual performance for the measure for the selected period. This rate is not risk adjusted.
- HHA Prior Obs – Home Health Agency's Observed Rate from the Prior Period is the agency's prior performance for the measure for the selected period. This rate is not risk adjusted.
 - Home Health Agencies that are newly certified will not have available data in the HHA Prior Obs fields until they have 12 months of data.
- Nat'l Obs – National Observed Rate is the average (mean) performance of all home health agencies that have a quality episode of care for the selected period for the quality measure. [A quality episode is calculated from the beginning of care (start of care or resumption of care) to end of care (transfer to an inpatient facility, discharge from the agency, or death.)]
- Asterisks – Represents significant difference between the current (HHA Obs) and national observed (Nat'l Obs) values.
 - * The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 - ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.

NOTE: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level is not displayed on the report.

NOTE: The Process Measures Report may contain protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.

Figure 6-24. Process Measures Report*



* Fictitious, sample data are depicted.

PROCESS TALLY REPORT

The Process Tally Report details the episodes of care that ended during a specified period, identifying the Process quality measures triggered for that period. The Process Tally Report details the episodes of care used to calculate the Process Measures Report.

The criteria selection page (Figure 6-25) for the Process Tally Report presents *Begin Date* and *End Date* options.

Figure 6-25. CASPER Reports Submit Page – Process Tally Report

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: Process Tally Report

Begin Date: 03/2013
End Date: 07/2017

Template Folder: My Favorite Reports
Template Name: Process Tally Report

Submit Save & Submit Back Save

Begin Date defaults to the month and year of the most recent data available that begins a full 12-month reporting period.

NOTE: The earliest *Begin Date* available is 01/2010, which corresponds to the implementation date of OASIS-C.

End Date defaults to the most recent date available for reporting.

You can select an alternate *End Date* and/or *Begin Date* from the drop-down list provided. The *Begin Date* must be earlier than the *End Date*.

NOTE: The number of episodes of care is limited to 25,000 for this report unless the reporting period is one month. If the timeframe you request is greater than one month and includes more than 25,000 episodes of care, the report is not run. You are instructed to select the **Back** button to return to the criteria selection page and select a shorter timeframe that includes fewer episodes of care.

The Process Tally Report (Figure 6-26) lists each episode of care that ended during the specified period, including the Patient Name, SOC/ROC Date, and SOC/EOC Branch ID, and indicates the agency's performance of each Process quality measure in the following categories:

- Timely Care
- Assessment

- Care Plan Implementation
- Education
- Prevention

For each episode and Process measure one of the following is noted:


- “y” indicates the measure was achieved
- “n” indicates the measure was not achieved
- “-“ indicates no data were available
- “/” indicates the patient was excluded from this measure

The heading of the report provides the following information on each page:

- Agency Name
- Agency ID
- Location
- CCN
- Medicaid Number
- Report Date

<p>NOTE: The Process Tally Report contains protected privacy information that should not be released to the public. Any alteration to this report is strictly prohibited.</p>
--

Figure 6-26. Process Tally Report*



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report
Process Tally Report

Page 1 of 2 - A

Agency Name: [REDACTED]

Agency ID: [REDACTED]

Location: [REDACTED]

CCN: [REDACTED]

Medicaid Number: [REDACTED]

Report Run Date: 11/12/2018

Report Period: 01/2017 - 01/2019			Process Quality Measures								
			Timely Care	Assessment		Care Plan Implementation					
<p>Legend:</p> <p>SOE = Start Of Episode</p> <p>POC = Plan Of Care</p> <p>SOC = Start Of Care</p> <p>ROC = Resumption Of Care</p> <p>EOC = Episodes Of Care</p> <p>y = Measure achieved</p> <p>n = Measure not achieved</p> <p>- = No data available</p> <p>/ = Excluded from this measure</p>											
Patient Name	SOC/ROC Date	SOC/EOC Branch ID	Timely Initiation Of Care	Depression Assessment Conducted	Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate	Depression Interventions Implemented During All EOC ¹	Diabetic Foot Care And Patient/Caregiver Education Implemented During All EOC	Pain Interventions Implemented During All Episodes Of Care ²	Treatment Of Pressure Ulcers Based On Stages Of Wound Healing For All EOC ¹		
[REDACTED]	12/15/16	N/N	y	y	y	-	-	y	-		
[REDACTED]	01/26/17	N/N	y	y	y	-	-	-	-		
[REDACTED]	02/26/17	N/N	y	y	-	-	y	y	-		
[REDACTED]	03/18/17	N/N	y	y	y	-	-	y	-		
[REDACTED]	03/29/17	N/N	y	y	y	-	-	-	-		
[REDACTED]	05/08/17	N/N	y	y	-	-	-	y	-		
[REDACTED]	01/16/17	N/N	y	y	y	-	-	-	-		
[REDACTED]	01/20/17	N/N	y	y	y	-	y	y	-		
[REDACTED]	03/10/17	N/N	y	-	-	-	-	-	-		
[REDACTED]	02/23/17	N/N	y	y	y	-	-	y	-		

Footnote Legend

¹ This measure has been removed from the CMS Home Health Quality Initiative effective January 1, 2017. Data are provided here for agencies' internal quality monitoring and improvement efforts.

² This measure has been removed from the CMS Home Health Quality Reporting Program effective January 1, 2017. Data are provided here for agencies' internal quality monitoring and improvement efforts.

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

¹ This measure has been removed from the CMS Home Health Quality Initiative effective January 1, 2017. Data are provided here for agencies' internal quality monitoring and improvement efforts.

² This measure has been removed from the CMS Home Health Quality Reporting Program effective January 1, 2017. Data are provided here for agencies' internal quality monitoring and improvement efforts.

Definitions of acronyms used:

- SOE = Start of Episode
- POC = Plan of Care
- SOC = Start of Care
- ROC = Resumption of Care
- EOC = Episodes of Care