

# **HOME HEALTH PAY FOR PERFORMACE**

A

CMS Demonstration Project

## **HOME HEALTH P4P DEMONSTRATION**

- 2 Year Demonstration
- Voluntary Participation
- No Risk
- Using Existing Data and Quality Measures
- Must be Budget Neutral
- Selected States

## **HOME HEALTH P4P DEMONSTRATION**

- Demonstration tested whether a performance-based system can improve the quality of care of Medicare beneficiaries while not increasing Medicare expenditures.
- Financial incentives were paid to Agencies providing high quality care and/or for significant improvement in the level of care provided

## **ENROLLMENT & DISTRIBUTION**

- 567 Agencies Enrolled
  - Midwest = 131
  - Northeast = 100
  - South = 201
  - West = 135
- Intervention Group = 274
- Control Group = 287

## **PERFORMANCE MEASURES**

- **Criteria for selecting measures**
  - Validity and reliability
  - Extent to which the measure is under the agency's control
  - Perceived room for improvement
  - Statistical performance
  - Importance

### **Proposed Performance Measures**

- Incidence of Acute Care Hospitalization
- Incidence of Any Emergent Care
- Improvement in Bathing
- Improvement in Ambulation / Locomotion
- Improvement in Transferring
- Improvement in Urinary Incontinence
- Improvement in Management of Oral Medications
- Improvement in Status of Surgical Wounds

## **Allocating Payments**

- Performance payments were allocated both to top performers and to Agencies that had the greatest degree of improvement over time.
  - Encourage participation and improvement for agencies with all types of quality at baseline.
  - Reward agencies that had already achieved high quality levels before the demonstration started and maintain their high performance levels.
  - Reward agencies that may not have high performance levels but that show substantial improvement.

## **Allocating Payments**

For each measure:

- Agencies with the top 20% performance level (in each state) qualify for an incentive payment
- Qualifying agencies with top 20% rates of improvement qualify for an incentive payment.
  - The Fine Print:
    - Not already high performer in same measure
    - Performance in measure is above minimum threshold (e.g., 30%)
    - Improvement rate >0%
- Agency can be a “high performer” on some measures and a “high improver” on others.

## **Allocating Payments**

- 100% of Identified Savings goes to Incentives
- Incentive pool allocation is weighted
  - 30% Acute Care Hospitalization Measure
  - 20% Incidence of Any Emergent Care
  - 10% Each of the Remaining Measures
- Performance and improvement is weighted
  - 70% allocated to the Performance Pool
  - 25% allocated to the Improvement Pool

## **YEAR 1 PAYMENTS**

- 216 Agencies (79%) were Eligible for Incentives
- 3 of 4 Regions Produced Savings
- \$15.4 Million in the Incentive Pool
- 166 Agencies (59%) Received Incentives

## **SAVINGS CALCULATION**

- Size of the payment pool is determined by an estimate of the Medicare savings achieved by participating agencies
  - Comparison of rate change between Treatment & Control groups
  - Cost incurred during HH episode plus 30-days
  - Calculated separately for each region
  - No savings – No Incentives

## **SAVINGS CALCULATION**

What Medicare costs were considered?

- Home health
- Inpatient
- SNF
- Outpatient
- Part B
- DME
- Hospice

## **SAVINGS CALCULATION**

- Medicare savings were the largest in the South region (\$8.04 million) and were \$4.49 million in the West and \$2.82 million in the Northeast .
  
- There was an estimated loss to Medicare in the Midwest of almost \$8.7 million.

## **SAVINGS CALCULATION**

Medicare savings are defined as the difference between actual and target expenditures (i.e., savings per day) multiplied by the number of treatment group days in 2008.

Total Medicare Savings by Region and Group	Number of Days (2008)	Savings/Day	Total Medicare Savings
Midwest (IL)	3,607,685	-\$2.41	-\$8,699,844
Northeast (CT & MA)	4,712,339	\$0.60	\$2,819,338
South (AL, GA, TN)	8,077,626	\$1.00	\$8,042,528
West (CA)	2,527,262	\$1.78	\$4,490,892

**For More Demonstration  
Information**

**WWW.HHP4P.INFO**

# Medicare Home Health Update

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## The Patient Protection and Affordable Care Act (PPACA) Home Health Provisions

note: Congress may enact technical corrections to dates, ect.

## Rural Add On

- 3 percent rural add-on for those episodes ending on or after 4/1/2010 and continuing through calendar year 2015.
- Claims for episodes ending on or after April 1, 2010 which are received before the new Pricer is implemented will be paid without the add-on.
- Once the new Pricer is implemented, contractors will adjust all claims for rural home health services (claims with types of bill 329 or 339 and value code 61 amounts beginning with 999) with “through” dates on or after April 1, 2010 that were received before the Pricer implementation date.

## Outlier Cap

- Makes permanent the 10% agency outlier cap which was imposed in the CY 2010 final rule
- The provision reduces payments by 5 percent beginning in CY 2011, and instructs CMS to expend no more than 2.5 percent in outlier payments( using best estimates)

## Rebasing Home Health Payments

- Requires the Secretary to rebase home health payments beginning in CY 2014, to reflect changes such as the number of visits and mix of services provided, intensity of services provided and other factors which the Secretary determines appropriate
- Transition the rebasing reductions equally over 4 years (2014 through 2017) such that the rebasing reduction in payments for the year doesn't exceed 3.5 percent.

## Market Basket Changes

- For CY 2011 and CY 2012, reduce the market basket update by 1 percent.
- For 2015 and each subsequent year, reduce the market basket update by the productivity adjustment

## Studies

- MedPAC is required to perform a study to assess the impact of the rebasing on quality, access and rural providers. (Report due in 2015)
- The Secretary is required to perform a study and produce a Report to Congress no later than March, 2014 on home health agency costs associated with providing access to low-income beneficiaries in underserved areas with varying levels of severity of illness, and analyze whether HH PPS changes are needed to better account for these costs.
- The Secretary may provide for a demonstration project based on the study results.

## Program Integrity Provisions

- Doctors who certify patients for Home Health Services and/or write orders for home health services must be enrolled providers
- Physicians who certify patients for home health must have face-to-face encounter with the patient:
  - During the six month period prior to recertification, or a timeframe determined by the Secretary
  - NPs, CNS, PA, or certified nurse mid-wife working in collaboration with or under the supervision of the physician may perform these encounters
  - Use of telehealth is allowed to satisfy the requirements, subject to the requirements in 1864 m

## Bundling Pilot

- No later than January 2013 the Secretary shall establish a pilot program for integrated care during an episode of care around a hospitalization:
  - 3 days prior to hospital admission, time in the hospital 30 days following hospital discharge
  - Allows the Secretary to change the episode definition, define patient conditions, ect.
  - Duration of pilot is 5 years
  - Includes use of an assessment instrument and quality measures

## Plan for Value Based Purchasing

- The Secretary shall develop a plan to implement a value-based purchasing program home health
- In developing this plan the Secretary shall consider
  - Ongoing development, selection and modification for measures, to the extent possible, of all dimensions of quality and efficiency
- Report to Congress is due October, 2011

## 2008 Refinement Analysis

- Increases in the provision of 14 therapies, especially evident in areas such as Miami-Dade and other targeted PI areas
- Increases in provision of 6-9 therapies as well
- Growth in reporting of co-morbid conditions
- MedPAC reports HH PPS needs to be revised, benefit is ill-defined, encourages the provision of unnecessary services

## Contact Information

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## Overview of the Home Health Care CAHPS Survey

*National Association for Home Care and  
Hospice*



April 12, 2010

## The Home Health Care CAHPS Survey

### Overview

- Background about Survey Development and Implementation
- Overview of the Survey Instrument
- Roles of CMS, HHAs and Survey Vendors
- Survey Implementation
- Public Reporting of the Survey Results
- Quality Reporting Requirements for Home Health CAHPS



## Design of the Home Health Care CAHPS Survey

- The survey measures the experiences of Medicare and/or Medicaid patients receiving home health care from Medicare-certified home health agencies (HHAs)
- Survey is be conducted by multiple independent survey vendors working under contract with HHAs.
- Survey vendors must meet specific requirements to be an approved Home Health Care CAHPS Survey vendor.
- Sampling and data collection is conducted on a monthly basis.
- Three modes of data collection allowed—mail, phone, and mixed-mode (mail with telephone follow-up of non-respondents).
- Proxy respondents are permitted.

## The Home Health Care CAHPS Survey Development Timeline

- September 2006: Call for measures issued
- 2007: Several rounds of cognitive testing conducted
- February – April 2008: Field test was conducted
- March 2009: Survey was approved by the National Quality Forum
- July 2009: Survey was approved by the Office of Management and Budget
- Summer 2009: Vendors could start applying to become approved HHCAHPS vendors
- Fall 2009: Mode Experiment conducted
- October 2009: Voluntary participation began

## Overview of the Survey Instrument

- Survey contains 34 questions
  - Available in mail mode: English, Spanish, Mandarin Chinese, Russian and Vietnamese
  - Available in telephone and mixed mode: English, Spanish, Russian and Vietnamese
- Questions about access to care, communication and interactions with agency staff
- Patients asked to rate the care received from the HHA and to indicate willingness to recommend the HHA
- Demographic questions (health status, education, whether patient lives alone)
- Supplemental questions can be added

## Home Health Care CAHPS Survey Eligible Population

Which patients are eligible for the survey?

- Medicare and/or Medicaid patients,
- 18 years old and older and alive,
- current or discharged patients who had at least one skilled visit in the sample month and two within the 60-day look-back period,
- are not receiving hospice care,
- routine maternity care is not primary reason for receiving home health care,
- did not request “no publicity” status, and
- have not been included in the survey sample in the past 5 months.

## Data Collection

### Mail Mode

- Mail initial survey—no later than 3 weeks after close of sample month
- Mail 2<sup>nd</sup> survey to non-respondents — 3 weeks after the 1st survey is mailed
- Complete data collection—6 weeks after the 1<sup>st</sup> survey is mailed

### Telephone Mode

- Begin phone contact—no later than 3 weeks after the close of the sample month
- Complete phone data collection—6 weeks after initial phone contact begins

### Mixed Mode

- Mail survey—no later than 3 weeks after close of sample month
- Initiate phone follow-up contact for all mail survey non-respondents—3 weeks after the survey is mailed
- Complete data collection—6 weeks after the survey is mailed

## Roles and Responsibilities

- **CMS**
  - Approval of vendors
  - Training and technical assistance
  - Oversight
  - Data analysis
- **Home Health Agencies**
  - Can contract with an approved survey vendor to collect and submit the data to CMS
  - Provide sampling frame of eligible patients to their survey vendor on a monthly basis
  - Preview for public reporting
- **Survey Vendors**
  - Must meet minimum business requirements
  - Data collection and submission of data
  - Participation in all Introductory and Update trainings

## HHA Participation in the Home Health Care CAHPS Survey Overview

- To participate, HHAs must
  - be a Medicare-certified home health agency
  - contract with an approved Home Health Care CAHPS Survey vendor
    - a list of approved survey vendors is available at  
<https://homehealthcahps.org>
  - apply for access to secure sections of the Home Health Care CAHPS Survey website
  - authorize an approved survey vendor to submit data on their behalf

## Vendor Participation in the Home Health Care CAHPS Survey Overview

- Vendors interested in participating must:
  - Submit a Vendor Participation Form (available on the project's website)
  - Attend the introduction training session and all update training sessions
  - Have proven experience conducting surveys using requested mode of data collection
  - Have a minimum of 3 years prior business experience
    - Have a minimum of 2 years conducting surveys with person-level data in selected data collection modes
  - Prepare and submit a Quality Assurance Plan (QAP)
  - Participate in oversight activities

# Home Health Care CAHPS Website Home Page

Login Wednesday, December 30, 2009

## Home Health Care CAHPS Survey

[Home](#) | [General Information](#) | [Training](#) | [Forms for Vendors](#) | [Survey and Protocols](#) | [Data Submission](#) | [For HIAs](#)

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**Welcome to the Home Health Care CAHPS Survey Home Page**

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, hereafter referred to as the "Home Health Care CAHPS Survey" is designed to measure the experiences of people receiving home health care from Medicare-certified home health agencies. The Home Health Care CAHPS Survey will be conducted for home health agencies by approved Home Health Care CAHPS Survey vendors.


For more information on the history and background of the Home Health Care CAHPS Survey, participation requirements, and public reporting, please click on the [About Home Health Care CAHPS Survey](#) link on the left.

For information about how to become a Home Health Care CAHPS Survey vendor, please click on the [General Information](#) link above.

Information about the National Implementation of the Home Health Care CAHPS Survey will be periodically updated on this site. Viewers are encouraged to check this site regularly for updated information about the Home Health Care CAHPS Survey.


For more information, please contact [HHCAHPS@RTI.org](mailto:HHCAHPS@RTI.org) or call 1-866-354-0985.

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## Public Reporting

- Survey started in October 2009
- Publicly reported results will be based on 12 months (4 quarters) of data
- Public reporting on <http://www.medicare.gov> will begin in Spring 2011
- Adjusted for survey mode and patient-mix as needed
- Results will be updated each quarter

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## Public Reporting (cont'd)

- Measures to be publicly reported:
  - Composite measures
    - Care of patients
    - Communications between providers and patients
    - Specific care issues (medications, home safety and pain)
  - Two global ratings:
    - Overall rating of care given by HHA's care providers
    - Patient willingness to recommend the HHA to family and friends

## Testing of Public Reporting Displays

- Three rounds of combined cognitive and usability testing with consumers (including family caregivers) and health care professionals were conducted.
  - Round 1—January 2009 in Baltimore, MD.
  - Round 2—April 2009 in Providence, RI. A subset of the second round of testing with professionals (physicians and physician assistants) was completed in Baltimore, MD.
  - Round 3—October 2009 in Riverside, CA.

## Quality Reporting Requirements

- The November 10, 2009 final rule expands the quality reporting requirements for Medicare-certified HHAs to include HHCAHPS for the CY 2012 Annual Payment Update (APU)
- For agencies that do not report the required measures, including HHCAHPS, the home health market basket percentage increase for the applicable year shall be reduced by 2 percentage points for CY 2012

## HHCAHPS Requirements

- To be eligible for the 2012 APU, HHAs must:
  - Participate in a dry run in the 3<sup>rd</sup> quarter of 2010 for at least 1 month in that quarter
    - Dry run data are not publicly reported
  - Start ongoing data collection in October 2010
  - Data submission deadlines:
    - For dry run in 3<sup>rd</sup> quarter 2010 -- 1/21/2011
    - For 4<sup>th</sup> quarter 2011 -- 4/21/2011
    - For 1<sup>st</sup> quarter 2012 -- 7/21/2011

## Exemption from Participating in the Survey for CY 2012 APU Requirements

- Agencies with fewer than 60 eligible unduplicated HHCAHPS patients between April 1, 2009 and March 31, 2010 are exempt from the HHCAHPS data collection requirements for CY 2012, but need to provide CMS with patient counts for this period
- Agencies wishing to apply for an exemption need to report their patient counts by June 16, 2010 on a form posted on the project's website:  
<http://www.homehealthcahps.org>

## Contact Information

### Liz Goldstein

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### Technical Assistance

- Toll-free telephone number: 1-866-354-0985
- E-mail Address: [hhcahps@rti.org](mailto:hhcahps@rti.org)
- Home Health Care CAHPS Survey website  
<https://homehealthcahps.org/>
- Mailboxes for Inquiries: [hhcahps@rti.org](mailto:hhcahps@rti.org) or [homehealthcahps@cms.hhs.gov](mailto:homehealthcahps@cms.hhs.gov)

**National Association for Home Care and  
Hospice**

2010 Home Care & Hospice March on  
Washington & Law  
Symposium & Exposition

**Home Health**

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**Conditions of Participation**

- Appendix B of State Operations Manual
- Revisions proposed March 1997
- Publication delayed
- Revised Conditions in clearance now

## Survey Frequency

- Statutory requirement to survey HHAs no less frequently than every 36 months
- Mission and Priority Document
  - States receive Tier 1 list – all statutory requirements
  - Tier 2 list - 5% Targeted sample based on algorithm - previous survey timing and quality)
- Validation Surveys
  - Federal
  - Accrediting Organizations (AOs)

## Surveyor Focus

- Quality of Care
- Patient Safety
- Outcome Oriented
- Types of Surveys
  - Standard Survey
  - Partial Extended
  - Fully Extended

## Survey Tasks

- Pre-survey preparation
- Entrance Interview
- Information gathering
- Information analysis
- Exit Conference
- Formation of Statement of Deficiencies  
(2567)

## Revised Surveyor Protocols

- Based on GAO and OIG reports
- In development
- Priority tags
- Types of surveys defined
- Guidance for determining standard versus condition level deficiencies

## Top 10 Survey Deficiencies – Home Health

- G158 – Written Plan of Care established & periodically reviewed
- G159 – Plan of Care covers diagnosis, required services, visits, etc.
- G236 – Record with past/current findings maintained for all patients
- G337 – Assessment includes review of all medications
- G143 – Coordination of patient services

## Top 10 Survey Deficiencies –Home Health

- G229 – Supervisory visits if skilled care no less than once every 2 weeks
- G165 – Drugs and treatment administered only as ordered by physician
- G164 – Alert physician to changes that suggest need to alter plan
- G145 – Written report for each patient to attending physician every 62 days
- G121 – Compliance with accepted professional standards/principles

## **Top 10 OASIS Transmission Errors**

- 286 – Warning – Inconsistent M0090/Submission Date
- 82 – Warning – Patient provider updated
- 257- Warning – The submitted HIPPS\_CODE/HIPPS\_Version must match the calculated value

## **Top 10 OASIS Transmission Errors**

- 81 – Warning – Patient information updated
- 1000 – Fatal Record – Duplicate assessment
- 1002 – Warning - Inconsistent record sequence
- 1003 – Warning - Inconsistent effective date sequence

## **Top 10 OASIS Transmission Errors**

- 262 – Warning – Inconsistent M0090 date – the recertification date is not within the CMS guidelines.
- 169 – Warning - Inconsistent M0830 values: If Emergent Care “UK” response is checked
- 294 – Warning - Inconsistent NPI number

## **Resources Data Transmission**

OASIS Educations and Automation  
Coordinators

- <http://www.cms.hhs.gov/oasis/>
- QTSO help
  - Phone: 800-339-9313
  - E-mail: [help@qtso.com](mailto:help@qtso.com)

## **Other Resources**

- HHA Center -  
<http://www.cms.hhs.gov/center/hha.asp>
- OBQI -  
<http://www.cms.hhs.gov/HomeHealthQualityInits/>
- HHA PPS -  
<http://www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/list.asp>
- Open Door Forums -  
[http://www.cms.hhs.gov/OpenDoorForums/17\\_ODF\\_HHHDME.asp](http://www.cms.hhs.gov/OpenDoorForums/17_ODF_HHHDME.asp)

## **Other Resources (cont.)**

- State Operations Manual – SOM -  
<http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf>
- Conditions of Participation - CoPs  
[http://cms.hhs.gov/manuals/Downloads/som107ap\\_b\\_hha.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf)

# **National Association for Home Care and Hospice**

2010 Home Care & Hospice  
March on Washington &  
Law Symposium & Exposition

## **Home Health Quality Measurement**

Robin Dowell  
Office of Clinical Standards and Quality  
Centers for Medicare & Medicaid Services  
April 12, 2010

## Measuring Quality of Care

- **Outcome measures:**
  - Assess the health state of a patient, including physiologic, functional, cognitive, emotional, and behavioral
  - Reflect the cumulative impact of multiple processes of care or natural progression of disease and disability, or both
  - Can be used to assess quality of care **to the extent that health care services influence the likelihood of desired health outcomes**

## Measuring Quality of Care

- **Process measures:**

- Assess the health care services provided
- Assess adherence to recommendations for clinical practice based on evidence or consensus
- Are the quantifiable details of what should be done, to whom, and how frequently, based on best practices
- Can **identify** specific areas of care that may require improvement and intermediary steps necessary to achieve better outcomes

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## Use of Evidence-based Care Practices

- By incorporating process data items into OASIS-C, clinicians are reminded and encouraged to use specific evidence-based care practices
- MedPAC 2006:  
“If...Medicare were to adopt and use process measures, it could speed the adoption of best practices and reduce some of the variation in care that arises from failures to adhere to best practices.”

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## Process Items: 3 Points to Remember

1. Care processes in the OASIS-C **are not mandated** under the current Conditions of Participation
2. A rate of **100% is not expected** for any agency for any measure
3. Process measures in OASIS-C are **not an all-inclusive set** of all evidence-based practices for home health care

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## PUBLICLY REPORTED MEASURES

OUTCOME MEASURES	CURRENTLY ON HHC	NQF ENDORSED 3/2009
Discharge to community	YES	NO
Emergent care for wound infections, deteriorating wound status	YES	NO
Improvement in urinary incontinence	YES	NO
Improvement in transferring	YES	YES Improvement in <u>bed</u> transferring
Emergent care	YES	YES ED use w/out hospitalization
Improvement in ambulation/locomotion	YES	YES

## PUBLICLY REPORTED MEASURES

OUTCOME MEASURES	CURRENTLY ON HHC	NQF ENDORSED 3/2009
Improvement in bathing	YES	YES
Improvement in management of oral medications	YES	YES
Improvement in pain interfering with activity	YES	YES
Acute care hospitalization	YES	YES
Improvement in dyspnea	YES	YES
Improvement in status of surgical wounds	YES	YES
Increase in number of pressure ulcers	NO	YES

## PUBLICLY REPORTED MEASURES

PROCESS MEASURES	CURRENTLY ON HHC	NQF TLE* 3/2009
Timely initiation of care	NO	YES
Influenza immunization received for current flu season	NO	YES
Pneumococcal polysaccharide vaccine ever received	NO	YES
Heart failure symptoms addressed during short-term episodes	NO	YES
Diabetic foot care and patient education implemented during short-term episodes of care	NO	YES
Pain assessment conducted	NO	YES
*TLE = Time Limited Endorsement		

## **PUBLICLY REPORTED MEASURES**

<b>PROCESS MEASURES</b>	<b>CURRENTLY ON HHC</b>	<b>NQF TLE* 3/2009</b>
Pain interventions implemented during short-term episodes	NO	YES
Depression assessment conducted	NO	YES
Drug education on all medications provided to patient/caregiver during short-term episodes	NO	YES
Falls risk assessment for patients 65 and older	NO	YES
Pressure ulcer prevention plans implemented	NO	YES
Pressure ulcer risk assessment conducted	NO	YES
Pressure ulcer prevention included in the plan of care	NO	YES
*TLE = Time Limited Endorsement		

## **OASIS-C**

### **Impact on Measure Reporting Schedule**

## **Static Period and Public Reporting**

- Need sufficient numbers of patient episodes before reporting of measures based on new OASIS-C data can begin
- Measures based on patient sample sizes taken over short periods of time can be inaccurate and misleading

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## **Static Period and Public Reporting**

- Current risk adjustment models for outcome measures are based on OASIS-B1 data elements
  - Many data items in OASIS-C are different from OASIS-B1 items
  - Risk adjustment models will need to be re-estimated using OASIS-C data

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## HHC and CASPER Performance Reporting Schedule

Measure Type	Report Method	Date Available	Data Period of:
OASIS-B1	CASPER	12/2009	10/2008-9/2009
OASIS-B1	HH Compare	1/2010	10/2008-9/2009
OASIS-B1	HH Compare	4/2010	1/2009-12/2009
OASIS-C Process	CASPER	9/2010	1/2010-6/2010
OASIS-C Process	HH Compare	10/2010	1/2010-6/2010
OASIS-C Outcome	CASPER	05/2011	3/2010-2/2011
OASIS-C Outcome	HH Compare	07/2011	4/2010-3/2011

## Resources-OASIS Items

### OASIS Home Page

- <http://www.cms.hhs.gov/oasis/>

### OASIS data set

- OASIS Guidance Manual - Chapter 3
- Revised December 2009
- [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HH\\_QIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HH_QIOASISUserManual.asp#TopOfPage)

### National Provider Calls

- [http://www.cms.hhs.gov/HomeHealthQualityInits/03\\_EducationalResources.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/03_EducationalResources.asp#TopOfPage)

## Public Utility Files

- [http://www.cms.hhs.gov/OASIS/09b\\_hhareports.asp#  
TopOfPage](http://www.cms.hhs.gov/OASIS/09b_hhareports.asp#TopOfPage)
- Risk-adjusted Home Health Outcome Reports
- State-wide percentages for each outcome
- Compared to the National Average
- Compared to National Range

**Thank you**

Robin Dowell

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