Preview of Home Health Agency Quality Measure Scores for Year April 2014 - March 2015
To Be Posted on Home Health Compare

(Please note that a separate preview report will be distributed for Star Ratings.)

State:	OH
Provider Name:	OHIO VALLEY HOME HEALTH, INC
Provider Number:	367762
Street Address:	1480 JACKSON PIKE
City:	GALLIPOLIS
ZIP Code:	45631
Phone:	(740) 441-1393
Agency's Initial Date of Medicare Certification:	06/17/1999
Type of Ownership:	PROPRIETARY

Services Provided

Nursing Care:	Y	Speech Pathology:	N
Physical Therapy:	Y	Medical Social Services:	N
Occupational Therapy:	N	Home Health Aide:	Y

PROCESS MEASURES *	Agency ** Average%	State*** Average%	National Average%
Timely Initiation of Care	91.5	91.8	91.8
Depression Assessment Conducted	97.4	97.8	97.8
Multifactor Fall Risk Assessment for Patients who Can Ambulate	99.6	98.3	98.3
Pain Assessment Conducted	100.0	98.8	98.8
Pressure Ulcer Risk Assessment Conducted	99.6	98.7	98.7
Pressure Ulcer Prevention In Plan Of Care	100.0	97.8	97.8
Diabetic Foot Care and Pt/CG Ed Implemented	100.0	94.9	94.9
Heart Failure Symptoms Addressed	100.0	98.0	98.0
Pain Interventions Implemented	100.0	98.5	98.5
Drug Ed On All Meds Provided to Pt/CG	99.2	93.5	93.5
Flu Immunization Rec'd For Current Flu Season	97.8	71.1	71.1
Pneumonia Vaccination Ever Received	99.2	71.7	71.7
Pressure Ulcer Prevention Implemented	100.0	96.8	96.8
OUTCOME MEASURES *			
Improvement in Bathing	89.4	68.7	68.7
Improvement in Bed Transfer	100.0	59.1	59.1
Improvement in Ambulation	78.7	63.8	63.8
Improvement in Management of Oral Medications	83.5	53.4	53.4
Improvement in Pain Interfering With Activity	86.2	68.1	68.1
Improvement in Dyspnea	86.5	66.1	66.1
Improvement in Status of Surgical Wounds	100.0	89.5	89.5
CLAIMS BASED OUTCOMES DURING THE FIRST 60 DAYS OF HOME HEALTH *			
Acute Care Hospitalization	15.9	15.9	15.9
Emergency Department Use without Hospitalization	11.4	12.2	12.2

CLAIMS BASED OUTCOMES FOR PREVIOUSLY HOSPITALIZED PATIENTS

Rehospitalization
During First 30 Days of Home Health: Same As Expected

Emergency Department Use without Hospital Readmission
During First 30 Days of Home Health: Same As Expected

* All measure values will be displayed to one decimal place on Home Health Compare.

** A value of 199 means the number of episodes is too small to report; 201 means the measure currently does not have data or has less than 6 months of data. Codes of 199 and 201 will be reported as 'Not Available' on the Home Health

Compare website and a footnote of '4' or '5' will display next to the text with an associated tooltip indicating why the information is unavailable.

*** Each state average is the aggregate rate for all patients served by providers in that state. The national average is the aggregate rate for all patients served by providers in the nation.

IMPORTANT NOTES:

-- Please review the data about your agency. Details about how to update data and who to contact for questions are available on the Home Health Quality Initiative Web site at www.Medicare.gov/HHCompare/Home.asp. Select Resources tab and then Note to Home Health Agencies link.

-- The order of the Measures in the table above may not represent the order displayed on Home Health Compare.

-- The titles of the Measures in the table above are not the Consumer Language titles that appear on Home Health Compare. The crosswalk between these titles can be found in the download section on the Home Health Quality Initiative Web site at http://www.medicare.gov/HomeHealthCompare/Data/Quality-Measures-List.html

Home Health
Quality of Patient Care Star Rating
Provider Preview Report

Based on completed quality episodes with end-of-care OASIS assessment dates from April 1, 2014 through March 31, 2015 and claims data with through dates from January 1, 2014 through December 31, 2014

Rating for Ohio Valley Home Health, Inc (367762) Gallipolis, Ohio
Quality of Patient Care Star Rating
★★★★★ (5.0 stars)

The Quality of Patient Care Star Rating will be displayed on Home Health Compare (HHC) in October 2015.

How the Ratings are Calculated

The Home Health Quality of Patient Care Star Rating is calculated using 9 of the quality measures currently reported on HHC. To have a star rating computed on HHC, HHAs must have reported data on HHC for at least 5 of the 9 measures used in the ratings.[1] The 9 measures used in the Quality of Patient Care Star Ratings are:

Process Measures:
1. Timely Initiation of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Influenza Immunization Received for Current Flu Season

Outcome measures:[2]
4. Improvement in Ambulation
5. Improvement in Bed Transferring
6. Improvement in Bathing
7. Improvement in Pain Interfering With Activity
8. Improvement in Shortness of Breath
9. Acute Care Hospitalization

These measures are combined into the Quality of Patient Care Star Rating using the steps described below.

The Quality of Patient Care Star Rating Scorecard at the end of this report provides information specific to your HHA for each of the steps below.

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[1] *For a measure to be reported on Home Health Compare, HHAs must have data for at least 20 complete quality episodes with end dates within the 12-month reporting period (regardless of episode start date). Completed episodes are paired start or resumption of care and end of care OASIS assessments.*

[2] *Outcome measures are risk adjusted. For technical documentation, see the Downloads section:* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html

1. Construct Initial Deciles: For each of the 9 quality measures, all HHAs' scores are sorted low to high and divided into 10 approximately equal sized groups (deciles) of HHAs. For all measures, except acute care hospitalization, a higher measure value means a better score. The decile cut points for each measure are shown in the "Measure Score Cut Points by Initial Decile Rating (All Agencies)" table in the Quality of Patient Care Star Rating Scorecard (Rows 1-11). The cut points apply to all agencies and do not vary by agency. (However, they will be updated each quarter.)

2. Assign Initial Decile Rating: The HHA's score on each measure is then assigned its decile location as a preliminary rating. Each decile is assigned an initial ranking from 0.5 to 5.0 in 0.5 increments. Rows 12 and 13, labeled "Your HHA Score" and "Your Initial Decile Rating" on the scorecard, show your HHA's score for each measure and the corresponding initial decile rating based on the score, respectively.

3. Adjust Initial Ratings if your HHA's Score is Not Statistically Different from the National Median: The initial decile rating is adjusted according to a statistical test of the difference between your agency's individual measure score and the national median score across all HHAs for that measure.[3] The overall HHA median score is shown in Row 15 on the scorecard, labeled "National (All HHA) Median". The resulting probability value from the statistical test is shown in Row 16, "Your Statistical Test Probability Value (p-value)". A probability value greater than 0.050 indicates that your HHA is not significantly different from the overall national median (at a standard 5 percent significance level). Row 17, "Your Statistical Test Results" indicates "Yes" if the p-value is equal to or less than 0.050 and "No" if the p-value is greater than 0.050. If your HHA's initial decile rating for a measure is anything other than a 2.5 or 3.0 (the two middle decile categories), and the statistical test results show a p-value greater than 0.050 (indicating a "No" for being significantly different from the national median), the initial rating is adjusted to the next decile closer to the middle categories of 2.5 or 3.0. The adjusted ratings are shown in Row 18 "Your HHA Adjusted Rating" on the scorecard.

4. Obtain Average Adjusted Rating: To obtain one overall score for each HHA, the adjusted ratings are averaged across the 9 measures and rounded to the nearest 0.5. For your HHA, these results are shown in Row 19 "Your Average Adjusted Rating" and Row 20 "Your Average Adjusted Rating Rounded" on the scorecard. The final Quality of Patient Care Star Rating (Row 21) is then assigned to your HHA incorporating an additional adjustment made so that ratings will range from 1.0 to 5.0 in half star increments (see table below). Thus, there are 9 star categories, with 3.0 stars being the middle category in this distribution.

Average Adjusted Rating Rounded	Final Quality of Patient Care Star Rating
4.5 and 5.0	★★★★★ (5.0)
4.0	★★★★½ (4.5)
3.5	★★★★ (4.0)
3.0	★★★½ (3.5)
2.5	★★★ (3.0)
2.0	★★½ (2.5)
1.5	★★ (2.0)
1.0	★½ (1.5)
0.5	★ (1.0)

[3] *Because all the proposed measures are proportions, the calculation uses a one-sided binomial significance test.*

For more information on the Quality of Patient Care Star Rating Methodology:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html

Home Health Quality Measures:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html

Home Health Compare:
http://www.medicare.gov/homehealthcompare/search.html

If Your Rating Isn't What You Think it Should Be

If your star rating states 'data not available,' it means that there were an insufficient number of episodes reported on Home Health Compare for more than 4 of the quality measures included in the star rating calculation. This is usually because there are fewer than 20 eligible episodes for those quality measures. It can also mean that your agency has been certified/re-certified for less than six months.

If you have evidence that errors in data submitted to CMS may have resulted in an incorrect Quality of Patient Care Star rating, you may submit that evidence along with a plan documenting how you will correct all errors by August 21, 2015 and request review and suppression of your rating. Requests must be submitted by July 17, 2015 to HHC_Star_Ratings_Review_Request@cms.hhs.gov.

Your request should include at least the following information:

- Provider name and CCN
- Provider contact person – Name, Telephone #, email address
- Measure(s) affected
- Type of data error (inaccurate or missing assessments)
- Date range for data errors
- Volume (number of episodes affected)
- Nature of the error in sufficient detail to allow evaluation of its possible impact on the star ratings, such as what values were reported and what values SHOULD HAVE BEEN reported. For example, "All of our 100 episodes during the period were incorrectly picked up by our data system and reported as "0" on (M2015) Patient/Caregiver Drug Education Intervention, when 95 were assessed as "1".
- Plan for submitting missing or corrected assessments by August 21, 2015
- Any other information to assist CMS in determining if the data errors have affected your star rating.

PLEASE DO NOT SEND ANY IDENTIFIABLE PATIENT INFORMATION THROUGH EMAIL! This includes medical record numbers, dates of birth, service dates (including visit dates, admission dates, or discharge dates), or any other data items considered identifiers or Protected Health Information (PHI) under HIPAA.

You should receive an acknowledgement of your request within 2 business days. You may be asked to provide additional information to allow us to fully evaluate your request. Such requests will be sent to the contact person named in the review request.

If the evaluation of the evidence confirms that the erroneous data has affected the final star rating and you have presented a feasible plan for correction, you may be granted suppression of your star rating and any erroneous measures for one quarter while corrections are made. You will receive a final determination on your request by September 30, 2015; this final determination will also be sent by email to the contact person named in your review request.

Questions, Comments, or Suggestions?

Any comments, questions, and suggestions about the Quality of Patient Care Star Ratings can be submitted to: HomeHealthQualityQuestions@cms.hhs.gov

Quality of Patient Care Star Rating Scorecard[1] Ohio Valley Home Health, Inc (367762) Gallipolis, Ohio

		Measure Score Cut Points by Initial Decile Rating								
1	Initial Decile Rating	Timely initiation of care	Drug education on all medications	Received flu shot for current season	Improved walking or moving around	Improved getting in and out of bed	Improved bathing	Had less pain moving around	Breathing improved	Admitted to hospital
2	0.5	0.0-80.3	0.0-81.0	0.0-42.9	0.0-44.0	0.0-35.9	0.0-46.0	0.0-43.6	0.0-34.6	17.4-100.0
3	1.0	80.4-85.9	81.1-88.8	43.0-56.3	44.1-51.3	36.0-43.7	46.1-55.1	43.7-54.0	34.7-47.1	15.3-17.3
4	1.5	86.0-89.0	88.9-92.6	56.4-63.5	51.4-55.6	43.8-49.0	55.2-60.3	54.1-59.4	47.2-55.2	14.0-15.2
5	2.0	89.1-91.3	92.7-94.9	63.6-68.6	55.7-58.9	49.1-53.3	60.4-63.9	59.5-63.3	55.3-60.6	13.0-13.9
6	2.5	91.4-93.1	95.0-96.3	68.7-72.8	59.0-61.7	53.4-56.6	64.0-66.8	63.4-66.5	60.7-64.8	12.0-12.9
7	3.0	93.2-94.6	96.4-97.4	72.9-76.4	61.8-64.1	56.7-59.6	66.9-69.6	66.6-70.0	64.9-68.4	11.0-11.9
8	3.5	94.7-95.9	97.5-98.3	76.5-79.7	64.2-66.6	59.7-62.6	69.7-72.5	70.1-73.9	68.5-71.8	10.0-10.9
9	4.0	96.0-97.2	98.4-99.1	79.8-83.5	66.7-69.9	62.7-66.0	72.6-75.9	74.0-79.1	71.9-75.5	8.7-9.9
10	4.5	97.3-98.6	99.2-99.9	83.6-88.7	70.0-75.0	66.1-71.6	76.0-81.2	79.2-86.6	75.6-80.7	6.9-8.6
11	5.0	98.7-100.0	100.0-100.0	88.8-100.0	75.1-100.0	71.7-100.0	81.3-100.0	86.7-100.0	80.8-100.0	0.0-6.8
12	Your HHA Score	91.5	99.2	97.8	78.7	100.0	89.4	86.2	86.5	11.4
13	Your Initial Decile Rating	2.5	4.5	5.0	5.0	5.0	5.0	4.5	5.0	3.0
14	Your Number of Cases (N)	270	261	179	102	97	107	106	97	72
15	National (All HHA) Median	93.1	96.4	72.8	61.7	56.7	66.9	66.6	64.8	12.0
16	Your Statistical Test Probability Value (p-value)	0.174	0.004	0.000	0.000	0.000	0.000	0.000	0.000	0.502
17	Your Statistical Test Results (Is the p-value ≤ 0.050?)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
18	Your HHA Adjusted Rating	2.5	4.5	5.0	5.0	5.0	5.0	4.5	5.0	3.0

19	Your Average Adjusted Rating	4.4
20	Your Average Adjusted Rating Rounded	4.5
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	**★★★★★ (5.0 stars)**

[1] *OASIS data from April 1, 2014 through March 31, 2015 and claims data from January 1, 2014 through December 31, 2014*

July 1, 2013 to June 30, 2014 Historical Quality Assessments Only (QAO) Performance Report

This QAO Performance Report is based on assessments completed by your HHA during the 2013-2014 Annual Payment Update (APU) performance period (July 1, 2013 – June 30, 2014) and submitted by July 31, 2014

The results displayed in this report do NOT affect any prior or current period APU adjustments for this agency.

QAO Score for Ohio Valley Home Health, Inc (367762) Gallipolis, Ohio
98.0 (exceeds 2015-2016 standard of 70)

The purpose of this 2013-2014 Historical Quality Assessments Only (QAO) Performance Report is to provide HHAs with an example of their QAO performance based on assessment submissions from a prior reporting period (i.e., 2013-2014). The displayed calculations reflect assessment submissions from that reporting period and may not be representative of the HHA's current or future QAO performance. The QAO Performance Report at the end of this document provides a detailed presentation of how the QAO score was calculated for this HHA.

Statutory Authority for the Home Health Quality Reporting Program

The Home Health Quality Reporting Program was implemented on January 1, 2007, and is based on the submission of home health quality data collected with the Outcome and Assessment Information Set ("OASIS") data collection instrument. Section 1895(b)(3)(B)(v)(I) of the Social Security Act ("the Act") states that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points." The mandate to report quality measure data to the Centers for Medicare & Medicaid Services (CMS) with a resulting reduction in Medicare payments for non-performance is also referred to as the annual percentage update (APU) program. Prior to the 2014 Final Rule, the quantity of OASIS assessments each HHA must submit to meet this requirement has never been proposed and finalized through rulemaking or through the sub-regulatory process. In the 2014 Final Rule the QAO metric to meet this requirement was described in detail and elements of how this metric is computed will be described in the next section.

How the QAO Performance Score is Calculated

The purpose of an OASIS assessment is to provide standardized documentation of the clinical condition of patients receiving home health care at the start or resumption of their care (SOC/ROC), at 60-day increments if their care is extended, and at the end of their care (EOC) (e.g., at transfer to an inpatient facility, at death, or at discharge to the community). OASIS assessments from SOC/ROC are combined OASIS assessments at EOC to form quality episodes and home health quality measures are calculated based on each HHA's quality episodes. When an HHA submits OASIS data forming quality episodes for all of its patients, CMS can be confident that the resulting quality measure reflects the care that the HHA's patients receive.

Because an APU reporting period is limited, not all submitted OASIS assessments can be formed into complete quality episodes of care. Hence, there are several additional criteria that are used to determine if a submitted OASIS assessment could be quality assessment if the reporting period were extended. An OASIS assessment would be considered a quality assessment if they can be characterized as any of the following:

- beginning of an episode of care that is not yet complete--an SOC/ROC that occurs in the last 60 days of the performance period (identified as a Late SOC/ROC);
- end of an episode of care that began in the previous reporting period--an EOC that occurs in the first 60 days of the performance period (identified as an Early EOC);
- an extension of an as yet incomplete quality episode of care--a SOC/ROC assessment that is followed by one or more Follow-up assessments, the last of which occurs in the last 60 days of the performance period (identified as an SOC/ROC Pseudo Episode);
- a continuation of a previously begun quality episode of care--an EOC assessment is preceded by one or more Follow-up assessments, the last of which occurs in the first 60 days of the performance period (identified as an EOC Pseudo Episode); or
- SOC/ROC assessment that is part of a known one-visit episode (identified as a One-visit episode).

All other SOC/ROC or EOC assessments that 1) could not be formed into a quality episode of care, or 2) do not meet the preceding criteria would be considered a non-quality assessment. For the purposes of computing the QAO metric all follow-up assessments (i.e., assessments that are completed to document a 60-day increment of care) are considered "neutral" and are not included in the computation of the QAO metric.

The Quality Assessments Only (QAO) metric is based on the proportion of Quality and Non-Quality assessments submitted by the HHA and ignoring the number of Neutral assessments submitted by the HHA. Hence, the QAO formula based on this definition would be as follows:

$$QAO = \frac{100 * \#\text{ of Quality Assessments}}{\#\text{ of Quality Assessments} + \#\text{ of Non-Quality Assessments}}$$

The 2013-2014 Historical Quality Assessments Only (QAO) Performance Report

The 2013-2014 QAO Performance Report that follows provides information specific to your HHA for the APU reporting period July 1, 2013 – June 30, 2014. The results only reflect your performance on the QAO metric for that period and may not accurately reflect your QAO performance on the current APU period (July 1, 2014 – June 30, 2015), nor during the performance period of July 1, 2015 – June 30, 2016 when the QAO metric becomes effective. The QAO performance standard for the July 1, 2015 – June 30, 2016 period will be a score of 70.

If Your QAO Performance Report Score Does Not Meet the 2015-2016 Standard of 70

You can compare your QAO score on this 2013-2014 QAO Performance Report to see if your previous performance does or does not meet the 2015-2016 standard score of 70 that will be first applied for the July 1, 2015 – June 30, 2016 APU period. If you have met the proposed standard score based on your historical submission of assessments, then keep performing as you have in the past. If you do not meet the proposed 2015-2016 standard score based on your historical submission of assessments, then examine your OASIS assessment submission practices to ensure that you 1) complete all required OASIS assessments (i.e., both those for SOC/ROC and for all EOC events), and 2) successfully submit all required OASIS assessments (i.e., both those for SOC/ROC and for all EOC events). For example, if you notice that your 2013-2014 QAO Performance Report has a large number of non-quality SOC/ROC assessments, then you probably have either not completed the associated EOC assessments for these patients or you have completed the EOC assessments but have not submitted them successfully.

If You Have Questions About Calculation of the QAO Performance Metric or Your Report

If you have questions about the calculation of the QAO metric or your QAO Historical Performance Report, you can send them to: HomeHealthQualityQuestions@cms.hhs.gov. Note that CMS will provide a different mailbox for any questions relating to this year's P4R determinations (which will NOT use the QAO metric.)

July 1, 2013 to June 30, 2014 QAO Historical Performance Report
Ohio Valley Home Health, Inc (367762) Gallipolis, Ohio

Step	Start or Resumption of Care (SOC ROC) Assessments	#	Step	End of Care (EOC) Assessments	#
	Quality Assessments			**Quality Assessments**	
[1]a	# matched to EOC assessments to form a quality episode of care	210	[1]b	# matched to SOC/ROC assessments to form a quality episode of care	210
[2]a	# matched to follow-up assessment (occurring in last 60 days of APU period)	45	[2]b	# matched to follow-up assessment (occurring in first 60 days of APU period)	62
[3]a	# that occurred in last 60 days of APU period	49	[3]b	# that occurred in first 60 days of APU period	25
[4]a	# with no expected EOC assessment per claims data	0	[4]b	N/A	N/A
[5]a	**Total SOC/ROC Quality Assessments**	**304**	**[5]b**	**Total EOC Quality Assessments**	**297**
	Non-Quality Assessments			**Non-Quality Assessments**	
[6]a	# that do not meet above Quality Assessment criteria	12	[6]b	# that do not meet above Quality Assessment criteria	0
	Calculation of Quality Assessments Only (QAO) Score				
[7]	Total Quality Assessments ([5]a + [5]b)	601			
[8]	Total Non-Quality Assessments ([6]a + [6]b)	12			
[9]	Total Assessments	613			
	QAO Score				
[10]	= 100 x [7] / [9]	98.0			

Notes and Explanations for each line item

[1] This is the number of OASIS assessments completed that can be linked from when a patient started or resumed care at your agency to an assessment at the end of their care, completed either at discharge to the community or transfer to an inpatient facility.
[2] This is the number of OASIS assessments completed that can be linked to a follow-up assessment that occurred within the last 60 days of the APU period (if it's an SOC/ROC assessment) or within the first 60 days of the APU period (if it's an EOC assessment).
[3] This is the number of OASIS assessments completed that occurred within the last 60 days of the APU period (if it's an SOC/ROC assessment) or within the first 60 days of the APU period (if it's an EOC assessment).
[4] This is the number of OASIS assessments completed during the APU that do not expect an EOC assessment - only one assessment is anticipated for that particular episode.
[5]a = [1]a + [2]a + [3]a + [4]a. This is the total number of SOC/ROC Quality Assessments you completed and submitted.
[5]b = [1]b + [2]b + [3]b + [4]b. This is the total number of EOC Quality Assessments you completed and submitted.
[6] This is the number of OASIS assessments completed that do not meet any of the criteria as outlined under notes: [1], [2], [3], and [4].
[7] = [5]a + [5]b. This is the total number of SOC/ROC Quality Assessments plus the total number of EOC Quality Assessments that you completed and submitted.
[8] = [6]a + [6]b. This is the total number of SOC/ROC Non-Quality Assessments plus the total number of EOC Non-Quality Assessments you completed and submitted.
[9] = [7] + [8]. This is the total number of SOC/ROC and EOC assessments that you completed and submitted.
[10] = 100 x [7] / [9]. This represents the percentage of the total SOC/ROC and EOC Assessments that you completed and submitted that could be could be counted as a quality episode of care.

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