A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

Home health care is an important and rapidly growing segment of the U.S. health care system. National health expenditure data show that spending for home health care was more than $47 billion in 2005—an 11.1% increase over the previous year. Public spending for home health services, which accounts for three quarters of such spending, rose 12.4% in 2005. Spending for home health care is expected to continue to increase. The Centers for Medicare & Medicaid Services (CMS) has projected that by 2010, spending for home health care will top $70 billion annually and is expected to be more than $110 billion annually by 2016. (These figures come from http://www.cms.hhs.gov/NationalHealthExpendData/. Last viewed August 27, 2007.)

Home health care is a key benefit covered under Medicare Part A. The benefit includes coverage of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician. If patients are eligible for skilled services, they can also receive part-time assistance with personal care needs by a home health aide. Patients are required to be "homebound" as a condition of eligibility for Medicare home health benefits. Home health care services are delivered at home to patients who are recovering from care in hospitals or nursing homes; patients who are disabled; the frail elderly; and chronically or terminally ill persons in need of medical, nursing, or therapeutic treatment and assistance with the essential activities of daily living. There are approximately 9,000 Medicare-certified home health agencies throughout the United States. In 2006, more than 3 million beneficiaries were served, and 103,931,188 visits made. As baby boomers age, the need for patient-centered, cost-effective care will be a priority to CMS—78 million baby boomers are about to begin turning 65 (http://www.cms.hhs.gov/HomeHealthQualityInits/).

For some patients, home health care can be an alternative to more costly institutional health care. Monitoring and improving the quality of home health care, as with all Medicare services, is an important policy issue. Monitoring and ensuring home health care, in particular, can be a challenge because care is provided in patients'

residences and therefore lacks some of the oversight feasible in institutional settings. In 2001, Secretary Thompson of the Department of Health and Human Services (DHHS) announced the *Quality Initiative* to ensure the quality of health care for all Americans through accountability and public disclosure. The goals of the initiative are to empower consumers with quality-of-care information so they can make more informed decisions about their health care and to stimulate and support providers and clinicians to improve the quality of health care. The Quality Initiative was launched nationally in November 2002 for nursing homes and was expanded to home health agencies (the Home Health Quality Initiative) in 2003. A major gap in the information currently available regarding the quality of home health care is the lack of information from the patient perspective.

As part of the DHHS Transparency Initiative on Quality Reporting, CMS plans to implement a process to measure and publicly report patients' experiences with home health care they receive from Medicare-certified home health agencies through the data collection effort described in this request: the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey. The Home Health Care CAHPS Survey, which was developed and tested by the Agency for Healthcare Research and Quality (AHRQ) and is part of the family of CAHPS surveys, is a standardized survey for home health patients to assess their home health care providers and the quality of the home health care they receive. Prior to the Home Health Care CAHPS survey, there was no national standard for collecting data about home health care patients' experience with their home health care.

In the first half of 2008, AHRQ conducted a field test of the Home Health Care CAHPS Survey to determine its length and contents and to test the reliability and validity of the survey items. After reviewing field test results with a technical expert panel consisting of home health industry experts, patient advocates, and researchers, the Home Health Care CAHPS Survey was finalized as a ~~36~~ 34-item survey instrument. (See ***Appendix A*** for a copy of the Home Health Care CAHPS Survey questionnaire.) The survey contains questions about the patient's interactions with the home health agency, interactions with the agency's providers, provider care and communications, and patient characteristics. Patients will also be asked to provide an overall rating of the home health care they receive. ~~CMS has submitted the final Home Health Care CAHPS Survey to the~~

~~National Quality Forum (NQF) for approval and expects to receive endorsement by the end of March 2009. The NQF endorsement will represent the consensus opinion of many healthcare providers, consumer groups, professional organizations, purchasers, federal agencies, and research and quality organizations.~~ CMS submitted the final Home Health Care CAHPS Survey to the National Quality Forum (NQF) for endorsement. The survey was endorsed March 31, 2009. The NQF endorsement represents the consensus opinion of many healthcare providers, consumer groups, professional organizations, purchasers, federal agencies, and research and quality organizations. As a result of the endorsement process, a few minor changes were made to the survey. The words "over the counter" were added to Questions 4 and 5. In Question 14, the word "important" was removed since a respondent may have difficulty determining which side effects are important. Questions regarding age and gender were removed from the survey since they are available from home health administrative data. The revised survey is 34 questions long.

Questions 1-25 on the instrument are the core survey items, and questions 26-36 are the "About You" questions. Five measures from this survey will be used for public reporting – 3 composite measures and 2 global ratings. The 3 composites cover "Care of Patients," "Communication between Providers and Patients" and "Specific Care Issues." The global items include the overall rating of agency care, and would you recommend this agency to friends and family.

Initially, confirmatory factor analysis (CFA) based on structural equation modeling (SEM) was conducted to see whether the field test data were consistent with the hypothesized composite structure. The CFA of the field test questionnaire revealed that the observed data did not fit this model. Following the poor CFA results, exploratory analyses were conducted to identify the structure underlying the observed responses. Analyses were conducted upon a random sample of 50% of the single-imputation data set. This enabled us to evaluate the generalizability of the final model in the other 50% of the data, as well as the data sets comprised of each of the other four imputations. An exploratory factor analysis (EFA) was conducted on the correlation matrix using the principle factor method with squared multiple correlations as initial communality estimates and oblique rotation (promax) with Kaiser normalization. The number of

factors was determined by the eigenvalues, and the interpretability of the rotated factor pattern matrix.

The internal consistency reliability (alpha) (a measure of how well the items in a composite hang together) was .75 for Care of Patients, .73 for Communication between Providers and Patients and .84 for Specific Care Issues. The scaling success (a measure that summarizes the discriminant validity of the composites, that is, the degree to which each item correlates more highly with its own scale than it does with competing scales) is 88% for Care of Patients, 90% for Communication between Providers and Patients and 100% for Specific Care Issues.