Introduction to HHVBP and Clinician Impacts

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Home Health Fundamentals'
2023 Winter Workshop

HHVBP Overview

- History of the five-year pilot and what CMS saw as success with 141 million dollars saved in hospital and SNF stays in the nine pilot states.
- 2023 is the first “performance year”- where data that is already provided to CMS through OASIS, claims and HHCAHPS will be captured from all agencies. (RECITAL!)
- The 2023 data will be analyzed, and every agency will have a financial impact- **up to 5% positive or negative on all Medicare payments in 2025.**
  - The analysis will allow points based on the national percentile, or on the individual agency’s improvement– *whichever is better*!
  - All data will be “risk adjusted”.
  - New Interim Performance Report for October 2023 is NOW available in iQIES
  - **The “improvement measure” baseline is 2022 data.**

What's Important? The Measures and Weights

Measure Category and TPS Weight	Quality Measures Within Category	Weight in Category
OASIS= 35% Total Performance	TNC Self Care	25%
	TNC Mobility	25%
	Dyspnea	16.67%
	Discharged to Community	16.67%
	Oral Medications	16.67%
CLAIMS= 35% Total Performance	Acute Care Admission	75%
	Emergency Department Use	25%
HHCAPS= 30% Total Performance	Professional Care	20%
	Communication	20%
	Team Discussion	20%
	Overall Rating	20%
	Willingness to Recommend	20%

The OASIS Measures

Domain	Title	Type	Source	Numerator	Denominator
Clinical Quality	Imp in Dyspnea	Outcome	M1400	Number of episodes of care where DC assessment shows less dyspnea at DC than at SOC	Number of episodes of care ending with a DC during the period
Communication and Care Coordination	Discharge to the Community	Outcome	M2420	Number of episodes where assessment completed at DC shows the patient remained in the community	Number of episodes of care ending with DC or transfer to i/p facility during the period
Patient Safety	Imp in Mgmt of Oral Meds	Outcome	M2020	Number of episodes of care where the value on the DC OASIS shows less impairment in taking oral meds than at the SOC	Number of episodes of care ending with a DC during the period

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The OASIS Composites

- ***The "normalized change" is based on the opportunities to improve- and then the actual improvement.
- This is the first time that agencies are seeing an impact to "How much" a patient improves vs just "improvement"

Domain	Title	Type	Source	Numerator	Denominator
Patient & Family Engagement	Composite Change in Mobility	Outcome (composite score)	M1840 M1850 M1860	Total normalized change in mobility functioning across 3 OASIS items (toilet transfers, transferring and ambulation)	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency
Patient & Family Engagement	Composite Change in Self Care	Outcome	M1800 M1810 M1820 M1830 M1845 M1870	Total normalized change in self care functioning across the 6 OASIS items (grooming, bathing, dressing, toilet hygiene and eating)	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency

Claims Based Measures: Cost Savings

Domain	Title	Type	Source	Numerator	Denominator
Efficiency & Cost Reduction	Acute Care Hosp – First 60 days of HH	Outcome	CCW – Claims	Number of stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the SOC	Number of stays that begin during the 12-month observation period. Stay is a sequence of payment periods separated from other payment periods by at least 60 days.
Efficiency & Cost Reduction	ED Use Without Hosp – First 60 days of HH	Outcome	CCW – Claims	Number of stays for patients who have a Medicare claim for outpatient ED use and no claims for hospitalization ion the 60 days following the SOC	Number of stays that begin during the 12-month observation period. Stay calculated the same as above

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HHCAHPS Measures: The "Other 30%"

"Patient and Caregiver Experience", consisting of questions from:

- Care of Patients/Professional Care
- Communications between Providers and Patients
- Specific Care Issues
- Overall Rating
- Willingness to Recommend

Measure	Score	National average	Maine average
How often the home health team gave care in a professional way	94% [11]	National average: 88%	Maine average: 91%
How well did the home health team communicate with patients	97% [11]	National average: 85%	Maine average: 89%
Did the home health team discuss medicines, pain, and home safety with patients	92% [11]	National average: 81%	Maine average: 84%
How do patients rate the overall care from the home health agency	91% [11]	National average: 84%	Maine average: 88%
Would patients recommend the home health agency to friends and family	96% [11]	National average: 77%	Maine average: 87%

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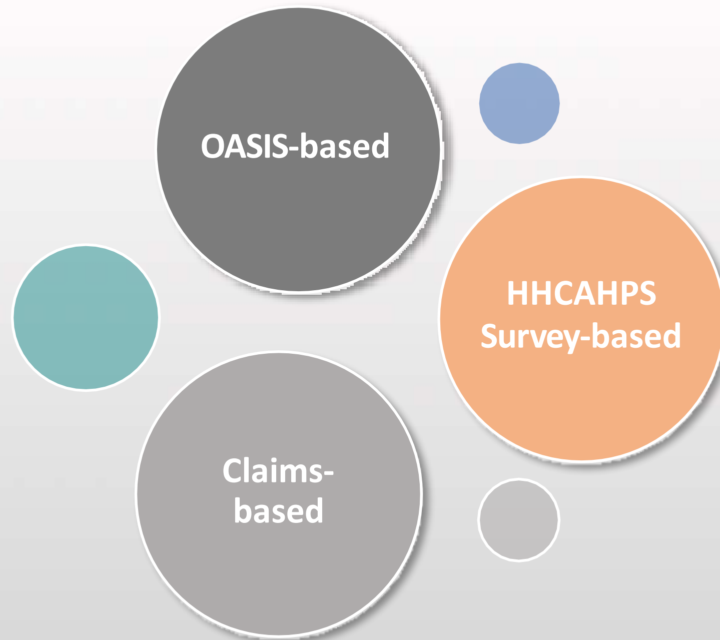
Submission of Quality Measure Data



- HHAs must electronically report all **OASIS data** collected in accordance with § 484.55, in order to meet the Medicare Conditions of Participation (CoPs), and as a condition for payment at § 484.205(c). HHAs submit the OASIS assessments in iQIES.
- HHAs are required to submit **HHCAHPS** survey measure data for HH QRP. HHAs are required to contract with an approved, independent HHCAHPS survey vendor to administer the HHCAHPS on its behalf (§ 484.245(b)(1)(iii)(B)).
- The **Acute Care Hospitalization (ACH)** and **Emergency Department (ED) Use** measures are derived from claims data submitted to CMS for payment purposes and do not require HHAs to submit additional data.

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Payers

- The HHVBP Model includes the following payers for each measure category:
  - **OASIS-based Measures**: Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid managed care
  - **Claims-based Measures**: Medicare FFS
  - **HHCAHPS Measure**: Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid managed care.

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Data Required for Quality Measures

- The calculation of a TPS requires sufficient measure data.

1. The minimum threshold of data an HHA must have per reporting period is the following for each measure category:

Measure Category	Threshold
OASIS-based	20 home health quality episodes
Claims-based	20 home health stays
HHCAHPS Survey-based	40 completed surveys

2. In addition, an HHA must have sufficient data to allow calculation of at least five (5) of the twelve (12) measures to calculate a TPS.

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Achievement Threshold & Benchmarks

Achievement Threshold

The median (50th percentile) of Medicare-certified HHAs' performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller-volume cohorts.

Benchmark

The mean of the top decile (90th percentile) of all HHAs' performance scores on the specified quality measure during the baseline year, calculated separately for the larger and smaller-volume cohorts.

Used to calculate both the achievement score and the improvement score.

- CMS will measure each agency's quality measure percentages against the rest of the cohort

- To have a positive outcome, the agency score must meet the "Achievement threshold", or 50th percentile
- To gain the full 10 points for the measure, the agency score must meet the "Benchmark", or 90th percentile

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Improvement Threshold

Improvement Threshold

An individual competing HHA's performance on an applicable measure during the HHA's baseline year.

- The HHA data will also be compared to the same agency's baseline data. The current baseline year is 2022 for improvement.
- Points will be awarded based on how much improvement has been made. The top points (90th percentile for improvement) will be awarded 9 points, instead of the 10 for achievement

* An HHA must have sufficient data to establish their HHA baseline year for a particular measure.

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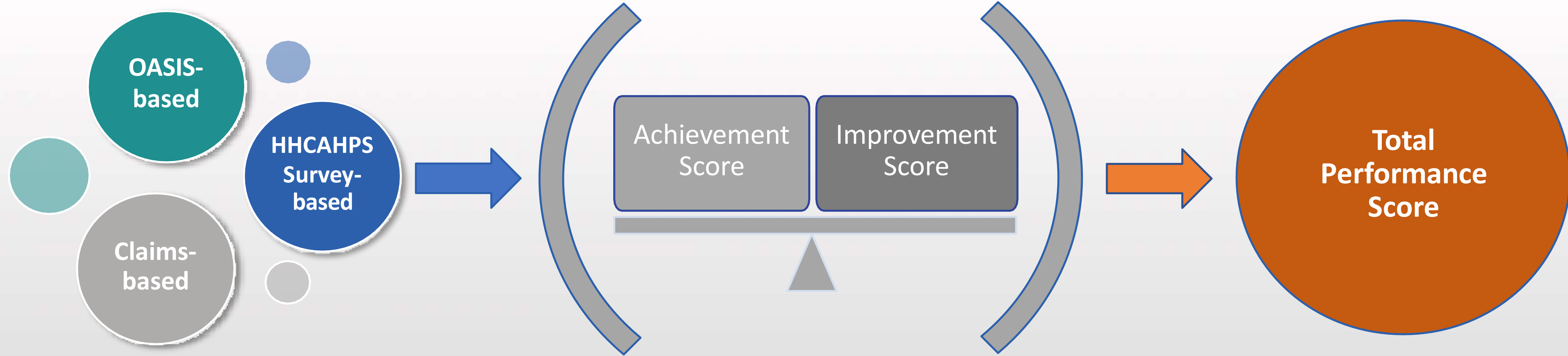
Total Performance Score (TPS)

- The numeric score awarded to each qualifying HHA based on the weighted sum of the performance scores for each applicable measure.
- A qualifying HHA will receive a numeric score ranging from zero (0) to one hundred (100).

Total Performance Scoring Methodology: Overview



Calculation of HHA performance score for each quality measure for a designated performance year.

The greater of achievement or improvement score for each applicable measure becomes points that are weighted and totaled.

The numeric score ranging from 0 to 100, awarded to each competing HHA based on its performance.

Lessons Learned from the Pilot States

WITH LOVE, FROM IOWA

What Got Measured, Did Improve!

- Low hanging fruit was the OASIS items
  - Coaching, standardization, QA standard with a focused approach, tandem visits with those who do the most SOC/ROC, and standard “expect improvement model” for the DC assessments
- Focus on reducing hospitalizations by intense disease management and case management skills
  - Anticipation of needs, providing tools, requesting PRN medications and visits upfront to plan for changes, adding telehealth, adding calls prior to weekends, ensure appropriate disciplines are in the home (therapies?)
  - By increasing function, medication management and symptoms like dyspnea, the patient improves in end result outcomes, in ACH/ED use, and their experience with HH- impacting HHCAHPS scores
- CAHPS- What is going well, what is not going well. Return rates? Specific care issues, such as meds? Focus training on customer service mindset- plus those areas that are lagging

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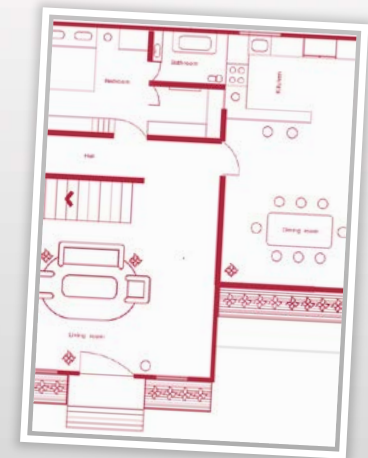
Running the OASIS Bases…

The comprehensive assessment must include the trifecta of:

- ❑Observation of some of the harder tasks
- ❑Interview about items that are patient reported, or patient experience, and regarding the timeframe allowed for this OASIS item prior to the visit
- ❑Third-party input- the caregiver, the medical record

- ❑A standardized approach in the home will increase accuracy:
  - ❑ Bed mobility
  - ❑ Clothes access
  - ❑ Bathing access
  - ❑ Toilet and grooming access
  - ❑ Where do you keep the medications



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Assessment to Data

- The OASIS scoring = the holistic assessment + application of CMS guidance “**protocols***”
  - This is DATA- not just assessment now!
  - May not always be “clinically intuitive”
- OASIS guidance will generally “funnel” you to the correct score to report
- Ensures interrater reliability makes the data MEANINGFUL
  - Avoid “Garbage in- Garbage out!”

CMS OASIS Data Protocols*- Timeframes

- Assessment timeframes
  - SOC=5 days, ROC=2 days, Recert= day 56-60, Other Follow up= 2 days, DC= 2 days
- Timeframe under consideration for OASIS items
  - Most are "Day of assessment"= last 24 hours and time in the home
  - Other timeframes are noted in the items "In the last 14 days", "Prior to the most recent illness, injury or exacerbation"
  - Multiple "Day of assessments" can occur within the assessment timeframe
    - RN visits on Monday- and includes Sunday/Monday as "day of assessment"
    - PT visits on Wednesday- and includes Tuesday/Wednesday "day of assessment"

Assessment: The Rollercoaster Patient Protocol: Usual Status

- If we review the last 24 hours for “day of assessment”, how do we score when the patient looks different at different times of day?
- OASIS doesn’t have a score for how safe the patient is, or their status in the morning, at noon, and at night- we have one chance to pick a response.
- PROTOCOL Convention: “Usual status”- when the patient’s ability/status varies over the timeframe under consideration- score what is true “most of the time”. This is NOT used for Medications, where the score is the most dependent status over 24 hours.

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Protocol: "Assistance" in OASIS

- PEOPLE POWER! Assistance is whenever the patient's safe ability depends on another person for support
- Not limited to touch/manual labor!
- Includes cues, stand by, contact guard, etc

- PRO TIP: If you find you are stepping in to ensure the patient is safe- you just intervened- and that "assistance" should be noted. The easiest way to assess how much assistance is needed to be safe is to ask the patient to perform (when appropriate) and insert yourself as needed. The interventions you provided are a direct answer to the question!
- PRO TIP#2: Remember to take note of all of your subtle cues/interventions! Home Health Nurses have SUPER POWERS you don't even take credit for!

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Protocol: Know the Items' Inclusions/Exclusions

- **M1830 Bathing**

- ☒ Includes washing the body
- and transferring in/out of tub/shower

☐ Excludes washing face & hands,

- and shampooing hair

- **GG0130E Shower/bathe self**

- ☒ Includes washing, rinsing and drying the body

☐ Excludes washing the back & hair and transferring in/out of tub/shower

How would we score the patient who needs stand-by assist to get into shower and hands-on assist to wash their back, but can safely wash/rinse and dry the rest of their body?

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Protocol- Report "Ability" vs "Performance"

- The OASIS Score is to be based on SAFE ABILITY. (Ability always implies safety was considered)
- Many patients perform beyond their ability – which is risky. Some perform below their ability.
- If a patient's safe ability is she/he can do a task with assist, but she/he doesn't have the caregiver to assist them– they may choose to perform above their ability- or not perform the task. The patient's innate ability did not change.
- If a physician orders a restriction- for example- bedrest– then the OASIS score, based on safe ability, is that the patient is bedfast- despite the patient ambulating to greet you at the door.

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Protocols for Grooming and Dressing

- Only consider what is “typical” for the patient
  - Don’t consider makeup or shaving if this isn’t typical. Don’t consider suspenders and buckles or lace up shoes if this isn’t “usual”.
  - Don’t only consider the PJs, or sweats, or MooMoo the patient is wearing now because she/he just got home from the hospital and is fatigued. This may not be their typical
  - If altering grooming or dressing temporarily for ease- assess what assist would be needed if doing/wearing the “typical items” (Page 337)
  - If altering grooming or dressing tasks long term- this is the assessed task
    - Grandpa only wore work boots or lace up dress shoes for years, never owning tennies
    - After CABG, Grandpa was advised to get Velcro tennies –which at first he despised (SOC)
    - Within a month, Grandpa swore off any other shoes except his Velcro tennies! (DC)
  - Consider EACH task as an individual “mini-OASIS” measure- and score EACH (mentally). Then review and determine, which score had the MAJORITY of responses
  - **Response “1”** is all about ACCESS. If the patient only needs you to provide access to water, grooming equipment used or clothes, but then is safe performing task- this is a “1”. **To provide ACCESS- you can take items to patient, or you can take patient to the items!**

Grooming M1800

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

0 Able to groom self unaided, with or without the use of assistive devices or adapted methods.

1 Grooming utensils must be placed within reach before able to complete grooming activities.

2 Someone must assist the patient to groom self.

3 Patient depends entirely upon someone else for grooming needs.

Majority Rule and Usual Status applies!

KEY:

GREEN: Independent/with Access Assist, but no "People Power" needed during task itself

ORANGE: Needs some assist (hands on/cue/reminder)

(2. Intermittent or constantly, if patient is participating/3. constantly if patient not participating)

RED: Dependent- Patient not able to participate EFFECTIVELY

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Upper Dressing: M1810

(M1810) Current Ability to **Dress Upper Body safely (with or without dressing aids)** including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

1. Able to dress upper body without assistance if clothing is laid out or handed to the patient.

2. Someone must help the patient put on upper body clothing.

3. Patient depends entirely upon another person to dress the upper body.

Majority Rule and Usual Status applies!

KEY:

GREEN: Independent/with Access Assist, but no "People Power" needed during task itself

ORANGE: Needs some assist (hands on/cue/reminder)
(2. Intermittent or constantly, if patient is participating/3. constantly if patient not participating)

RED: Dependent- Patient not able to participate EFFECTIVELY

Lower Body Dressing: M1820

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

0. Able to obtain, put on, and remove clothing and shoes without assistance.

1. Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.

2. Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes

3. Patient depends entirely upon another person to dress lower body.

Majority Rule and Usual Status applies!
KEY:
GREEN: Independent/with Access Assist, but no "People Power" needed during task itself
ORANGE: Needs some assist (hands on/cue/reminder)
(2. Intermittent or constantly, if patient is participating/3. constantly if patient not participating)

RED: Dependent- Patient not able to participate EFFECTIVELY

Bathing: M1830

(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 bathe 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.

Majority of TASKS does not apply here. Usual Status DOES

KEY:

GREEN: Independent/with device, no "People power" needed during the task(s) itself

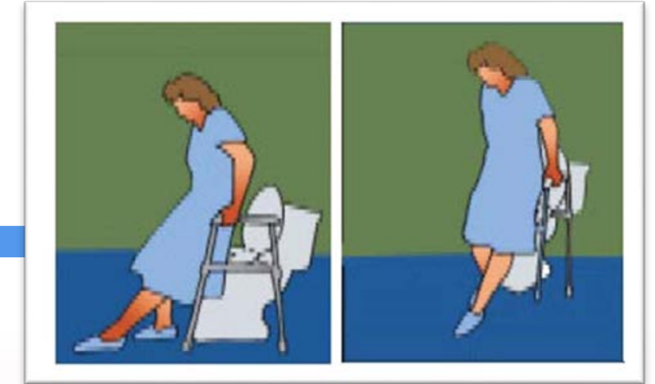
ORANGE: Needs some assist (hands on/cue/reminders/Stand-by assist)
(2. Intermittent/3. constant
5.Any level of People power with sink bathing)

RED: Dependent, bathed anywhere

Other Helpful Bathing Q&As

- What if the patient has their tub full of laundry? Or a TV is being store in it?
  - Assess why. Does it work? Did she quit showering due to fear/concern for safety? Preference because she doesn't want her hair wet? Assess ability- and include environment. Q141.4
- What if the patient admits such fear, she does not choose to bathe in shower, but instead is safe at sink. With your encouragement, changing environment and providing assist into shower, she is safe and willing to have an aide come to assist her.
  - SOC? 4
  - After your intervention? 2 Q134.2
- What if the Dr said no showering- but patient did it, and reported being safe?
  - Medical restriction to shower= best the pt can be is a "4", Q134.1

Toilet Transfer: M1840



(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

0. Able to get to and from the toilet and transfer independently with or without a device.

1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. (must be able to use bedpan- not just urinal)

4 Is totally dependent in toileting.

KEY

GREEN: Independent with or without a device to toilet

ORANGE: Needs assist (including SBA/cues) to get "to/from" and/or "off/on" toilet
OR can use Commode with or without assist

RED: Dependent

Question: Toilet is Upstairs

- Emma was performing the initial comprehensive assessment on a new patient, Joe. She asked Joe to show her where the bathroom is, so she could assess his safe ability to get to and from/on and off the toilet for M1840. He replied that it was actually upstairs, and he was afraid that he would not be able to make it up the stairs because he was so fatigued and his "legs keep giving out". Emma agreed that this was concerning, based on the assessment she had completed so far, and felt she would not be able to make him safe on the stairs, even with assistance.
- Emma asked Joe if he had a commode or urinal, etc. He replied he did not, but his daughter was going to get one after work today.
- How would you score Joe today, if you were Emma?
- Logic: Can Joe get to/from toilet, even with assist? No.
- Can Joe use a commode or bedpan? Unknown- can't make assumptions about equipment not in the home.
- Can only score as dependent.

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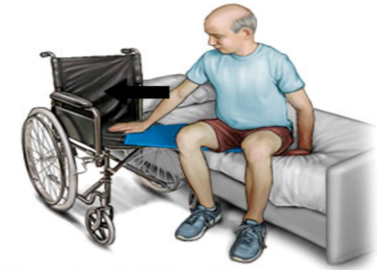
Other Helpful Q&As

- What if the patient has a catheter and an ostomy? Q142
- Patient can use urinal, but unable to use bedpan effectively? Q146.1
- You assess the patient is safe getting to/from, off/on toilet with your moderate assist. Patient lives alone, so typically uses a commode. What do you score this patient? Toilet with assist, or commode? Q143.1

Transfer: M1850


How to Use a Slide Board

(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.

KEY

GREEN: Independent

PURPLE: Depends on And/Or response (see flow chart)

ORANGE: Needs some assist (hands on/cue/reminder)

RED: Dependent

BLACK: Unable to Transfer

M1850: Bed Transferring Decision Tree

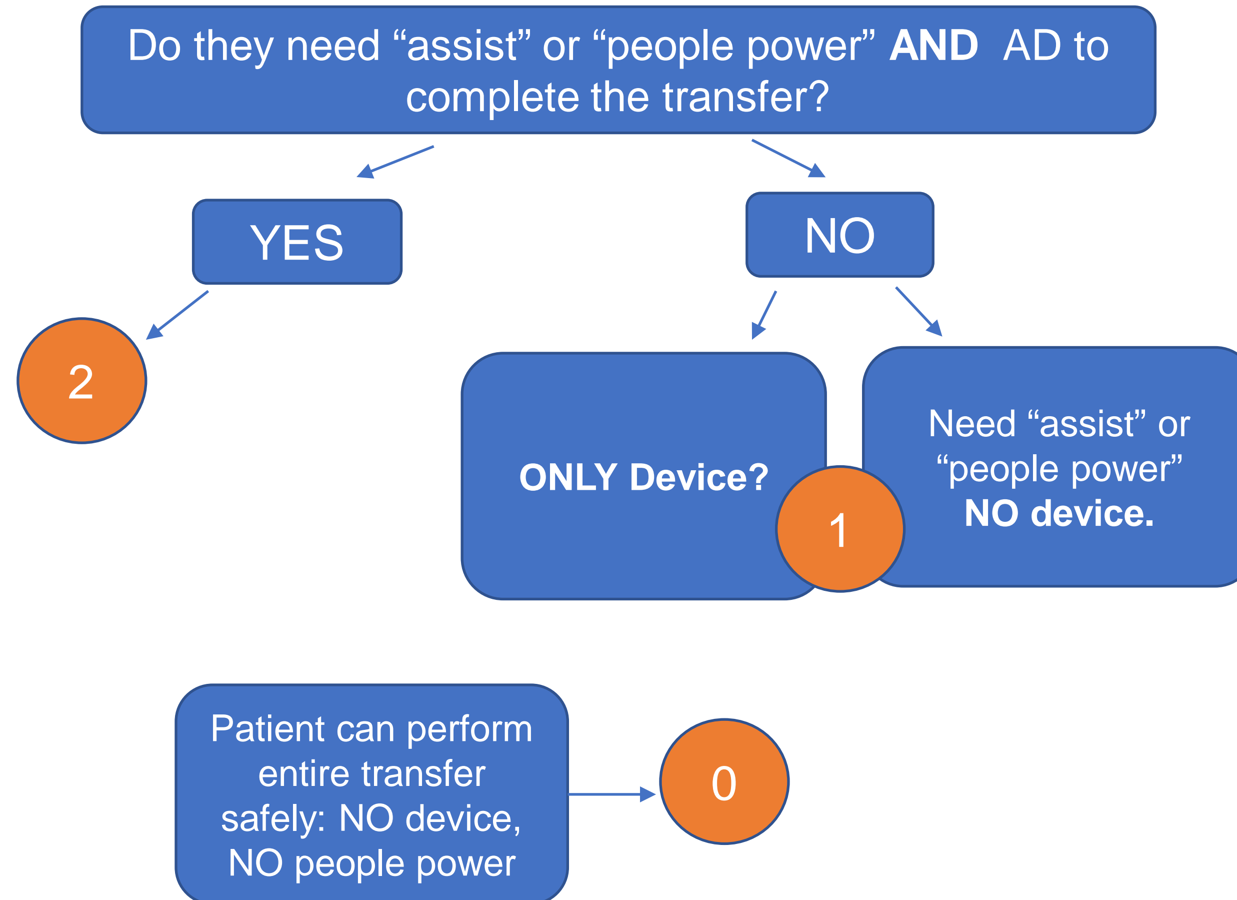
Bed transfer: From lying supine, sitting at EOB, sit to stand at EOB, ambulate to chair, sit in chair, stand from chair, ambulate to EOB, lie back down.

Can the patient tolerate being out of bed SAFELY?

- YES → Are they able to bear weight **and** pivot while being transferred?
  - NO → 3
  - YES → 0-2 (Continue)
- NO → Bedfast 4 or 5 → Do they need "people power" to turn and position themselves?
  - YES → 5
  - NO → 4

M1850: Bed Transferring Decision Tree

Bed transfer: From lying supine, sitting at EOB, sit to stand at EOB, ambulate to chair, sit in chair, stand from chair, ambulate to EOB, lie back down.



Transferring Scenarios

- The patient was able to lie down, and then sit up on the side of the bed independently. Upon attempt to rise from sit to stand, the patient struggled a bit, and you stepped in to provide a tactile cue, as the patient pushed up from the attached half bed rail. The patient was then able to make a pivot transfer to the chair and back to bed to lie down. What do you score M1850?
- 2, because the patient used BOTH people power (min assist or less) and a device to be safe (Q151.1)
- Same scenario, but there was no assistive device and you had to provide moderate assistance .
- 2. Response 1 only includes “MIN assist” for people power (RSI bullet 5 on Pg 367)
- Same scenario, but you had to physically assist the patient with moderate assist and the patient was able to bear weight, but unable to pivot.
- 3, because the patient must be able to bear wt AND pivot for response 2 (RSI bullet 6 on Pg 367, and Q151.6, page 371)

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The “OR” or “AND/OR” Dilemma

- Noting that there is the guidance for M1850 that states when response has the “OR” between minimal assist and a device for “#1”, we are to move our scoring down to a “2”– does this guidance follow suit in the other M items noted to have the “OR” with multiple options of assistance- such as M1840/M1860/M2020?
- No- only applies to M1850, Transferring. Everywhere else CMS allows the “OR” to really mean “AND/OR” Q151.8

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Ambulation: M1860

(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 (specifically: 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.

KEY

BLACK: Task

GREEN: Independent with/without specific devices

ORANGE: Needs some assist (hands on/cue/reminder)
(2. Intermittent/3. constant for ambulators, 5. for chairfast)

RED: Dependent

M1860: Ambulation Decision Tree

Can the patient tolerate being out of bed SAFELY?

- YES → Can they mobilize more than a few steps to the chair safely with assist?
  - NO → Chairfast 4 or 5 → No w/c? → 5
  - YES → Ambulator: Do they need "assist" at all times on all surfaces for safety?
    - YES → 3
    - NO → Do they need "assist" on more difficult surfaces or turns to be safe?
      - YES → 2
      - NO → Do they need AD to be safe?
        - YES → 1 or 2
        - NO → 0
- NO → Bedfast -6

Common M1860: Ambulation Scenarios

- Consider "people power" or "assist"
- Do not consider DME if not present
- Consider all surfaces typically traversed

Scenario	Appropriate Response
Pt. has a walker and refuses to use it and is cognitively intact. Demo with walker, safety on ALL surfaces in her senior living bldg OR needs assist only intermittently	2
Pt has a walker in the home, but forgets to use it due to mild dementia. You note the patient is very unsteady and unsafe without walker- but demo with walker makes him safe on all surfaces he traverses in his ALF.	3
Pt. ambulated a short distance with your max assist, unsafely the whole way, you are glad to get them into a chair! They do not have a wheelchair.	5
Pt is unsteady when ambulating. You stay close by (SBA) the entire assessment to ensure safety. You contact the Dr and request a PT eval. Your clinical judgement tells you that with PT and a walker, he will manage in the home.	3

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Rehospitalizations and ER Use

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?

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 checkins for at risk

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Awareness is First Step

- Thoughts?
- Can you identify top patients that you feel may be at risk currently?
  - What are you currently doing?
  - What could be next steps?

Actions of a Prudent Home Health Agency™

1. Review the Provider Preview reports and the Interim Performance Report (IPR) for HHVBP quarterly (next up: Jan 24)
2. Monitor your rehospitalizations, ER use and observation stays- when, why, who
3. Review CAHPS return rates, top box percentages
4. Look for gaps- and brainstorm in QAPI for reasons and solutions!

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Questions?

Contact Us

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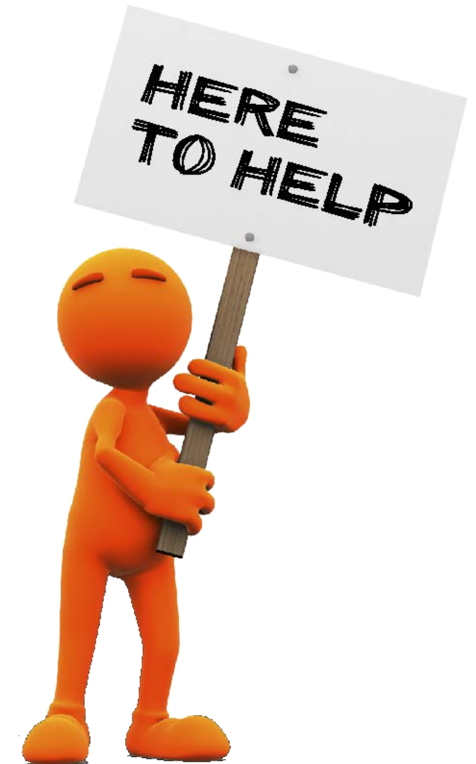

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