Home Health Quality Measures

The following two categories of quality measures are used in the Home Health Quality Reporting Program (HH QRP): Outcomes measure/Process Measures

Outcome measures: Outcome measures assess the results of health care that are experienced by patients. The data for the Home Health outcome measures are derived from 2 sources: (1) data collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies; and (2) data submitted in Medicare claims.

There are 3 types of Outcome measures used in the HH QRP:
Improvement measures (i.e., measures describing a patient's ability to get around, perform activities of daily living, and general health);
Measures of potentially avoidable events (i.e., markers for potential problems in care)
Utilization of care measures (i.e., measures describing how often patients access other health care resources either while home health care is in progress or after home health care is completed).

Home Health Quality Measures (cont)

Process Measures: evaluate the rate of home health agency use of specific evidence-based processes of care. The HH QRP process measures focus on high-risk, high-volume, problem-prone areas for home health care. These include measures pertaining to all or most home care patients, such as timeliness of home care admission, immunizations, and use of risk assessment tools for falls, pain, depression, and pressure ulcer development. There are also measures for specific diagnoses (heart failure, diabetes, pressure ulcers) and measures of care planning and clinical interventions delivered for patients experiencing certain symptoms (pain, depression).

Process measures are derived from data collected in the Outcome and Assessment Information Set (OASIS) submitted by home health agencies and are calculated using a completed episode of care that begins with admission to a home health agency (or a resumption of care following an inpatient facility stay) and ends with discharge or transfer to inpatient facility.

Why are we Measuring?

1. Prevent exacerbation of Serious Illness
2. Improve care received by individual patients
3. Providing guidance to agencies related to improving care and avoiding adverse events

Examples of Measures and Outcomes monitoring:

- ✓ Assessment
- ✓ Care Planning
- ✓ Care Coordination
- ✓ Clinical Intervention
- ✓ Education
- ✓ Prevention

What is OASIS?

OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and proposed to be an integral part of the revised Conditions of Participation for Medicare-certified home health agencies (HHAs).

It was designed to provide the necessary data items to measure both outcomes and patient risk factors. The OASIS data items have utility for clinical assessment, care planning and other internal agency-level applications.

OASIS data items address sociodemographic, environmental, support system, health status, functional status, and health service utilization characteristics of the adult patient (18 years or older, non maternity patients) receiving skilled services with Medicare or Medicaid as a payer source.

Data is collected at the start of care, 60-day follow-ups, and at discharge.

HOME HEALTH UTILIZATION
Jurisdiction 6

PAID CLAIMS PERIOD:
January 2015 thru June 2015

NGS Home Health & Hospice Workloads

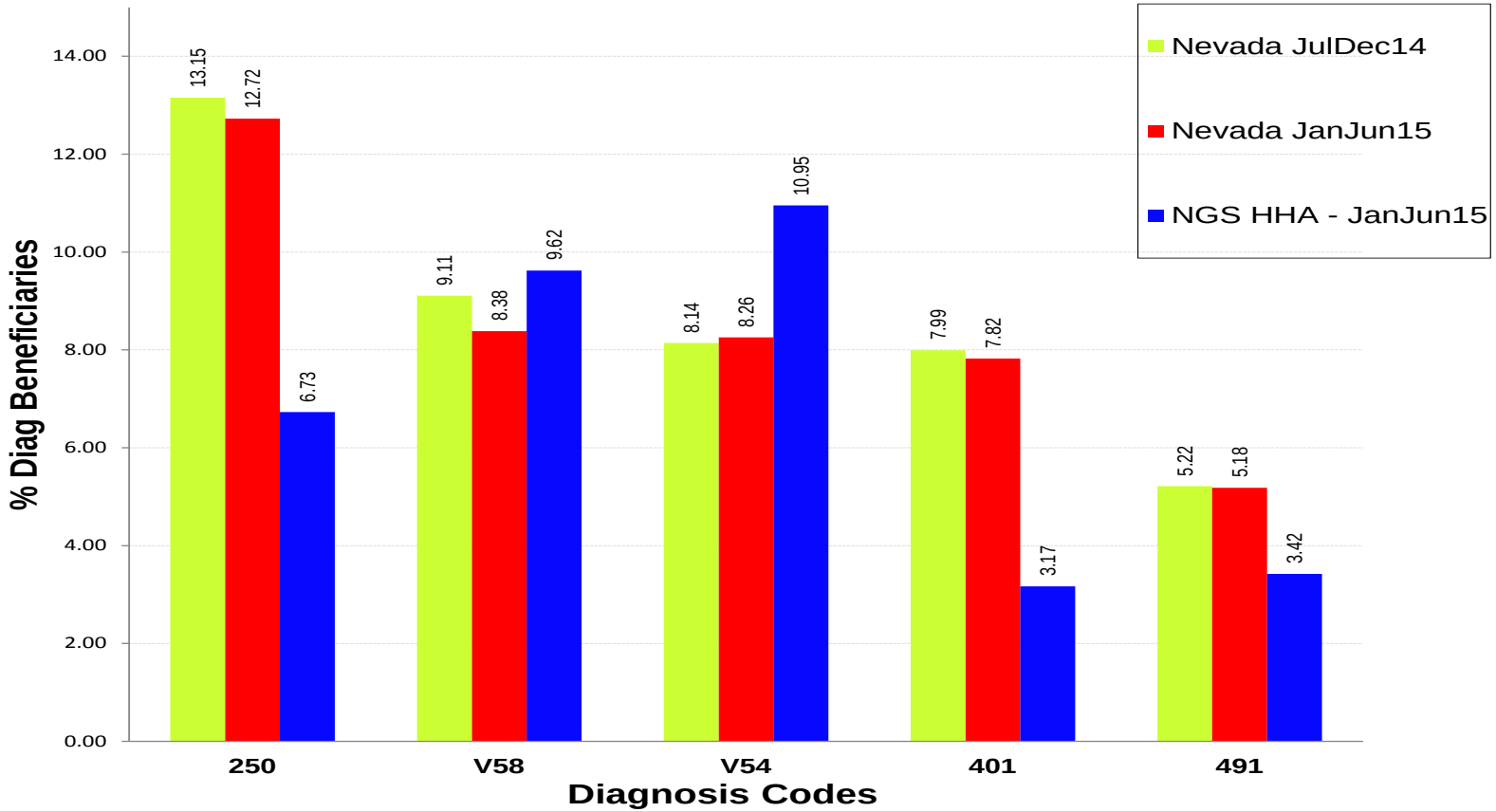
California Workload – J6	Wisconsin Workload – J6	Maine Workload
Alaska	New Jersey	Massachusetts
American Samoa	New York	Connecticut
Arizona	Michigan	Rhode Island
California	Minnesota	Vermont
Guam	Puerto Rico	Maine
Hawaii	US Virgin Islands	New Hampshire
Idaho	Wisconsin	
Nevada		
Northern Mariana Islands		
Oregon		
Washington		

Diag Trend Report

- **Based On:**
  - **HHA Paid Claims Data: Jan'15 – Jun'15**
  - **Three Digit Primary Diag Codes**
  - **% Diag Beneficiaries in each state**

- **Graphs show trend in top five diag codes (Identified in terms of % diag beneficiaries during paid dates Jan'15– Jun'15) in each state**

Trend in Top Five Diagnosis Codes (for Paid Dates Jan'15 - Jun'15) in Nevada



State	Diag	Diag Description	Nevada JulDec14	Nevada JanJun15	NGS HHA - JanJun15
29 NV	250	DIABETES MELLITUS*	13.15	12.72	6.73
29 NV	V58	ENCOUNTR PROC/AFTRCR NEC*	9.11	8.38	9.62
29 NV	V54	OTH ORTHOPEDIC AFTERCARE*	8.14	8.26	10.95
29 NV	401	ESSENTIAL HYPERTENSION*	7.99	7.82	3.17
29 NV	491	CHRONIC BRONCHITIS*	5.22	5.18	3.42

Home Health Claims Statistics: Visits per Episode by Discipline (2 Digit Group)

J6

State	42x (Physical Therapy)	43x (Occupational Therapy)	44x (Speech Therapy)	55x (Skilled Nursing)	56x (Medical Social Services)	57x (Home Health Aide)
Alaska	6.98	4.76	3.54	8.97	1.93	9.40
Arizona	7.41	4.46	5.35	8.89	1.38	8.27
California	7.19	3.87	3.71	10.92	1.48	8.60
Hawaii	8.10	4.61	4.36	8.24	1.96	9.03
Idaho	10.05	5.26	5.58	10.33	1.62	10.02
Michigan	8.83	4.95	5.24	8.16	1.84	7.72
Minnesota	6.91	4.44	5.86	8.90	1.34	8.55
Nevada	7.30	5.36	3.36	10.60	1.22	10.31
New Jersey	6.68	4.61	4.48	7.81	1.26	8.74
New York	6.88	4.91	5.01	9.86	1.61	19.05
Oregon	7.20	4.09	4.15	8.56	1.81	7.86
Puerto Rico	11.34	5.27	7.07	10.48	2.38	12.46
Washingotn	7.47	3.98	4.53	8.40	1.42	6.94
Wisconsin	6.85	4.51	4.58	10.11	1.54	10.99
NGS	**7.44**	**4.58**	**4.62**	**9.75**	**1.60**	**12.13**

10 Components of Quality Hospice Care

1. Patient and Family Centered Care: Providing care and services that are responsive to the needs and exceed the expectations of those we serve

2. Ethical Behaviors and Consumer Rights: Upholding and advocating for the rights of patients and their family caregivers

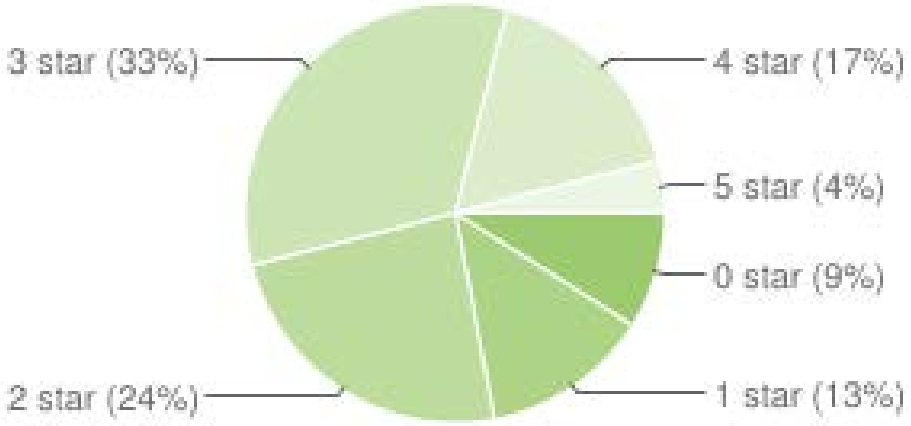
3. Clinical Excellence and Safety: Ensuring clinical excellence and promoting safety through standards of practice

4. Inclusion and Access: ensuring that all people regardless of race, ethnicity, color, religion, gender, disability , sexual orientation, age or other characteristics have access to our programs and services.

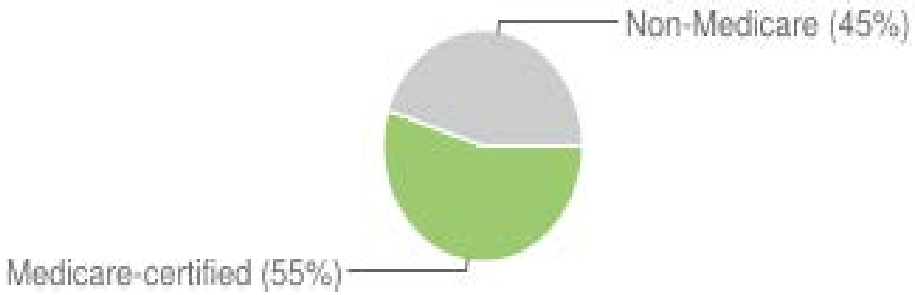
5. Organizational Excellence: Building a culture of quality accountability within our organization that values collaboration and communication and ensures ethical business practices.

Nevada Statistics

Nevada Quality of Care (#22 in the U.S.)



Percentage of Home Care Agencies that Accept Medicare



Nevada Statistics (cont)

Nevada Home Care Services

Of the home care agencies in Nevada that were surveyed by Medicare, the percentage of agencies that provide common services is listed below.

Nursing Care Services	100.0%
Physical Therapy Services	98.5%
Home Health Aid Services	97.8%
Occupational Therapy Services	94.0%
Medical Social Services	92.5%
Speech Pathology Services	91.8%

What are our patients saying?

Top States According to Patient Reviews Gathered by Medicare

Mississippi Louisiana Alabama Arkansas Kentucky West Virginia South Carolina Delaware Tennessee Maine North Carolina North Dakota New Hampshire South Dakota Pennsylvania Missouri Oklahoma Alaska Wyoming Massachusetts Texas Hawaii Kansas Georgia Vermont Iowa Virginia Wisconsin Indiana Nebraska Michigan Rhode Island Ohio Illinois Idaho Montana Florida New Mexico Maryland Connecticut New Jersey Colorado Utah Arizona Washington Minnesota California Oregon New York Nevada Washington D.C.

Nevada is rated 50 /51

Nevada Statistics (cont)

According to our data, approximately 55% of Nevada home care agencies are certified by Medicare.

We have found 110 Nevada certified Medicare home health care agencies and another 134 Nevada home care companies.

10 Components of Quality Hospice Care (cont.)

6. Workforce Excellence: fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability and workforce excellence, through professional development, training, and support to all staff and volunteers

7. Standards: Adopting the NHPCO Standards of Practice for Hospice Programs and/or the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care as the foundation for organization.

8. Compliance with Laws and Regulations: ensuring compliance with all applicable laws, regulations, and professional standards of practice and implementing systems and processes that prevent fraud and abuse

9. Stewardship and Accountability: Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight

10. Performance Measurement: Collecting, analyzing and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.

Performance Measures

Patient Outcomes and Measures (POM)- patient centered measures related to managing pain within 48 hours of admission

Family Evaluation of Hospice Care- is post-death survey that asks families perception of care provided to the patient, as well as their own hospice experience

Family Evaluation of Palliative Care- post-death survey capturing families perceptions about the quality of the palliative care that their love one received

Family Evaluation of Bereavement Services- The survey takes a comprehensive approach by including questions on a wide range of services, with instructions to skip if it did not pertain to them

CMS Quality Reporting Requirements

A. Hospice Item Set (HIS) The HIS is a patient-level data collection tool that will be used to collect data for 7 process measures:
NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
NQF #1634 Pain Screening
NQF #1637 Pain Assessment
NQF #1638 Dyspnea Treatment
NQF #1639 Dyspnea Screening
NQF #1641 Treatment Preferences Modified
NQF #1647 Beliefs/Values Addressed (if desired by the patient)

*Hospices that fail to report quality data via the HIS system in 2014 will incur a 2% market basket reduction for FY 2016 (starts October 1, 2015).

CAHPS®Hospice Survey

A post-death family caregiver survey developed by CMS for the assessment of patient and family experiences with hospice care. Data collection: Begin dry run 1/1/15 – 3/31/15 Ongoing 4/1/15 – 12/31/15Data

Penalty for failure to participate: FY 2017 (starting 10/1/16)

Sources/ Articles/Definitions

National Hospice and Palliative Care Organization
www.nhpco.org

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of patient surveys rating health care experiences in the United States. The surveys, conducted annually since 1995, are available in the public domain and focus on healthcare quality aspects that patients find important and are well equipped to assess.[2][3] **Results are used by Medicare in determining Diagnostic Related Group payment for each hospital.**

www.CMS.org

National Government Services, Inc. (06102, MAC - Part B)

Nevada Division of Aging