

October 12, 2004

Kenneth W. Kizer, M.D., M.P.H.
President and CEO
National Quality Forum
601 Thirteenth Street, NW
Suite 500 North
Washington, DC 20005

Dear Dr. Kizer:

On behalf of the American Health Quality Association (AHQA), a National Quality Forum (NQF) member representing the national network of Quality Improvement Organizations (QIOs), thank you for this opportunity to comment on the draft NQF National Voluntary Consensus Standards for Home Health Care.

The American Health Quality Association supports the efforts of NQF to measure and improve the care delivered to recipients of home health care. In recent years, QIOs have worked closely with home health agencies under the Centers for Medicare & Medicaid Services (CMS) Home Health Quality Initiative. We are beginning to see data demonstrating the benefits of this partnership to provide consumers with home care quality data, and improve the quality of care as measured by the Outcomes-Based Quality Improvement measures. We are extremely grateful to the NQF staff and the members of the Standardizing Home Health Care Performance Measures' Steering Committee for their valuable service, and we hope our comments will contribute to their efforts.

AHQA supports using the following OBQI home care measures for both quality improvement and public reporting:

- Measure #1: Improvement in ambulation/locomotion
- Measure #2: Improvement in bathing
- Measure #3: Improvement in transferring
- Measure #4: Improvement in management of oral meds
- Measure #6: Improvement in pain interfering with activity
- Measure #8: Improvement in dyspnea
- Measure #9: Improvement in urinary incontinence
- Measure #18: Acute care hospitalization
- Measure #20: Discharged to community
- Measure #21: Any emergent care

In the past two years, QIOs have trained the personnel of more than 75% of U.S. home health agencies in the use of OBQI methodology to identify and address problems in agency systems of care. Across the country, agencies have demonstrated tremendous commitment to collaborating with QIOs using these OBQI measures, and we support NQF's endorsement of these measures,

which sends a consistent message to agencies that it is worthwhile to learn the OBQI measures and use them to improve care.

However, AHQA recommends that NQF give careful consideration to some of the shortcomings inherent in the OBQI measures. First, it must recognize that unlike process measures, these outcome measures are also influenced by elements that are outside of the home care agency's control, particularly patient compliance with care plans between home care visits. There also are a number of issues related to the accuracy and precision of specific OBQI measures. For instance, the ambulation measure (Measure #1) doesn't account for a patient's progress in moving from a walker to a cane, or from a quad cane to a straight cane. In addition, measures #18 (hospitalization) and #21 (emergent care) involve actions that are predominantly determined by the admitting hospital or the patient's physician, respectively. Based on feedback from QIOs and home care agencies, AHQA also has concerns about the adequacy of OASIS assessment training for home care agency staff, which can result in faulty data.

We encourage NQF to make a recommendation to CMS and related entities that establishes a process that learns from the national implementation of these measures and creates a transparent method to improve and refine these measures over time.

If the OBQI measures are endorsed for public reporting, we'd also recommend that NQF address the OBQI stabilization measures, which were rejected by the committee. It would be important for consumers to understand that patients not included in the numerator for the OBQI improvement measures are not necessarily worsening, but in fact may be stabilized at a high functional level. This is a critical component for NQF to consider for a recommendation targeted to entities that might publicly report OBQI measures.

AHQA supports the use of **Measure #7 (Improvement in status of surgical wounds)** for quality improvement purposes, but not for public accountability. At this time, this measure is not risk-adjusted to account for varying levels of severity of illness among patients and therefore is inappropriate for provider comparisons.

AHQA supports using the following OBQM measures for quality improvement, but NOT for public reporting:

- Measure #5: Substantial decline in management of oral medications.
- Measure #10: Increase in number of pressure ulcers.
- Measure #14: Emergent care for wound infections
- Measure #15: Emergent care for improper medication administration
- Measure #16: Emergent care for hypo/hyperglycemia
- Measure #17: Discharge to the community needing wound care or medication assistance
- Measure #19: Unexpected nursing home admission.

While AHQA believes the OBQMs are useful for agencies to improve quality by identifying and preventing potential adverse events, we maintain that this information is inappropriate for public reporting to consumers. Because these measures are not risk adjusted and occur infrequently, agencies treating a higher proportion of sicker patients

would predictably appear worse off in public displays and face a comparative disadvantage.

As Appendix D of the NQF draft report acknowledges, the OBQM measures were not developed for public reporting purposes. In 2001, CMS told its surveyors “It is important to emphasize the word ‘potential’ in the definition of adverse event outcomes as markers for ‘potential problems’ in care provision. Whether or not an individual patient situation resulted from inadequate care provision can only be determined through investigation of the care actually provided to specific patients” (Memorandum Ref: S&C 01-06—*Implementation of the Outcome Based Quality Monitoring (OBQM) Reports as Part of the Home Health Agency (HHA) Survey Process*).

Our understanding is that the steering committee initially recommended that these measures not be endorsed for public reporting. Ultimately, the committee reversed its decision based on NQF’s prior endorsement of “serious reportable events,” which are not risk adjusted. In contrast, AHQA believes that the OBQMs are not analogous to the previously endorsed adverse event measures because the OBQMs reflect the potential for harm, rather than actual harm. For public reporting purposes, risk adjusting actual events is unnecessary because every actual incident is known to be significant, but it is necessary to risk adjust for potential events, which may or may not occur—however, there is no known methodology for risk-adjusting OBQMs. NQF’s rationale for including these measures for endorsement is appropriate for quality improvement purposes, but not for public reporting. Therefore, we urge NQF to apply in this instance its policy identifying some endorsed measures as unsuitable for public reporting.

AHQA has concerns about the following ACOVE measures:

- Measure #22: Comprehensive geriatric assessment
- Measure #23: Evaluation of pressure ulcers
- Measure #24: Risk assessment for pressure ulcers
- Measure #25: Evaluation of reversible causes of malnutrition
- Measure #26: Evaluation of falls
- Measure #27: Caregiver support and patient safety for dementia patients
- Measure #28: Documentation of advance directive, surrogate of preferences

AHQA is concerned about the lack of a widespread, standardized data collection method for the ACOVE measures. The assessment and medical record abstraction required for the ACOVE measures would add unreasonable burden to the already lengthy (up to two hours) OASIS admission assessment.

While AHQA feels that the ACOVE training materials are useful in helping agencies improve their care practices, we feel that these measures are at this time inappropriate for national home health care quality improvement and public reporting. The measures represent the aspects of care for vulnerable elders across the continuum of care and were not tested for quality improvement use by home care providers. As RAND, which developed the measures to assess care provided at the system level, stated:

“This means that the (indicators) cannot be used to evaluate individual physicians. Furthermore, the indicators have not yet been tested with sufficient numbers of

patients to ensure their utility for evaluating the care of an individual patient or the treatment of a single condition. Rather, the indicators currently allow us to assess the overall care delivered to vulnerable elders by their health care plans or medical groups and thus could be used to identify areas in need of improvement. (Developing Quality of Care Indicators for the Vulnerable Elderly: The ACOVE Project).”

Thank you for providing this opportunity to comment on the proposed home health quality measures. Please contact Dave Adler or me at (202) 261-7572 with any questions regarding this letter.

Sincerely,

David G. Schulke
Executive Vice President