

Quality Partners of Rhode Island
Questions and Answers about Task 1b - Home Health
In the QIO 8th Statement of Work
Conference Call
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(Operator) You are on hold for today's HH Kiosk National Conference Call. [Instructions]

(Moderator) Please standby. Good day everyone, and welcome to the Home Health Kiosk National Conference Call. Today's call is being recorded. At this time I'd like to turn the call over to QIO (1). QIO (1), please go ahead.

QIO (1): Hello everyone. Today is the call that we're addressing questions and answers about Task 1b, Home Health in the 8th Statement of Work. And we have with us from CMS Lieutenant Government Official (1) who is the government task leader for home health, Government Official (3) who works with Government Official (1) and Government Official (2) who also has worked with Government Official (1) on the Statement of Work. So I'm going to turn it over to Government Official (1).

Government Official (1): Good afternoon and thanks a lot QIO (1). In the next hour and a half we'll try to answer as many questions as we can regarding the 8th Scope of Work. I've gotten a lot of really good questions off QNet Quest that I'm in the process of answering, about forty-nine pages worth. So that's keeping us busy here. If we don't have answer to all of your questions on the phone, we'll get them as soon as possible. Some language will be adjusted in the Scope of Work as it will be with all the tasks. There have been some good things pointed out, and before I take any questions and answers, let me just begin by addressing several of the most frequently asked questions. There are about five or six that are reappearing very frequently. First of all, the baseline question--the baseline that's stated in the Scope of Work right now will be readjusted to the following. In regards to IP and statement, the baselines will be split up round one, round two, round three, round one being August 2003 to July 2004, round two November 2003 to October 2004, round three

February 2004 to January 2005. In regards to the QIO getting the state read on the size and number of home health agencies in each state, we will be using Casper February data which will appear in May the second weekend. So look for that the second weekend of May, and that will reflect February data, and that is what we'll be using for the scope. Even if home health agencies fluctuate and whatnot, we'll be sticking with this data. Also, in regards to the clinical measures for the IP group, identified participants will be working on a total of three measures. One of those must be acute care hospitalizations, one of the three. The other two will be of the home health agency's choosing. The statewide will work on two, one of those being acute care hospitalization, the other one being of the QIO's choosing. In regards to the extra ten home health agencies that you may work on, in case a home health agency in your state goes out of business or changes ownership, the extra--if you do--let's say for the sake of argument that you replace three of your IP's with three of the ten. You would have seven left over. Those seven will be put back into the statewide evaluation, the statewide pool, the non IP pool. So any extra of the ten that you have or say you have all the ten that you don't use, they'll be put back in the statewide. So they will be used for something. They just won't sit there. That is all I was going to say off the top of my head. Why don't we begin with questions regarding identified participants and that--we'll just go down the agenda. I know all of you received it via QIO (1). So that is all I have to say, and I guess we can start with Q&A.

(Moderator) Our question and answer session will be connected electronically. If you'd like to ask a question or make a comment, please press *1 on your touchtone telephone. Once again, if you'd like to ask a question, please press *1. If you are using a speakerphone, please make sure that

your mute function is turned off to allow your signal to reach our equipment. Once again, if you'd like to ask a question, please press *1 at this time, and we'll pause for just a moment. And we'll take a question from QIO (2) from Oklahoma.

QIO (2): Hi, good afternoon Government Official (1).

Government Official (1): Hello.

QIO (2): We just got into the call, so you may have made some comments about the identified participant group measures prior to our getting on. So forgive me if you're repeating yourself, but can you speak again about the number of measures the identified participants are going to be working on?

Government Official (1): Sure, number of IP's we'll be working on total of three measures. One of those must be acute care hospitalization. The other two will be of the home health agency's selection. So total of three measures.

QIO (2): Okay, thank you.

Government Official (1): Sure.

(Moderator) I'd like to remind our audience if you'd like to ask a question please press *1 at this time. And we'll take a call from QIO (3) from Texas. QIO (3), your line is open; please go ahead.

QIO (3): I'm sorry, I had it on mute. On the identified participants for those three measures, we're talking about both the clinical performance group and the system's performance group?

Government Official (1): It depends. If you overlap the two groups--if you just use one group for both of those, for both clinical performance and system's culture change, then they'll be the total of the three measures. Now you have the

choice. Either you can break those up and have one group of IP's work on just clinical performance, and that group will work on three measures. And then the other group, the system's improvement and culture change will work on those types of activities, but the Telehealth component will also be concentrating on acute care hospitalization.

QIO (3): Okay, so the systems performance group works on acute care hospitalization, has to include Telehealth and has to work on culture change. Is that correct?

Government Official (1): That's correct.

QIO (3): Okay, and so their focus is on acute care hospitalization using those additional change modes of Telehealth and culture change.

Government Official (1): Correct.

QIO (3): Okay, thank you.

Government Official (1): Uh-huh.

(Moderator) We'll now hear from QIO (4).

QIO (4): The measures that are selected--I'm assuming those are from the publicly reported measures Government Official (1)?

Government Official (1): Yes, the N2F ones that were recommended to CMS last fall. The majority of them should be up by early September, late August minus status and surgical wounds. That one may be up a few months later.

(Moderator) Moving on to QIO (5) from Washington.

QIO (7): Actually it's QIO (7) from Washington. QIO (5) is from Idaho. We're here together. My question is if we have a home health agency that's in the identified participants so they're doing acute care hospitalization and two others, and they choose for one of their two others--they

choose the one that we're doing, that we've identified for the statewide, and we have that overlap.

Government Official (1): Yeah, it would overlap if it's the same measure. You could do that.

QIO (7): Okay, what I'm trying to make sure is that it's okay for the IP group to also be working on one of the same measures. Obviously they're going to be working on acute care hospitalization. But I want to make sure it's okay if they're also working on one of those statewide ones.

Government Official (1): Yeah, it's okay if there's overlap in that regard.

QIO (7): Okay, thanks.

Government Official (1): Sure.

(Moderator) We'll now hear from QIO (8) from Florida.

QIO (8): For the IP group, how will the evaluation piece be corrected to reflect the two measures? Will they pick the best of the two? Or will both of them be included?

Government Official (1): Both of them will be included.

QIO (8): Thanks.

Government Official (1): Sure.

(Moderator) I'd like to remind our audience, if you'd like to ask a question or make a comment, please press *1, and we'll now hear from QIO (9) from Minnesota.

QIO (10): This is QIO (10), and I have a question about the 50% reduction in (inaudible) rate for acute care hospitalization.

Government Official (1): Sure.

QIO (10): When an agency is starting--say they have about a 40% acute care hospitalization rate of 50% reduction would be 20% approximately. Is there a minimum threshold that you find acceptable? I know we talked in the technical expert panel about having a zero as an optimum--having zero hospitalization is not optimal. That's almost unsafe and undesirable. Is it feasible to have a 50% reduction in failure rate set for a zero percent optimal?

Government Official (1): Right, actually that's a good question QIO (10). We're not basing on 0%. I know that the tech road couldn't come to an agreement last fall. But we're basing it right now on the best attainable rate of 23%. So in regards to an RFR, if you're starting at 40%, and it's 50% decrease, you're--the best attainable for that agency would be 23%. And I mean there are definitely arguments that that may be too low, but a quarter of the home health agencies right now in the country are at that point.

QIO (10): So we need to achieve a 50% relative failure rate to the 23%?

Government Official (2): Yes, this is Government Official (2). The example that you mentioned for 40%, they would have to go--I mean there's maximum attainable reduction of 17%, 40% minus 17% is 23%. So they'd have to get--the target would be 31.5%.

QIO (10): Great, thank you.

(Moderator) We'll now hear from QIO (28) from Iowa.

QIO (28): Thank you for taking my call. There's several of us from here in Iowa, and the question regarding the IP's and the three measures that they'll be working on--you indicated two of those would be selected by the home health agency. Can the QIO select as a state quality measure and suggest that those identified participants work

on those, or must the agency select their own without our coaching so to speak?

Government Official (1): You know that's a really good question. Obviously the QIO's you guys will be able to provide input in, and you could steer them in a direction. You know, I would hope you would do work that would be beneficial to that home health agency. Like the question earlier, it can overlap with the statewide, and CMS doesn't have a problem with the overlapping. But I mean in the spirit of quality improvement, I would hope that there would be minimal gaming. So I mean I guess it's just using your own judgment. You know, if you see--if one of your home health agencies really needs to do work in ambulation locomotion, but you have a statewide measure in improving (inaudible), you really want them to work on that even though they're doing the job in that particular outcome. You know, I guess it's your call and how you'd be representing the program and actually working to improve outcomes with that home health agency. So it's really the QIO's call.

QIO (28): Thank you, and along that same line, is the expectation to be that for everyone working on acute care hospitalization the statewide measures that a plan of action is submitted for each one of these quality measures?

Government Official (1): Yes.

QIO (28): Thank you.

(Moderator) And we'll take another question from QIO (5)'s line.

QIO (7): It's QIO (7) again actually. So a lot of our agencies are considerably lower than the national. So if one of my agencies starts out with 15%, they may need to accomplish a 50% reduction. Is that correct?

Government Official (1): No, actually in the Statement

of Work if an agency or the state--if the statewide is at 23% or lower--if the statewide rate is 23% or lower, then they get to create their own quality improvement plan in regards to keeping your hospitalization which would include based on their judgment and the home health agencies in their state an attainable rate. And that has to be approved by the project officer and the GTO. So say for example there's a state out there right now that's at 23%. They would write a couple page proposal to their project officer and myself, explain their statewide situation, what they perceive as a real estate goal. For example, 21% or 21.75%--they present that to us, and then we would comment on it and okay it.

QIO (7): Now will it work individually with our project officer or with our science officer on that?

Government Official (1): Right, it would go through them, and then we would work together at central office. So there would be the project officer and myself and the QIO.

QIO (7): Okay, because our state is one that qualifies.

Government Official (1): Right, and like I said you would put together a paper several pages long addressing the situation in your state, what you believe is a realistic goal, how would you go about achieving it. We'd get together in a conference call and okay your plan. And you would go ahead with it.

QIO (7): Will the format for that documentation be sent out?

Government Official (1): There is no format, so you can use your imagination.

QIO (7): Okay, thank you.

Government Official (1): Sure.

(Moderator) We'll now take a question from QIO (14) from Oregon.

QIO (29): This is QIO (29), and that was going to be my question also regarding the strategic plan because I believe that we're a state that has experienced quite a low utilization and just wanted to know how to go about putting a plan together or then whether it was a mutually agreed upon improvement or who would set that.

Government Official (1): It will be mutually agreed upon based upon the recommendations of the QIO, but we'll be very flexible in those regards with the states that are below 22%. But you know, we expect a real estate workable strategic plan not term paper length, several pages getting to the point--what's the work that you 'd like to do in terms of reducing hospitalization in your state over the next three years.

QIO (29): Okay, thank you very much.

Government Official (1): Sure.

(Moderator) We'll take a question from QIO (16) from Missouri.

QIO (16): Hi Government Official (1).

Government Official (1): Hi QIO (16).

QIO (16): We're just kind of--you've rocked our world here. The reduction in failure is based on 23% lower. That's correct in what you said, right?

Government Official (1): Yeah, I can't hear you very well, but the 23% is the attainable.

QIO (16): That's the floor, okay.

Government Official (1): Right.

QIO (16): Now, is there--that would not prohibit us from working with an identified participant

agency who may start out below that floor because this is going to be determined in the aggregate amongst all the identified participants?

Government Official (1): Right.

QIO (16): So if you've got an agency who is at 21% now, and they get to 18%, that still goes in just pulling the whole average down?

Government Official (1): Correct.

QIO (16): Okay, thank you.

(Moderator) We'll move onto QIO (2) from Oklahoma.

QIO (2): Hi Government Official (1), again, just to confirm, the evaluation will be taken from Home Health Compare numbers, or will they be from the OVQI reports for each agency?

Government Official (1): They'll be taken from the Home Health Compare numbers.

(Moderator) We'll now hear from QIO (30) from Colorado.

QIO (30): Hi Government Official (1), I wanted to just have you clarify about collecting POA's in May. If we're collecting them, are you assuming that we would be entering them into partner with an implementation date in May?

Government Official (1): No, what you can begin doing is collecting them in May with the May date, holding onto them until we get the partner application up and running which will be by August 1 and then entering that information in August 1 so you'll have a record of the POA prior to August. However, I think more--I mean starting the work as soon as possible is definitely important. But the focus this time around more or less is the baseline, where you guys are starting from. So I don't know if that answers your question but I mean definitely getting the TOA's in May, you just hold onto it

and then enter it in in August when the application is up and running.

QIO (30): Okay, so then if we're meeting with them or kicking off with the conference in the fall and we have the change packets available and there are some change practices there that could benefit them on that POA, we'd almost be just in essence having them refresh their POA with some new change practices?

Government Official (1): Right, and that's fine.

QIO (30): And that would be their starting implementation date then I would assume?

Government Official (1): Well, May can be the initial--the initial implementation date can be the starting one. If you have revise the TOA, revisions are okay. I'm going to be pretty lenient with that. Revisions are fine.

QIO (30): Okay, great, thank you.

Government Official (1): Sure.

(Moderator) I'll take a question from QIO (12) from California.

QIO (15): Actually this is QIO (15) from California. My question is is there an achievable benchmark going to be set for outcomes other than the hospitalization outcome that will be used when you compute the RFR?

Government Official (1): Yeah, actually that's a good question. For the post reported measures minus acute care, discharge of community and emerging care which won't be used anyhow, we set the achievable benchmark at 90%. We used 100% for status of surgical wounds. So we don't know to be honest with you if 100% is realistic in all of these measures. So that's why we chose the 90%. In status and surgical wounds, there are cases where--that (inaudible) that 100% is achieved.

So we stuck with 100% for that one. So if that answers your question--

QIO (15): So it's 90%, not a 90 percentile?

Government Official (1): Right, 90%.

QIO (15): Okay, thank you.

(Moderator) We'll take a question from QIO (5)'s line.

QIO (7): Hi Government Official (1), I'm still a little confused on this 23% floor rate. When we talked about 23%, (inaudible) at 23%, we need to have an individual plan for our state that we confer with you and the project officer. Is that the 23%--is that the statewide rate? Or is that the aggregate rate of your identified participants?

Government Official (1): Statewide rate.

QIO (7): Thank you.

Government Official (1): Uh-huh.

(Moderator) We'll take a question from QIO (14) from Oregon.

QIO (29): Government Official (1), this is QIO (29) again. And you might have stated this, but I didn't hear it. So I'm going to ask.

Government Official (1): Sure.

QIO (29): In clarifying on the evaluation, in the RFP on page 52, it states that the baseline data is from the last quarter of 2004. Usually it's based on a year's collection of data, and I just want to clarify, is it really just the last quarter of 2004?

Government Official (1): No, actually it's like I said before. We're going to use the baseline (inaudible) mentioned in this call. And I'll say them again for people who joined late. And I

have to amend this actually in the Scope of Work, so it will be fixed. Round one the baseline will be August 2003 to July 2004, round two, November 2003 to October 2004, and round three, February 2004 to January 2005.

QIO (29): Thank you.

Government Official (1): Sure.

(Moderator) Moving on to QIO (25) from Missouri.

QIO (25): This is from Michigan actually. I wanted a clarification on ACH and two other outcome indicators. Does all HHA work on the same outcome measures, or do they get to choose?

Government Official (1): They get to choose. It can vary, so I would automatically say a lot of the (inaudible) would select different measures.

QIO (25): Can you restate one more time? I couldn't get you properly.

Government Official (1): Sure, regarding the measures than IP home health agency would choose, they will most likely be different from one another. I won't expect all of your IP's to choose similar measures.

QIO (25): Okay, thank you.

Government Official (1): You're welcome.

(Moderator) We're going to take a question from QIO (16) from Missouri.

QIO (16): Okay, I have two that are related to IP's. I'm assuming you're going to get into more details about the evaluation a little later?

Government Official (1): If the questions precipitate it, sure.

QIO (16): Okay, because I have a lot of evaluation questions, but let time ask these two.

Government Official (1): Sure, can you just speak up a little.

QIO (16): Okay, is this better?

Government Official (1): Yeah, that's--

QIO (16): I'm speaking into the phone. I'm literally laying on top of it. Okay, will the identified participant groups still be excluded from the statewide evaluation?

Government Official (1): Yes.

QIO (16): Okay, and the second question is in the table where it talks about the clinical group being 20% of all agencies in the state and the system improvement group being 8% of all the agencies in the state, the (inaudible)--oh, the--okay, how does that relate to the table that talks about the proportion of small, medium and large? Are those propositions the 10% or 15% for the small, medium and large out of the 20% or out of the state overall? So if your state has a hundred agencies, do you need ten small, ten medium and fifteen large, or if you--

Government Official (1): Yeah, you would need that. The size pertains to the total number of home health agencies in your state.

QIO (16): In the state, not in the IP group?

Government Official (1): Right.

QIO (16): Okay, great, thanks.

(Moderator) Moving on to QIO (4) from Wisconsin.

QIO (4): I had a question with the reason for the difference in the time periods for the rounds are the--is the contract going to be starting different times for the rounds? Or can we all begin--we're around three for example. Can we begin submitting POA's in May or collecting them rather? Or are we starting our contract at a

different time?

Government Official (1): From what I know we're all starting at the same time. These baselines just provide an accurate baseline because in the seventh scope of work the QIO's all started at different times depending on your round, but you can begin right now. You'll be using your round three baseline data as opposed to around one QIO in the seventh scope. So this kind of provides just a shift from the 7th scope to the 8th scope a reference point.

QIO (1): Government Official (1), this is QIO (1). I just want to check whether we want to move onto another--I know the questions are kind of moving around, and whether it's okay for people to just ask any question or whether we need--if we need to move down the line so that people make sure that they get their questions in.

Government Official (1): Actually this is fine. I know we're moving around a lot. And that's fine, but how about we save the evaluation questions at least for another twenty minutes. So if anyone has evaluation type questions, please hold onto those, but I mean jumping around from topic to topic is fine.

QIO (1): Okay, thanks.

Government Official (1): Sure.

(Moderator) We're going to take a question from QIO (11) in Washington.

QIO (11): Hi Government Official (1). I have a question. In the scope of work, it says initially that the IPG is going to be working on acute care hospitalization in two additionally public reported measures for Oasis, and then later it says that they would only have to meet the performance criteria for one of the publicly reported measures. Does that mean that they have to select two, but they have to show improvement

in only one?

Government Official (1): No, there was a misprint, a typo in the Scope of Work. The IP group will have to work on three measures total, one of those being acute care hospitalization and two of those being two other publicly reported measures. They have to meet the RFR's, the performance criteria in all three.

QIO (11): Okay, and then I have a second question for you. It says here that we can work with ten additional home health agencies to work with us in case our identified participant people go out of business or change ownership. So whoever replaces that agency who goes out of business, does their demographics have to mimic that agency we're replacing?

Government Official (1): The size of agency does.

QIO (11): Okay, alright. Okay, great, thanks.

Government Official (1): Uh-huh.

(Moderator) We'll take a question from QIO (5)'s line.

QIO (7): Thank you, related to the baseline period that you identified for each of the rounds, is that as information that's on Home Health Compare for those dates? Or is that going to come from somewhere else?

Government Official (1): It should come from Home Health Compare.

QIO (7): Thank you.

(Moderator) Once again, if you'd like to ask a question, please press *1. We'll take a question from QIO (12).

QIO (15): Actually this is QIO (15) again. My question is what data source is going to be used to determine the number of home health agencies

there are in the state particularly when you're figuring out how many identified participants we have to have.

Government Official (1): I can give you the exact data source. I'll have to get back to you on that. But it will be on the Casper application, but I'll have to find out the exact data source.

QIO (15): And do you have it at a particular point and time because what happens is that the number of home health agencies varies over time. So it would be useful to know what the target is.

Government Official (1): Right, we'll be using February data that will be available the second weekend of May for the entire 8th Scope of Work. So the data which is up on Casper the second weekend of May--that is what we'll be using for the 8th Scope of Work no matter during the 8th Scope of Work if your state has a hundred more agencies, it won't matter in terms of evaluation purposes or area workload because we'll be working with the February data as a constant.

QIO (15): Okay, and so like on the immunization survey for instance, we would be conducting it on the agencies who exist at that point and time?

Government Official (1): Correct.

QIO (15): --rather than ones that (inaudible) drop and the ones that drop out?

Government Official (1): Well, yeah, the ones that drop out just aren't there. So--

QIO (15): Okay, thank you.

Government Official (1): Sure.

(Moderator) We'll now hear from QIO (9) in Minnesota.

QIO (10): Hi, this is QIO (10). I have a question about the IPG selection. If they're submitting

plans of actions, and they can pick one or two measures, will the QIO be held accountable for all ten of the measures? Or what if there are certain measures that aren't chosen by any of the IPG groups?

Government Official (1): That's fine. The QIO will not be held accountable for all ten measures, only ones in which the home health agencies work on.

QIO (10): So if one agency picks a measure to work on, say it's (inaudible). Do they have to achieve that relative failure rate that's set out? That's a pretty big pull for just one agency.

Government Official (2): It's the average reduction failure rate of the three measures that they choose.

QIO (10): Of the three measures that they choose.

Government Official (2): Yes, acute care hospitalization and two other publicly reported measures. They would submit plans of action for acute care and two other publicly reported measures.

QIO (10): So do they have to reach those relative failure rate goals?

Government Official (2): Not necessarily, it's the average reduction in failure rate compared to what the target is. So it could average out they could achieve the target in one out of three, but if they really did well and went over the target but didn't achieve that target for the other two, the one where they did very well could compensate for the other two for that agency's contribution to the identified participant evaluation. So they're not required to achieve the target rate for all of the target measures.

QIO (10): Okay.

Government Official (2): Thanks.

(Moderator) Moving on to QIO (3) from Texas.

QIO (3): Hi Government Official (1), I have
(inaudible) about the flue and pneumonia survey.

Government Official (1): Okay.

QIO (3): We're going to survey all the agencies in
the state as of our baseline. Is there any kind
of percentage response that we're required to get
on that survey? In other words a return rate?

Government Official (1): Let's see here. Not
specifically but I'll have to get back to you on
that. Actually that's something I'm going to
have to address and rewrite anyhow.

QIO (3): Okay.

Government Official (1): That's an excellent question.

QIO (3): Okay, great.

(Moderator) We're going to hear from QIO (4).

QIO (23): This is actually QIO (23) in Wisconsin, and
I just wanted to clarify something I'm not sure I
understood earlier. When we were talking about
the 10%, 10% and 15% for small, medium and large,
did you say that was 10% of the entire, or that's
10% of your IP?

Government Official (1): It's 10% of your IP.

QIO (23): Thank you.

(Moderator) We'll now hear from QIO (8).

QIO (24): This is actually QIO (24) from Florida.
Going back to the calculating the average
reduction in failure rate for a facility, you
said it was the average across all three
measures. Does that mean that the average IPG
rate is an average of all the averages?

Government Official (2): That's correct. It's an un-weighted average of all the averages. So regardless of the agency size, each agency will contribute equally to the identified participant (inaudible) score. Does that answer your question?

QIO (24): Yes, it does, thank you.

(Moderator) We'll now hear from QIO (22).

QIO (22): Government Official (1), I'm looking for a definition of Telehealth. Now what is it inclusive of?

Government Official (1): Wow, that's a great question. Actually I do not have one right in front of me, but I can look that up. If--I know QIO (31) of Pennsylvania is putting together the Telehealth care guidelines which explicitly define it. But if I can get something up from the national (inaudible) first thing tomorrow morning, I'll have a nice two to three sentence definition of it.

QIO (22): Terrific, that would help.

Government Official (1): But it's very vague. It's not all fancy lights and monitors and whatnot. It can be as simple as installing just a telephone program to monitor your patients on a frequency during the week as determined by the home health agency.

QIO (22): Okay, thanks a lot.

Government Official (1): Sure.

(Moderator) Moving on to QIO (28).

QIO (32): This is actually QIO (32) in Iowa. I am here with QIO (28). And we need clarification on talking about the averaging of the RFR's. We misunderstand because there are different percentages for each of the measures, so I don't understand how three measures could be averaged

to help you figure out--I'm confused. Could you repeat that?

Government Official (2): It's an actual relative to a target, and then a score is computed based on actual relative to the target, and it's the average of those three scores that comes up with the agency's relative score contribution. Let's say--because as you pointed out, there are different targets, so we're comparing the actual reduction and the failure rate to the target. So that's how it's standardized because as you pointed out, there's different target reduction rates. For example for improvement in bathing is 34%. Improvement in transferring is 31%. So we're standardizing the scores across measures by comparing the actual to the target and coming up with a score. So--

QIO (32): Will this be written into some kind of an addendum to explain--

Government Official (2): We plan to issue a spreadsheet that illustrates an example for the calculation. We were just talking about it internally. That's why we didn't get it out in time for the meeting, but we hope to issue it soon meaning within days if not a week or two.

Government Official (1): By the end of next week.

QIO (32): Thank you, that would be helpful.

(Moderator) We'll now hear from QIO (16).

QIO (16): Question goes back to the one asked earlier about the Telehealth, and that is when we talk about agencies implementing Telehealth, does that include agencies that have already started some Telehealth initiatives, or do they have to be kind of brand new startup?

Government Official (1): That can include agencies that have already begun to initiate Telehealth initiatives.

QIO (16): Okay, thanks.

(Moderator) We'll now hear from QIO (4).

QIO (4): I have a question on we met with our advisory group on the immunizations for both pneumonia and for flu. And they tell us that they concentrate their efforts of setting up and organization and giving in just certain months of the year. How will that be reflected?

Government Official (1): Well, if I were a QIO, I would organize a lot of my not necessarily the assessment, but at least when I'm speaking with and working with home health agencies immunization activities during those times of the year. It's--I know it's based on our data here and the people that we've contacted several times a year. And there is adequate window to giving vaccinations. But we're not evaluating on immunization or vaccination rates. We're evaluating on getting immunization, finding out if the patient has had immunization, getting that patient assessment and a home health agency's ability to offer the vaccination or immunization. We're not evaluating on any progress or any rates, at least not in the scope of work.

(Moderator) Moving onto QIO (33).

QIO (33): My question is in regards to the data that we're going to be using. I think I understood you earlier to say that our baseline and evaluation data would come from the Home Health Compare, and I'm just wondering if that is what we'll be using, will that data be provided to us in some format, or are we going to be expected to download it every month as it comes online?

Government Official (1): It will be provided at intervals, but it won't be provided by CMS or a Kiosk on a monthly basis. It may be provided quarterly. I haven't worked that out with the Kiosk yet. So (inaudible) it depends on how

frequently you want to monitor the data.

Government Official (2): We might--

QIO (33): Will we receive any sort of historical data also, past data a month?

Government Official (1): We will--that I do not know yet. We'll definitely tell you where and when to look for it, but I don't know if we'll be organizing it in some fashion, probably QIO's.

QIO (33): Okay.

(Moderator) We'll now hear from QIO (26).

QIO (26): Yeah, I had a question on that implementation of Telehealth and the greater RFR for IP's working on both clinic performance and system's improvement. Does that imply that there will have to be some overlap between the ITT's order to calculate that?

Government Official (1): No, it doesn't. Within your IP group, there will be a certain portion using Telehealth and a certain portion won't be using Telehealth. Both of those groups will be working on acute care hospitalization, and the group that is working on Telehealth will have a greater (inaudible) than--should have a greater (inaudible) than the non Telehealth group. And that's what you'd be evaluated on.

QIO (26): Okay, and that's within the system improvement/organizational change (inaudible). Is that correct?

Government Official (1): Right.

QIO (26): Alright, thank you.

(Moderator) We're going to hear from QIO (27).

QIO (27): Government Official (1), could you clarify please in the immunization section, part of the evaluation will be based on their ability to

incorporate assessment into the comprehensive patient assessment. Will it also incorporate--did they offer the vaccine, and in here the verbiage says as providing follow-up. Is there a definition of follow-up?

Government Official (1): Follow-up is if they actually received the vaccine and/or experienced any adverse affects. You know, there are a lot of ways to go about this. I know some home health agencies will not have the capacity to offer--to store or offer vaccination, but if they can coordinate with physician offices or their public health departments or venues, that's follow-up though--just checking on them after they received an immunization if they know that they received one.

QIO (27): Okay, so it will be all three of those components that we'd be measured on?

Government Official (1): Yes.

QIO (27): Okay, and can I do one more question? Organizational culture change--do we have the specific indicators that will be measured for that?

Government Official (1): Not at this time. The Kiosk is working on an organization culture change survey tool. So we don't have anything to release at this point. I'm hoping on the next monthly call that we'll get into it in greater detail.

QIO (27): Okay, thank you.

Government Official (1): Uh-huh.

(Moderator) I'd like to remind our audience if you'd like to ask a question, please press *1. Let's take a question from QIO (16).

QIO (16): I have follow-ups to the last two questions. One is the culture survey, and my understanding

what was written here correctly, who is developing the POA around that? Is that the QIO's developing it, or is the agency developing the POA around that?

Government Official (1): The agency will develop the POA with the assistance of the QIO just like within the clinical performance.

QIO (16): Okay, and the second question has to do with evaluating the reduction of failure rate of the hospitalization for agencies who participate in Telehealth and the ones who don't. But if you have your IP groups since there doesn't seem to be any maximum of the overlap, how would you evaluate if those two groups completely overlap? Your clinical group and your IP group--the contract the way it's written allows there to be 100% overlap between those two groups in which case how would you evaluate whether they do better with it or not?

Government Official (1): Yeah, actually we thought about that, and we'll have to provide our follow-up answer at another time.

QIO (16): Okay.

Government Official (1): But that's an excellent question.

QIO (16): Yeah, I mean we're just thinking as a statewide strategy use of Telehealth to some extent is pretty much going to be universal. And so we're having a hard time figuring out since the way--at least the way Telehealth is used to describe it at the meetings includes use of the telephone follow-up.

Government Official (1): No, that's a really good question QIO (16). We will get back to that. That's something that we've been talking about actually for a little bit now.

(Moderator) Moving on to QIO (6).

QIO (6): Hi Government Official (1), I'm with Missouri also. In talking about the number of eligible agencies in the state and that that will be taken off of Casper data that's from February but will be available in May--is that--that will only include I'm assuming agencies that had-- [end of Side A] --2004. They won't have any baseline data.

Government Official (1): We'll have to get back to that question actually. We'll have to clarify that also.

QIO (6): Okay.

(Moderator) We'll now take a question from QIO (3).

QIO (3): My question already got answered. Thanks.

(Moderator) Once again if you'd like to ask a question, please press *1. We'll take a question from QIO (5)'s line.

QIO (7): In looking back through my notes on this concept of 10%, 10% and 15% in the small, medium and large, it's been asked a couple of times, and I have it written both ways. One is that it's of the total number of home health agencies, and then I have it again in my notes saying that it's based on the number of identified participants. Can you clarify so I know which one to cross off please?

Government Official (1): Yeah, the 10%, 10% or 15%--that is minimum percent of identified purchases of home health agencies. So out of your entire IP group, you have to have 10%, 10% and 15%.

QIO (7): Thank you very much.

Government Official (1): Uh-huh.

(Moderator) We'll now take a question from Don QIO (25).

QIO (26): This is QIO (26) from Michigan. I have a question about the immunization survey. It sounds like we will get the immunization survey in August of 2005. And can the QIO administer the survey in the fall of 2005 and use that as the baseline to be submitted into SPPS on September 1, 2006?

Government Official (1): Yeah.

QIO (26): Okay, thank you.

Government Official (1): Uh-huh.

(Moderator) We'll now hear from QIO (19).

QIO (19): Hi Government Official (1), this is QIO (19) in Kansas. On Page 57 of the (inaudible) it talks about--there's a phrase under the immunization process that says excluding patients that self reported a recent vaccination and assessment. Can you tell us what that's referring to?

Government Official (1): Not at this time actually. I will have to get back to that statement also.

QIO (19): Okay, thanks.

(Moderator) Once again if you have a question please press *1 at this time. We'll pause for just a moment. We do have a question from Wendy Boverk.

QIO (20): Actually this is QIO (20) from Arkansas. And I have a question about the IPT group. Is there a cap on the number of homes that you can pick?

Government Official (1): Is there a cap on the number of homes you can pick? No. I mean you can--well there's a specific number of IP's you can work with. So depending on how many home health agencies there are in the state, you can only identify a certain number as IP's. So I guess--

QIO (20): Well, for instance a nursing home like an evaluation. You can only pick up to 15%, so I didn't know if it was anything similar to like home health.

Government Official (1): It is (inaudible) table within the scope of work that illustrates the number of home health agencies in your state. And then the next tab over would be your number of IP's that you'd work with.

QIO (20): So there's no maximum number of homes that you can pick?

Government Official (1): There is a maximum of homes you can work with. It's in the table.

QIO (20): So it would be like if you were greater than ninety-one for the first group, it would be 20%. That's the maximum that you can work with?

Government Official (1): Yeah, that is the maximum.

QIO (20): Okay, thank you.

Government Official (1): Uh-huh.

(Moderator) We'll now hear from QIO (21).

QIO (21): Hi Government Official (1), I have a question about on page 56, organizational change, and I think you might have a (inaudible) there in that they say there's going to be a submission of a POA for the culture change. Taking the word of POA being OBQI POA's, you really mean like a narrative or some other--

Government Official (1): It will be a narrative but adapted to organizational change. It will be similar yet different from the POA's used for clinical measures. But it will be the same type of concept where you would work with (inaudible) to pick out some type of cultural change activity they'd want to work with or work to improve like staff satisfaction or patient satisfaction, and that would be logged onto this POA form. So it's

the same concept, but it will be a slightly different tool.

QIO (21): Okay, thank you.

(Moderator) We'll now hear from QIO (16).

QIO (16): Government Official (1), I want to clarify what you said a minute ago about the percentage of each in the IP groups. In the large state category, the table says 20% for the clinical and 8% for the culture change.

Government Official (1): It's 8% out of that 20%.

QIO (16): Okay, so 20% is the maximum.

Government Official (1): Right, and it's 8%.

QIO (16): Of the 20%.

Government Official (1): Of the 20%.

QIO (16): So you could have--sorry for doing this in my head, but 12% doing just clinical and 8% doing just Telehealth or any combination up to 20% doing both?

Government Official (1): Correct.

QIO (16): Okay.

(Moderator) We'll now take a question from QIO (34). Ms. Day, your line is open.

QIO (34): Yes, thank you. The seventh scope of work, OBQI training was such a huge piece of it. Will agencies have to have been OBQI trained in order for them to be an identified participant and submit that POA and be eligible?

Government Official (1): No.

QIO (34): Thank you.

(Moderator) We'll now hear from QIO (22).

QIO (22): Government Official (1), quick question,

with home health comparing--you said that's where the number of agencies is going to come from. One of the problems that we ran into--

Government Official (1): (inaudible).

QIO (22): --I'm not sure that it's been 100% solved--is the number of agencies that appear in there that are really not in our case New Jersey based. In other words, they're New York, or they're Pennsylvania. And they're showing up in our compare. I don't know if that's been fully resolved yet or not because I haven't really looked.

Government Official (1): Actually that application will be Casper. It won't be Home Health Compare. And you know, I don't know if it will (inaudible) but we'll have to look into that if that situation does occur.

QIO (22): Okay, thanks.

Government Official (2): To account for the baseline.

Government Official (1): Right, to account for the baseline, right.

QIO (22): Right, that's what I'm concerned about.

Government Official (1): Okay, it's a valid concern.

(Moderator) We'll now hear from QIO (4).

QIO (4): I have a question based on QIO (16)'s question. When I looked at the contract on page 53 about the percentage of agencies, when it talks about improvement and organizational culture it says 8% of all the home health agencies in the state. Now what I heard QIO (16) asking was was that 8% of the 20%, and I thought you said yes. Can you just please explain that again?

Government Official (1): It will be 8% of the 20%. That's another--

Government Official (2): That's a relative--

Government Official (1): It's a relative?

Government Official (2): Yeah, 8% of 20% is something like 1.6%. Is that your question whether it's 8% absolute or 8% of the 20%?

QIO (4): Yes, that's my question.

Government Official (2): 8% of 20% or 8% total?

Government Official (1): Actually--okay, okay, I see here. I was looking. It is 8%--I'm sorry, okay--

Government Official (2): --of all the home health agencies in the state, so that's an absolute number.

Government Official (1): Okay, it's an absolute, so I was mistaken in QIO (16)'s answer. It won't be 8% of the 20%. It will be 8% of the entire home health agencies in the state. So to reiterate this, if all of you are looking at the table, let's take the first line for example, less than or equal to fourteen. Six out of the fourteen home health agencies would work on clinical performance. Okay? Two out of the fourteen would work on systems improvement and culture change. So that would be a total of--yes sorry. First line right here.

Government Official (2): First line, 6%--let's see, number--

Government Official (1): Six number--right.

Government Official (2): Well, if you have fewer than fourteen--fourteen or fewer, that's going to be more than--

Government Official (1): Right, exactly. It adjusts to state size.

Government Official (2): Yeah, it will be somewhere in

the order of over 40% of the home health agency of the state.

Government Official (1): Right, so actually you know, I'll explain this better in writing tomorrow. So let me get back to this also. So just hold onto that question.

QIO (4): Thank you.

(Moderator) We'll now hear from QIO (12).

QIO (12): Yes, actually that last question was also my question. So I'm fine.

(Moderator) We'll now hear from QIO (5)s line.

QIO (7): It's QIO (7) actually. And I may be real obtuse here, but I'm having trouble understanding. So our baseline number--you gave us the date that it's from. But it sounds like it's not going to be from Home Health Compare for the reasons that were stated just a few minutes ago because there is overlap in other state's agencies or in our numbers. Is that correct?

Government Official (1): The based on data will be from Casper. It won't be from Home Health Compare. We'll have to look into that if there is a lot of overlap from other states because we are not familiar with that problem.

QIO (7): Okay and so if it's going to come from Casper because we don't get--I don't at least get a report that says what our state radius based on Casper--how are we going to be able to get to that number one? When we be able to get to that number two? And number three, if we are because I believe we will be, under the 23%, what's the timeframe for us to send you that paperwork and have that negotiation about what our rates will need to be?

Government Official (1): Go ahead, you go first.

Government Official (2): The baseline count or the

number of home health agencies in a state would be generated from Casper. It would be similar to what happened in nursing home in the seventh scope where there'd be a tally of a number of home health agencies as of--definition to be defined whether it be one month of data or twelve months of data and what would possibly happen like in the seventh scope is that an STPS memo would come forth saying this is the count of the number of home health agencies in your state as of a certain period of time.

QIO (7): And we'll get that sent out to us?

Government Official (2): Yes.

QIO (7): Okay, do you know approximately when we should be getting that?

Government Official (2): I mean we're going to have to be meeting to define that and issue those definitions, you know, memo prior to that. I mean details are to come. I hesitate on giving a specific date.

QIO (7): Okay, but am I correct in assuming that that will take out the number that are (inaudible) only and take out any that have not had a full year's worth of data prior to that time?

Government Official (2): Those are details that we would have to work out.

QIO (7): Okay.

Government Official (1): Yes, those are details we'll have to work out. In regards to the document, yes, about if you're state is less than or equal to 23%, that will be due at the same time the other (inaudible) reported the clinical performance POA's do. And I don't have that data right in front of me.

Government Official (2): Yeah, I just want to clarify that the count of the number of home health

agencies would come from Casper, and the rates would come from Home Health Compare.

QIO (7): But my concern then is the rates from Home Health Compare as was mentioned on a previous individual could include carryover from other states. In Washington, there's a couple from Idaho that are on my list. And there's a couple from Oregon that are on my list.

Government Official (1): But you we're talking about the rates not the actual state or geographic coding of the home health agency. We're going to have to look into those concerns if there are misclassifications in geographic coding in the definition. All we're going to be doing is linking by provider number then to pull off the rates from home health compare. We're going to make sure that in the definition of the counts that we get the correct provider ID linked up in Home Health Compare versus Casper.

QIO (7): Okay, because those particular states like Idaho that borders six states--there's overlap in six directions.

Government Official (1): Yeah, I mean we would have to watch out for if there are let's say multiple or branch agencies per provider ID that might go across states. I'm not that familiar with say the state regulation. I would hope that you would have-- that home health agencies would separate provider ID's by state which they're regulated by the state survey agencies.

QIO (7): Actually my understanding is that that's not where the Home Health Compare identification comes from, but the Home Health Compare identification--at least it originally did--was from where the patients put down their zip codes.

Government Official (1): Okay, well that's--

QIO (1): Government Official (1) and Government Official (2), this is QIO (1). I'll just mention

one other thing about this. There is actually a difference on Home Health Compare. The thing that QIO (7) mentioned about being keyed off of the patient zip code in Oasis is something that's used for finding home health agencies in your state, but my understanding is about the actual state rates is that it's only based for agencies that are submitting data to a particular state. So I think there's a difference in this issue in terms of whether it's used strictly to locate agencies versus what date is actually going into those state rates.

Government Official (1): Yeah, that's a good point QIO (1). For example, an agency let's say in Paramus, New Jersey might be pulled off of a New York search and a New Jersey search and possibly a Connecticut search. Also agencies in the Portland MSA might be pulled off of a Washington state as well as an Oregon search. But because of the state regulation in the Casper database, we would be pulling off of where the state where the home health agency was actually based out of and was regulated by that particular state survey agency.

QIO (7): Okay this is--can you hear QIO (7) still? The question then remains if at the top of my Home Health Compare report that I pull up, it says the national rate is this; the state rate is this. Does that state rate that's listed on home health compare--is that for all of the agencies that are listed on that Home Health Compare report or just the ones that are in Washington because that's different.

Government Official (1): Okay, I did not participate in the tabulations in home health compare. What we'll be doing for the statewide rate for the base scope evaluation is taking non identified participants that are based out of a particular state meaning they're--that's where their headquarters are based out of--would be tallied.

I--and all we'll be doing off of Home Health Compare is linking by provider ID which the home health agencies have to submit when they get their reimbursement from Medicare.

QIO (7): I understand. My concern is to figure out our state rate for the acute care hospitalization to determine whether we're above or below that 23%.

Government Official (1): Right.

QIO (7): I'm trying to figure out where I'm going to get that number from.

Government Official (1): Okay, it's going to most likely be off of a dashboard report. It's not going to be statewide rates I mean because we're talking about the non-identified participant component of the state. You wouldn't be able to pull right off of home health compare for that quote/unquote state's average rate. We would have to tally that separately and provide that to the QIO community probably in a dashboard report.

QIO (7): Okay, so historically the dashboard reports have been significantly delayed. Will that change because we're going to need to know very quickly what that rate is and what that number is so that we're knowing more about who we're picking and where we're picking for our identified participants?

Government Official (1): Right, yeah, we understand your concern. We're going to do the best that we can to work with the folks at STT (inaudible) IFMC to get those data to you.

QIO (7): Okay, thank you very much.

(Moderator) We'll now take a question from QIO (18).

QIO (17): Hi, this is actually QIO (17) in Kansas. And I know you touched on this a little bit

before. But I have--I'd like some more clarification. On page 54, could you go over again how the top chart correlates with the bottom one in regards to the home health agency size? Are the minimum percent--the 10%, 10% and 15% based on that 20%? Or like the 15% large--is that all of the large agencies in our state?

Government Official (2): The 10%, 10% and 15%--that will be the makeup of your IP pool, of your 20%. So the 10%, 10% and 15% are the total number of HHA's in your state. Those represent the 10%, 10%, 15% out of the total number of home health agencies. So if you have a hundred agencies in your group, you need ten small, ten medium and fifteen large percentage at least. And out of those percentages you would choose twenty home health agencies.

QIO (17): Okay, okay, I think I got it.

(Moderator) We'll now hear from QIO (13).

QIO (13): I have a question on the new publicly reported measure. How do we get the state average rates for those like (inaudible) and incontinence and discharge to community because currently we don't have that information that I'm aware of.

Government Official (1): We'll have to get back with you on that one. There's been a little interruption here in the office. We'll get back to that question.

QIO (13): Thank you.

(Moderator) We have no further questions at this time.

QIO (1): Government Official (1), do you want to take your evaluation questions now? Or maybe everyone has already asked those, but--

Government Official (1): We can take a couple of

evaluation calls right now.

Government Official (2): Five minutes?

Government Official (1): Five minutes worth.

(Moderator) Once again if you'd like to ask a question, please press *1. We'll take a question from QIO (16).

QIO (16): QIO (17) won't ask this question, but it's killing him. In the evaluation for the Task 1b score calculation formula, is that the multiplication by the factor .75 really supposed to be there?

Government Official (2): Yes, what the .75 does is just standardizes the score. We're using the same metric as the other subtasks. In general the raw score is if you get a score of 1.00 or above you pass that element. And just multiplying it by .75 just standardizes it so that 75% is passing. Does that answer your question?

QIO (16): He's still shaking his head, but we're going to have to analyze it some more.

Government Official (2): Hopefully the spreadsheet that we'll be providing soon will help to illustrate. It's just a way of standardizing it across subtasks because we wanted to be able to have 75% as passing and 95% as excellent.

(Moderator) We'll now take a question from QIO (13).

QIO (13): Hi, this is (inaudible) from the Tennessee QIO. For the measures that have pass fail indicators, and if we don't make .1 but we make .99 instead, does that mean we just get an outright fail on that measure?

Government Official (2): We're not using significance levels for the eighth scope of work. It's going to be reduction and failure rates for the point

estimates, the re-measurement relative to the baseline similar to some of the other subtasks in the seventh scope of work.

QIO (13): Okay, so we don't actually have pass or fail measure that go into evaluation.

Government Official (2): That's correct. Yeah, each of the three targeted measures if they're an identified participant will contribute equally, and it will be target relative--it will be the actual relative to the target.

QIO (13): Okay, thank you.

Government Official (2): Sure.

(Moderator) And we have no further questions at this point.

QIO (1): Okay, Government Official (1) or Government Official (2), do you have any other summary remarks? Otherwise if there's no other questions, I guess we can wrap it up.

Government Official (1): QIO (1), actually there's been a lot of really good questions. Some obviously we'll have to get back to people on data sources and a couple of specific dates. These will be decided in the next day or two and communicated out. Nothing really significant is going to change in the scope of work, just a couple of clarification points and more detailed specifications. Government Official (2) can explain the table a little better than I did. It's a table in regards to total number of IP's within a state divided by the (inaudible) and culture change group.

Government Official (2): Alright, on page 48, the one table left most column, number of home health agencies in the state--that would be the number tabbed off of Casper, definitions to be provided at a later date. The middle most column is the number of clinical performance identified

participants if you have fourteen or fewer. The max number is six. Fifteen to twenty-five it would be eight. And you go down to where--to the bottom most row with data greater than ninety-one agencies in the state so that 20% of all home health agencies per Casper would be your max number of clinical identified participants. For example, if you have a hundred it would be twenty. And the right most column, it mentions--that's the number of systems improvement in organizational culture change, identified participants. The note above it mentioned that the two groups may overlap. So in the hundred agency example that I provided, a max of eight home health agencies in the state--if there's a hundred in the state per Casper, then we would expect that QIO's work with eight home health agencies in the state, and that eight working on systems improvement and organizational culture may overlap with twenty that are working with clinical performance. So the number of total identified participants could range between twenty if the two groups completely overlap and twenty-eight if the two groups do not overlap, if they're mutually exclusive.

Government Official (1): Thank you Government Official (2). As I mentioned, we'll get some definitions and clarifications out on the List Serve as soon as possible. Otherwise we'll have to wait until the 8th Scope of Work is corrected which will probably be mid next week to late next week. Anyhow, thank you all for your participation. And I'll look forward to all of you participating in the national call next week. Thanks a lot QIO (1).

QIO (1): Thank you. Alright, as Government Official (1) said, we have our regularly scheduled end of the month national call for next Tuesday at 4:00, and we'll put a reminder of the List Serve about that. And in the meantime, feel free to post questions or comments on the List Serve. Thank

you all very much for joining us. Bye.

(Moderator) That concludes today's conference call.
I'd like to thank everyone for their
participation.