



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information
<p><b>NQF #:</b> 0521</p> <p><b>Corresponding Measures:</b></p> <p><b>De.2. Measure Title:</b> Heart Failure Symptoms Assessed and Addressed</p> <p><b>Co.1.1. Measure Steward:</b> Centers for Medicare &amp; Medicaid Services</p> <p><b>De.3. Brief Description of Measure:</b> Percentage of home health episodes of care during which patients with heart failure were assessed for symptoms of heart failure, and appropriate actions were taken when the patient exhibited symptoms of heart failure</p> <p><b>1b.1. Developer Rationale:</b> This process measure is designed to reduce the need for urgent care, both emergency department and hospital care, by early identification of heart failure symptoms and through coordination with physicians and other providers to intervene in the event of heart failure exacerbation.</p>
<p><b>S.4. Numerator Statement:</b> Number of home health episodes of care during which patients with heart failure were assessed for symptoms of heart failure and appropriate actions were taken when the patient exhibited symptoms of heart failure.</p> <p><b>S.7. Denominator Statement:</b> Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period for patients with a diagnosis of heart failure, other than those covered by generic or measure-specific exclusions.</p> <p><b>S.10. Denominator Exclusions:</b> Episodes in which the patient did not have a diagnosis of heart failure and was not assessed to have symptoms of heart failure since the last OASIS assessment. Episodes ending in patient death.</p>
<p><b>De.1. Measure Type:</b> Process</p> <p><b>S.23. Data Source:</b> Electronic Health Records</p> <p><b>S.26. Level of Analysis:</b> Facility</p>
<p><b>IF Endorsement Maintenance – Original Endorsement Date:</b> Mar 31, 2009 <b>Most Recent Endorsement Date:</b> Mar 31, 2009</p>
<p><b>IF this measure is included in a composite, NQF Composite#/title:</b></p> <p><b>IF this measure is paired/grouped, NQF#/title:</b></p> <p><b>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</b></p>

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
<p>Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. <b>Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.</b></p>
<p><b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b>  <a href="#">Importance_0521_12.23.13.docx</a></p>
<p><b>1b. Performance Gap</b></p> <p>Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> <li>considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or</li> </ul>

- disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., the benefits or improvements in quality envisioned by use of this measure)

This process measure is designed to reduce the need for urgent care, both emergency department and hospital care, by early identification of heart failure symptoms and through coordination with physicians and other providers to intervene in the event of heart failure exacerbation.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Performance Gap of Measure with Revised Specifications (Across All Agencies)

Specification	Mean	Min	10th	25th	50th	75th	90th	Max
Observed Rates	92.5%	0.0%	83.3%	90.5%	95.2%	100.0%	100.0%	100.0%

Performance Gap:

75th - 25th Percentile = 9.5%

90th - 10th Percentile = 16.7%

To see comparison of performance gap for measure with existing specifications, see Attachment 1 in Section A1

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

The measure included Medicare-certified agencies with at least 20 home health quality episodes beginning between July 1, 2012 and June 30, 2013 and meeting the measure denominator criteria. There were 8,822 such agencies (74.5 percent of the 11,849 agencies with at least one quality episode ending during the same time period). Our sample included all quality episodes (1,932,296 in total) from July 1, 2012 to June 30, 2013.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Data on Disparities for Measure with Revised Specifications

Observed Rate (Numerator/Denominator) by Patient Race

	White	Black	Hispanic	Other
Observed Rate	92.4%	92.6%	93.7%	94.1%

Observed Rate (Numerator/Denominator) by Patient Age

	<65	65-75	75-85	85+
Observed Rate	93.4%	93.0%	92.6%	91.9%

Observed Rate (Numerator/Denominator) by Patient Gender

	Male	Female
Observed Rate	92.6%	92.6%

To see comparison of disparities for measure with existing specifications, see Attachment 1 in Section A1

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

The measure included Medicare-certified agencies with at least 20 home health quality episodes beginning between July 1, 2012 and June 30, 2013 and meeting the measure denominator criteria. There were 8,822 such agencies (74.5 percent of the 11,849 agencies with at least one quality episode ending during the same time period). Our sample included all quality episodes (1,932,296 in total) from July 1, 2012 to June 30, 2013.

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.**

**List citations in 1c.4.**

The American Heart Association (AHA) 2013 Heart Disease and Stroke Statistical Update reports the following data on heart failure prevalence, mortality and resource use:

- there were an estimated 5.1 million people with HF in the United States in 2010 (National Health and Nutrition Examination Survey 2007–2010)
- the prevalence of heart failure increases with age: 1.5/1000 for men and 0.7/1000 for women for ages 40 – 59; 7.8/1000 for men and 4.5/1000 for women for ages 60 – 79; and 8.8/1000 for men and 11.5 /1000 for women for ages 80+ (Framingham Heart Study: 1980–2003. Source: National Heart, Lung, and Blood Institute (NHLBI)).
- 1 in 9 deaths has heart failure mentioned on the death certificate (NCHS, NHLBI). The number of any-mention deaths attributable to HF was approximately as high in 1995 (287,000) as it was in 2009 (275,000); (NCHS, NHLBI).
- In 2010, there were 1.801 million physician office visits with a primary diagnosis of HF. In 2009, there were 668 000 ED visits and 293 000 outpatient department visits for HF (NHAMCS, NHLBI tabulation).
- First-listed hospital discharges for 2010 were 1.023 million (NHDS, NHLBI)
- Estimated total cost of heart failure in 2013 is \$32 billion (AHA computation)

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

Go AS, Mozaffarian D, Roger VL, et al. Heart disease and stroke statistics--2013 update: a report from the American Heart Association. *Circulation* 2013; 127:e6. <http://circ.ahajournals.org/content/127/1/e6.full.pdf+html>

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)**

**2. Reliability and Validity—Scientific Acceptability of Measure Properties**

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Cardiovascular, Cardiovascular : Congestive Heart Failure

**De.6. Non-Condition Specific** (check all the areas that apply):

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html>

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

**This is not an eMeasure Attachment:**

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

**Attachment Attachment:** [OASISQM\\_data\\_dictionary.xls](#)

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

Currently the measure assesses whether the clinician addressed a patient's symptoms of heart failure when the clinician assessed the patient to have symptoms of heart failure. We have proposed revisions to the measure specifications so that agencies will be held accountable for assessing heart failure symptoms in all patients with a diagnosis of heart failure, in addition to addressing those symptoms when they are present. In addition, the measure now applies to both short-term and long-term home health care episodes - long-term home health care episodes are no longer excluded. See Section A1, Attachment A for details on changes to measure specifications.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Number of home health episodes of care during which patients with heart failure were assessed for symptoms of heart failure and appropriate actions were taken when the patient exhibited symptoms of heart failure.

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

CMS systems report data on episodes that end within a rolling 12 month period, updated quarterly.

**S.6. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Patient episodes in which the patient has a diagnosis of heart failure, defined as a response of anything other than NA to M1500 (Symptoms in Heart Failure Patients) OR in which there is an ICD-9 value in M1020/M1022 (Primary/Secondary Diagnoses) of one of the following codes:

402.01 402.11 402.91 404.01 404.03 404.11 404.13 404.91 404.93 428.0 428.1 428.20 428.21 428.22 428.23 428.30 428.31 428.32 428.33 428.40 428.41 428.42 428.43 428.9.

[Note: Attachment A maps these ICD-9 codes to their corresponding ICD-10-CM codes]

PLUS

appropriate actions were taken in response to heart failure symptoms, defined as a response of anything other than 0 to M1510 (Heart Failure Follow-up) OR the patient had no symptoms of heart failure, defined as M1500 = 0 – No

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period for patients with a diagnosis of heart failure, other than those covered by generic or measure-specific exclusions.

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk : Individuals with multiple chronic conditions

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions,

*specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

A start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of cA start/resumption of care assessment ((M0100) Reason for Assessment = 1 (Start of care) or 3 (Resumption of care)) paired with a corresponding discharge/transfer assessment ((M0100) Reason for Assessment = 6 (Transfer to inpatient facility – not discharged), 7 (Transfer to inpatient facility – discharged), 8 (Death at home), or 9 (Discharge from agency)), other than those covered by denominator exclusions PLUS

- the response to M1500 (Symptoms in Heart Failure Patients) is anything other than NA OR in which there is an ICD-9 value in M1020/M1022 (Primary/Secondary Diagnoses) of one of the following codes:

402.01 402.11 402.91 404.01 404.03 404.11 404.13 404.91 404.93 428.0 428.1 428.20 428.21 428.22 428.23 428.30 428.31 428.32 428.33 428.40 428.41 428.42 428.43 428.9.

[Note: Attachment A maps these ICD-9 codes to their corresponding ICD-10-CM codes]

**S.10. Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*

Episodes in which the patient did not have a diagnosis of heart failure and was not assessed to have symptoms of heart failure since the last OASIS assessment. Episodes ending in patient death.

**S.11. Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

**Denominator Exclusion Details**

**Measure-Specific Exclusions:**

Number of home health patient episodes of care where at end of episode:

- (M0100) Reason for Assessment = 8 (death at home)

AND

Patient was not assessed to have symptoms of heart failure, defined as the response to M1500 (Symptoms in Heart Failure Patients) is 0 (No)

AND

Patient does not have a diagnosis of heart failure, defines as no ICD-9 value in M1020/M1022 (Primary/Secondary Diagnoses) of any of the following codes:

402.01 402.11 402.91 404.01 404.03 404.11 404.13 404.91 404.93 428.0 428.1 428.20 428.21 428.22 428.23 428.30 428.31 428.32 428.33 428.40 428.41 428.42 428.43 428.9.

[Note: Attachment A maps these ICD-9 codes to their corresponding ICD-10-CM codes]

**Generic Exclusions:**

Medicare-certified home health agencies are currently required to collect and submit OASIS data only for adult (aged 18 and over) non-maternity Medicare and Medicaid patients who are receiving skilled home health care. Therefore, maternity patients, patients less than 18 years of age, non-Medicare/Medicaid patients, and patients who are not receiving skilled home services are all excluded from the measure calculation. However, the OASIS items and related measures could potentially be used for other adult patients receiving services in a community setting, ideally with further testing. The publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.

**S.12. Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

NA - not stratified

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

NA - process measure

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.18. Calculation Algorithm/Measure Logic** (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

This measure excludes patients who do not have a diagnosis of heart failure (identified as no heart failure ICD-9 codes in M1020 or M1022 and M1500\_SYMTM\_HRT\_FAILR\_PTNTS[2] = NA), as well as any assessments that ended in death. The exclusion also applies to the corresponding measures for short term and long term episodes of care. A diagnosis of heart failure is defined as a ICD-9 value found under M1020 or M1022 of one of the following codes:

402.01 402.11 402.91 404.01 404.03 404.11 404.13 404.91 404.93 428.0 428.1 428.20 428.21 428.22 428.23 428.30 428.31 428.32 428.33 428.40 428.41 428.42 428.43 428.9.

Attachment A maps these ICD-9 codes to their corresponding ICD-10-CM codes, which include I11.0 I13.0 I13.2 I50.9 I50.1 I50.20 I50.21 I50.22 I50.23 I50.30 I50.31 I50.32 I50.33 I50.40 I50.41 I50.42 I50.43 I50.9

IF (M1500\_SYMTM\_HRT\_FAILR\_PTNTS[2] <>NA OR (Heart Failure DGN identified in M1020\_PRI\_DGN\_ICD1 OR M1022\_OTH\_DGN1\_ICD\_1 through M1022\_OTH\_DGN5\_ICD\_1)

THEN

HAS\_HEART\_FAILURE=1

ELSE

HAS\_HEART\_FAILURE=0

IF HAS\_HEART\_FAILURE = 1 AND M0100\_ASSMT\_REASON[2] <> 08

THEN

IF M1500\_SYMTM\_HR\_FAILR\_PTNTS[2]=0 OR M1510\_HRT\_FAILR\_NO\_ACTN[2] = 0

THEN

Heart\_Failure\_Assessed\_Treated\_All = 1

ELSE

Heart\_Failure\_Assessed\_Treated\_All = 0

END IF

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No diagram provided

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

NA - no sampling.

**S.21. Survey/Patient-reported data** (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

NA - no survey

**S.22. Missing data** (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

NA - no missing data - data collection instrument submissions with missing data are rejected and the provider must then resubmit the assessment.

**S.23. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Records

**S.24. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

The measure is calculated based on data obtained from the Home Health Outcome and Assessment Information Set (OASIS-C), which is a core standard assessment data set that home health agencies integrate into their own patient-specific, comprehensive assessment to identify each patient's need for home care. The data set is the foundation for valid and reliable information for patient assessment, care planning, and service delivery in the home health setting, as well as for the home health quality assessment and performance improvement program. HH agencies are required to collect OASIS data on all non-maternity Medicare/Medicaid patients, 18 or over, receiving skilled services. Data are collected at specific time points (admission, resumption of care after inpatient stay, recertification every 60 days that the patient remains in care, transfer, and at discharge). HH agencies are required to encode and transmit patient OASIS data to the state OASIS repositories. Each HHA has on-line access to outcome and process measure reports based on their own OASIS data submissions, as well as comparative state and national aggregate reports, case mix reports, and potentially avoidable event reports. CMS regularly collects OASIS data from the states for storage in the national OASIS repository, and makes measures based on these data (including the Heart Failure Symptoms Assessed measure) available to consumers and to the general public through the Medicare Home Health Compare website.

**S.25. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

**S.27. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Home Care

If other:

**S.28. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

Scientific\_Acceptability\_Heart\_Failure\_Symptoms\_Addressed\_0521\_final.docx

### 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

**3a. Byproduct of Care Processes**

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).



**3a.1. Data Elements Generated as Byproduct of Care Processes.**

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

**3b. Electronic Sources**

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

ALL data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

**3c. Data Collection Strategy**

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

OASIS data collection and transmission is a requirement of the Medicare Home Health Conditions of Participation. OASIS data are collected by the home health agency during the care episode as part of the Conditions of Participation, and transmitted electronically to the state and CMS national OASIS repository. No issues regarding availability of data, missing data, timing or frequency of data collection, patient confidentiality, time or cost of data collection, feasibility or implementation have become apparent since OASIS-C was implemented 1/1/2010. In 2008, CMS contractors Abt Associates and subcontractors University of Colorado Health Sciences Center and Case Western Reserve University conducted field testing including analysis of time required for collection of OASIS-C and focus groups with clinicians on perceived burden of OASIS-C. CMS eliminated a number of items that participants reported to be burdensome prior to OASIS-C implementation. Focus group feedback and data collected during the field test indicated minimal additional time burden related to collection of OASIS C data items.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** (*e.g., value/code set, risk model, programming code, algorithm*).

NA

**4. Usability and Use**

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

**4a. Accountability and Transparency**



Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Planned	Current Use (for current use provide URL)
Quality Improvement (Internal to the specific organization)	Public Reporting Home Health Compare <a href="http://www.medicare.gov/HomeHealthCompare/search.aspx">http://www.medicare.gov/HomeHealthCompare/search.aspx</a>

##### 4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

The Home Health Compare website is federal government website managed by the Centers for Medicare & Medicaid Services (CMS). It provides information to consumers about the quality of care provided by Medicare-certified home health agencies throughout the nation. The measures reported on Home Health Compare includes all Medicare-certified agencies with at least 20 home health quality episodes. In the period ending June 30, 2013, there were 8,822 such agencies (74.5 percent of the 11,849 agencies with at least one quality episode) that met the measure denominator criteria for reporting of Heart Failure Symptoms Assessed and Addressed.

CMS's Home Health Quality Initiative "Process Quality Measure Report" provides all Medicare-certified home health agencies with opportunities to use process measures for process-based quality improvement. Forty-five evidence-based process of care measures (including Heart Failure Symptoms Addressed) are included on reports made available to agencies for use in quality/performance monitoring and improvement. The report allows agencies to benchmark their performance against other agencies across the state and nationally, as well as with their own performance from prior time periods. All Medicare-certified home health agencies can access their Process Quality Measure Reports via CMS's online CASPER system.

**4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

**4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

#### 4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

##### 4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

Based on analysis of the data from 11,849 agencies from July 1, 2012 through June 30, 2013, we calculated home health agencies' performance rates for the measure using the existing specifications and found levels of performance have increased to the level that there is no longer significant variation in the measure scores across agencies and therefore, little room for improvement. As shown

in Attachment 1 in Section A.1, the average agency rate with the current specifications is 98.0 percent across agencies with at least 20 valid episodes of care.

We have proposed changes to the measure so that agencies will be held accountable both for assessing heart failure symptoms in all patients with a diagnosis of heart failure, in addition to addressing those symptoms. These proposed changes raise the quality standards required to meet the measure criteria and this is reflected in a greater opportunity for improvement for this measure.

Overall, implementing the revised specification causes the average performance rate to decrease from 98.0 percent to 92.6 percent among all patients, and by several percentage points across all population groups. The denominator under the revised specifications is larger across all population groups because it includes all patients with a diagnosis of heart failure and with symptoms assessed, compared to the current inclusion criteria of all patients who exhibited symptoms since the previous assessment. In addition, the number of agencies with at least 20 valid episodes of care increases from only 3,618 under the current measure logic to 8,882 under the revised logic, expanding public reporting eligibility.

**4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

#### **4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

No unintended consequences identified.

### **5. Comparison to Related or Competing Measures**

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

#### **5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

#### **5a. Harmonization**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

see 5b.1

#### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

#### 5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

There are no measures that conceptually address both the same measure focus (heart failure assessment and intervention) and the same target population (homebound patients). We found one process measure on Heart Failure Assessment 0078 Heart Failure (HF) : Assessment of Clinical Symptoms of Volume Overload (Excess. Measure 0521 is harmonized with 0078 is that it defines HF using the same codes and identifies HF symptoms the same way (symptoms identified by clinical heart failure guidelines including dyspnea, orthopnea, edema, or weight gain). Measure 0078 has a different target population (ambulatory adults) and does not include a requirement for intervention.

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment** Attachment: [Attachment\\_A\\_\\_0521\\_Specification\\_Changes.docx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Sophia, Chan, [Sophia.Chan@cms.hhs.gov](mailto:Sophia.Chan@cms.hhs.gov), 410-786-5050-

**Co.3 Measure Developer if different from Measure Steward:** Acumen LLC

**Co.4 Point of Contact:** Keziah, Cook, [kcook@acumenllc.com](mailto:kcook@acumenllc.com), 650-558-8882-

## Additional Information

### Ad.1 Workgroup/Expert Panel involved in measure development

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

In December 2010, a Technical Expert Panel (TEP) was convened to review the analysis conducted on the home health measures. The TEP was comprised of individuals selected by CMS for their expertise and perspectives related to the panel objectives, from a pool of individuals who were nominated in response to the September 2010 Call for TEP notice. At the end of a two day meeting, during which the measure developer presented the TEP with a variety of information about each measure, the TEP members were asked to individually rate each measure for importance, validity, and usability using a score card, created by the measure developer and modeled after the NQF criteria.

2010 HH Measure Review TEP Members:

Mary Carr RN, MPH - Associate Director for Regulatory Affairs, National Association of Home Care and Hospice

Rick Fortinsky, PhD- Professor of Medicine, Physicians Health Services Endowed Chair in Geriatrics and Gerontology, UConn Center for Health Services Research

Barbara Gage, PhD - Deputy Director of Aging, Disability, and Long-term Care, Post-Acute Care Research Lead, Research Triangle Institute

Margherita Labson, R.N., Executive Director for the Home Care Program at The Joint Commission

Steve Landers MD, MPH - Director, Center for Home Care and Community Rehabilitation, Cleveland Clinic

Bruce Leff, MD – Associate Director, Elder House Call Program,

Barbara McCann, MSW - Chief Industry Officer, Interim Health Care

Jennifer S. Mensik PhD, RN, NEA-BC, FACHE - Director, Clinical Practices and Research, Banner Health, Arizona and Western Regions

Dana Mukamel, Professor, Department of Medicine, Division of General Internal Medicine & Primary Care, University of California, Irvine & Senior Fellow, Health Policy Research Institute, Irvine, California  
Robert J. Rosati Ph.D - Vice President, Clinical Informatics, Visiting Nurse Service of New York, Center for Home Care Policy and Research  
Judy Sangl Sc.D. – Health Scientist Administrator, Agency for Healthcare Research and Quality (AHRQ), Center for Patient Safety and Quality Improvement (CQuIPS), Rockville, MD

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2011

**Ad.3 Month and Year of most recent revision:** 12, 2013

**Ad.4 What is your frequency for review/update of this measure?** annual

**Ad.5 When is the next scheduled review/update for this measure?** 09, 2014

**Ad.6 Copyright statement:** NA

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**