



**2026 ANNUAL
CONFERENCE & EXPO**
Celebrating 60 Years
Then. Now. Next.


HHCAHPS – Improving Results

Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc

June 24, 2026

2026 Annual Conference & Expo © 2026 California Association for Health Services at Home

1



Melinda A. Gaboury, with more than 35 years in home care, has over 24 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the Alliance/HFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E2 and Home Health Billing Answers, 2025.

Melinda A. Gaboury
Chief Executive Officer

2

HHCAHPS - Overview

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, hereafter referred to as the "Home Health Care CAHPS Survey" is designed to measure the experiences of people receiving home health care from Medicare-certified home health care agencies. The survey is designed to meet the following three broad goals:
- To produce comparable data on the patient's perspective that allows objective and meaningful comparisons between home health agencies on domains that are important to consumers.
- Public reporting of survey results will create incentives for agencies to improve their quality of care.
- Public reporting will enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.

3

HCAHPS as a Measure of Satisfaction

A selection of HCAHPS items are used for three composite, public-facing Star Ratings

also

- Agency must be eligible for public reporting
- Additionally, must have at least 40 or more completed surveys over the 4-quarter reporting period

The CAHPS based, composite Star Ratings measures are:

- Care of Patients
- Communication Between Providers and Patients
- Specific Care Issues

4

HCAHPS as a Measure of Satisfaction

- The HCAHPS survey is composed of 25 multiple choice questions
- Only 2 of them are now used as 2026 HHVBP Quality Measures
 - Each of the two measures below make up 10% each of the HCAHPS based measure score, which is 20% of 2026 HHVBP Total Performance score for Large Cohorts
- The CAHPS-based 2026 HHVBP measures are:
 - ~~Care of Patients~~
 - ~~Communication Between Providers and Patients~~
 - ~~Specific Care Issues~~
 - Overall Rating of Home Health Care
 - Willingness to Recommend the Agency

5

TABLE C-19: MEASURES CURRENTLY ADOPTED FOR THE CY 2026 HH QRP

Sheet Name	Measure Name & Data Source
ONSER-based	
AMBULATION	Improvement in Ambulation/Locomotion (CBE #0167)
APPLICATION OF FALLS	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CBE #0674)
BATHING	Improvement in Bathing (CBE #0174)
BED TRANSFERRING	Improvement in Bed Transferring (CBE # 0175)
PATIENT COVID-19 VACCINATION	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
DRG	Drug Regimen Review Conducted With Follow-Up for Identified Issues: Post-Acute Care (PAC) HH QRP
DC FUNCTION	Discharge Function Score
DYSPINOEA	Improvement in Dyspnoea
INFLUENZA	Influenza Immunization Received for Current Flu Season
ORAL MEDICATIONS	Improvement in Management of Oral Medications (CBE #0176)
PREVENTION OF SKIN INJURY	Changes in Skin Integrity: Post-Acute Care
TIMELY CARE	Timely Initiation of Care (CBE #0526)
TOH-PROVIDER	Transfer of Health Information to Provider-Post-Acute Care ¹
TOH-PATIENT	Transfer of Health Information to Patient-Post-Acute Care ²
Claims-based	
DTC	Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) (CBE #3477)
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) - Post Acute Care (PAC) HH QRP
PPH	Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program
PPH	Home Health Within Stay Potentially Preventable Hospitalization
HCAHPS-based	
CAHPS Home Health Survey	CAHPS® Home Health Care Survey (experience with care) (CBE #0517) ³ <ul style="list-style-type: none"> - How often the HH team gave care in a professional way. - How well did the HH team communicate with patients. - Did the HH team discuss medicines, pain, and home safety with patients. - How do patients rate the overall care from the HHA. - Will patients recommend the HHA to friends and family.

¹Data collection delayed due to the COVID-19 public health emergency for the TOH-Patient and TOH-Provider.
²The HCAHPS has five components that together are used to represent one CBE-endorsed measure.

6

Patient-Mix Adjustment - example

For example, analyses of the data on which results that are being currently publicly reported showed that patients who were aged 50-64 in the regression on the Overall Rating global measure were 2.4 percent less likely to provide the most positive ("top box") response (rating of a 9 or 10 for this HHCAHPS measure) when compared to the reference group of patients aged 65-74. Consequently, the adjustment factor for patients aged 50-64 is +2.4

- Patient age
- Patient education
- Self-reported overall health
- Self-reported mental health
- Diagnosis - ELIMINATED
- Whether the patient lives at home
- Whether the patient or a proxy answered the survey, and
- Language in which the survey was completed

7

HHCAHPS Star Ratings

- Minimum Number of Surveys for HHCAHPS Star Ratings To receive HHCAHPS Star Ratings, home health agencies must have at least 40 completed HHCAHPS surveys over the publicly reported four-quarter period. HHAs with fewer than 40 completed HHCAHPS surveys will not receive Star Ratings; however, their individual HHCAHPS measure scores will still be publicly reported on Home Health Compare as long as they are eligible to be reported during that time period (i.e., the agency has 12 months of HHCAHPS Survey data).
- CMS applies the patient-mix adjustment (PMA) to quarterly HHCAHPS scores to account for the tendency of certain patient subgroups to respond more positively or negatively to the HHCAHPS Survey. PMA allows for fair comparisons across HHAs by adjusting HHA scores as if all HHAs had an identical mix of patient characteristics. The PMA table can be found in Appendix A, Table 1, while Appendix A, Table 2 contains the national means for patient-mix variables

8

CY 2026 HHCAHPS Public Reporting Period	January 2026	April 2026	July 2026	October 2026
Results represent patients who received skilled home care	July 2024–June 2025	October 2024–September 2025	January 2025–December 2025	April 2025–March 2026
Quarters that results represent	CY2024,Q3–CY2025,Q2	CY2024,Q4–CY2025,Q3	CY2025,Q1–CY2025,Q4	CY2025,Q2–CY2026,Q1
Preview reports will be posted on the HHCAHPS website	Preview Report was posted in December 2025	Preview Report will be posted in March 2026	Preview Report will be posted in June 2026	Preview Report will be posted in September 2026

Anticipated HH Refreshes and Data Periods



2026 Annual Conference & Expo

9

Planned publicly reported measures with revised survey:*

Measure	Modified or Unchanged Measure	Item(s) in Updated Survey
Care of Patients	Modified	Q6, Q7, Q10, Q11, Q13
Communications Between Providers and Patients	Modified	Q5, Q8, Q9, Q12, Q16
Talk About Home Safety	Modified	Q2
Review Medicines	Modified	Q3
Talk About Medicine Side Effects	Modified	Q4
Overall Rating	Unchanged	Q14
Willingness to Recommend	Unchanged	Q17

10

HHCAHPS – Measures

Care of Patients (Q6, Q7, Q10, Q11 & Q13)

- Q6. In the last 2 months of care, how often did home health staff from this agency seem to be **aware of all the care or treatment** you were getting at home? **Never, Sometimes, Usually, Always**
- Q7. In the last 2 months of care, how often did home health staff from this agency **treat you with care** – for example, when moving you around or changing a bandage? **Never, Sometimes, Usually, Always**
- Q10. In the last 2 months of care, how often did home health staff from this agency treat you with **courtesy and respect**? **Never, Sometimes, Usually, Always**
- Q11. In the last 2 months of care, how often did you feel that home health staff from the agency **cared about you as a person**? **Never, Sometimes, Usually, Always**
- Q13. In the last 2 months of care, how often have the services you received from this agency **helped you take care of your health**? **Never, Sometimes, Usually, Always**

11

Question 6: Aware of All the Care

Q6. In the last 2 months of care, how often did home health staff from this agency seem to be **aware of all the care or treatment** you were getting at home? **Never, Sometimes, Usually, Always**

1. Is staff fully aware of the plan of care, what is happening with patients, and what has changed since their last visit? This must be considered even if this clinician doesn't normally see this patient. This may be the first time the clinician has treated the patient, so it's important that they review the plan of care before they arrive to make sure they're up to date with the patients' condition.
2. A seamless transition of care will help make the patient feel like they're being cared for by a cohesive team, not being passed off from nurse to nurse. And if the patient has had an appointment with their primary care provider between visits, ask them about it and engage with them to see what happened. This will help gather important information about their current condition and also help them feel valued and heard.

12

Question 7: Treat with Care

Q7. In the last 2 months of care, how often did home health staff from this agency **treat you with care** - for example, when moving you around or changing a bandage? **Never, Sometimes, Usually, Always**

1. If a patient needs to go through a potentially pain treatment on their next visit, like wound care, it can help to contact your patient and remind them to take any appropriate medications for pain thirty to sixty minutes before arrival. This way, the medicine has had time to take effect, lessening the discomfort or pain of the procedure that is going to be performed.
2. You should also periodically check in during the procedure and see how the patient is handling it and make adjustments as needed—maybe we need to slow down or saturate the dressing more—and be sure to look for nonverbal cues as well.
3. Clinicians have their own treatment styles....rougher than normal staff members should not be assigned to the most fragile patients.
4. Ensure that ANY complaints in this regard are handled immediately.

13

Question 10: Courtesy & Respect

Q10. In the last 2 months of care, how often did home health staff from this agency **treat you with courtesy and respect?** **Never, Sometimes, Usually, Always**

1. Many times patients might not understand exactly what is happening when beginning a treatment, or perhaps they started off on the wrong foot with a bad experience at the hospital before their care transition. Make sure to address their concerns, validate them, and put them at ease when treatment is to be performed.
2. We are performing care in their house, that same courtesy needs to be extended to their home. Do they prefer communication through text or phone call? Do they want to receive the call or is it better if a family member helps? When is the best time to call and what time of day do they want the visit to occur? Keeping these considerations in mind helps center the patient and respect their wishes.
3. Ensure any complaints are addressed immediately.

14

Question 11: Cared About You (New 2026)

Q11. In the last 2 months of care, how often did you feel that home health staff from the agency **cared about you as a person?** **Never, Sometimes, Usually, Always**

1. The question could be a turning point of the whole survey.
2. Patients may not remember the wound care or medication that you provided, but they will remember how you made them feel as a person.
3. It is not just about the wound or the oxygen or the vital signs, it is about the patient, the family and the fact that they are wanting to see improvement in the patient's condition.
4. Realize that you or a family member of yours may need home health one day...how would you want to be treated.

15

Question 13: Your Health (New 2026)

Q13. In the last 2 months of care, how often have the services you received from this agency **helped you take care of your health?** **Never, Sometimes, Usually, Always**

1. Are we having conversations with patients about the patient's about their meds and whether they are continuing to be able to take them as scheduled and at the appropriate doses? Are we asking about home exercise programs and how it is working, etc? Are we following up on improvement in patient's diet when needed and confirming they are eating according to prescribed diet?
2. It is not just about the wound or the oxygen or the vital signs, it is about the patient, the family and the fact that they are going through the difficult situation of the patient's impending death.
3. Realize that you or a family member of yours may need home health one day...how would you want to be treated.

16

HHCAPHS – Measures

Communication Between Providers and Patients (Q5, Q8, Q9, Q12, Q16)

- **Q5.** In the last 2 months of care, how often did home health staff from this agency keep you informed about **when they would arrive** at your home? **Never, Sometimes, Usually, Always**
- **Q8.** In the last 2 months of care, how often did home health staff from this agency **explain things** in a way that was easy to understand? **Never, Sometimes, Usually, Always**
- **Q9.** In the last 2 months of care, how often did home health staff from this agency **listen carefully** to you? **Never, Sometimes, Usually, Always**
- **Q12.** In the last 2 months of care, did home health staff from this agency **provide your family or friends with information or instructions** about your care as much as you wanted? **Yes, No, I don't know, I did not want or need this**
- **Q16.** When you contacted this agency's office, did you get the help or advice you needed? **Yes, No**

17

Communication - Question 5

Q5. In the last 2 months of care, how often did home health staff from this agency keep you informed about **when they would arrive** at your home? **Never, Sometimes, Usually, Always**

What is the agency policy about visit times and days in the patients' homes?

- Do clinicians call the night before, morning of?
- Is it a blanket policy so that all are on the same page?
- What happens when staff are on vacation?
- Is contact made if the day falls apart and you are going to be late to the patient's home?

18

Communication – Question 8

Q8. In the last 2 months of care, how often did home health staff from this agency **explain things** in a way that was easy to understand? **Never, Sometimes, Usually, Always**

Throughout care, periodically reinforce the goals of the home healthcare services, and actively associate all care provided to the patient’s diagnosis.

- Is there education happening with staff regarding communication in NON-MEDICAL terms to assist the patient in understanding?
- Example: Instead of just saying we are going to work on your gait - - We are going to work on the coordinated movement, involving your feet, legs, and arms, that comes into play when you walk. In short, it’s how you walk.
- Use changes in patient condition as an opportunity to establish new goals and objectives, and to reinforce education about the patient’s condition, and how the services provided will address and improve patient desired goals.

19

Communication – Question 9

Q9. In the last 2 months of care, how often did home health staff from this agency **listen carefully** to you? **Never, Sometimes, Usually, Always**

Employ subtle cues to convey attentive listening. Body language is a powerful indicator of whether someone is listening. Sit nearby and face the speaker to demonstrate listening. Maintain an open posture, and refrain from crossing your arms (which can often signal to the speaker that you are closed off or dismissive). Make eye contact, nod your head as appropriate, and emulate the speaker’s emotional intensity with your expressions. Periodically repeat or summarize the speaker’s communication to further signal that you are listening and understanding the information being expressed.

Remain present when listening to the patient/caregiver:

- Eliminate outside distractions (e.g., phone, alarms, computer screen, and patient charts).
- Extend undivided attention to the speaker, particularly during the first moments of the visit when patients and caregivers are likely to provide key information upfront.

20

Communication – Question 12 (NEW 2026)

Q12. In the last 2 months of care, did home health staff from this agency **provide your family or friends with information or instructions** about your care as much as you wanted? **Yes, No, I don’t know, I did not want or need this**

- Are you training staff to identify new caregivers or family members that may need information to care for the patient in between visits.
 - Wound care
 - Home exercise program
- 2nd part of this question – AS MUCH AS YOU WANTED – ensure staff are clear about who the patient WANTS them to share information about the patient’s health

21

Communication – Question 16

Q16. When you contacted this agency's office, did you get the help or advice you needed? **Yes, No**

- Provide agency contact information to patients in several formats and at various times.
- Ensure patient phone calls are prioritized based on urgency, and forwarded to the appropriate staff member as needed.
- Follow up with patients and families at a later time to confirm appropriate help was provided.
- Establish a set of structured agency standards for responding to patient/caregiver requests, and ensure agency-wide training is provided (and not limited only to staff members responsible for answering phone calls).

22

HHCAHPS – Measures

Talk About Home Safety (Q2)

Q2. When you first started getting home health care from this agency, did someone from the agency talk about **ways to help make your home safer**? For example, they may have suggested adding grab bars in the shower or removing tripping hazards. **Yes, No, I don't know, I did not need help with home safety**

- Establish clear and thorough organizational standards around home safety, and provide ongoing staff training on expectations.
- Provide home safety evaluations routinely at the Start of Care and notify patients of any recommendations to improve home safety.
- Administer follow-up safety inspections throughout care to ensure home conditions remain safe.
- Following home safety evaluations, provide a copy of key findings to the patient, and leave a copy in the home.

23

HHCAHPS – Measures

Review Medicines (Q3)

Q3. Has someone from the agency ever **reviewed the prescribed and over-the-counter medicines** you were taking? For example, they might have asked you to show them your medicines and talked with you about how and when to take each one. **Yes, No, I don't know, I don't take any medicines**

- Ensure clinicians always request and discuss patient medications at Start of Care, Resumption of Care, and Transfers
- Reassess patient medications on each visit, and address any changes as needed.
- Use teaching aids liberally and leave instructional resources in patient homes.

24


HHCAPHS – Measures

Talk About Medicine Side Effects (Q4)


- **Q4.** In the last 2 months of care, did home health staff from this agency talk with you about any **side effects** of your medicines? **Yes, No, I don't know, I don't take any medicines**
 - Reassess patient medications on each visit to ensure continued effectiveness and sustained progress toward treatment goals.
 - Identify and address any need to change medications, allowing patient input to help direct the decision-making process for medication changes.
 - Use teaching tools (e.g., teach-back) to verify patients' understanding of medication purposes and engage patients in ongoing discussions on medication to ensure critical information is retained throughout care.
 - Discuss the benefits *and risks* (e.g., side effects and residual symptoms) of each medication so patients have a holistic understanding of their medicines and can make informed healthcare decisions.

25

HHCAPHS – MEASURES

 **Overall rating of home health care/Overall Rating**

"Using any number from 0–10, where 0 is the worst home health care possible, and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?"

 **Willingness to recommend the agency/Willing to Recommend**

"Would you recommend this agency to your family and friends if they needed home health care?"

26

Care Points					
Measure	Sufficient Data for Measure Inclusion?	Your HHA's Achievement Points	Your HHA's Improvement Points	Your HHA's Care Points [a]	Your HHA's Percentile Ranking Within Your HHA's Cohort [b]
OASIS-based Measures					
Discharge Function (DC Function)	Yes	0.000	0.000	0.000	<25
Improvement in Dyspnea	Yes	4.903	6.102	6.102	60-74
Improvement in Management of Oral Medications	Yes	4.686	4.495	4.686	
Claims-based Measures					
Discharge to Community – Post Acute Care (DTC-PAC)	Yes	3.946	0.000	3.946	
Potentially Preventable Hospitalizations (PPH)	Yes	0.000	0.000	0.000	
HHCAPHS Survey-based Measures					
Care of Patients	Yes	0.000	0.732	0.732	25-49
Communications Between Providers and Patients	Yes	0.000	0.730	0.730	25-49
Specific Care Issues	Yes	0.000	0.000	0.000	<25
Overall Rating of Home Health Care	Yes	0.000	2.029	2.029	50-74
Willingness to Recommend the Agency	Yes	0.000	3.038	3.038	50-74
Number of Measures Included	10		Summed Care Points:	21.863	25-49

Less than 51%
Should be focus!

27

TABLE 34—CY 2025 AND ~~2026~~ INDIVIDUAL MEASURE WEIGHTS AND CATEGORY WEIGHTS FOR THE EXPANDED HHVBP MODEL

Measure	CY 2025 Measure Weights		Weights	
	Larger-Volume Cohort	Smaller-Volume Cohort	Larger-Volume Cohort	Smaller-Volume Cohort
Improvement in Dyspnea	6.00%	8.57%	7.00%	8.75%
Improvement in Management of Oral Medications	9.00%	12.86%	11.00%	13.75%
Discharge Function Score (DC Function)	20.00%	28.57%	15.00%	18.75%
Improvement in Bathing	-	-	3.50%	4.38%
Improvement in Upper Body Dressing	-	-	1.75%	2.19%
Improvement in Lower Body Dressing	-	-	1.75%	2.19%
Sum of OASIS-based Measures	35.00%	50.00%	40.00%	50.00%
Home Health within-stay Potentially Preventable Hospitalization (PPH)	26.00%	37.14%	15.00%	18.75%
Discharge to Community – Post Acute Care (DTC-PAC)	9.00%	12.86%	15.00%	18.75%
Medicare Spending Per Beneficiary, Post-Acute Care (MSPB-PAC)	-	-	10.00%	12.50%
Sum of Claims-based measures	35.00%	50.00%	40.00%	50.00%
Care of Patients	6.00%	0.00%	-	-
Communication Between Providers and Patients	6.00%	0.00%	-	-
Specific Care Issues	6.00%	0.00%	-	-
Overall Rating of Home Health Care	6.00%	0.00%	10.00%	0.00%
Willingness to Recommend the Agency	6.00%	0.00%	10.00%	0.00%
Sum of HHC AHPs Survey-based measures	30.00%	0.00%	20.00%	0.00%
Sum of All Measures	100.00%	100.00%	100.00%	100.00%

28

OASIS & HHVBP

Exhibit 6. Payers Included in the Expanded HHVBP Model

Measure Category	Payer			
	Medicare FFS	Medicare Advantage	Medicaid FFS	Medicaid Managed Care
OASIS-based*	X	X	X	X
Claims-based	X			
HHC AHPs Survey-based	X	X	X	X

* Although HHAs are required to collect and submit OASIS data on all patients, regardless of payer effective 7/1/2025 (with a voluntary phase-in period of 1/1/2025 – 6/30/2025), the OASIS-based quality measures in the expanded HHVBP Model will continue to report only data for Medicare FFS, Medicare Advantage (Medicare managed care), Medicaid, and Medicaid managed care. CMS will monitor the all-payer OASIS data and will notify providers when decisions are made for future uses for quality or payment purposes, including if, when or how non-Medicare/non-Medicaid OASIS data will be used for the expanded HHVBP Model.

2026 Annual Conference & Expo

29

Improving HHCAHPS Results

Tip #1: Define HHCAHPS Goals, Expectations and Responsibilities

- Define your expectations for staff members and set goals based on the measures. Incorporate these measures into score cards and utilize new industry benchmarks to measure your progress.
 - This can be done for the HHCAHPS Star Rating as well as HHVBP

Tip #2: Utilize a Team Approach

- Assign a team/individual to oversee the HHCAHPS program. The team is responsible for assessing staff education needs, facilitating staff training and instituting a culture within your organization that focuses on patient outcomes.
 - This person should be the one or assigns someone to conducts surveys of your own, follow up with patients and caregivers after complaints, etc.

Tip #3: Educate ALL Staff

- Educate the entire agency, especially field staff teams, on the HHCAHPS survey and reports. Make sure they understand what the patient is being asked to rate and incorporate actual survey language into their daily communications with patients.

30

Improving HHCAHPS Results

Tip #4: Educate Patients/Caregivers

- Advise patients that they may receive a survey in the mail. Tell them that you value their feedback and cite examples of how your agency has utilized patient feedback in the past to improve quality of care to patients.
 - This should be stressed upon Admission, every recert at a minimum and at discharge. This should also be stressed if you do conduct your own surveys.
 - Make sure to let the note how the survey will be delivered...phone, mail, etc.

Tip #5: Evaluate Procedures

- Evaluate how your current policies and procedures relate to your results on the HHCAHPS measures. Create or refine policies to address needed improvements and raise HHCAHPS scores.
 - Examples might include: Policy that everyone follows for notifying patients when you will arrive. Developing a strict policy on how and when complaint calls are handled.

Tip #6: Keep Track of Reported Scores

- Utilize HHCAHPS Star Ratings & HHVBP Scores to focus on your publicly reported scores, and continually strive to improve these scores. Also, monitor any reports from HHCAHPS vendor that processes your surveys

31



32

Thank You!
Melinda A. Gaboury, COS-C
Chief Executive Officer

Healthcare Provider Solutions, Inc.
 402 BNA Drive, Suite 212
 Nashville, TN 37217

615.399.7499
 info@healthcareprovidersolutions.com

© 2026 California Association for Health Services at Home

33