How Conditions of Participation Relate to HHVBP

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Home Health Fundamentals'
2023 Winter Workshop

A different way of thinking…

- HHVBP is almost though our first “performance year”- where our data counts!
- July brought our first “Interim Performance Reports”- and many of us were surprised we didn’t look better. We have seen some improvement with Octobers’ IPRs- (just released last week)
- Typical response- Education and QA of OASIS- but HHVBP is so much more
- This session looks at the unique view of how good knowledge and compliance with our COPs will actually aide in improving our HHVBP!

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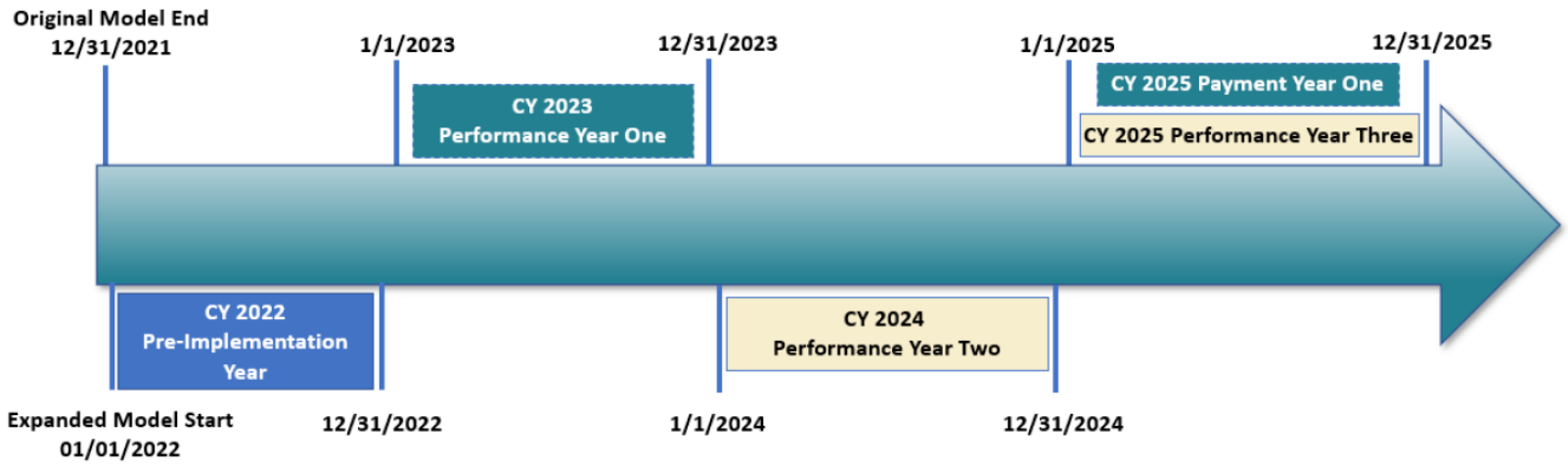
HHVBP Timeline

Exhibit 4. Timeline for initial rollout of the expanded HHVBP Model



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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%

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This is for TODAY-

- Just a note- when we discuss the measures, we will be discussing our current measures.

- CMS is changing our functional scoring methodology, as well as the hospitalization rate.
- The new measures will not take place until 2025, so the current measures are vital to “get right” as well!

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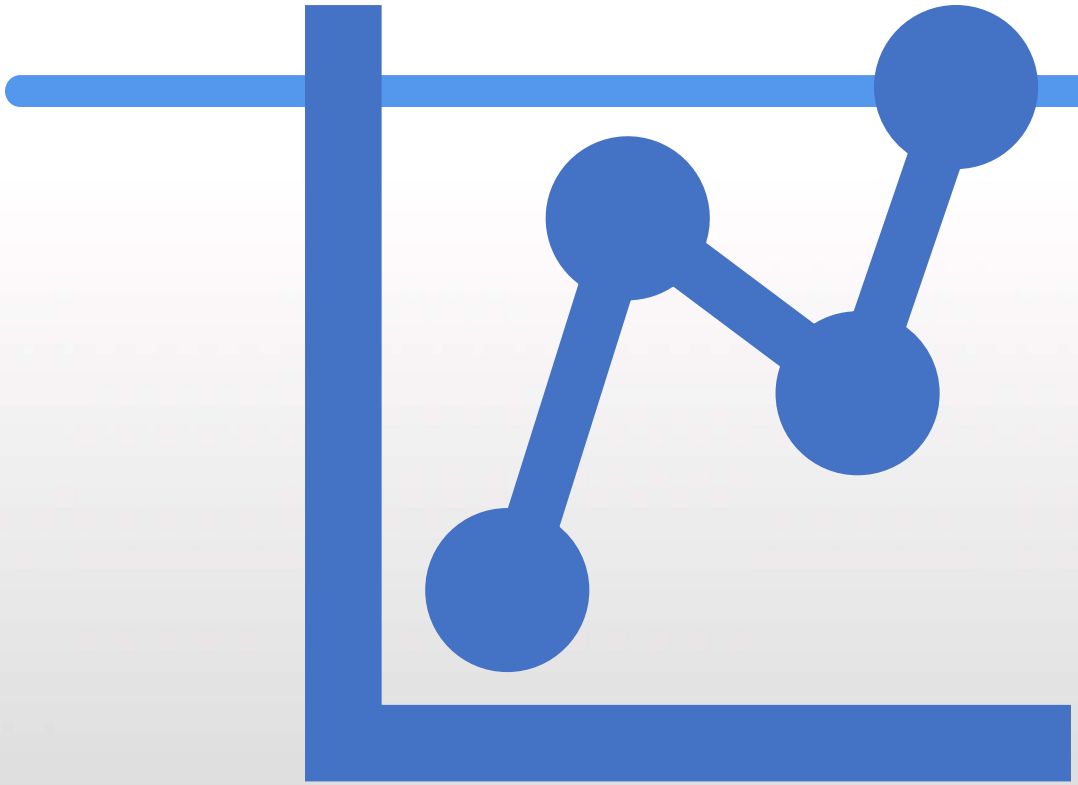

Could there be a correlation between the COPS and HHVBP success?

YES! We think so! Let's dig in!

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COPS and The OASIS data items…

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OASIS Items- General (M1800s, M1400, M2020 and M2420)

- **G574**

§484.45(b) Standard: **Accuracy of encoded OASIS data**. The encoded OASIS data must accurately reflect the patient's status at the time of assessment.

  - Interpretive Guidelines §484.45(b) “Accurate” means that the OASIS data transmitted to CMS is consistent with the current status of the patient at the time the OASIS was completed.

HOW do we impact? Education, tandem visits, QA, QAPI

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OASIS Items- General (M1800s, M1400, M2020 and M2420)

- **G520**
- §484.55(b)(1) The comprehensive assessment must be completed in **a timely manner,** consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. (& standards related to the timely UPDATE of the comprehensive assessment under 484.55d)

- HOW does this impact? Ensuring timeliness will increase accuracy of the assessment, and captures the patient "at their worst", after the health crisis or change in condition that initiated a HH referral
- HOW do we ensure? Clear intake process, clear tracking and oversight of timeframes for updates to comprehensive assessment (EMRs track for us – but oversight still needed)

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OASIS Items- General (M1800s, M1400, M2020 and M2420)

- §484.55(c) Standard: **Content of the comprehensive assessment**. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:
- **G528:** The patient's current health, psychosocial, functional, and cognitive status;
- **G530:** The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;

HOW? Ensuring a true comprehensive assessment (and not just the data points of OASIS)
will increase the accuracy of the data
"OASIS Walk" – running the OASIS Basics" (bedroom, bath, normal sitting area, kitchen, meds, etc)

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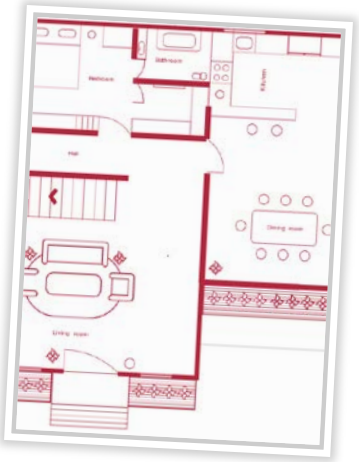
OASIS Bases!

BEDROOM

M1850-Transferring

- "Show me how you get on/off bed."
- "Show me how you get from your bed to the nearest chai
- "Show me how you get up/down from a chair."
- Note use of unsafe techniques or "plopping" when sitting
- Are verbal cues needed for safety?



M1810-Upper Body Dressing

- "Show me how you get a shirt out of the closet."
- Note use of dressing aids and balance.

M1820-Lower Body Dressing

- "Show me how you get pants out of your dresser."
- "Show me how you take off your shoes and socks. I need to check your feet."
- Note use of dressing aids and balance.

BATHROOM

M1840-Toilet Transferring

- "Show me how you get to the bathroom from other rooms."
- "Show me how you get on/off the toilet."
- Note presence of raised commode seat, toilet frame, and/or grab bars.
- Observe unsafe use of toilet roll holder, towel rack or sink countertops.

M1830-Bathing

- "Show me how you get into your tub/shower."
- Note presence of grab bars, hand-held shower head and shower seat.
- Observe incorrect use of fixtures, towel rack, shower door/frame, or curtain rod.

M1800-Grooming

- "Where do you keep your grooming supplies?"
- "Can you get them out for me?"
- Observe items located out of safe reach.

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!"

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OASIS Item M2020- Oral Medications

- **G536:** A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
- IG: The patient's clinical record should identify all medications that the patient is taking (both prescription and non-prescription) as well as times of medication administration and route. As part of the comprehensive assessment the HHA nurse should consider, and the clinical record should document, that the HHA nurse considered each medication the patient is currently taking for possible side effects and the list of medications in its entirety for possible drug interactions.
- The HHA should have policies that guide HHA clinical staff in the event there is a concern identified with a patient's medication that should be reported to the physician. In rehabilitation therapy only cases, the patient's therapist must submit a list of patient medications, which the therapist must collect during the comprehensive assessment, to an HHA nurse for review. The HHA should contact the physician if indicated
- **HOW:** A complete DRR will aide in the understanding of the patient's need for assist to take right med, right dose and right time for oral meds on the day of assessment
- Be sure to provide specific medication reconciliation and DRR training to entire staff! (the medication Easter egg hunt is something not taught in nursing school!)

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OASIS Item M2420- DC Disposition

- **G534:** (under comprehensive assessment content) The patient's medical, nursing, rehabilitative, social, and **discharge planning needs must be assessed**

- **G562:** (a) Standard: Discharge planning. A home health agency must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and "their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

- **HOW?** The agency must have policies to guide and train the clinical team on how to appropriately plan for discharge to the proper entity (home, hospice, NF) through ongoing assessment and careplanning
- **Remember!** Since January 2023, if a patient is DC'd to hospice, the patient's outcome data will not be used for outcomes for HHVBP (or five star/Care compare)

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COPS, ER Use and Re-Hospitalizations

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Comprehensive Assessment Standards and Re-Hospitalizations

- **G520**
- §484.55(b)(1) The comprehensive assessment must be completed in **a timely manner,** consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. (& standards related to the timely UPDATE of the comprehensive assessment under 484.55d)

Content of the comprehensive assessment- including all standards:

- **G528:** The patient's current health, psychosocial, functional, and cognitive status;
- **G530:** The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;
- **G534:** The patient's medical, nursing, rehabilitative, social, and discharge planning needs;

Comp Assessment and Hospitalizations

- **G536**: A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy
- **G538:** The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules;
- **G544**: The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status

- **HOW?** The comprehensive assessment is the first step towards an effective plan of care! We need these pieces to complete a plan that will work for the patient, and allow us to anticipate their needs and utilize their preferences, strengths, caregivers, etc!

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Care Planning COP and Re-Hospitalization

- §484.60 Condition of participation: Care planning, coordination of services, and quality of care.

❑ Patients are **accepted** for treatment on **the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.**

❑ **HOW?** Make sure you have the RIGHT patient at the RIGHT time, for the RIGHT services (Initial assessment prior to admission- and ongoing!

❑ Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.

Care Planning

- **G572:** Each patient must receive the home health services that are written in an **individualized plan of care** that identifies patient-specific measurable outcomes and goals

- HOW? Certainly an INDIVIDUALIZED plan will be more effective than 1w9 and all the same favorite interventions!

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And the actual care…

- **G580:** Drugs, services, and treatments are administered only as ordered by a physician.
- **G588:** The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.
- **G590:** The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered
- **How?** Ensuring all care was ordered, specific for the patient, and administered as ordered is imperative for the best outcomes. Alerting the ordering provider when interventions are not working, or there is a change in condition is the best tool to ensure the agency is still providing the right care and get the best outcomes! This is an ONGOING process.

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Coordination and Communication

- **G606:** Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.
- **G608:** Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. **G610:** Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

QAPI and Hospitalizations

- **G644:** The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program
- The HHA must use the data collected to **Monitor the effectiveness and safety of services and quality of care**; and **Identify opportunities for improvement.**
- **G648:** Focus on high risk, high volume, or problem-prone areas
- **G652:** Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
- **G654:** Performance improvement activities must **track adverse patient events, analyze their causes, and implement preventive actions.**
- **HOW?** Do you track data re: hospitalizations- including cause, day of week, case manager, location of care, Dr? These can provide insight! Use your adverse events reports also to identify these risks- and any CMS data (five star preview) that shines a light on gaps your agency has

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Infection Control

- G682: The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.
- How? The interpretive guidelines tell us!
- 1. Hand Hygiene;
- 2. Environmental Cleaning and Disinfection;
- 3. Injection and Medication Safety;
- 4. Appropriate Use of Personal Protective Equipment;
- 5. Minimizing Potential Exposures; and
- 6. Reprocessing of reusable medical equipment between each patient and when soiled.

COPS, and CAHPS

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The Patient Experience

- CAHPS is beyond the patient satisfaction- but also gathers the patient's perspective about their experience with home health and your agency

- Many factors play into CAHPS success- the number of surveys, the one cranky patient–BUT, we also have an impact of some of those factors- such as optimal treatment of symptoms, decreasing the need to use ER or hospitalization, coordinating care for the patient, empowering the patient and caregiver by education

- There are also many questions that directly tie to COPS!

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What's a Good Score? The "Top Box"

Care of Patient Composite

- Q9 Providers informed and up to date: percentage of "always" responses.
- Q16 Treated gently: Percentage of "always" responses.
- Q19 Treated with courtesy, respect: percentage of "always" responses.
- Q24 Problems with care: percentage of "no" responses.
- Q20 Rate 1-10- Must be a 9 or 10

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Composite 1: Care of Patients/Professional Care

Care of Patients Composite ("Patients who reported that their home health team gave care in a professional way.")		Response Categories
Q9.	In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?	Never, Sometimes, Usually, Always
Q16.	In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?	Never, Sometimes, Usually, Always
Q19.	In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?	Never, Sometimes, Usually, Always
Q24.	In the last 2 months of care, did you have any problems with the care you got through this agency?	Yes, No

Informed, Gentle, Courtesy, Respect, Any Problems

Patient Rights

- **G428**: Have his or her property and person treated with respect
- **G430**: Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;
- **G434**: **Participate** in, be informed about, and consent or refuse care in advance of and during treatment (visits, disciplines, preferences, treatments, etc)
- "**Participation**" means that the patient is given options regarding care choices and preferences. For example, patient preferences should be respected in encouraging the patient to choose between a bath and a shower, unless there are physical restrictions or medical contraindications that limit patient choice.

Composite 2: Communication between patients and providers

Communications Between Providers and Patients Composite ("Patients who reported that their home health team communicated well with them.")		Response Categories
Q2.	When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?	Yes, No
Q15.	In the last 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?	Never, Sometimes, Usually, Always
Q17.	In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?	Never, Sometimes, Usually, Always
Q18.	In the last 2 months of care, how often did home health providers from this agency listen carefully to you?	Never, Sometimes, Usually, Always
Q22.	In the last 2 months of care, when you contacted this agency's office did you get the help or advice you needed?	Yes, No
Q23.	When you contacted this agency's office, how long did it take for you to get the help or advice you needed?	Same day, 1 to 5 days, 6 to 14 days, More than 14 days

Were services explained, arrival updates, easy to understand, listen carefully, did you get help needed, how long did it take to get help

Plan Communications

- G608: Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.
- G610: Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

Written “Mini POC” to Patient

- §484.60(e) Standard: Written information to the patient. (Just these five things- see tool!)
- **G614**: Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
- **G616:** Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA
- **G618:** Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
- **G620:** Any other pertinent instruction related to the patient’s care and treatments that the HHA will provide, specific to the patient’s care needs.
- **G622**: Name and contact information of the HHA clinical manager.

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Composite 3: Special Home Health Issues

Specific Care Issues Composite ("Patients who reported that their home health team discussed medicines, pain and home safety with them.")		Response Categories
Q3.	When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?	Yes, No
Q4.	When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?	Yes, No
Q5.	When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?	Yes, No
Q10.	In the last 2 months of care, did you and a home health provider from this agency talk about pain?	Yes, No
Q12.	In the last 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?	Yes, No
Q13.	In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?	Yes, No
Q14.	In the last 2 months of care, did home health providers from this agency talk with you about the **side effects** of these medicines?	Yes, No

Safety, Pain, Medicines: What, how, when, and side effects

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Medication Education Issues

- **G536:** A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy
- G570: EDUCATION! The individualized plan of care must also specify the patient and caregiver education and training
- G610: Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

Actions of a Prudent Home Health Agency™

1. Recognize that compliance with the COPs does impact the HHVBP measures!
2. Utilize this knowledge when filling the gaps for your agency's measures
3. QAPI supports strategies for measure improvement as well as compliance (hot topic of OIG)!

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Questions.?

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THANK YOU!!!

Contact Us

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