

Opportunities for Improving Medicare HOS Results

Through Practices in Quality Preventive Health Care for the Elderly

A Guide for Medicare Advantage Organizations



Contents

Acknowledgments..... 2

Introduction

About This Guide 3

About HOS 3

Calculating Physical Component Summary and
Mental Component Summary Change Scores 4

Calculating Effectiveness of Care Items 6

National Performance on Medicare Advantage Star Ratings Components

*Functional Health Outcomes: Physical Component
Summary and Mental Component Summary
Change Scores* 8

Urinary Incontinence 9

Lack of Physical Activity 9

Falls Risk 10

Bone Health and Osteoporosis Testing 10

National Performance 11

Providing Quality Preventive Health Care for the Elderly

Care Management 12

Patient Education and Resources 13

Quality Improvement 14

Conclusions 15

Resources

Data Dissemination 16

HOS Web Site and E-Mail 17

NCQA Web Site and E-Mail 17

CMS Web Site and E-Mail 17

*HEDIS® Volume 6: Specifications for the Medicare
Health Outcomes Survey* 17

References 18

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Medicare Advantage Organizations and Quality Improvement Organizations,

The Centers for Medicare and Medicaid Services (CMS) is pleased to release this guide as a resource to help Medicare Advantage organizations develop and apply strategies that address the Medicare Health Outcomes Survey (HOS) items used in the CMS Medicare Advantage Part C Star Ratings.

This guide includes a brief overview of HOS, national performance results on HOS items included in the Medicare Advantage Star Ratings system, best practices in promoting quality preventive health care for the elderly and HOS resources available to Medicare Advantage organizations.

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- UnitedHealthcare Insurance Company of Florida
- UnitedHealthcare Insurance Company of Colorado
- VNS Choice of New York

Please submit questions about this guide to hos@ncqa.org. Also visit the HOS web site at www.HOSonline.org for comprehensive program information about the survey.

Sincerely,

A handwritten signature in black ink that reads "T W Reilly". The signature is written in a cursive, slightly slanted style.

Thomas W. Reilly, Ph.D.

Director

Data Development and Services Group

Acknowledgements

Introduction

- **About This Guide/About HOS**
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Introduction

About This Guide

This guide is a resource to help Medicare Advantage organizations develop and apply strategies that address the Medicare Health Outcomes Survey (HOS) items used in the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Part C Star Ratings (“Star Ratings”). It comprises the following two sections:

Section 1: A discussion of the prevalence of the conditions measured by HOS items and a summary of national HOS results to highlight opportunities for improvement and intervention strategies

Section 2: Examples of interventions that some Medicare Advantage organizations have used to promote patient-physician communication, screening services or maintenance of functional status among their members

About HOS

HOS assesses the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its members over time. It is a longitudinal survey administered each spring to a random sample of members from eligible organizations. The same group of members is resurveyed after two years.

HOS comprises several components. At its core is a set of questions known as the *Veterans RAND 12 Item Health Survey (VR-12)*, which evaluates physical and mental health using Physical Component Summary and Mental Component Summary scores. HOS also includes questions addressing important problems associated with poor physical and mental functioning in the elderly, called “effectiveness of care” items (e.g., urinary incontinence, lack of physical activity, falls risk, poor bone health). Additional HOS questions relate to chronic conditions, activities of daily living and sociodemographic information.

The *VR-12*’s physical and mental health results and the effectiveness of care results are publicly reported as part of CMS quality improvement efforts. Since 2009, these results have been included in the Star Ratings. Beginning in 2012, these ratings will link quality of care to payment for Medicare Advantage organizations and will provide incentives for improving quality through bonus payments authorized by the Affordable Care Act. The Star Ratings components corresponding to each HOS item are mapped on the next page.



Acknowledgements

Introduction

- About This Guide/About HOS
- [Calculating Physical Component Summary and Mental Component Summary Change Scores](#)
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

HOS Item	Star Ratings Component
Physical Component Summary change score	Improving or Maintaining Physical Health
Mental Component Summary change score	Improving or Maintaining Mental Health
Management of Urinary Incontinence in Older Adults	Improving Bladder Control
Physical Activity in Older Adults	Monitoring Physical Activity
Falls Risk Management	Reducing the Risk of Falling
Osteoporosis Testing in Older Women*	Osteoporosis Testing*

Calculating Physical Component Summary and Mental Component Summary Change Scores

The *VR-12* items evaluate how well a Medicare Advantage organization manages the physical and mental health of its members by assessing members' physical and mental health status at the beginning and at the end of a two-year period, when a change score is calculated. Eight health concepts, or "scales," are included and results of each scale are scored and aggregated into two summary measures: Physical Component Summary scores and Mental Component Summary scores.

Each scale is weighted to calculate the composite summary scores. Some scales have more weight than others (refer to Tables 1 and 2). A constant is included in the calculation to standardize the Physical Component Summary and Mental Component Summary to the general U.S. population (Kazis et al.), with a mean of 50 and a standard deviation of 10. In order to use as many cases as possible (including cases with missing items), a regression model is employed for imputing and scoring missing data so that summary scores can be calculated even if as many as 9 of the 12 items are missing from the *VR-12* (Kazis et al.).

After each member's Physical Component Summary and Mental Component Summary scores are calculated, they are risk adjusted and categorized as "better than expected," "same as expected" or "worse than expected." Results are expressed as the percentage of Medicare Advantage members whose two-year changes in Physical Component Summary scores are "better" than expected or the "same" as expected, compared with those whose health is worse than expected or who died, and members whose two-year change in Mental Component Summary scores are "better" than expected or the "same" as expected, compared with those whose health is worse than expected.

Note: For detailed information on how Physical Component Summary and Mental Component Summary Change Scores are calculated for HOS, refer to Appendix 1 of the Medicare Advantage organization's most recent HOS Performance Measurement Report, accessible from the CMS Health Plan Management System.

*Osteoporosis Testing rate is reported to plans as a Part C Display Measure but will no longer remain as a Star Ratings component.

Acknowledgements

Introduction

- About This Guide/About HOS
- **Calculating Physical Component Summary and Mental Component Summary Change Scores**
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Tables 1 and 2 detail the scales and scale items used to calculate HOS Physical Component Summary and Mental Component Summary scores in the Star Ratings components.

TABLE 1: Improving or Maintaining Physical Health (Physical Component Summary Score)

Q1. General Health	Q2. Physical Functioning	Q3. Role—Physical	Q5. Bodily Pain
In general, would you say your health is:	The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? b. Climbing several flights of stairs?	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? a. Accomplished less than you would like? b. Were limited in the kind of work or other activities?	During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

TABLE 2: Improving or Maintaining Mental Health (Mental Component Summary Score)

Q4. Role—Emotional	Q6. Vitality & Mental Health	Q7. Social Functioning
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? a. Accomplished less than you would like? b. Didn't do work or other activities as carefully as usual?	How much of the time during the past 4 weeks: a. Have you felt calm and peaceful? b. Did you have a lot of energy? c. Have you felt downhearted and blue?	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- **Calculating Effectiveness of Care Items**

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Calculating Effectiveness of Care Items

Table 3 details the Medicare Star Ratings Component/Effectiveness of Care items and the criteria for assessment in Medicare Advantage organizations:

TABLE 3

Medicare Advantage Star Ratings Component/HOS Item	Q2. HOS Question About the Care Received (Response Choices: Yes or No)	Eligible Members (Denominator)	Receipt of Care (Numerator)	Calculating Results
Improving Bladder Control	“Have you talked with your current doctor or other health provider about your urine leakage problem?”	(Both questions)	Number of members who responded “yes.”	Results are calculated by dividing numerator over denominator. Results are reported as rates for each organization.
Urinary Incontinence Care in Past 6 Months	“There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?”	Number of members ages 65 years and older and reported a urinary incontinence problem in past 6 months		
Monitoring Physical Activity	“In the past 12 months, did you talk with your doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.”	(Both questions)		
Physical Activity Care in Past 12 Months	“In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.”	Number of members ages 65 years and older and reported an office visit in past 12 months		

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- **Calculating Effectiveness of Care Items**

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

TABLE 3 *continued*

Medicare Advantage Star Ratings Component/HOS Item	Q2. HOS Question About the Care Received (Response Choices: Yes or No)	Eligible Members (Denominator)	Receipt of Care (Numerator)	Calculating Results
Reducing the Risk of Falling	“A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?”	Number of members ages 75 years and older and reported an office visit in past 12 months; or ages 65-74 years, reported an office visit in past 12 months, and reported a fall or balance problem in past 12 months	Number of members who responded “yes.”	Results are calculated by dividing numerator over denominator. Results are reported as rates for each organization.
Falls Risk Management Care in Past 12 Months	“Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: suggest you use a cane or walker, check your blood pressure lying or standing, suggest you do an exercise or physical therapy program, suggest a vision or hearing testing.”	Number of members ages 65 years and older, reported an office visit in past 12 months, and reported a fall or balance problem in past 12 months		
Osteoporosis Testing	“Have you ever had a bone density test to check for osteoporosis, sometimes thought of as ‘brittle bones’?”	Number of members ages 65 years and older and female		
Osteoporosis Screening (at any time)	The test may have been done to your back, hip, wrist, heel or finger.”			

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- **Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores**
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

National Performance on Medicare Advantage Star Ratings Components

Medicare Advantage organizations play a key role by providing health care services to maintain functional health outcomes and to address important problems related to urinary incontinence, lack of physical activity, falls risk and poor bone health in the elderly. Services range from screening tests to patient-physician communication and intervention on urinary incontinence and falls risk reduction (American Geriatrics Society, 2001; American Geriatrics Society, 2008; Meriwether, Lee, Lafleur and Wiseman, 2008). This section provides a brief background on the scope and importance of these priority areas and discusses the performance of organizations across the country in managing these problems among their elderly members.

Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores

Maintaining health and functioning is a major goal in providing care to older adults in the United States. Medicare Advantage organizations currently enroll 24 percent (11.1 million) of the 47 million people in Medicare, a proportion that more than doubled between 2005 and 2010 (Kaiser Family Foundation, 2010). Gaps in quality of care have long been identified in this population, and it is widely acknowledged that improvements in clinical management could lead to better functional health outcomes for organization members (Bierman et al., 2001). The importance of measuring and improving functional outcomes in this population has been recognized for the better part of the past decade (IOM, 2001). Physical Component Summary and Mental Component Summary scores have been widely used in outcomes research and have increasing importance in quality measurement (Bierman et al., 2001).



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- **Urinary Incontinence**
- **Lack of Physical Activity**
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Urinary Incontinence

An estimated 17 million Americans suffer from involuntary leakage of urine, also known as urinary incontinence. In adults 65 and older, up to 32 percent of men and 39 percent of women suffer from urinary incontinence (Shamliyan et al., 2007). Studies indicate an association between incontinence and impaired cognitive or physical functioning (Fultz et al., 2001). Urinary incontinence is a common condition among older adults. It is assumed to be a normal part of aging, even though it can be treated or improved in 8 of 10 cases (Chang et al., 2008).

But patients may not discuss their condition with providers. There are a variety of reasons for this, including embarrassment, viewing urinary incontinence as normal, feeling they can cope on their own or low expectations of treatment benefits (Kichen, 2003). Interventions include medication therapies, behavioral therapies, electrical stimulation and surgical and palliative/supportive treatments, but whether these treatments restore physical functioning is unclear.

For information on studies about management of urinary incontinence in older adults, click this link: http://www.hosonline.org/surveys/hos/download/Functional_Status_in_Older_Adults_2011.pdf and see pages 14-16.

Lack of Physical Activity

Physical inactivity is widely known as an independent risk factor for a range of chronic diseases and conditions that threaten the health of the nation, but only a small proportion of the population currently meets recommended levels of physical activity. Older adults are at risk for leading sedentary lifestyles (King, 2001;

Evans, 1999). Most older adults suffer from at least one chronic condition for which there is a clinical guideline recommending physicians to counsel patients to exercise (AHRQ, 2002).

Physical activity is positively related to physical and mental functioning for the general adult population (Bize et al., 2007). Physical activity studies suggest that interventions combining different strategies (e.g., counseling and aerobic or other structured physical activities) affect functional outcomes more effectively and more dramatically in elderly and frail sedentary patients (Kelley et al., 2009). One study showed that patients with cardiac, respiratory and gastrointestinal disease who received an individualized program of exercise strategies demonstrated moderate changes in physical health scores (as measured by the Physical Component Summary score) and fewer emergency hospital readmissions (Courtney et al., 2009).

For information on studies about the effects of physical activity in older adults, click this link: http://www.hosonline.org/surveys/hos/download/Functional_Status_in_Older_Adults_2011.pdf and see pages 16-17.



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Falls Risk

Falls are a serious public health problem for older adults. They are the leading cause of death from injury for the 65-and-older population, as well as the most common cause of nonfatal injuries and trauma-related hospital admissions. In 2008, over 2 million older adults required emergency care as a result of a fall—559,000 of these required hospitalization (CDC, 2010). An estimated 10 percent of all falls cause major injuries, including fractures, serious soft tissue damage and traumatic brain injury (Tinetti, 2010). It is estimated that each year, 1 in every 3 adults over age 65 will fall (CDC, 2010). The rate of falls increases with age (Dykes et al., 2010; Doherty et al., 2009). It is estimated that by 2020, the annual direct and indirect cost of fall injuries will reach \$54.9 billion (CDC, 2010).

Falls can be a life-changing event for the elderly; a sudden loss of functional ability can drastically affect physical and mental functioning—up to a 10-point decrease in Physical Component Summary scores and a 5-point decrease in Mental Component Summary scores. Literature indicates that successful fall-reduction strategies include vitamin D supplements, vision correction using cataract surgery and vision screening and referral (Michael et al., 2010), as well as multiple-component group exercise such as tai chi or individually prescribed, multiple-component, home-based exercise programs (Gillespie et al., 2009).

For information on studies about falls risk management, click this link: [http://www.hosonline.org/surveys/hos/download/Functional Status in Older Adults 2011.pdf](http://www.hosonline.org/surveys/hos/download/Functional%20Status%20in%20Older%20Adults%202011.pdf) and see pages 17-18.

Bone Health and Osteoporosis Testing

Osteoporosis is characterized by low bone density—a result of bone mass loss—and is the most common metabolic bone disease. About 44 million Americans live with osteoporosis or osteopenia; 68 percent of this group are women (NIAMS, 2010). Osteoporosis causes structural deterioration of the bone tissue, which increases the risk of bone fractures. Studies show that elderly osteoporotic patients who suffer a vertebral fracture have worse quality of life and physical functioning, including low scores for domains of physical function, social function and general health perception (Romagnoli, 2004).

Many fracture survivors do not return to pre-fracture functional status, which can result in long-term nursing home care (National Osteoporosis Foundation, 2010). In the United States, the estimated national direct costs for osteoporosis and related fractures total \$14 billion annually (NIAMS, 2010). The U.S. Preventive Services Task Force recommends that women age 65 and older be screened routinely for osteoporosis (<http://www.uspreventiveservicestaskforce.org/uspstf/uspso.htm>).

For information on studies about osteoporosis testing in older women, click this link: [http://www.hosonline.org/surveys/hos/download/Functional Status in Older Adults 2011.pdf](http://www.hosonline.org/surveys/hos/download/Functional%20Status%20in%20Older%20Adults%202011.pdf) and see pages 18-19.



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- **National Performance**

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

National Performance

Tables 4 and 5 show national performance on the Physical Component Summary and Mental Component Summary change scores and care addressing urinary incontinence, physical activity, falls risk and bone health/osteoporosis testing in elderly Medicare Advantage members. The majority of members improved or maintained their physical health (67 percent) and mental health (77 percent) over two years (Table 4), but there was ample room for improvement across all areas of

care (Table 5). For example, only about 1 in 3 members reported receiving treatment for urinary incontinence (36 percent) and discussing falls with their physician (31 percent). Performance was higher for other types of care (e.g., up to a national plan mean of 69 percent for members reporting ever having an osteoporosis test), but even this relatively higher rate indicates that 30 percent (almost 1 in 3) of eligible elderly members do not receive osteoporosis testing recommended by national guidelines.

TABLE 4: National Performance on Physical Component Summary and Mental Component Summary Change Scores – Percent Improved or Maintained Health, HOS 2007–2009

Medicare Stars Component	Number of Organizations Assessed	National Mean
Physical Component Summary change score	n = 268	67%
Mental Component Summary change score	n = 268	77%

TABLE 5: National Performance on Care for Elderly Medicare Advantage Members, HOS 2009

Medicare Stars Component	Percentage of Members Who:	Number of Organizations Assessed	National Mean
Urinary Incontinence	Discussed Urinary Incontinence Problem	n = 377	58%
	Received Urinary Incontinence Treatment	n = 377	36%
Physical Activity	Discussed Physical Activity	n = 419	52%
	Received Advice on Physical Activity	n = 419	47%
Falls Risk	Discussed Falls	n = 416	31%
	Received Falls Risk Management	n = 406	57%
Bone Health	Received an Osteoporosis Test	n = 416	69%

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- **Care Management**
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Providing Quality Preventive Health Care for the Elderly

NCQA talked to Medicare Advantage organizations whose results were in the highest national quartile of current performance on measures related to urinary incontinence, lack of physical activity, falls risk and poor bone health. NCQA asked about strategies these organizations use to address risk factors for poor mental and physical functioning among their members. Eight high-performing organizations agreed to be interviewed. Five offered a Special Needs Plan (SNP) benefit package. Organization size was diverse, ranging from 1,500 members to over 45,000 members, as was patient population (from predominantly white to predominantly non-white, minority populations) and location (four geographic census regions: Mid-Atlantic, Mountain, Pacific and South Atlantic).

Each of the top performing plans highlighted best practices focused in the areas of Care Management, Patient Education and Resources, and/or Quality Improvement. These broad categories should be familiar

to all plans, as they also represent areas of focus that are required as part of the Medicare Advantage and Special Needs Plan programs.

Care Management

According to the high-performing organizations that were interviewed, care management is important for maintaining general health in patients and for enhancing preventive care for older adults. Different types of staff are involved in care management, including case managers, primary care physicians, health educators and interdisciplinary teams consisting of both clinical (e.g., social workers) and nonclinical staff.

Although organizations use a variety of methods to manage care for their members, an essential component of care management is communication and exchange of information. Some organizations convene frequent, regular meetings between primary care physicians and case managers or among members of an interdisciplinary care team. Special Needs Plans are required to have a model of care (MOC) that is approved by NCQA, based on standards developed by the Secretary. The models of care contain 11 required elements, one of which is to develop an individualized care plan and provide to each patient enrolled in the Special Needs Plan. Two Special Needs Plans print “visit summaries” to complement the exchange of information, and every special needs patient has a care plan that reflects individual patient goals.



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- **Patient Education and Resources**
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Many organizations conduct regular patient health assessments and describe the importance of customized, patient-specific care for higher-needs patients which is a requirement for Special Needs Plans. One organization continuously mines claims and other health data — including referrals and lab results—and uses predictive modeling to target patients with acute or chronic health needs, for additional care management.

Organizations emphasize the importance of practitioner discussions with patients and patients’ families about health issues, possible interventions, treatments and care plans. Some organizations use care templates or electronic systems with physician reminders about patients who need follow-up; some implement unique care management approaches, such as community wellness programs, fitness and health education and telephone management of patients at higher risk (e.g., with fractures and osteoporosis).

High-performing organizations recommend these useful care management strategies:

- Communicate with members of the interdisciplinary team regularly to enhance care coordination
- Track patient progress through regular patient health assessments
- Customize patient-specific care for higher-need patients
- Work closely with patients, family and providers to establish goals
- Implement innovative care management approaches

One organization describes the use of primary care physicians and other basic care management components as important, “...because things like physical activity or osteoporosis testing, urinary incontinence...[will not] be handled in a rescue type system. It’s hard to imagine specialists dealing with almost anything on the Medicare Health Outcomes Survey HOS...because they don’t. They...focus on a very narrow problem or question. [The] HOS questions have to do with...maintenance of somebody versus actually dealing with a specific medical problem.”

Patient Education and Resources

Patient education is crucial for high-performing organizations and plays a key role in providing effective care. Organizations use an extensive variety of resources to enhance patient education and care. Many offer health classes whose subjects range from physical activity, to driver safety, to wellness programs; provide gym access; distribute newsletters; make local television appearances to discuss topics important to a specific segment of their population; and develop education programs for continuing medical education events.

Some organizations emphasize the importance of community partners and resources. One organization partners with a large grocery store to address polypharmacy issues, encouraging patients to bring their prescription medications to their local store for review by a pharmacist, free of charge. Another organization partners with medical equipment providers to educate patients who call with questions about the equipment. Some organizations work with community resources, such as Meals on Wheels and transportation assistance.

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- **Quality Improvement**
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

There are three categories of Special Needs Plans in the Medicare Advantage Program: (1) Chronic condition Special Needs Plans or C-SNPs; (2) Dual eligible Special Needs Plans or D-SNPs; and (3) Institutional Special Needs Plans or I-SNPs. To determine the appropriate chronic conditions for enrolling in a C-SNP, CMS convened a panel of experts and 15 chronic conditions were identified. Medicare beneficiaries with one or more of these specific chronic conditions are eligible to enroll in a C-SNP. Medicare beneficiaries who meet the eligibility requirements for the Medicare/Medicaid duals program may enroll in the D-SNPs. Persons who are certified to be eligible to be placed in a nursing home may enroll in the I-SNP and either remain in the community or become a resident in an institutional facility. Eligibility to enroll in a Special Needs Plan is not dependent on race and/or ethnicity.

There are a variety of approaches to patient education for special needs or racial/ethnic minority patients. For Special Needs Plans in particular, patient education is not limited to patients—discussions often involve the patient's family or caregiver. For organizations with a diverse racial/ethnic patient population, a culturally appropriate approach to patient education is especially important. For example, one organization knows that

High-performing organizations recommend these useful patient education strategies:

- Offer a variety of resources to help enhance or maintain patient health
- Partner with the community
- Target patient's family or caregiver
- Ensure that education is culturally appropriate

the topic of urinary incontinence is a culturally sensitive one for its elderly Hispanic and Vietnamese patients, and ensures that the patients' adult children are not in the room during a discussion about urinary incontinence between doctor and patient.

Quality Improvement

All high-performing organizations that were interviewed have a comprehensive system in place that tracks quality improvement data, and many described using HOS, HEDIS® (Health Effectiveness and Data Information Set) and Medicare CAHPS®² (Consumer Assessment of Healthcare Providers and Systems) results to track patient outcomes and experiences of care. The Medicare Advantage Program requires that all Medicare Advantage Organizations have a quality improvement program to address on-going improvements in the quality of care provided to the Medicare beneficiaries. Examples of requirements in the Quality Improvement Program are (1) developing and implementing at least one clinical chronic care improvement program and (2) designing and conducting at least one quality improvement project that may be clinical or non-clinical depending on the area being targeted for improvement. Additional information on the Medicare Advantage Quality Improvement Program can be found in Chapter 5 of the Medicare Managed Care Manual.

These organizations feel that it is important to provide feedback about provider performance. One organization sends personnel to divisions or practices that are not performing well, so it can understand the barriers to high performance and educate providers on methods for improving their performance.

²CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- **Conclusions**

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Most high-performing organizations prioritize measures and goals regularly and choose different measures on which to focus during a given period. For example, one organization spent a year focusing on urinary incontinence and educated its providers on the importance of incorporating discussions about urinary incontinence into patient conversations. Another organization focused on avoiding unnecessary or inappropriate hospitalizations.

Organizations mentioned the importance of using population-appropriate quality measures. Most concentrate on HOS measures and consider them relevant, but Special Needs Plans do not always find that measures relevant to community-dwelling elderly are also relevant to the institutionalized elderly. For example, Special Needs Plans do not want high rates of osteoporosis testing in their institutionalized female patients because of their frail state and (usually assumed) osteoporosis. These plans adapt care specific to patient needs.



High-performing organizations recommend these useful quality improvement strategies:

- Give feedback to providers
- Prioritize measures and goals regularly
- Ensure that quality measures are appropriate for the patient population

Conclusions

High-performing Medicare Advantage organizations consider multiple, simultaneous approaches to caring for their elderly populations, focusing on care management, quality improvement and extensive patient education. These strategies reflect a proactive approach to care that anticipates patient needs, rather than a reactive one. High-performing organizations implement efforts on multiple levels and activities are focused on patients, providers and the community.

For published literature that provides approaches to enhancing quality of care, click this link:

[http://www.hosonline.org/surveys/hos/download/Functional Status in Older Adults 2011.pdf](http://www.hosonline.org/surveys/hos/download/Functional%20Status%20in%20Older%20Adults%202011.pdf)

These are only a few examples of approaches to providing quality care. To some extent, these strategies reflect general requirements for Medicare Advantage (e.g., initial health assessments) and specific requirements for Special Needs Plans (e.g., a care plan in place). There are many strategies for enhancing care; what other organizations can accomplish will depend on community, health plan and time-related resources. But these examples represent a starting point for a larger discussion about processes to maintain the functional status of elderly organization members.

Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- [Data Dissemination](#)
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

Resources

Data Dissemination

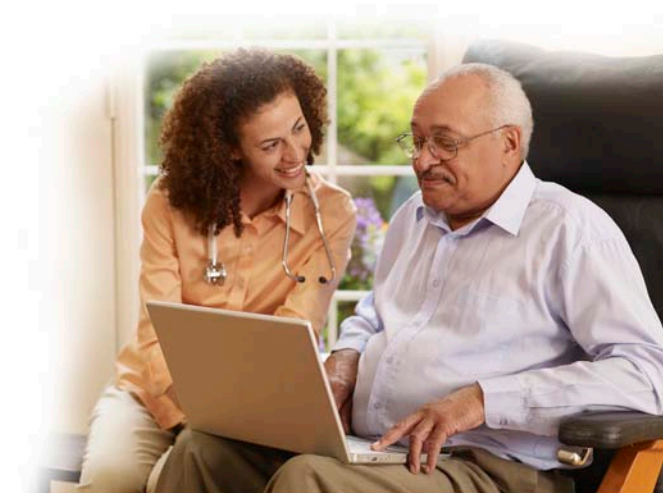
CMS disseminates HOS results through its Health Plan Management System (HPMS). **All report distribution occurs electronically.** Contact your organization's CMS Quality Point of Contact for questions about access to HPMS. Visit the HPMS Web site at <https://gateway.cms.gov/>.

Although member-level HOS results initially are not provided to plans after Baseline data collection, Medicare Advantage organizations will receive the following information from CMS through the Health Plan Management System.

- **HOS Baseline Profile Report.** This report is made available to all Medicare Advantage organizations that participated in the previous year's Baseline cohort. This report, which presents an aggregate overview of the Baseline health status of an organization's members, was developed and extensively tested to ensure that data are useful and actionable. State Quality Improvement Organizations (QIO) also receive Baseline reports. Baseline reports are made available the year after administration of the Baseline cohort.

- **HOS Performance Measurement Report and Data.** After administration of each Follow-Up cohort, a cohort-specific performance measurement report is produced. Survey responses from Baseline and Follow-Up are merged to create a two-year performance measurement data set. Performance measurement results are computed using a rigorous case-mix/risk adjustment model, and the reports and corresponding data results are designed to support quality improvement activities. Member-level performance measurement data are made available to Medicare Advantage organizations upon request and are disseminated electronically to all participating Quality Improvement Organizations after distribution of performance measurement reports.

Availability of HOS reports and data are announced through Health Plan Management System memorandums.



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- [HOS Web Site and E-Mail](#)
- [NCQA Web Site and E-Mail](#)
- [CMS Web Site and E-Mail](#)
- [HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey](#)

References

You can get information about HOS from these sources:

HOS Web Site and E-Mail

E-mail hos@azqio.sdps.org or call 888-880-0077 for requesting plan data and technical support. Find current information on the HOS program at <http://www.hosonline.org/Content/Default.aspx>.

NCQA Web Site and E-Mail

E-mail hos@ncqa.org for general administrative questions. Direct technical questions to NCQA's Policy Clarification Support (PCS) system at www.ncqa.org, or call 888-275-7585.

CMS Web Site and E-Mail

E-mail hos@cms.hhs.gov for program policy questions. Find information about HOS on the CMS Web site at <http://www.cms.gov/HOS/>.

HEDIS® Volume 6: Specifications for the Medicare Health Outcomes Survey

An updated version of the HOS manual, Volume 6 is published in February each year. This volume can be obtained by calling NCQA's Customer Support line at 888-275-7585 or by ordering online at www.ncqa.org.



Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

References

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Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

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Acknowledgements

Introduction

- About This Guide/About HOS
- Calculating Physical Component Summary and Mental Component Summary Change Scores
- Calculating Effectiveness of Care Items

National Performance on Medicare Advantage Star Ratings Components

- Functional Health Outcomes: Physical Component Summary and Mental Component Summary Change Scores
- Urinary Incontinence
- Lack of Physical Activity
- Falls Risk
- Bone Health and Osteoporosis Testing
- National Performance

Providing Quality Preventive Health Care for the Elderly

- Care Management
- Patient Education and Resources
- Quality Improvement
- Conclusions

Resources

- Data Dissemination
- HOS Web Site and E-Mail
- NCQA Web Site and E-Mail
- CMS Web Site and E-Mail
- HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey

References

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