Star Ratings and Outcomes

Annette Lee RN, MS, HCS-D, COS-C
Zuzana Ton, MHSA

Day 2-Session 1
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Summer 2023

How Your Agency Is Measured

- HHAs have been measured by their “Five star rating” since 2015
  - Comprised of “Outcomes per OASIS”, “Rehospitalizations from Claims” and a “Process Measure” from your operations/OASIS coding
- Payers/contracts/referral sources are paying attention
- Hospitals are highly incentivized to reduce rehospitalizations
  - Home Health agencies can be seen as a partner in reducing returns
  - Hospitals also avoided by increasing outpatient billing of “observation”, which falsely also brought down HHA’s scores
  - Potentially Preventable Hospitalization rates for 2023 WILL include observation!

How CMS Sees Us

- Five Star rating
- Rehospitalizations/ED/PPH
- PEPPER- claims based utilization and reimbursement data
- Claims- PDGM
- HHVBP- In our first “recital year”- where our data matters!

- Many of these views overlap… (what’s important to CMS)

Tool Included!

Review the Data…

- WHY do our patients return to the hospital?
  - Specific disease trends?
  - Inadequate education/management of expectations?
  - Provider tells them to go to ER as the “easy” route
- WHEN do our patients return to the hospital?
  - Trend in day of week? Time of day?
  - Within first five days? 30 days? 60 days?

Acute Care Hospitalization (Claims-based)

Consumer Lang.	How often home health patients had to be admitted to the hospital while under care of the home health team.
Type	Outcome Measure – Utilization
Measure Description	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.
Numerator	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay.
Numerator Exclusions	Planned hospitalizations (Based on AHRQ Procedure and Condition Clinical Classifications Software as well as other sets of ICD procedure codes.)
Denominator	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Denominator Exclusions	Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. Home health stays in which the patient receives service from multiple agencies during the first 60 days. Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to and the 60 days following the start of the home health stay or until death.
OASIS Items Used	**NONE** -- based on Medicare FFS claims

How Does an Episode Get Included?

Measure: Acute Care Hospitalization – Claims-based

- No OASIS items influence ACH rate for HHC or Star Rating ---rate comes ***only*** from hospital claims for **Medicare FFS** patients!

- ***Planned*** hospitalizations are **excluded** by condition and procedure codes on the hospital claim.

How Did My Agency Do?

Measure: Acute Care Hospitalization – Claims-based

	Your HH Score	National Average
How often home health patients had to be admitted to the hospital	_____%	_14.2_%

Could This Be as Simple as Case Management?

- Case managers are not just a task- oriented visit nurse
  - Knows the patients
  - Notes subtle symptoms
  - Communicates routinely with patient/family/physician's office
  - Anticipates needs
    - What would provide control in this patient's situation?
      - PRN orders for visits?
      - PRN medication for uptick in s/s?
      - Green/yellow/red tools?
      - Telephone check-ins for at risk

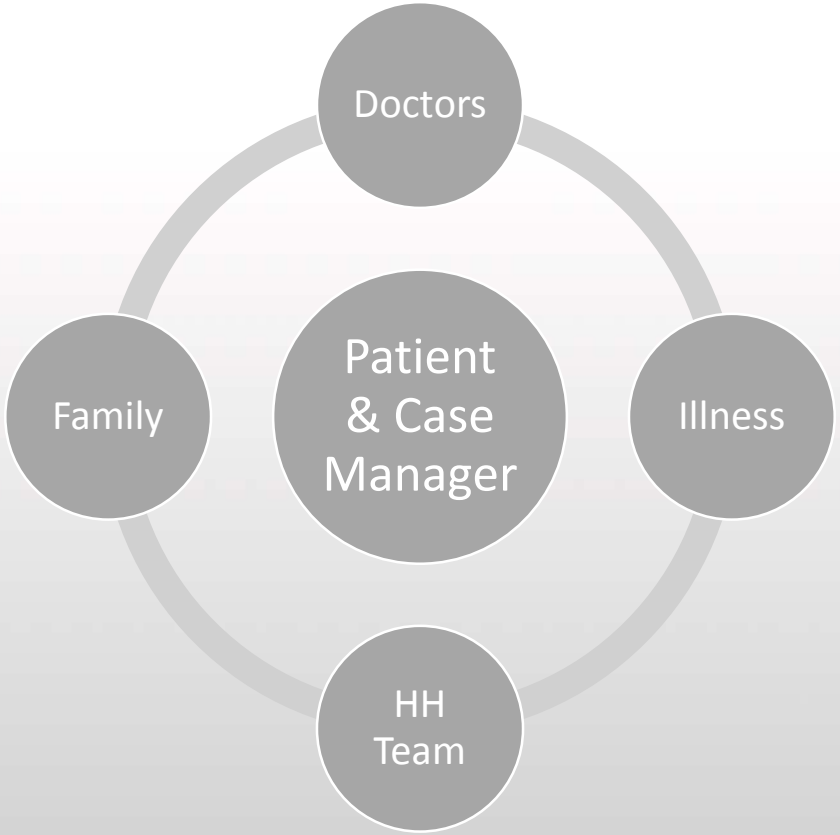
Awareness is First Step

- Thoughts?
- Can you identify top patients that you feel may be at risk currently?
  - How did you identify them?
    - Gut feeling
    - Leverage technology
    - Standardized hospitalization risk assessment
  - What are you currently doing?
  - What could be next steps?

What is Case Management?

- Per the “Case Manager Society of America”:
  - Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes
- In home health, you are the “Go-to”
  - Guiding, directing care in harmony with Doctor and patient
  - Provides oversight to efficiently and effectively care for patient
  - Health coach

Yes, You're in the Middle!



Role of Case Manager (CM)

- Can be RN or professional therapist
  - Up to agency if therapist can manage own case, or if RN remains involved
- Directs and advocates for appropriate care/services
- ACTIVELY oversees plan
  - Makes changes as appropriate
  - Keeps everyone “in the loop”

  - NAME ONE DIFFICULTY/BARRIER and ONE SUCCESS/HINT!
  - _____
  - _____

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

So, How Do We Do It Best?

Managing Caseload

- Step 1: Know your patients
  - Working knowledge of disease processes, skilled need
  - Specific needs, disciplines involved
  - If visits delegated, know by whom/when patient seen
  - Managing Barriers to care

Managing Caseload

- Step 2: Know your own organizational style
  - Electronic (24 hr access)
  - Must know:
    - Current status of POC and current orders
    - Current med list
    - Emergency plan, numbers
    - Dr. and pharmacy info

Managing Caseload

- Step 3: Own the Calendar of Events
  - Each patient has 60-day calendar- and most have 30-day billing
  - Know who is seeing patient and when
  - Reduce multiple disciplines on same day visits
  - If need to be available for admits, inform scheduler of patients who can be moved, or should not be
  - AGENCY is responsible at the end of day and must know each of their current schedules

Managing Caseload

- Step 4: Being prepared with supplies
  - Maintain forms (if paper is used), such as HHCCNs, ABNs, Notice of Non-Coverage, HHA plan of care and med profiles
  - Keep frequently used medical supplies, such as gauze, tape, wound cleanser- but be sure to charge/document when used!
  - Be sure patient has supplies needed for care- whether it is Medicare and the agency supplies, or other insurance and we facilitate!

Managing Caseload

- Step 5: Case Conferences /Staffing (HOW do YOU do it?)
  - Discuss (re)assessments for best data
    - Collaboration Encouraged! ☺
  - Ongoing appropriateness and utilization for each patient
    - Mindful of patient needs first- payer second!
  - Evaluate status, plan, changes
  - Collaboration/continuity of care
  - Progress towards goals
  - Use disease management programs (if available)

  - **Note– the “phone rings both ways”

Managing Caseload

- Step 6: Effective communicator and documenter
  - Clearly give report of patient status, needs and specific POC tasks to those visiting your patient
  - Each visit should have an intended purpose/goal
  - Document in the home- don’t have to bother later!
  - Communicating all changes to physician- proactively
  - OASIS ACCURACY! ☺
- Step 7: Professional development
  - Read regulations for yourself
  - Stay updated- Ask questions
  - Share with others- be a mentor

Aspects of CM : Clinical

- Holistic care plan, based on assessments and other discipline's evaluations
- Collaborate with physician
- Prevent duplication of services or times
- Care conference after admission and ongoing
  - Current assessment/problems
  - Goals
  - Anticipated frequency/duration of each service
  - Payer
  - Barriers- environment, attitudes, caregivers, psychosocial

Aspects of CM: Utilization/Delegation

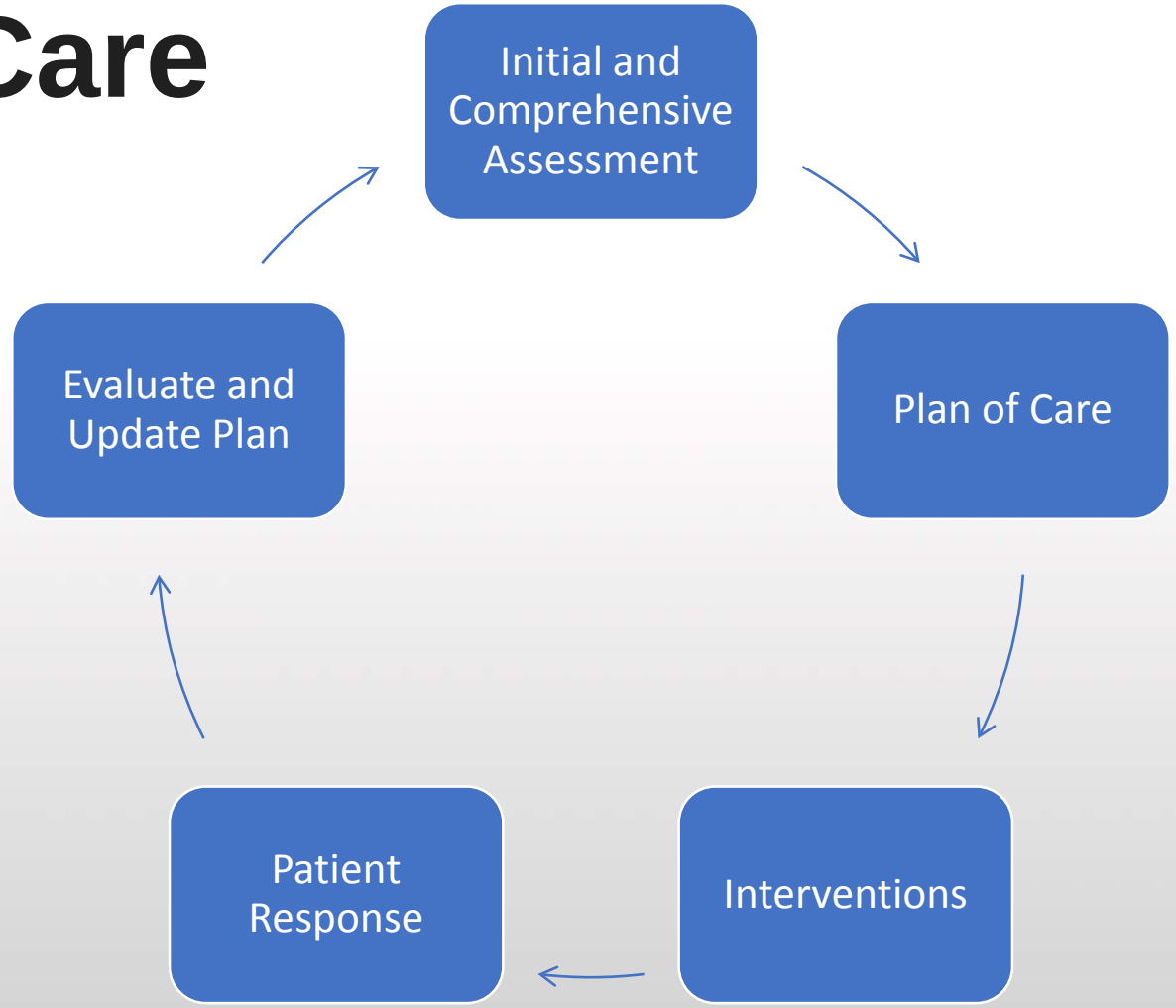
- Keeping top of mind: first patient needs, second: all monies for care comes from one “Medicare Bucket”
    - Ensure each visit does have that purpose- no fluff
- Don’t get stuck in a standardized visit frequency
    - FRONT LOAD!!!
- Ensure proper documentation of supervision
    - Every 30 days for therapy assistants
    - Every two weeks for HHA

Aspects of CM: Orders/Supplies

- Ultimately CM's responsibility for all orders
  - Other disciplines can obtain
- Ensuring authorization, if necessary

- CM will also ensure supplies are in home, and ordered regularly to ensure POC can be carried out

Cycle of Care



Case Management Must be Taught!

Case Management Process Competency Worksheet

Activities	Preceptor Responsibilities	Date Assessed	Date Complete
Patient Management Visit Activities			
✓ Performs admission visit or evaluates content of admission visit completed by others for appropriateness. ✓ Evaluates comprehensive assessment data and assures appropriate development of individualized plan of care. ✓ If visits are to be delegated, assures appropriately qualified clinicians are assigned.	**Discuss/Demonstrate:** • Use this time to evaluate and answer questions related to the admission process **Evaluate:** • Ability to perform/evaluate comprehensive assessment and develop/assure appropriate care plan development		
Clinical Management			
✓ Obtains report of other discipline evaluations and plans of care ✓ Coordinates interdisciplinary care to assure effective care delivery ✓ Evaluates holistic care plan with all disciplines to assure appropriate treatment for goal attainment taking into consideration learning style, cognitive abilities, environment, and potential barriers ✓ Assures compliance with all applicable State and Federal Regulations ✓ Utilizes Disease State Management Programs when applicable ✓ Routinely evaluates status of goal attainment and adjusts care plans accordingly ✓ Provides appropriate supervision	**Discuss:** • Case Manager's responsibility for developing/oversight of interdisciplinary plan of care development and implementation • Effective use of Disease Management Programs • Regulations pertaining to supervision **Demonstrate:** • Application of above concepts in development of appropriate plans of care • Incorporation of other discipline findings and collaboration with other disciplines for effective care		

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The OASIS DATA

What is the Five Star Rating?

- Amazon?
  - You give 5 star, friends give 5 star
- Uber?
  - All want a five star!!
  - All have potential to get 5!

Quality Measures Used for Star Rating

- **Process Measures:**
- Timely Initiation of Care

- **Utilization Measure**
- Rehospitalization (CLAIMS based- Medicare only)

NOTE: hospitalizations are evenly weighed in the star rating- but make up 26% of total HHVBP score!

- **"End Result" Outcome Measures (must have Discharge to obtain):**
- Improvement in Ambulation
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Shortness of Breath
- Management of Oral Meds

How to IMPACT Your Scores

- Know the CMS guidance on the items
- Know the CMS guidance on the items that impact risk adjustment
- Train on thorough assessment techniques
- Audit for appropriate responses
- Leverage technology (such as SHP)
  - Drill down to areas where there are gaps
  - Drill down to specific clinicians who are lagging
  - Reward for accuracy and outcomes

Timely Initiation of Care

Consumer Language	How often patients are seen for their start of care or resumption of care assessments on the date specified by the physician or within two days of the referral date or inpatient discharge date.
Type	Process Measure – Timely Care
Measure Description	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician specified date or within two days of the referral date or inpatient discharge date, whichever is later.
Numerator	Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within two days of the referral date or inpatient discharge date, whichever is later. For a resumption of care, per the Medicare Conditions of Participation, the patient must be seen within two days of inpatient discharge, even if the physician specifies a later date.
Denominator	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	None
OASIS Items Used	M0030 Start of Care Date or M0032 Resumption of Care Date M0100 Reason for Assessment M0102 Date of Physician-ordered Start of Care M0104 Date of Referral M1000 Inpatient Facility Discharge M1005 Inpatient Discharge Date

What Do We Need to Succeed?

Measure: Timely Initiation of Care

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

=

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
__ __/__ __/__ __ __ __
month / day / year

OR

NA –No specific SOC date ordered by physician

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

< +2 days

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
__ __/__ __/__ __ __ __
month / day / year

OR

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

< +2 days

(M1005) Inpatient Discharge Date (most recent):
__ __/__ __/__ __ __ __ UK - Unknown
month / day / year

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How Do We Miss The Mark?

Measure: Timely Initiation of Care

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

≠

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.
__ __/__ __/__ __ __ __
month / day / year
NA –No specific SOC date ordered by physician

OR

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

> +2 days

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
__ __/__ __/__ __ __ __
month / day / year

OR

(M0030) Start of Care Date:
__ __/__ __/__ __ __ __
month / day / year

(M0032) Resumption of Care Date:
__ __/__ __/__ __ __ __
month / day / year

> +2 days

(M1005) Inpatient Discharge Date (most recent):
__ __/__ __/__ __ __ __ UK - Unknown
month / day / year

How Did My Agency Do?

Measure: Timely Initiation of Care

	Your HH Score	National Average
How often the home health team began their patients' care in a timely manner	_____%	_95.7__%

Improvement in Dyspnea

Consumer Language	How often patients' breathing improved.
Type	End Result Outcome Measure
Measure Description	Percentage of home health episodes of care during which the patient became less short of breath or dyspneic.
Numerator	Number of episodes of care where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.
Denominator	Number of episodes of care ending with a discharge during the reporting period other than those covered by generic or measure-specific exclusions.
Exclusions	Home health episodes of care for which the patient, at SOC/ROC, was not short of breath at any time, episodes that end with inpatient facility transfer or death.
OASIS Items Used	(M1400) When is the patient dyspneic?

M1400 Dyspnea

OASIS ITEM
(M1400) When is the patient dyspneic or noticeably Short of Breath? 0 - Patient is not short of breath 1 - When walking more than 20 feet, climbing stairs 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation 4 - At rest (during day or night)
SOC/ROC & DC

LEVEL OF EXERTION/ACTIVITY CAUSING DYSPNEA OR SOB

- Report what's true on the day of assessment
  - Observe if patient is noticeably SOB + Interview re prior 24 hours
- Use of oxygen
- Examples are not finite

How Did My Agency Do?

Measure: Improvement in Dyspnea

	Your HH Score	National Average
How often patients' breathing improved	_____%	_82.8 %

Improvement in Bathing

Consumer Language	How often patients got better at bathing.
Type	Outcome Measure – End Result
Measure Description	Percentage of home health episodes of care during which the patient got better at bathing self.
Numerator	Number of home health episodes of care where the value recorded on the Discharge assessment indicates less impairment in bathing at Discharge than at Start (Resumption) of Care.
Denominator	Number of home health episodes of care ending with a Discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	Home health episodes of care for which the patient, at Start/Resumption of Care, was able to bath self independently, episodes that end with inpatient facility transfer or death, or patient is nonresponsive.
OASIS Items Used	(M1830) Bathing (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

M1830 - Bathing

OASIS ITEM
(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).** 0-Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1-With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2-Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3-Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4-Unable to use the shower or tub, but able to bath self independently with or without the use of devices at the sink, in chair, or on commode. 5- Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6-Unable to participate effectively in bathing and is bathed totally by another person. SOC/ROC & DC

M1830 - Bathing

- **Focus on Ability to Access the Tub/Shower, Transfer In and Out, and Bathe the Entire Body Once the Needed Items Are Within Reach.**
  - What's INCLUDED
  - Any environmental barriers?
  - Patient barriers? Fear included!
  - Safety ALWAYS at root of response!
  - Look at cognitive status, balance, ROM, pain, dyspnea, type of bath, etc

- **Medical Restrictions** impacting OASIS-included bathing tasks are considered
  - Order "Do not get into tub" impacts ability to bathe in tub
  - Order "Keep cast dry" may impact ability

How Did My Agency Do?

Measure: Improvement in Bathing

	Your HH Score	National Average
How often patients got better at bathing	____%	_82.3%

NOTE! For five-star, the agency only needs to improve by one level- and wll show a positive rating. In HHVBP, the M1800s are tallied by “total normalized changes”- and takes into account how MUCH did the patient improve (or decline).
SOC/ROC “0” are included in HHVBP, in case of decline.

Improvement in Bed Transferring

Consumer Language	How often patients got better at getting in and out of bed.
Type	Outcome Measure – End Result
Measure Description	Percentage of home health episodes of care during which the patient improved in ability to get in and out of bed.
Numerator	Number of home health episodes of care where the value recorded on the Discharge assessment indicates less impairment in bed transferring at Discharge than at Start (Resumption) of Care.
Denominator	Number of home health episodes of care ending with a Discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	Home health episodes of care for which the patient, at Start/Resumption of Care, was able to transfer independently, episodes that end with inpatient facility transfer or death or patient is nonresponsive.
OASIS Items Used	(M1850) Transferring (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

M1850 – Bed Transferring

OASIS ITEM
(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. 0 - Able to independently transfer. 1 - Able to transfer with minimal human assistance or with use of an assistive device. 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 - Bedfast, unable to transfer but is able to turn and position self in bed. 5 - Bedfast, unable to transfer and is unable to turn and position self. SOC/ROC & DC

M1850 – Bed Transferring

- **Response 1** means patient can transfer safely with minimal human assistance **OR** with the use of an assistive device
- **Response 2** appropriate if:
  - Unsafe with just minimal human assistance OR
  - Unsafe transferring while just using an assistive device OR
  - Requires BOTH
- Minimal human assistance could include any combination of verbal cueing, environmental set-up, and or actual hands-on assistance- but must be LESS than 25% of total work!

How Did My Agency Do?

Measure: Improvement in Bed Transferring

	Your HH Score	National Average
How often patients got better at getting in and out of bed	_____%	81.1_%

Improvement in Ambulation/Locomotion

Consumer Language	How often patients got better at walking or moving around.
Type	Outcome Measure – End Result
Measure Description	Percentage of home health episodes during which the patient improved in ability to ambulate.
Numerator	Number of home health episodes of care where the value recorded on the Discharge assessment indicates less impairment in ambulation/locomotion at Discharge than at SOC/ROC
Denominator	Number of home health episodes of care ending with a Discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	Home health episodes of care for which the patient, at Start/Resumption of Care, was able to ambulate independently, episodes that end with inpatient facility transfer or death or patient is nonresponsive.
OASIS Items Used	(M1860) Ambulation/Locomotion (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

M1860 – Ambulation/Locomotion

OASIS ITEM
(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. 0-Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (for example, needs no human assistance or assistive device). 1-With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2-Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3-Able to walk only with the supervision or assistance of another person at all times. 4-Chairfast, unable to ambulate but is able to wheel self independently. 5-Chairfast, unable to ambulate and is unable to wheel self. 6-Bedfast, unable to ambulate or be up in a chair SOC/ROC & DC

M1860 – Ambulation/Locomotion

Response 0 =
No assistive device AND
No human assistance

NO human assistance needed

Response 1 =
One-handed device AND
No human assistance

Response 2 =
Two-handed device AND/OR
intermittent human assistance

Response 3 =
Continuous human assistance OR
supervision at all times

How Did My Agency Do?

Measure: Improvement in Ambulation/Locomotion

	Your HH Score	National Average
How often patients got better at walking or moving around	_____%	79.6 %

M2020 Management of Oral Medications:

ACCESS Matters!

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**	
Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.

How Did My Agency Do?

Measure: Improvement in Management of Oral Meds

	Your HH Score	National Average
How often patients got better at walking or moving around	_____%	_75_%

Star Ratings: Key Resources

- **Home Health Star Ratings webpage:**
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html
- **CMS Star Rating Help Desk:**
  - HomeHealthQualityQuestions@cms.hhs.gov
- **Care Compare website:**
  - www.medicare.gov/care-compare
- **Home Health Quality Measures Tables, OBQI/OBQM/PBQI Manuals, Risk Adjustment Models:**
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html

What’s the Big Deal?

Impact of Case Manager

- HHCAHPS: Healthier, happier patients and agency
- Decreased after hour calls
- Increased efficiency of services- Services with a plan
  - Not just “checking in”
- Increased compliance with Conditions of Participation*
- Decreased emergent care use*
- Decreased re-hospitalizations*
- May improve OBQI and decrease all Potentially Avoidable Events*

Remember Joe?

- Do you think he is at high risk for rehospitalization?
- Where do you think we have opportunity for Joe to avoid hospitalization?
  - The tried and true- stoplight teaching tools, call first, etc.
  - Effective DRR- assess/teach correct use of current medications or need for change in meds
  - Address anxiety related to shortness of air and health
  - Therapies to increase activity tolerance
  - Need to be able to treat change in symptoms autonomously, such as PRN diuretic, additional nebulizers/inhalers, ensure proper mechanical use of inhalers

Remember Joe?

- Where do you think our biggest risks would be with Joe related to satisfaction?
  - Remember the anxiety related to shortness of air and any chronic, progressive disease related to loss of control

Where Do You Stand?

- What are your scores? Gaps?
- Are you using QAPI to aide in improvement?

Hospitalization PIP Example

Agency ABC Performance Improvement
Reducing Re-Hospitalizations 2022

Problem(s):

- Increased utilization rate of emergency department and hospitals
- Agency is rarely notified by patient/family before going to emergency department with non-life threatening events.
- Patient/family reinforcement education is inconsistent as to who, when, and how to call agency vs. 911.
- Noted increase of rehospitalizations over weekends

Data Source: Home Health Compare and Five Star Preview Reports

Baseline Data Results: Hospitalization Rate is **14.7, in the Five star preview, 11/21, up two percent from the last time CMS provided the data or ACH prior to COVID-19**

Expected Outcome: Decrease number of episodes ending in hospitalization to 13.7 as of July 2022 as evidenced by risk-adjusted ACH Rate on CMS Five Star Preview Reports

Interventions:

- Ensure all patients understand the availability of ABC County on weekends and eveningsand how to reach our staff. Consider Test call at SOC
- Provide a Call Me First Poster to every patient.
- Instruct all staff including on-call staff on how to use the poster and reinforce it on every visit by every discipline.
- Call high-risk patients on Fridays to ensure
- Anticipate specific needs and request PRN visits upfront
- Focus on increased medical management of chronic diseases with teaching, tools, PRN medications, etc.

Barriers:

- Process to get printed copies of the Call Me First poster to staff for new and existing patients (initially and ongoing)
- Established habits by some patient population to go to ER for routine health care needs

PDSA Cycle:

STAGE	ACTIONS
PLAN:	• Customize the Call Me First Poster ○ Agency logo, phone number, etc.

DO:	• Select one champion to test Call Me First Poster with five patients (existing or new)
	  ○ Provide education on purpose, how to use, ideas of where to place the poster in patient's home, etc.
	  ○ Gather feedback on the tool and ideas for patient/family education
	• Provide phone calls to all high risk patients on Fridays to ensure they know to call agency over weekend if needed
	• QA Peer review on all transfers to ensure all appropriate steps were taken to avoid rehospitalizations.

STUDY:	• Refine the Call Me First Poster with larger font size for Agency Phone Number
ACT:	• Test English version with five patients

Monitor Plan: Monitor Five Star preview reports data for reduction, increase, or plateau of the ACH rate over the next 12 months. [Note: Each PDSA cycle is unique, depending on the problem statement and the allowance of implementation and data lag time.]

Questions?

HOME HEALTH FUNDAMENTALS

KNOWLEDGE • EXPERTISE • COMMON SENSE

- **Annette Lee RN MS, HCS-D, COS-C**
- **Zuzana Ton, MHSA**

Contact Us

CALL US:
(561) 454-8121

EMAIL US:
heretohelp@homehealthfundamentals.com

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