AHRQ REPORT ON HOME HEALTH QUALITY MEASURES FOR CMS PUBLIC REPORTING
RESULTS OF TECHNICAL EXPERT PANEL MEETING AND AHRQ RECOMMENDATIONS

Executive Summary

This report focuses on the Agency for Healthcare Research and Quality (AHRQ) home health quality measure recommendations for the Centers for Medicare & Medicaid Services (CMS) public reporting initiative. A separate comprehensive public report will be released which encompasses AHRQ's measure recommendations for both the CMS public reporting initiative and the NHQR report.

AHRQ convened a technical expert panel to obtain their individual views and suggestions regarding a short set of home health quality measures for each of the above purposes. As a starting point, the panel members were given the measures derived from the Outcome and Assessment Information Set (OASIS). Based on the list of priority measures submitted at the end of the 2 day meeting by each Panel member, their additional written comments and the meeting discussion, AHRQ recommends 10 measures for CMS's public reporting pilot for home health. AHRQ provides a list of 4 additional measures for consideration by CMS for its initiative. Advantages and disadvantages of each of these measures are presented in the report.

Introduction and Background

Under an Intraagency Agreement with the CMS, AHRQ convened a technical expert panel on October 21-22, 2002 focused on home health quality of care measures. The purpose of this meeting was to conduct and align two independent but overlapping efforts being planned by CMS and AHRQ. The goal of the CMS effort was to select measures for its home health public reporting initiative. The goal of the AHRQ effort was to select candidate measures for the National Healthcare Quality Report (NHQR), described below. To address both of these goals, AHRQ convened the panel to review a set of existing home health quality measures as candidates for the CMS home health public reporting initiative and the NHQR, respectively.

In line with the Secretary's initiative to provide consumers with more information to empower them to make health care decisions on the basis of quality, CMS is committed to the public reporting of home health quality measures on every Medicare-certified home health agency (HHA) in the United States. This information will allow consumers to compare the quality of care of HHAs and to use this information when selecting an agency to provide home health care. In addition, public release of this information should prompt HHAs to do a better job monitoring their own quality performance, targeting areas for improvement, and implementing plans to improve specific quality of care outcomes. The public reporting effort, along with CMS programs to assist HHAs in improving the quality of their outcomes, should raise the standard of care across all HHAs. CMS requested AHRQ's assistance and guidance on appropriate measures to use for a multi-state pilot of home health public reporting.

AHRQ has a congressional mandate to produce an annual report to the nation on health care quality (P.L. 106-129). The NHQR will include a broad set of performance measures, including home health measures**,** which will be used to monitor the nation's progress toward improved health care quality. For the initial reports, AHRQ will rely heavily on existing data sources, which in the field of home health is the OASIS data. AHRQ issued a call for public comment on the preliminary measure set for the first NHQR; however, no home health quality measures were proposed.

The OASIS data set is the only national, standardized data source on adult home health care delivery. The OASIS instrument was created over a 14-year period to measure functional outcomes for improving quality of care. It was developed through a scientific process, using input from the home healthcare industry, and has been tested for validity and reliability. All Medicare certified HHAs implemented the OASIS instrument nationwide for collection and reporting of comprehensive patient assessments in October 1999. Since both of the above-described CMS and AHRQ efforts were to begin by using OASIS-derived home health quality measures, it was deemed in the best interests of the government that these two critical review and initial selection efforts be coordinated.

It should be noted that "home health care" in this report refers primarily to the home health care benefit for Medicare beneficiaries needing intermittent in-home skilled nursing, physical and occupational therapy, speech-language therapy, medical social work and home health aide services. This type of care is more limited in scope than the entire spectrum of "home care"services which encompasses these Medicare covered services as well as all other home and community based services.

The University of Colorado, under contract with CMS, developed Outcome-Based Quality Improvement (OBQI) reports based on the OASIS measures to assist home care agencies to measure the improvement in the quality of care provided to Medicare beneficiaries and other patients. Home health agencies use the reports to target outcomes for improvement, compare the staff behaviors used to treat patients with best practice behaviors, identify the behaviors needed to change for improvement, develop and implement plans, and assess their improvement rates over time. All Medicare certified agencies received OBQI reports in early 2002.

Panel Composition

The Technical Expert Panel was composed of 18 members representing a wide range of disciplines and interests: home health agency representatives, clinicians (both physicians and nurses), an epidemiologist, consumer reporting experts and a consumer group organization*,* quality improvement organizations, state survey agencies, and home health services researchers. The panelist list is in Attachment A.

Meeting Process

AHRQ and CMS staff gave introductory remarks and overviews of the two parallel purposes and goals of the meeting. Then, Dr. Peter Shaughnessey and others from the

University of Colorado, gave background presentations on development of the OASIS measures, their statistical properties, and their use in quality improvement. In addition, Dr. Margaret Gerteis of BearingPoint, Inc. presented results of testing OASIS measures (in plain language) in focus groups with consumers and interviews with physicians and discharge planners, who would be users of such quality measure information.

When the speakers completed presenting the introductory background material, Dr. Larry Bartlett, the meeting facilitator, described how the remainder of the meeting would proceed. He explained that since this technical expert panel was not established as a formal federal advisory committee, AHRQ would not seek consensus from the panel members nor seek any formal vote***(s)*** from the panel. Instead, the emphasis would be on viewpoints of the individual panel members as each of the existing OASIS measures were discussed according to pre-established criteria (Attachment B), derived from criteria developed by the Institute of Medicine for the NHQR. Panelists were given a workbook with criteria worksheets and statistical properties for each of the measures. The presenters stayed during the entire meeting for technical support and clarifications.

At the end of the second day, all of the panel members were asked to bring together their values, insights, and knowledge to provide input to AHRQ, on which of the 41 OASIS measures should be priority items, first, for CMS public reporting purposes and, second, for AHRQ's publication of the NHQR. It was acknowledged that these two lists might be different.

The meeting was open to the public and representatives from the home health industry trade associations, industry consultants, agencies and journalists attended.

OASIS Measures Reviewed by Panel

The Panel was charged with focusing on 41 OASIS measures, a subset of the 54 measures in OASIS. To facilitate discussion, these 41 measures were put into 13 categories (used in consumer testing) and three domains (adapted from the Foundation for Accountability framework) as follows:

DOMAIN: GETTING BETTER

Category 1: PHYSICAL HEALTH

1. Improvement in Dyspnea
2. Improvement in Status of Surgical Wounds
3. Improvement in Number of Surgical Wounds
4. Improvement in Urinary Tract Infection
5. Improvement in Urinary Incontinence
6. Improvement in Bowel Incontinence

Category 2: MENTAL HEALTH

7. Improvement in Behavior Problem Frequency
8. Improvement in Cognitive Functioning
9. Improvement in Confusion Frequency
10. Improvement in Anxiety Level

Category 3: MEETING BASIC DAILY NEEDS
11. Improvement in Eating
12. Improvement in Upper Body Dressing
13. Improvement in Lower Body Dressing
14. Improvement in Bathing
15. Improvement in Grooming
16. Improvement in Management of Oral Medications

Category 4: GETTING AROUND
17. Improvement in Ambulation/Locomotion
18. Improvement in Toileting
19. Improvement in Transferring
20. Improvement in Pain Interfering with Activity

Category 5: MEETING HOUSEHOLD NEEDS
21. Improvement in Light Meal Preparation
22. Improvement in Laundry
23. Improvement in Shopping
24. Improvement in Housekeeping

Category 6: TALKING WITH PEOPLE
25. Improvement in Speech and Language
26. Improvement in Phone Use

Category 7: STAYING AT HOME WITHOUT HOME CARE
27. Discharged to Community

DOMAIN: LIVING WITH ILLNESS OR DISABILITY

Category 8: MEETING BASIC DAILY NEEDS
28. Stabilization in Bathing
29. Stabilization in Grooming
30. Stabilization in Management of Oral Medications

Category 9: MEETING HOUSEHOLD NEEDS
31. Stabilization in Light Meal Preparation
32. Stabilization in Laundry
33. Stabilization in Shopping
34. Stabilization in Housekeeping

Category 10: MENTAL HEALTH
35. Stabilization in Cognitive Functioning
36. Stabilization in Anxiety level

Category 11: GETTING AROUND
37. Stabilization in Transferring

Category 12: TALKING WITH PEOPLE
38. Stabilization in Speech and Language
39. Stabilization in Phone Use

DOMAIN: STAYING HEALTHY/AVOIDING INJURY OR HARM

Category 13: MEDICAL EMERGENCIES
40. Any emergency care provided
41. Acute care hospitalization

CMS and AHRQ focused panel attention on just these 41 measures because they assess long-term quality improvement issues that every home health agency should address. These OASIS measures are not specific to particular diagnoses but the functional outcomes they measure apply to many diagnoses. There are an additional 13 adverse event outcome OASIS measures that were not considered by the panel because they cover events that occur infrequently. Although the primary focus at the meeting was on these existing OASIS measures, Dr. Bartlett explained that other suggestions would be entertained at the end of the meeting as a developmental list.

Summary of Major Discussion Points

- The panelists preferred measures that HHAs could be held clearly accountable for in the short time period typically covered by the Medicare home health benefits (see distinction above), such as physical symptoms, ambulation and basic daily needs commonly called activities of daily living (ADLs). Many panelists had more concern about using cognitive function and basic household needs, commonly called instrumental activities of daily living (IADLs), for quality measures for public reporting. Many tended to view IADLs as more appropriate for a long term home care function. In fact, many on the panel noted that IADLs were not a key focus of home health care and conflicted with the Medicare homebound requirement.(e.g., ability to go shopping).

- The panelists tended to prefer improvement rather than stabilization measures (emphasizing the large number of Medicare postacute cases) and suggested that measures for chronic and acute patient populations be separate.

- Many of the panelists acknowledged that stabilization measures reflect more realistic expectations since not all home care patient can improve. This fact would be emphasized if measures were shown separately for acute versus chronic patients, as suggested by a number of panelists (see suggested measure refinements below).

- Some panelists noted that the corresponding improvement measures generally seemed more straight forward than the stabilization measures. They indicated the stabilization measures have less variability and that there may be some problems of ceiling effects. They also noted that keeping to a consistent approach (i.e., only reporting improvement measures) makes it easier for the users. The stabilization measures would need careful wording for use by consumers since initial testing showed consumers had difficulty with the stabilization concept.

- Most of the panelists often considered the size of the patient population affected by the measure for selection, i.e., selecting measures that affected the largest number of patients. For example, they considered bathing preferable to eating since there were more patients affected.

- In general, the panelists expressed the belief that measures for CMS public reporting should be risk adjusted. However, many of the panelists seemed to think that two of

the measures might be acceptable without risk adjustment (Pain Interfering with Activity and Any Emergency Care).

- The panelists expressed more interest in those measures which had been targeted by a larger percentage of home health agencies in the demonstration projects and had the greatest percentage of agencies showing improvement.

- The panelists suggested several refinements of current OASIS measures, additional measures and other ideas. These suggestions included:

  a. Separate measures for acute and chronic patients: Many panelists suggested that, parallel to what was done for CMS nursing home reporting measures, home health measures be specified separately for acute and chronic home health patients. They noted that these are two distinct populations with very different needs.

  b. Composite measures: Some panelists thought composite measures for each clinical domain should be considered (e.g., physical functioning, mental health) as well as composites of smaller groupings (e.g., upper and lower body dressing) to provide a more aggregate measure of HHA performance.

  c. Addition of handoff measures to show quality of transition between home health agencies and other providers in the health care continuum.

  d. Refinement of OASIS measures (detail in Attachment C) including:

     a. Acute hospitalization definition
     b. Emergency care definition
     c. Stabilization labeling
     d. Ambulation levels

  e. Reporting considerations: The panel suggested that consumers need to be helped to understand features of the OASIS data that affect interpretation of the measures, such as beginning and ending points of home health care and how this may not correspond to what they think of as an episode of care etc.

A summary of major points by measure domain, category and individual measures are in Attachment C.

AHRQ Recommendations for CMS Public Reporting

Based on the Home Health Quality Measures Technical Expert Panel input: the individual panelist prioritization lists (i.e., a significant proportion of panelists indicating particular measure***s*** as priority items for inclusion), their written comments and the meeting discussion, AHRQ recommends the following 10 measures (not in any rank order) for the CMS home health public reporting pilot:

- Improvement in dyspnea (physical health category)
- Improvement in urinary incontinence (physical health category)
- Improvement in upper body dressing (basic daily needs category)
- Improvement in bathing (basic daily needs category)
- Improvement in management of oral medications (basic daily needs category)
- Improvement in ambulation/locomotion (getting around category)
- Improvement in toileting (getting around category)
- Improvement in transferring (getting around category)
- Improvement in pain interfering with activity (getting around category)
- Acute care hospitalization (medical emergencies category)

These measures represent areas of quality home health care which are perceived as important to consumers, their families and intermediaries (e.g., discharge planners) and which home health agencies can impact and improve. Nine out of ten of these measures are currently risk-adjusted. The one measure that is not risk adjusted, Improvement in Pain Interfering with Activity, was included because (1) it was considered important enough that lack of risk adjustment should not preclude it, and (2) the reason for pain is not as much of an issue as adequate management of symptoms by the agency.

These recommended measures include improvement measures from categories of physical health, meeting basic daily needs and mobility related needs, and an acute care hospitalization measure. Of note, nine of these measures focus on improvement rather than stabilization, because, as noted earlier, the stabilization concept was found difficult to explain to consumers in the initial testing. This recommended list also does not contain measures on mental health, IADLs (household needs), or speech/communication.

A summary of each individual measure's advantages and disadvantages based on panel discussion and written comments is included in Attachment C.

Other Possible Measures for CMS Consideration

There are four additional measures which were selected as a priority by a fair number of the panel, although not as strongly supported as the first ten measures. If CMS wishes to include additional measures in its public reporting initiative, it might well consider the following:

- Improvement in confusion frequency (mental health category)
- Improvement in light meal preparation (IADL/household needs category)
- Stabilization in bathing (basic daily needs category)
- Any emergency care provided (medical emergency category)

This list includes one mental health measure, which one panelist thought was very important to have in the CMS report. Inclusion of a stabilization measure acknowledges the more realistic expectation that not all home care patients can be expected to improve. Inclusion of stabilization in bathing would permit paired reporting with the improvement in bathing to give a more comprehensive view of home health agency effect in one

important care area. However, except for the measure on stabilization in bathing, industry panelists expressed much less support than other panelists for these measures. These panelists were concerned about emergency care not being properly defined nor risk adjusted. However, a more robust risk adjustment model is expected to be available soon for this measure.

A summary of each individual measure's advantages and disadvantages based on panel discussion and written comments is included in Attachment C.

ATTACHMENT A

Technical Expert Panel Meeting on Home Health Measures

Agency for Healthcare Research and Quality
Rockville, MD
October 21-22, 2002

Panel Members

Shulamit Bernard, Ph.D., R.N., RTI International
Suzanne Clark, R.N., Office of Health Care Quality, State of Maryland
Julie Crocker, M.S.N., R.N., Delmarva Foundation for Medical Care (by telephone)
Carol Cronin, Annapolis, MD
Matthew Fitzgerald,Ph.D., Delmarva Foundation for Medical Care
Phyllis Fredland, R.N., Health Personnel, Inc.
William E. Golden, M.D., F.A.C.P., University of Arkansas for Medical Sciences
Rhonda Ketcham, R.N., Christiana Visiting Nurse Association
Brian W. Lindberg, Consumer Coalition for Quality Health Care
Nelda McCall, M.S., Laguna Research Associates
Jeanne McGee, Ph.D., McGee & Evers Consulting, Inc.
Christopher Murtaugh, Ph.D., Visiting Nurse Service of New York
Mary Nguyen, R.N., Welcome Homecare
Frances B. Petrella, R.N., Outcome Concept Systems, Inc.
Robin E. Remsburg, Ph.D., R.N., National Center for Health Statistics
Debra Saliba, M.D., M.P.H., UCLA/VAMC Multicampus Program in Geriatrics and RAND Corporation
Linda Scott, M.S.H.A., R.N., Johns Hopkins Home Care Group
Pamela Teenier, R.N., Gentiva Health Services
Margaret Terry, R.N., MedStar Health Vesting Nurse Association

Facilitator

Larry Bartlett, Ph.D., Health Systems Research

Speakers

Kathy Crisler, R.N., M.S., University of Colorado
Margaret Gerteis, Ph.D., BearingPoint
David Hittle, Ph.D., University of Colorado
Pete Shaughnessy, Ph.D., University of Colorado

ATTACHMENT B

MEASURE REVIEW CRITERIA [1]

CATEGORY	CRITERION
MEANINGFULNESS	• Is measure salient to policymakers? • Is measure salient to consumer? • Is measure understandable to consumer? • Is there sufficient variation in measure for consumer to differentiate agencies? *
ACTIONABLE	• Can the health system/provider meaningfully address the problem, i.e., can one determine what actions are needed for improving the measure? (in a reasonable time period?)
IMPORTANCE	• Is the measure clinically important, i.e., does it indicate problems that can have a substantial effect on morbidity, disability, functional status, mortality or overall health? • Does the measure address area in which there is a clear gap between actual and potential levels that can be influenced by improvements in quality of care? • Does measure track events that occur with sufficient frequency?
SCIENTIFIC SOUNDNESS	• Is measure valid and reliable? • Can extraneous factors beyond the control of the health system/provider be removed from/controlled for measure, i.e., can measure be risk or case mix adjusted appropriately?
FEASIBILITY	• Can measure be used to compare different population subgroups?

*** not relevant for NHQR purpose**

[1] Adapted from Envisioning the National Health Care Quality Report, Institute of Medicine, Washington, DC: National Academy Press, 2001

ATTACHMENT C

SUMMARY OF OASIS MEASURE ADVANTAGES AND DISADVANTAGES BY DOMAIN, CATEGORY AND INDIVIDUAL MEASURES

DOMAIN: GETTING BETTER

Category 1: PHYSICAL HEALTH

1. Improvement in Dyspnea

Advantages: Many panelists felt that intervention by the home health clinician can impact on the patient's management of this uncomfortable symptom and is important to quality of life. The measure was considered important because of the size of the patient population that is affected.
Disadvantages: a few panelists believed that improvement is not always a realistic goal due to the chronic nature of the respiratory status of many home care patients
Suggested changes: one panelist suggested presenting measure as: % improved, % stayed same and % worsened

2. Improvement in Status of Surgical Wounds and
3. Improvement in Number of Surgical Wounds (discussed together)

Advantages: These measures address "healing" and consumers understand healing, even in high risk populations. Of the two measures, this wound status is more intuitively meaningful than number of wounds.
Disadvantages: Since this measure is not risk adjusted, it is not recommended for a CMS consumer report. It was noted that this measure may be risk adjusted in the near future.
Suggested changes: Measurement issues need to be reconciled before these are included in reporting but this should be a priority since these measures have the potential to be important indicators of quality. This question has wording problems that have been problematic to the provider agencies, and CMS plans to include healing on the scale. This item should be considered for the CMS report when these changes are made.

4. Improvement in Urinary Tract Infection

Advantages: Important but low incidence

Disadvantages: Some of the panelists perceived this as a medical care measure and as not reflective of important aspects of home health care.

Suggested changes: none specifically mentioned

5. Improvement in Urinary Incontinence

Advantages: This is an important measure for public reporting. It affects wound healing and psychological status, so is important in more than one way. It is also an important

predictor of institutionalization that can be impacted by good nursing intervention. It is meaningful and understandable to consumer.

Disadvantages: One panelist thought the item needs some work, e.g., perception of incontinence.

Suggested changes/reporting: none mentioned

6. Improvement in Bowel Incontinence

Advantages: This measure is also an important indicator of institutionalization

Disadvantages: There are a small number of patients with this problem and the etiology is such that it is not as amenable to intervention, except for bowel regimen. Urinary incontinence might be a better indicator than bowel incontinence.

Suggested changes/reporting: One panelist suggested a composite of both urinary and bowel incontinence.

Category 2: MENTAL HEALTH

7. Improvement in Behavior Problem Frequency

Advantages: None mentioned specifically except several panelists thought that one mental health measure should be included.

Disadvantages: Behavior problems are not usually the main reason HHAs are seeing the patient. This measure is not currently risk adjusted.

Suggested changes/reporting: none mentioned specifically

8. Improvement in Cognitive Functioning

Advantages: None mentioned specifically except several panelists thought that at least one mental health measure should be included.

Disadvantages: Some panelists expressed the view that cognitive function deficits were not under the control of the agency. One panelist thought that agencies could help stabilize function but it would be difficult to improve it during the short time frame in which they see patients. This measure is not currently risk adjusted.

Suggested changes/reporting: none mentioned specifically

9. Improvement in Confusion Frequency

Advantages: Of the mental health measures, this one seems to have the best properties and it is amenable to nursing intervention. Assessment by HHAs of a patient with confusion to determine the cause and provision of an appropriate intervention, i.e., MD contacts for medication adjustments, can positively impact on the problem with the result that the patient can remain in the home. This in an issue where evidence suggests that there is a lot that HHAs can do to manage this and it affects many other areas (meds, safety, falls, hydration, ER admission, hospitalization, etc.).

Disadvantages: One panelist thought this area was not usually something HHAs can do much about. Another panelist stated that only 5 agencies in demonstrations thought they could improve on this area, which is small in comparison to other areas. A few panelists noted that inter -rater reliability is not as high as other items (.67) although still acceptable (i.e., above .6). Another panelist commented that measurement may be an issue since agencies often have to rely on family report versus direct observation due to the intermittent nature of care.

Suggested changes/reporting: none mentioned specifically

10. Improvement in Anxiety Level

Advantages: This measure was viewed as important to patients by several panelists. One panelist noted that there is much more drug therapy now available to treat anxiety. Another panelist noted that agencies can also address anxiety effectively through nonmedical treatments, e.g., breathing exercises.

Disadvantages: One panelist noted that patients often deny having anxiety and staff often cannot determine whether anxiety is present through observation alone. They must sometimes rely on someone else to tell them whether the patient is anxious. This measure is not currently risk adjusted.

Suggested changes/reporting: none mentioned specifically

Category 3: MEETING BASIC DAILY NEEDS

11. Improvement in Eating

Advantages: Eating is a critical ADL.

Disadvantages: This measure affects the smallest number of persons. Individuals who need help with eating typically have other ADL or IADL dependencies. This measure is not currently risk adjusted.

Suggested changes/reporting: None mentioned specifically

12. Improvement in Upper Body Dressing

Advantages: This is an important indicator of usefulness and improvement for patients, and being able to stay home, care for themselves and be independent. This is a good indicator for a number of physical abilities (bathing, gross-motor and eating). Upper body dressing was viewed as more important than lower body dressing. This measure speaks to rehabilitation services (PT, OT) as well as aide services and moving the patient towards independence in care.

Disadvantages: none mentioned specifically

Suggested changes/reporting: CMS needs to explain why this measure is important to consumers. CMS might consider reporting measure as: % improved, % same, % decline

13. Improvement in Lower Body Dressing

Advantages: This is an important indicator of usefulness and improvement for patients, especially in regard to rehab/therapy and being able to stay home, care for themselves/be independent.

Disadvantages: Some panelists believed that this measure was not necessary if upper body dressing measure was used.

Suggested changes/reporting: One might consider composite measure of upper and lower body dressing with grooming since consumers are likely to regard them as belonging together. In addition, they three are highly correlated with each other.

14. Improvement in Bathing

Advantages: This measure addresses basic hygiene and consumers understand the concept. It is a key part of independence, and should be part of what an agency helps one to be able to do. If a person can't bath himself, then he probably can't remain at home. It is a significant reason agencies provide a lot of home care services and is a very relevant measure of care provided. This measure speaks to rehabilitation services (PT, OT) as well as aide services and moving the patient towards independence in care.

Disadvantages: A few panelists thought this measure was not necessary if eating and upper body measures were used instead.

Suggested changes/reporting: CMS might consider reporting measure as: % improved, % same, % decline

15. Improvement in Grooming

Advantages: Grooming was viewed as important and as enhancing dignity.

Disadvantages: Some panelists thought that grooming was not necessary if upper body dressing measures were used since they are highly correlated.

Suggested changes/reporting: Some panelists suggested considering composite measure of upper and lower body dressing with grooming since consumers are likely to regard them as belonging together. However, composite measures have not been field tested nor reported to agencies.

16. Improvement in Management of Oral Medications

Advantages: This measure is important on all counts and is a good example of a common use of homecare and incorporated into almost every plan of care for patients. Medication mismanagement is a frequent cause of symptom exacerbation, ER visits and hospitalization. Assisting the patient to develop a system to manage medication has a very positive effect on maintaining the patient in the home. HHA's should be accountable for instructing on medication management as medications are an integral part of patient health. This category is a primary reason (as well as secondary) for the HHA to be providing care.

Disadvantages: One panelist mentioned that only 56.4% of agencies in demonstrations were able to improve this targeted measure.

Suggested changes/reporting: CMS might consider reporting measure as: % improved, % same, % decline

Category 4: GETTING AROUND

17. Improvement in Ambulation/Locomotion

Advantages: This item reflects the patients' ability to remain independently in their home. Both nursing and therapy interventions to improve the patient's level of function can be provided through home care. Improvement in these areas would reflect the agency's assessment of the patient and introduction of needed services. Failure to demonstrate that patients can improve might indicate lack of assessment/identification of need. This is a reason HHAs provide a lot of care and an effective measure of the skilled nursing care. Despite the possible scoring problem (see below), this measure helps to summarize ability to "get around". Of the three measures related to mobility, a few panelists thought this was the most important.

Disadvantages: There is a need to address scoring issues so that if a patient moves from ambulating with an assistive device to ambulating without an assistive device, this gets captured in the scoring algorithm.

Suggested changes/reporting: CMS needs to explain to consumers that this would be important measure for those with post orthopedic surgery.

18. Improvement in Toileting

Advantages: This item reflects the patients' ability to remain independently in their home. Both nursing and therapy interventions to improve the patient's level of function can be provided through home care. Improvement in these areas would reflect the agency's assessment of the patient and introduction of needed services. Failure to demonstrate that patients can improve might indicate lack of assessment/identification of need. If they can't manage this, then they probably can't remain in their own home. This measures a critical self-care skill and is a predictor of independent living with strong relation to community safety at home. It is a quality of life indicator understood by the consumer. Again, this is a reason HHAs provide a lot of care and an effective measure of the skilled nursing care.

Disadvantages: One panelist thought this ability would be **c**overed by upper body dressing and ambulation.

Suggested changes/reporting: none mentioned specifically

19. **Improvement in Transferring**

Advantages: If a patient can't manage this, then he probably can't remain in his own home. This is important to patients and families. Again, this is a reason HHAs provide a lot of care and an effective measure of the skilled nursing care.

Disadvantages: none mentioned specifically

Suggested changes/reporting: CMS might consider reporting measure as: % improved, % same, % decline

20. Improvement in Pain Interfering with Activity

Advantages: Pain management is central to care and the lack of risk adjustment should not preclude its inclusion. The reason for the underlying pain is not as much of an issue as the adequate management of the symptoms. It is very amenable to modulation/management and definitely affects other areas of functioning. This is of national importance and is a huge problem that resonates with all consumers. Effective pain management is a major issue nationwide across the continuum of care and providers. This measure dovetails with publicly reported measures for other providers.

Disadvantages: A few panelists expressed concern that the measure is not risk adjusted.

Suggested changes/reporting: Other pain scales should be considered. The measure needs excellent verbiage in description on the CMS report.

Category 5: MEETING HOUSEHOLD NEEDS

21. Improvement in Light Meal Preparation

Advantages: Of all the IADL's light meal preparation is an activity that takes place several times a day and is key to independent living. Another panelist thought this should be included (even without wording change mentioned below) since it predicts nursing home and other use, mortality and ADL loss, plus it captures physical and cognitive function, as well as environmental adaptation.

Disadvantages: One panelist stated any of the IADL measures would be a second choice for a report on home health care since they would reflect the agency's introduction of OT services. Some panelists thought that anything in the category of IADLs, while important, was not a focus of home health care services, nor an area of care that reimbursement was provided.

Suggested changes/reporting: The item wording should be revised to be less gender biased. ADL'S are very important for future reference/modification.

22. Improvement in Laundry

Advantages: IADLs involve a cognitive as well as a physical component and are key to patient's ability to stay at home.

Disadvantages: One panelist stated any of the IADL measures would be a second choice for a report on home health care since they would reflect the agency's introduction of OT services. Some panelists thought that anything in the category of IADLs, while important, was not a focus of home health care services, nor an area of care that reimbursement was provided. IADLs are problematic as an outcome for the short duration of home health care. Home care staff never observe those activities and they are usually self report.

Suggested changes/reporting: none specifically mentioned

23. Improvement in Shopping

Advantages: IADLs involve a cognitive as well as a physical component and are key to a patient's ability to stay at home.

Disadvantages: One panelist stated any of the IADL measures would be a second choice for a report on home health care since they would reflect the agency's introduction of OT services. Some panelists thought that anything in the category of IADLs, while important, was not a focus of home health care services, nor an area of care for which reimbursement was provided. IADLs are problematic as an outcome for the short duration of home health care. Home care staff never observe those activities and they are usually self reported. This particular IADL measure would conflict with the homebound requirement for Medicare home health coverage.

Suggested changes/reporting: none specifically mentioned

24. Improvement in Housekeeping

Advantages: IADLs involve a cognitive as well as a physical component and are key to patient's ability to stay at home.

Disadvantages: The housekeeping item can be very subjective in assessment. One panelist stated any of the IADL measures would be a second choice for a report on home health care since they would reflect the agency's introduction of OT services. Some panelists thought that anything in the category of IADLs, while important, was not a focus of home health care services, nor an area of care that reimbursement was provided. IADLs are problematic as an outcome for the short duration of home care. Home care staff never observe those activities and they are usually self report.

Suggested changes/reporting: None specifically mentioned

Category 6: TALKING WITH PEOPLE

25. Improvement in Speech and Language

Advantages: This is an important measure for persons who suffer from stroke and receive speech therapy. This is the only outcome that is addressed by speech therapy.

Disadvantages: This measure affects a small number of persons. This measure is not risk adjusted.

Suggested changes/reporting: None specifically mentioned

26. Improvement in Phone Use

Advantages: Telephone use is related to cognitive functioning.

Disadvantages: This is not a major focus of HHAs. A more direct measure of cognitive function is preferable.

Suggested changes/reporting: This measure might be more useful if it were changed to address ability to contact others for emergency purposes.

Category 7: STAYING AT HOME WITHOUT HOME CARE

27. Discharged to Community

Advantages: This is a measure of home health success and is the objective of the patients in home health - people want to know that they can stay in their own home. This is a good measure of "are the right things being done." This could be a good measure - it is a possible measure of not discharged to an acute care facility and for a patient that did not die during the home-care episode.

Disadvantages: Acute care hospitalization might be a preferable measure. One panelist argued against using the Discharge to the Community measure because premature home health discharges cannot be measured.

Suggested changes/reporting: Panelists noted the need to explain carefully who is included and excluded from calculation of this measure.

DOMAIN: LIVING WITH ILLNESS OR DISABILITY

This domain includes 11 stabilization measures. The major **advantage** is that stabilization measures reflect more realistic expectations that not all home care patient can improve. The general **disadvantage** noted is that the corresponding improvement measures seemed more straight forward that the stabilization measures. Another **disadvantage** is that stabilization measures have less variability and there may be some problems of ceiling effects. Finally, keeping to a consistent approach (i.e., only reporting improvement measures) makes it easier for audiences. These measures would need careful wording for use by consumers**.**

Category 8: MEETING BASIC DAILY NEEDS

28. Stabilization in Bathing

Advantages: Bathing is critical to maintain and stabilize. It was seen by many panelists as an important aspect in being able to live alone or without additional help. It was seen as going hand in hand with the corresponding Improvement in Bathing measure. Some panelists thought they should be easily understood by consumers and fair to measure.

Disadvantages: see discussion of this domain above

Suggested changes/reporting: Change stabilization to maintaining ability to bathe, i.e., the patient not getting worse.

29. Stabilization in Grooming

Advantages: none specifically mentioned

Disadvantages: Grooming may be subsumed under bathing. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

30. Stabilization in Management of Oral Medications

Advantages: This was perceived as a key measure of independence. Medicine management is critical to overall quality of life, safety and staying independent in the community.

Disadvantages: see discussion of this domain above

Suggested changes/reporting: none specifically mentioned

Category 9: MEETING HOUSEHOLD NEEDS

31. Stabilization in Light Meal Preparation

Advantages: A few panelists saw this as a critical factor to keep stabilized that should be matched with improvement measure. It was considered important in being able to live alone or without additional help.

Disadvantages: Many panelists viewed all 4 measures in this category as not being the primary focus of HHAs. See discussion of this domain above.

Suggested changes/reporting: change to maintaining or improving the ability to prepare light meals

32. Stabilization in Laundry

Advantages: none specifically mentioned

Disadvantages: Many panelists viewed all 4 measures in this category as not being the primary focus of HHAs. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

33. Stabilization in Shopping

Advantages: none specifically mentioned

Disadvantages: Many panelists viewed all 4 measures in this category as not being the primary focus of HHAs. This particular IADL conflicts with the Medicare homebound requirement. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

34. Stabilization in Housekeeping

Advantages: none specifically mentioned

Disadvantages: Many panelists viewed all 4 measures in this category as not being the primary focus of HHAs. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

Category 10: MENTAL HEALTH

35. Stabilization in Cognitive Functioning
Advantages: This can be matched with Improvement in Cognitive Function to give limited look at mental health care issues.

Disadvantages: One panelist thought it was difficult for home health agencies to make a difference in this measure. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

36. Stabilization in Anxiety level

Advantages: One panelist thought that anxiety, while quite subjective, was understood better by patients and would be good area in which HHAs could focus. This could be matched with improvement measures for a limited look at mental healthcare issues.

Disadvantages: The length of stay in home care was considered by some as generally too short to impact via medications for this condition, and that medications are the purview of doctors. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

Category 11: GETTING AROUND

37. Stabilization in Transferring

Advantages: Several panelists noted that this measure goes hand in hand with Improvement in Transferring. One noted it was the only stabilization item she would include since it is the only one related to mobility. If the patient is mobile most other issues could be resolved.

Disadvantages: see discussion of this domain above

Suggested changes/reporting: none specifically mentioned

Category 12: TALKING WITH PEOPLE

38. Stabilization in Speech and Language

Advantages: This is an important measure for persons who suffer from stroke and receive speech therapy. This is the only outcome that is addressed by speech therapy

Disadvantages: Several panelists noted that very few patients used speech therapy. See discussion of this domain above.

Suggested changes/reporting: none specifically mentioned

39. Stabilization in Phone Use

Advantages: none specifically mentioned

Disadvantages: see discussion of this domain above

Suggested changes/reporting: Several panelists thought this measure would be useful if it addressed ability to call for emergency purposes.

DOMAIN: STAYING HEALTHY/AVOIDI NG INJURY OR HARM

Category 13: MEDICAL EMERGENCIES

40. Any emergent care provided

Advantages: This was considered to be a good indicator since one of the primary purposes of home health care is to prevent rehospitalizations. However, risk adjustment is important.

Disadvantages: This measure is not currently risk adjusted but more robust risk adjustment models are expected to be available soon. Several panelists thought that, although this is an important measure, this measure should not be included at this time because its current definition is problematic (e.g., it contains MD visits and ER visits that become admissions) – see below for suggested changes.

Suggested changes/reporting: It was suggested that this measure be restructured to Emergency Home Care not followed by a hospitalization (this would be consistent with how services are reported under Medicare) and focus more directly on services that home health might effectively impact. Careful reporting for consumers was recommended to explain the reasons some people enter hospitals during home care and that agencies are not accountable for all of them.

41. Acute care hospitalization

Advantages: This item is a measure of the appropriateness of many interventions or lack of intervention by the home care clinical staff. Clinical record reviews and complaint investigations have identified failure of the agency to identify and address symptoms has resulted in hospitalization and other negative outcomes. Unplanned hospitalizations are very costly, and although not all hospitalizations are avoidable, good care systems can

manage hospitalization. Consumers want to know this outcome. This measure is preferable to "any emergency care" since it is risk adjusted. This indicator is valuable for the CMS report as currently structured; however, refinements to the indicator could be made (see below).

Disadvantages: Some scheduled hospital admissions are included in current measure.

Suggested changes/reporting: It would be good to eventually eliminate scheduled admissions (e.g. chemotherapy or surgery) from this included population. Scheduled surgery or chemotherapy are not items that belong in a hospitalization rate as they represent ideal care. In the future, the indicator should be restructured and the numerator should include hospitalizations for only those reasons that are clearly under the control of the Home Health Agency i.e. sensitive to HHA Care quality. Obviously these include infections, proper medication administration, diabetes, control, CHF management etc. CMS might consider restructuring the rate to emphasize the positive i.e. "Percentage of residents not requiring hospitalization for Home Health Care preventable conditions." It needs to be made clear to consumers that hospital admissions after home health discharges (even 1 day) are not included.