Quality Measures used in the Expanded HHVBP Model

Recorded Webinar Transcript

Slide 1: Welcome to the learning and technical assistance event: “Quality Measures used in the Expanded HHVBP Model." My name is Carrie Kolleck and I'm joined by other members of the HHVBP Model Technical Assistance Team as we focus on the applicable quality measures used in the measure set of the expanded HHVBP Model. The target audience for this event are home health agencies.

Slide 2: As I mentioned, I'm Carrie Kolleck, and I am your moderator today. My colleagues on the HHVBP TA Team and speakers for this recording are Linda Krulish and Elaine Gardner from OASIS Answers, Inc.

Slide 3: The agenda includes details regarding the quality measures used in the expanded HHVBP Model from the following measure categories: the five measures in the OASIS-based category, two measures in the claims-based category, and five measures in the HHCAHPS survey-based category.

Additionally, we'll identify the quality measure data sources, performance information, and resources specific to quality measures that are currently available to home health agencies.

Finally, we will review next steps to consider.

Slide 4: Objectives for you are to describe the applicable quality measures used in the expanded HHVBP Model measure set, and to identify the locations of your agency's data and quality measure performance information available now to you and your team. Additionally, become more familiar with and access resources regarding the quality measures, and to support your “next steps,” the HHVBP TA Team will highlight an additional quality improvement resource we developed to support home health agency success in the expanded HHVBP Model.

Now, I'm going to turn it over to Linda Krulish to review the applicable quality measures that will be used to assess HHA performance in the expanded HHVBP Model. I'll turn it to you, Linda.

Slide 5: Thanks, Carrie. Let’s take a look at the applicable quality measures that will be used to assess home health agency performance in the expanded HHVBP Model.

We'll first review the measure set, and then we'll take a deeper dive into each applicable quality measure in the Model.

Slide 6: The measure set in the expanded HHVBP Model, as stated in the Calendar Year 2022 Home Health PPS final rule, includes five OASIS-based measures, two claims-based

measures, and five Home Health CAHPS survey-based measures. Each of the five components of the HHCAHPS survey serves as an individual measure in the expanded HHVBP Model.

The level of performance for each of these measures informs the calculation of a home health agency's Total Performance Score, which will be compared within cohorts to determine the adjusted payment percentage for each agency.

Using quality episodes, the OASIS-based measures are calculated using data from the Outcome and Assessment Information Set, or OASIS. The five OASIS-based measures included in the expanded HHVBP Model are Improvement in Dyspnea, Discharged to Community, Improvement in Management of Oral Medications, Total Normalized Composite or TNC Change in Self-Care, and Total Normalized Composite or TNC Change in Mobility.

Claims-based measures are calculated using Medicare fee-for-service claims data. The claims-based measures evaluate the rate of utilization of specific services that may indicate quality of care concerns within the agency. The two claims-based measures are Acute Care Hospitalization During the First 60 Days of Home Health Use and Emergency Department Use without Hospitalization During the First 60 Days of Home Health.

HHCAHPS survey-based measures are derived from the Home Health Consumer Assessment of Health Care Providers and Systems, or HHCAHPS survey, which measures the experiences of patients receiving home health care from Medicare-certified home health agencies. The five HHCAHPS survey-based measures include the following survey components: we have Care of Patients, Communication, Specific Care Issues, Overall Rating, and Willingness to Recommend.

Each of the quality measures are calculated using risk adjustment steps or patient-mix adjustment factors in the statistical process to take into account differences in home health agency patient characteristics. These adjustment calculations capture differences in patient characteristics that influence a health outcome. Such adjustments for risk or patient-mix factors are commonly used so patient characteristics are taken into account in the comparison to other providers.

As we examine these measures, keep in mind that no additional information or data for any home health agency needs to be collected and/or submitted at this time for the HHVBP Model. Any changes that CMS would make to this measure set included in the HHVBP Model will occur through future rulemaking.

Slide 7: This slide shows the same information as on the previous slide, with the addition of a fourth column: Payers.

Here the various payers are identified by measure category for patient data used in the quality measure calculations.

The OASIS-based measures include data for patients with Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care as the payer.

The claims-based measures only include data for patients with Medicare fee-for-service as the payer.

And the HHCAHPS survey-based measures include data for patients with the same payers as listed for the OASIS-based measures. That's Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care.

Slide 8: Before taking a deeper dive into each quality measure, let's first scan this summary of applicable quality measures, data sources, and uses. The purpose of this table is to highlight that data used in the expanded HHVBP Model is already collected, and to summarize the data sources and uses for each of the quality measures that are used in the Model.

On the left are the three categories of measures included in the HHVBP Model, and a listing of each measure by title or name. The next column identifies data sources used in measure calculations.

The checkmarks in the final columns identify which measures are used in CMS quality improvement initiatives, including the HHVBP Model, the Quality of Patient Care Star Rating, the Patient Survey Star Rating, and public reporting on Care Compare.

As you review and interpret your data and reports, keep in mind that time frames of data collection and reporting might vary by measure.

Slide 9: This table serves as a template for how details about each quality measure included in the expanded HHVBP Model will be organized during this presentation.

Each measure will be presented using the list of quality measure subtopics on the left. So, let's review these subtopics now.

The first subtopic is Use in Home Health by CMS. We know that Home Health measures may be used by CMS in multiple ways. Since our focus is the applicable measure set for the HHVBP Model, all of the measures presented in this session will be included in the HHVBP use. Then, if that same measure is also used for the Quality of Patient Care Star Rating, the Patient Survey Star Rating, and/or Care Compare, that information will be indicated in the first row as well.

The second sub-topic is Measure Category. Each measure in the HHVBP Model is assigned to one of the three measure categories: OASIS-based, claims-based, or HHCAHPS survey-based.

Next is Data Source, and this row identifies if the measure uses data from the OASIS assessment, including which OASIS items are used to calculate the measure, or if the data comes from Medicare fee-for-service claims that are submitted by a hospital or an Emergency Department, or if the data source is one or more questions from the HHCAHPS survey.

Next is the Measure Description, where for each measure we'll provide a brief description of what the measure reports, as defined in CMS resources.

For the Measure Calculation row, we'll dive a little deeper into the measure, and we'll review what is included in the numerator and the denominator and what exclusions apply for that quality measure.

And the last subtopic is Measure Type. Each measure in the HHVBP Model is a type of Outcome Measure. And this row provides more specific detail on the type of outcome measure, for example, a “functional” outcome measure, “utilization” outcome measure, or a “composite” outcome measure. It's helpful to note that none of the HHVBP measures are Process Measures.

Slide 10: So, let's begin with the OASIS-based measures.

Slide 11: The first OASIS-based measure that we’ll highlight is Improvement in Dyspnea. This is an OASIS-based measure that's used not only in the HHVBP Model, but also, it's used to calculate the Quality of Patient Care Star Rating, and it's publicly reported on Care Compare.

The Improvement in Dyspnea measure is calculated from OASIS item M1400: When is the patient dyspneic or noticeably short of breath? So, let’s take a closer look at that OASIS item.

Slide 12: M1400 is likely familiar to all of you. The coding responses range from “0. Patient is not short of breath” to “4. The patient is short of breath at rest during the day or night.” Additional codes reflect patients who demonstrate shortness of breath when they're walking distances of more than 20 feet or climbing stairs, or with moderate exertion, like when they're getting dressed, or with minimal exertion like when they're talking or when they get agitated.

The difference in the code that is reported for M1400 at the beginning of the quality episode is compared with the code reported at the end of the quality episode. Then, taking into account the measure exclusions, the measure is calculated.

The patient has improved in dyspnea when the OASIS score at discharge is numerically less than the score at the beginning of care. For the purposes of defining a quality episode used in these measure calculations, the beginning of care can either be the Start of Care or the Resumption of Care, whichever is most recent.

Slide 13: This measure is described as the percentage of home health quality episodes during which the patient became less short of breath or dyspneic.

Our table outlines details about how the measure is calculated, identifying the numerator and denominator that result in the measure rate. The measure exclusion applies to this quality measure. Patients that were not short of breath, as indicated by a "0. Patient is not short of breath" on M1400 at the Start or Resumption of Care, are excluded from the measure calculation. Also, quality episodes that end in a qualifying transfer to an inpatient facility, or that end with a death at home, are also excluded from the measure calculation, since M1400 is not assessed and collected at those time points.

As your agency takes a deeper dive into your own data, you may find it helpful to keep in mind that as of the last refresh of publicly available CMS data on Care Compare, the national rate of patient episodes demonstrating Improvement in Dyspnea is 86.7%.

Questions related to this or any of the OASIS-based measures can be directed to the CMS Home Health Quality Help Desk at homehealthqualityquestions@cms.hhs.gov. This email box address is included in the final slides of this presentation.

Slide 14: Now let's dive into the OASIS-based measure, Discharged to Community. So, to clarify, we are not talking about a similarly named claims-based measure, *Discharge* to Community, which is included in the Home Health Quality Reporting Program. The measure that's used in the HHVBP Model is derived from OASIS, not claims, and it's called *Discharged* to Community.

The OASIS-based Discharged to Community measure is not currently publicly reported or currently used in any other quality reporting initiatives except for the HHVBP Model. While this measure is not currently publicly reported, agencies can find their measure results in the agency's Outcome Quality Measure Reports in iQIES.

Discharged to Community is calculated using OASIS item M2420: "Where is the patient after discharge from your agency?" So, let's look at that item.

Slide 15: M2420, "Discharge Disposition: Where is the patient after discharge from your agency?" is collected at the Discharge time point, and responses include "1. The patient remained in the community without formal assistive services," "2. The patient remained in the community with formal assistive services," "3. The patient transferred to a non-institutional hospice," "4. Unknown, because the patient moved to a geographical location not served by this agency," or "Other unknown."

The coding of this item at the end of the quality episode provides the data that's used to calculate this measure.

Slide 16: The measure reports the percentage of home health quality episodes where patients remained at home after the home health discharge.

The numerator includes the number of home health episodes where, upon discharge from the home health agency, the patient remained in the community.

The denominator for this outcome measure calculation includes the total number of quality episodes that, during the reporting period, end with a discharge or a transfer to an inpatient facility. This measure does not include home health quality episodes that end in a patient death at home.

Slide 17: Now let's take a look at the OASIS-based measure “Improvement in Management of Oral Medications.”

This measure is not only used in the HHVBP Model, but also, it's used to calculate the Quality of Patient Care Star Rating, and it's publicly reported on Care Compare.

This measure’s calculated using OASIS item M2020, “Management of Oral Medications.”

Slide 18: M2020 captures the patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times or intervals. Item coding is not reporting the patient's compliance or their willingness to take their oral medications. The assessment for this item is intentionally limited to medications that are taken by mouth. It excludes injectables and IV medications and medications administered by any other route other than “by mouth.”

The coding responses range from “0. Where the patient's able to independently take the correct oral medication and proper dosage at the correct times” to a “3. Where the patient is unable to take medications unless the medications are administered by another person.” And then Codes 1 and 2 represent patients’ ability “in between” independent and dependent and provide considerations for the ability of the patient to take medications at the correct times if, for example, another individual prepares the dosages in advance, or another person develops a drug diary or chart, or gives the patient reminders when it's time to take their pills.

Slide 19: The code reported for M2020 at the beginning of the quality episode is compared to the code reported at the end of the quality episode and determines the percentage of home health quality episodes during which the patient improved in their ability to take their medicines correctly by mouth.

In other words, the patient has improved in the management of oral medications when the OASIS code at discharge is numerically smaller when compared to the code at the beginning of care. And remember that the beginning of care can be either a Start of Care or a Resumption of Care depending on which was most recent.

Some quality episodes would be excluded from this measure. Patients who at the Start of Care or Resumption of Care were already able to take their oral medications correctly without assistance or supervision, or patients who are non-responsive, or patients who have no oral medications prescribed are all excluded from this measure. Additionally quality episodes that end with a transfer to an inpatient facility or a death at home would also be excluded, as M2020 that's needed to calculate the measure is not collected at those time points.

The most recent national rate on Care Compare for this functional outcome measure is 79.6%. So, in other words, nationally, 79.6% of patient episodes demonstrated Improvement in Management of Oral Medications from the Start or Resumption of Care to Discharge. So, we invite you to consider this information as you look at your own data.

Slide 20: The next two OASIS-based measures are unique to the HHVBP Model, and they use a different measure calculation approach than the three measures just described. Let's start with a Total Normalized Composite Change in Self-Care measure, also referred to as the TNC Self-Care Measure.

This OASIS-based measure is a composite measure and it's calculated using data from six different OASIS items that reflect some aspect of patient self-care. Let's take a closer look at these items.

Slide 21: The six OASIS items used in the calculation of the self-care measure are M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Feeding or Eating.

Each of these items is coded based on an assessment of the patient's current ability to safely perform a specific task, such as completing grooming activities, or getting their clothes and getting dressed or undressed, or completing necessary toileting hygiene tasks. The coding responses for each OASIS item range from "able" to safely perform the task independently to "the patient depends entirely upon another person" to perform the task. M1870 Feeding or Eating includes additional response codes to accurately reflect the patient's condition when they receive nutrients through a nasogastric tube or gastrostomy.

The difference in the codes from the beginning of the quality episode to the end of the quality episode are used in the measure calculation to identify the magnitude of change, either positive or negative, that occurred from the Start or Resumption of Care until Discharge, for this Composite Outcome, comprised of these six OASIS items.

Look at the structure of these six OASIS items and notice that the number of response options to choose from varies among the 6 items that are used in this TNC measure. Grooming has only four response options to choose from (0, 1, 2, and 3),

and Bathing has seven response options to choose from. So, we'll circle back to this concept in a moment when we discuss how the individual OASIS activity scores are "normalized" when calculating this measure.

Because this TNC self-care measure is unique to the HHVBP Model, it is not currently publicly reported on Care Compare. However, you might consider looking at your agency's performance on your Confidential Feedback Reports and in Care Compare for individual measures that are derived from these same OASIS items to see if your performance offers any insights to you regarding your need to consider focused improvement efforts.

Slide 22: This TNC Self-Care measure reflects the magnitude of change, either positive or negative, based on the normalized amount of possible change on each of the six OASIS items.

Because the TNC Change in Self-Care measure is a composite measure, calculating the magnitude of change, the terms "numerator" and "denominator" do not apply. Instead, the measure, through a series of calculations, produces the total normalized change in self-care functioning across 6 activities included in the OASIS assessment.

The measure excludes home health quality episodes for non-responsive patients, and quality episodes that end with an inpatient facility transfer or death at home.

So, let's take a look at the 5-step process for computing this Composite Outcome measure, TNC Self-Care.

Slide 23: The calculations begin with the raw change score for each of the 6 OASIS items that is used in the quality episode. This step produces the difference between the patient's status at Start or Resumption of Care and the patient status at Discharge. The change may be positive, it may be negative, or there may be no change at all.

Then in Step 2 the quality episode raw change is *normalized* for each of the 6 OASIS items.

The term "normalized" is used in the name of the measure and in Steps 2 and 3 of this 5-step process. Normalizing occurs because there are multiple OASIS items used in the calculation of this composite measure, and among those OASIS items the number of coding options varies. Therefore, the raw change score is normalized to fit into a range of -1 to +1 for each OASIS item. This occurs by dividing the quality episode raw change by the maximum possible change for that OASIS item.

The number of coding response options in the OASIS items used in this self-care measure range from four for Grooming, Upper Body Dressing, Lower Body Dressing, and Toileting Hygiene, to as many as 7 for Bathing.

Through “normalizing” the change score fits a range of -1 to +1 for each item, regardless of how many response options that item has. In other words, the change is “normalized” for each OASIS item.

Once these normalized change scores are summed in Step 3, and the episode-level values are averaged for the home health agency in Step 4, then the agency's risk-adjusted value for TNC Self-Care is calculated in Step 5 using the same formula used to risk-adjust all other OASIS-based measures.

Resources providing more details about this measure and how it's calculated are available in the links that are listed at the end of this presentation.

Slide 24: Now let's review the details for the other OASIS-based Composite Outcome measure: Total Normalized Composite Change in Mobility, also referred to as TNC Mobility measure.

This measure is calculated using three OASIS items related to mobility. That's M1840 Toilet Transferring, M1850 Transferring, and M1860 Ambulation/Locomotion.

Slide 25: Each of these items is coded based on an assessment of the patient's current ability to safely perform a specific task, such as just getting to and from and transferring on and off a toilet, or transferring from a bed to a chair, or walking on level and unlevel surfaces. The coding responses for each OASIS item range from “able” to safely perform the task independently to the patient being “totally dependent” or “unable” to safely perform the task.

The difference in the codes from the beginning of the quality episode to the end of the quality episode are used in the measure calculation to identify the magnitude of change, either positive or negative, that occurred from the Start or Resumption of Care until Discharge.

Notice that in the structure of these three OASIS items they also demonstrate variation in the number of response options that you could choose from, so the same “normalization” process is used in the TNC Mobility measure that we previously discussed for the TNC Self-Care measure.

Because this TNC Mobility measure is unique to the HHVBP Model, it is not currently publicly reported on Care Compare, but again you can review your agency's performance on your Confidential Feedback Reports and Care Compare for the *individual* measures that are derived from these same OASIS items to determine if such review offers any insights regarding your need for quality improvement efforts.

Slide 26: This measure, like the TNC Self-Care measure, captures the magnitude of change, again either positive, negative, or none at all, in home health patients’ mobility between the Start or Resumption of Care and the patient’s Discharge.

Because the TNC Change in Mobility measure is a composite measure calculating the magnitude of change, the terms “numerator” and “denominator” do not apply. Rather the measure, through again a series of steps, produces the total normalized change in mobility functioning across the three OASIS items of Toilet Transferring, Bed Transferring, and Ambulation/Locomotion.

Like TNC in Self-Care, the measure excludes home health quality episodes for non-responsive patients and quality episodes that end with an inpatient facility transfer or a death at home.

Slide 27: Again, like the TNC Self-Care, the TNC Mobility measure calculations begin with the raw change score for each of the three OASIS items related to mobility, using the quality episode.

During Step 2, the normalization of the quality episode raw change is determined for each of the three OASIS items. This calculation considers the maximum possible change for each OASIS item. The coding options for these three items range from five options for M1840 Toilet Transferring to as many as 7 for M1860 Ambulation/Locomotion, and the normalizing occurs in the same way as for the TNC Self-Care, where the change score is normalized to fit into a range of -1 to +1 for each OASIS item. Again, this occurs by dividing the quality episode raw change by the maximum possible change for each OASIS item.

Then the normalized change scores are summed in Step 3. The episode-level values are averaged for the home health agency in Step 4, and then agency’s risk-adjusted value for TNC Mobility occurs in Step 5 using the same formula used to risk-adjust all other OASIS-based measures.

If you have questions regarding the computation of these two HHVBP TNC Composite Outcome measures, please consider submitting your question to the HHVBP Help Desk at HHVBPquestions@lewin.com, and you’ll find this help desk address listed in the slide at the end of this presentation. So now I'll pass it over to Elaine to cover the claims-based measures.

Slide 28: Okay, thank you, Linda. Now let's review the two claims-based measures included in the expanded HHVBP Model.

Slide 29: The quality measure Acute Care Hospitalization During the First 60 Days of Home Health Use is commonly referred to as Acute Care Hospitalization, or ACH. CMS uses this measure in the HHVBP Model, the Quality of Patient Care Star Rating, and for public reporting on Care Compare, as it reflects goals consistent with other CMS initiatives that focus on reducing avoidable hospital admissions. CMS believes the increased focus on accountability for areas of significant Medicare spending such as hospitalizations will help meet these goals.

The data used to calculate this measure comes from Medicare fee-for-service claims for an *unplanned* admission to an acute care hospital.

Slide 30: The measure description is the percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of home health stay.

The numerator includes only those home health stays for patients who have a Medicare fee-for-service claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay. Note that multiple unplanned hospitalizations for a patient in a home health stay are counted as one home health stay for this measure. Hospitalizations which occur after the first 60 days are not included in this quality measure.

Measure-specific exclusions for this utilization outcome measure are identified as: Home health stays that begin with a Low Utilization Payment Adjustment claim, or in which the patient receives services from multiple agencies during the first 60 days, or for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the home health stay, or for patients who are not continuously enrolled in fee-for-service Medicare for the 60 days following the start of the home health stay, or until death.

The most recent national rate on Care Compare for this measure shows that nationally, 15.4% of patients were admitted to an acute care hospital during the first 60 days following the start of their home health stay. As your agency takes a deeper dive into your own data, identify if your agency's rate is higher or lower than this risk-adjusted national rate, and how your agency is trending for this measure. If your agency's rate is lower than the national average of 15.4%, this means, if all other factors are equal, that your agency is performing better than the national average for this measure.

Slide 31: So, to calculate this quality measure for the home health agency, a hospital claim is used in combination with the home health claim.

In the calculations, the numerator is described as the number of home health stays for patients who have a Medicare fee-for-service claim for an *unplanned admission* to an acute care hospital, in the 60 days following the start of the home health stay. Note that *planned* hospitalizations are excluded from the numerator.

The numerator is then divided by the number of home health stays that begin during the 12-month observation period, and a home health stay is described as a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

Slide 32: So now let's discuss the second claims-based measure: Emergency Department Use without Hospitalization During the First 60 Days of Home Health, also referred to as ED Use. CMS uses this measure in the HHVBP Model and on Care Compare, as similar to the ACH measure, it reflects goals consistent with other CMS initiatives that focus on reducing Medicare spending.

Data sources for this measure are Medicare fee-for-service claims for patients using the Emergency Department, but who were not admitted to the hospital.

Slide 33: The measure is described as the percentage of home health stays in which patients used the Emergency Department but were *not admitted* to the hospital during the 60 days following the start of the home health stay.

The measure reflects those home health stays for patients who have a Medicare fee-for-service claim for outpatient Emergency Department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay, out of the number of home health stays that begin during the 12-month observation period.

Measure-specific exclusions for this utilization outcome measure are the same as for the ACH measure.

The most recent national rate for this measure shows that nationally on Care Compare, 13% of patient stays included use of a hospital Emergency Department during the 60 days following the start of the home health stay, where the patient was not admitted to the hospital. We invite you to analyze your own agency's ED use rate and if it's trending higher or lower than this national, risk-adjusted rate. If your agency rate is trending lower than 13%, then your agency is most likely performing better than the national average for this measure.

Slide 34: So to calculate this measure, the number of home health stays for patients who have a Medicare fee-for-service claim for outpatient Emergency Department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay, is divided by the number of home health stays that begin during the 12-month observation period.

It is perhaps helpful to note that the denominator used in this measure is the same denominator used in the Acute Care Hospitalization measure.

Slide 35: So now let's discuss the third category of measures included in the HHVBP Model: The Home Health CAHPS survey-based measures.

Slide 36: The Home Health CAHPS survey-based measures included in the expanded HHVBP Model consist of five HHCAPS survey components: Care for Patients, Communication, Specific Care Issues, Overall Rating, and Willingness to recommend the agency. The term "applicable measure" applies to each of the five components

for which a competing home health agency has submitted a minimum of 40 completed HHCAHPS surveys. That is, each component counts as one applicable measure towards the 5-measure minimum that is required for a home health agency to receive a Total Performance Score.

These measures are also used by CMS in the Patient Survey Star Rating and Care Compare.

The measures include 3 composite measures and two Global Rating measures that together represent the HHCAHPS measure category for the expanded Model.

So, each of the five HHCAHPS measures is calculated using data from one or more survey questions.

So, let's take a look at each of the HHCAHPS measures in more detail.

Slide 37: Calculation of Care of Patients, sometimes referred to as Professional Care under the expanded Model, includes the responses to four questions. As a composite measure, results from multiple questions that ask about a common topic area are combined.

The score for this composite is produced by combining the responses to the four questions. In the last 2 months of care, how often did home health providers from this agency?... for Question 9: “Seem informed and up to date about all the care or treatment received at home?”, Question 16: “Treat you as gently as possible?”, Question 19: “Treat you with courtesy and respect?”, and Question 24: “Did you have any problems with the care you got through this agency?”

The scoring on this composite represents the proportion of respondents who selected “Always” to Questions 9, 16, and 19, and “No” to Question 24.

To calculate the composite, the proportion of cases in the quarter in which the respondent gave the most positive response is determined, followed by the averaging of the proportions for the four questions. Next, the results obtained from each of the four separate quarters are averaged, and the patient-mix adjustment factors are applied to account for factors that are beyond a home health agency’s control.

The most recent national rate on Care Compare for this measure shows that following discharge from home health agency, 88% of patients reported that their home health team gave care to them in a professional way. You might consider this national rate as you analyze and trend your own data.

Slide 38: The calculation of Communication Between Providers and Patients includes the responses to six questions.

Question 2: “When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?” The responses are Yes or No.

Question 15 through Question 22 begin, in the last 2 months of care… “How often did home health providers from this agency keep you informed about when they would arrive at your home?”, “How often did home health providers from this agency explain things in a way that was easy to understand?”, “How often did they listen carefully to you?”, and “When you contacted this agency's office, did you get the help or advice you needed?”

Then Question 23 asks: “When you contacted the agency's office, how long did it take for you to get the help or advice you needed?”

The scoring on this composite represents the proportion of respondents who answered “Yes” to Questions 2 and 22, “Always” to Questions 15, 17 and 18, and “Same day” to Question 23. The composite uses the same calculation steps as reviewed for the Care of Patients measure.

The most recent national rate on Care Compare for this measure is 85%. In other words, nationally, 85% of patients report that their home health agency communicated well with them. As your agency considers your own data, you might keep in mind that this national rate and that the measure takes into account differences in patient characteristics.

Slide 39: Calculation of Specific Care Issues, sometimes referred to as Team Discussion under the expanded Model, includes the responses to these 7 questions:

When you first started getting home health care from this agency, did someone from the agency talk with you about… “How to set up your home so you can move around safely?” “All the prescription medicines you are taking?”, “Ask to see all the prescription medicines you were taking?”

Additionally, in the last 2 months of care did home health providers from this agency talk with you about… “Pain?”, "Purpose for taking your new or changed prescription medicines?", "When to take these medicines?", and "The important side effects of these medicines?"

Response options include Yes or No. The scoring on this composite represents the proportion of respondents who answered “Yes” to these questions. The composite uses the same calculation steps as the other two HHCAHPS composite measures.

Nationally, as reported on Care Compare, 82% of patients reported that their home health agency team discussed medicines, pain, and home safety with them. Compare your agency's data to this national rate as you identify measures in the HHVBP Model for quality improvement efforts.

Slide 40: Now let's take a look at the first of the two Global Ratings questions in the Home Health survey-based measures: Overall Rating.

Question 20 asks the discharged patient to use any number ranging from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible and select a number to rate their care from the agency's home health providers.

The global ratings measure is calculated using the proportion of survey responses in the quarter with an overall rating of 9 or 10, followed by the averaging of the results obtained from each of the four quarters. And the patient mix adjustment factors are statistically applied.

Nationally on Care Compare, 84% of patients gave their home health agency a rating of 9 or 10 on a scale of 0 to 10, with 10 as the highest possible score. Consider using this national rate as you compare the results to your agency's rate and trending and determine future quality improvement efforts.

Slide 41: The second of the two global ratings questions in the Home Health Survey-based measures asks the discharged patient, "Would you recommend this agency to your family and friends if they needed home health care?"

The Global Ratings measure is calculated using the proportion of respondents in the quarter who selected "Definitely Yes" for Question 25. The results obtained from each of the four quarters are averaged, and the patient mix adjustment factors are statistically applied.

Nationally on Care Compare, 78% of patients reported they would definitely recommend the home health agency to friends and family. To analyze your agency's results and consider improvement planning, compare your rate to this national rate.

Slide 42: This slide summarizes the HHCAHPS survey-based measures, and the factors used in the calculations.

After the CMS HHCAHPS Coordination Team calculates the scores for the reporting period, then they statistically adjust the data for differences in HHCAHPS scores resulting from differences in patient mix. Therefore, HHCAHPS Global Ratings and composite scores calculated by survey vendors may differ from results that CMS calculates, and which are publicly reported.

For detailed scoring information for this patient self-reported outcome measure, see the list of resources for the HHCAHPS measures at the end of this recording.

Slide 43: So, as you conduct these next steps, you might hope to access additional quality measure resources. And we've assembled a list of resources currently available to you and your home health agency.

Slide 44: These quality measure resources will provide you easy access for the applicable measures in the Home Health Value-Based Purchasing Model measure set. In addition, you will also see links to each help desk available to home health agencies.

Under the CMS Home Health Quality Reporting Program, you can access the Home Health Outcome Measures Table with measure details as well as technical specifications and risk adjustment steps for the claims-based and the OASIS-based measures, except for the TNC measures unique to the HHVBP Model.

Under the CMS Home Health CAHPS, you will find resources to understand in more detail the steps for calculating the five applicable measures and the use of patient mix adjustment factors in determining these patient self-reported outcomes.

And under the CMS Expanded HHVBP Model webpage, there are links to documents specific to the two TNC Change measures which are unique to the HHVBP Model, as well as the link to the Calendar Year 2022 Home Health PPS final rule.

We encourage you to access these resources as you discuss and analyze your home health agency's outcome measures. Remember to share with your team this recording, the slide deck, and the accompanying written resource to support your team's understanding of the measures and your quality improvement work.

Slide 45: In thinking about how quality intersects with Home Health Value-Based Purchasing, the Technical Assistance Team developed a written resource for you and your staff. The resource “How to use Existing Quality Assurance and Performance Improvement Processes to Support Improvement in the Expanded Home Health Value-Based Purchasing Model” is available for download from the CMS Expanded HHVBP Model webpage.

It provides an introduction to the quality improvement cycle, including the quality improvement steps of ongoing data collection and submission of quality measure data, a review of data, measures, and reports to monitor progress, and the identification of measures for performance improvement activities within your home health agency.

The written resource walks you through each of these four steps in the Quality Improvement Cycle, and how they relate to the expanded HHVBP Model. The visuals and accompanying text pose such considerations as identifying HHCAHPS data collection by the vendor, staff education and joint visits for accurate data collection, using trended results from individual quality measures and data already available to guide quality improvement planning, timeframes, and interventions.

Information on Home Health Quality Measures and Reports in iQIES is provided, as well as samples of measure results from the Quality of Patient Care Star Rating Scorecard, the Outcome Report in iQIES, and Care Compare.

Samples of planning tools and a list of resources are also provided. By applying this cyclical approach to quality improvement, measures can be targeted for improvement efforts and prioritized in your agency for the first performance year Calendar Year 2023, and the linked payment year, Calendar Year 2025. And now I will turn this back to Carrie for next steps.

Slide 46: Thanks, Elaine. Now that we have reviewed all of the measures and resources available, we'd like to think through how the quality measure information relates to the *expanded* HHVBP Model and some suggested next steps.

Slide 47: You may consider reviewing with your team the details of the applicable Quality Measures included in the expanded HHVBP Model measure set, and knowing the locations of your agency's data and quality measure information and then access these on a regular basis, and third, utilize this video recording and the written resource, “How to use Existing Quality Assurance and Performance Improvement Processes to Support Improvement in the Expanded HHVBP Model” that was developed by the Technical Assistance Team to support you as you implement quality improvement and your agency plans for success in the HHVBP Model.

Slide 48: Thank you. This concludes the video recording “Quality Measures used in the HHVBP Model.” We encourage you to share this recording and the accompanying resource as you start with where you are, identify the data and measure information available to you now, and implement quality improvement plans as your HHA implements the expanded HHVBP Model.