Home Health Value-Based Purchasing

Optimize reimbursements and drive better outcomes with solutions that boost OASIS accuracy, reduce readmissions, and elevate HHCAHPS scores.

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MEDBRIDGE

Strategies to Reduce ED Visits and Hospitalizations

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Learning Objectives

1. Review HHVBP as well as proposed rule changes related to ED utilization and hospitalization
2. Share strategies around best practice for chronic condition management
3. Leverage technology to support risk stratification and engagement of patients between onsite visits
4. Learn how to apply these solutions within your agency

Who We Are

- **SimiTree**
  - 450+ post-acute care industry experts
  - Over 770 active clients
  - We have helped over 16,000 agencies grow stronger and healthier by optimizing operations, revenue, and clinical performance
  - SimiTree brings industry expertise and a wide range of proven solutions together to guide organizations through challenges, changes, and growth
    - https://simitreehc.com/

Chapter 1

Current and Proposed Rule

Current Measures

- **Acute care hospitalization**
  - Numerator: number of home health (HH) stays for patients who have an unplanned admission to an acute care hospital in the 60 days following the start of the HH stay
- **ED use without hospitalization**
  - Number of HH stays for patients who have a Medicare FFS claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the HH stay

Current Measures (cont.)

- **Exclusions**
  - Home health stays that begin with a LUPA claim
  - Patients receiving service from multiple agencies during the first 60 days
  - Patients not continuously enrolled in Medicare FFS for the six months prior to the home health stay or for the 60 days following the start of the HH stay
  - Patients who die

Proposed Measure

- ACH and ED use will be removed in 2025
- **Home Health Within-Stay Potentially Preventable Hospitalization (PPH) will be included beginning 2025**
  - **Denominator:** the risk-adjusted expected number, or projected number of risk-adjusted hospitalizations if the same patients were treated at the average HHA, of hospitalizations or observation stays
  - **Numerator:** number of patients in the denominator with at least one potentially preventable hospitalization or observation stay during the HH stay

What Does This Mean?

- A well-developed hospitalization prevention strategy can help set up an agency for success
- Identify patients at risk of hospitalization
- Implement plans to mitigate that risk
- Continue to monitor and refine processes to meet individual patient needs

Summary

- Acute care hospitalization and ED use without hospitalization will be included in VBP at least through 2024
- A well-defined hospitalization prevention program can help to set up for success now and if the VBP metrics change in the future

Chapter 2

Chronic Condition Management

Chronic Condition Management

- Healthcare.gov defines chronic disease management as “an integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.”

Chronic Conditions

Below Are the 10 Most Common Primary Diagnoses in Early Periods for CY 2021

Primary Diagnosis		Percent
Z47	Ortho aftercare	9.6%
Z48	Other postprocedural aftercare	7.1%
E11	Type II diabetes	5.0%
U07	COVID-19	3.7%
I69	Sequelae of cerebrovascular disease	3.6%
S72	Femur fracture	2.8%
I10	Essential hypertension	2.7%
I11	Hypertensive heart disease	2.7%
J44	COPD	2.5%
I13	Hypertensive heart and renal disease	2.2%

Diabetes

- **Medications and equipment**
  - Insulin
  - Glucometer, strips, and lancets
- **Diet and nutrition**
  - Portions, carbohydrates, and sugar
- **Exacerbation**
  - **Hypoglycemia:** shakiness, sweating, headache, and dizzy
  - **Hyperglycemia:** frequent urination and increased thirst

Hypertension

- **Medications and equipment**
  - Defined parameters
  - Blood pressure monitor, scale
- **Diet and nutrition**
  - Sodium restriction
  - Limit alcohol
  - Avoid smoking
- **Exacerbation**
  - Blood pressure outside provider or agency established parameters
  - Headache, blurred vision, and nausea

Chronic Obstructive Pulmonary Disease

- **Medications and equipment**
  - Inhalers, nebulizers, and oxygen
  - Pulse oximeter, scale
- **Diet and nutrition**
  - Portions, frequency, and fluids
- **Exacerbation**
  - Increased cough or shortness of breath
  - Lower extremity swelling
  - Difficulty sleeping

Summary

- Chronic diseases are often seen in home health, developing strategies to manage these conditions can help to reduce hospitalizations
- Ensure the patient has the correct medications and equipment and is instructed on the proper diet to prevent disease exacerbation

Chapter 3

Leverage Technology

Available Options

- Telehealth
- Remote patient monitoring
- Video call
- Text message
- Phone call

Telehealth

- Even though telehealth is not currently reimbursed by CMS, there are voluntary codes that can be used on claims
- May contain two-way audio/visual or audio only components
- These visits cannot substitute for an ordered home visit, must be included on the plan of care, and related to patient specific needs

Remote Patient Monitoring

- **Allows for monitoring of biometrics daily so agencies can intervene if a change is noted, this may include**
  - Blood pressure
  - Heart rate
  - Pulse oximeter
  - Weight
  - Blood glucose
- Results can be trended over time and shared with the patient's provider

Video Calls

- Use this in high-risk patients to supplement visits
- Can help to visualize medications, further assess the home environment, and the patient's status
- Consider a video call if the patient calls the office with a question

Text Message

- This may be the primary method of communication if a patient is hard of hearing
- Can be used for nonurgent communication such as following up after a patient's appointment with their provider
- Consider how patients can contact the agency with questions

Phone Call

- Likely the primary method of communication for most patients
- Supervisors or other office staff can call patients to follow up on issues
- Utilize a script when making these calls to ensure all relevant items are addressed

Summary

- Several different options are available to stay connected with and monitor patients when visits are not made
- These range from the use of new equipment and technology to more routine and traditional forms of communication

Chapter 4

Application for Your Agency

Current Processes

- Evaluate which of the previously mentioned processes are being used
- Many can be employed with minimal additional cost
- Are there any disease specific protocols in place?

Risk Identification

- **Determine your high-risk patients for whom interventions are not already in place**
  - Many agencies focus on patients at high-risk for hospitalization, what about those at moderate risk?
- **Secondary diagnoses may impact the patient's condition and contribute to a hospitalization**
  - Diabetes can delay wound healing
  - COPD puts patients at increased risk of lung infections

Patient-Centered Care

- **Customize technology use to the patient's needs and abilities**
  - Phone calls may not work for a deaf patient, but text might
  - Remote patient monitoring may not be appropriate in areas with poor internet connectivity, but phone calls may be okay
- **Manage the patient's individual risk factors**
  - Unable to afford medications or healthy food
  - Unsafe environment
  - Lack of caregiver or understanding

Summary

- Evaluate current processes related to disease management and hospitalization prevention
- Incorporate patient-centered initiatives that focus on individual needs
- Consider various risk factors that may not be addressed by current interventions

Chapter 5

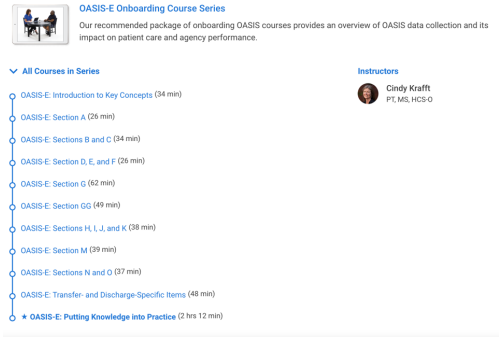
Additional Performance Improvement Strategies for Your Agency

Best Practice for Performance Improvement

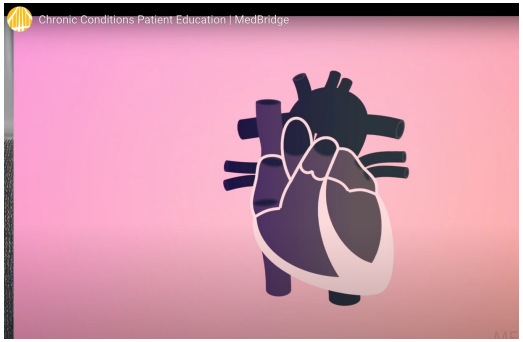
- **Questions to ask before implementing a plan…**
  - **Who/what** has any direct and indirect influence on the performance metrics?
    - **Hint:** It's not just your clinicians…
  - **What** is the most impactful way to remediate or improve performance of each of the influencers?
    - One-size-fits-all isn't always the best strategy…
    - Blend enhancements of **people, process,** and **technology**
- **Do you have the right tools to implement a successful plan?**

Implementing Performance Improvement Strategies for VBP

Step 1: OASIS Accuracy for All Staff



Step 2: Better (Chronic) Condition Management



Step 3: HHCAHPs and Customer-First Approaches

Patient	Response
1	7
2	8
3	5
4	9
5	10
6	9
7	6
8	5
9	10
10	10
(5/10=50%)	

Patient	Response
1	Definitely yes
2	Probably no
3	Definitely yes
4	Definitely no
5	Probably yes
6	Definitely yes
7	Definitely yes
8	Definitely no
9	Definitely yes
10	Probably yes
(5/10=50%)	

Step 1a: OASIS Accuracy for New Hires

Full OASIS Course Series

Prepare your team with our refreshed full course series for OASIS-E, featuring new patient demonstrations.
6 hours

OASIS-E: Section A
presented by Cindy Krafft, PT, MS, HCS-O

Case Scenarios

Help clinicians apply their knowledge and practice scoring OASIS items with demonstrations and quizzes.
10 minutes each

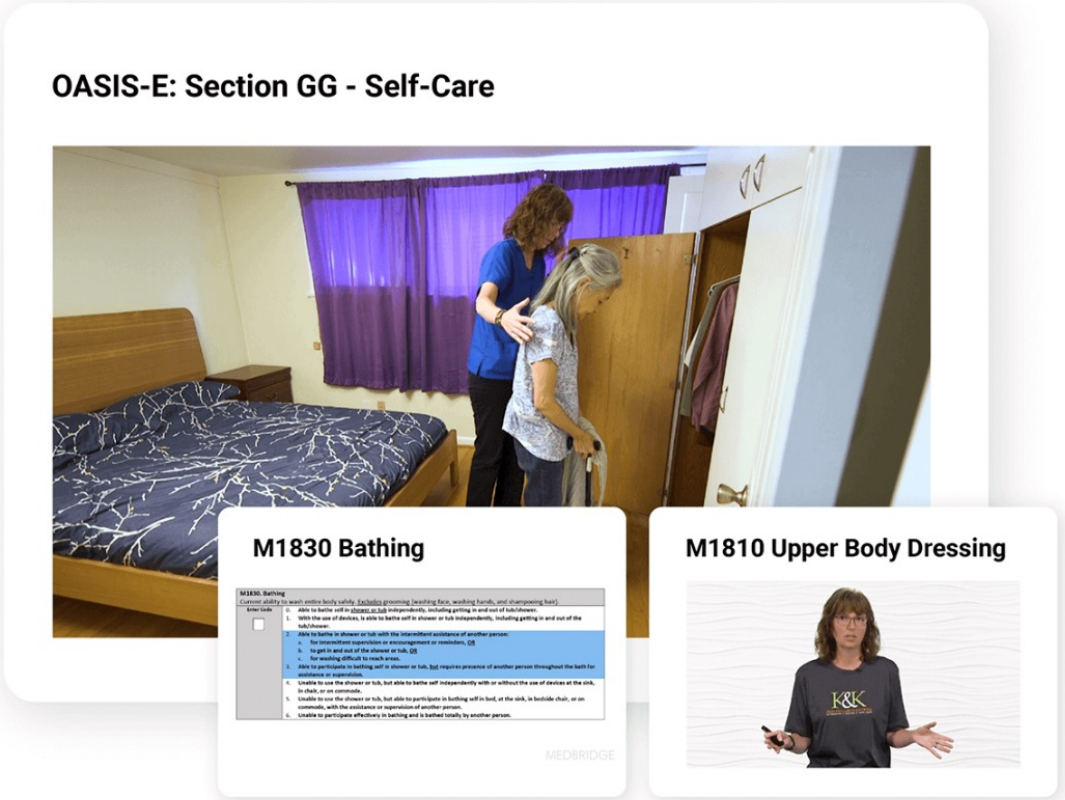
OASIS-E: Section GG
presented by Cindy Krafft, PT, MS, HCS-O

Step 1b: OASIS Accuracy for Tenured Staff

Boosters Updates

Keep skills sharp with targeted microlearning, focused on items impacting HHVBP and reimbursement.

5–8 minutes each



1b. Booster Example

Step 1:
OASIS Accuracy Case Study

- **MedBridge Solution:** Everest partnered with MedBridge to develop an improvement program for their staff responsible for OASIS completion. The program focused on areas identified by HCA as the most commonly corrected at their agency and provided content in a method compatible with the needs of home health staff, both online and mobile.

- **Results:** Everest Home Health & Hospice deployed their OASIS improvement program and saw results right away. Recommended OASIS corrections decreased by as much as **28 percent for each of the targeted M-items.**

- **The program included:**
  - MedBridge microlearning content targeted to areas of correction and OASIS concepts
  - Staff satisfaction and confidence surveys
  - MedBridge Learning Management System and Clinician App providing assignment, reminders, and tracking support for a mobile workforce
  - OASIS data pre- and post-implementation, provided by Home Care Answers

M-Item	Percent Reduction in Recommended Corrections
M1810: Dress Upper	26.54%
M1820: Dress Lower	26.54%
M1830: Bathing	14.7%
M1840: Toileting	28%
M1850: Transferring	21.89%
M1860: Ambulation	12.88%

Step 2:
Better (Chronic) Condition Management

- **People**
  - **How can we enhance knowledge about best practice for condition management to all people involved?**
    - Clinicians, managers/schedulers/etc., patients, caregivers, etc.
- **Process**
  - What types of process updates can we make to have an impact on avoidable ED and ACH?
  - Example: 5 in 10 scheduling strategy
- **Technology**
  - What are the best technologies we can deploy to work on improving patient's physical functioning, condition management, remote monitoring, etc.?

Step 2:
Better (Chronic) Condition Management (cont.)

2a. Implement a Multi-Tier Strategy to Enhance Knowledge of Your People

Home Health Value-Based Purchasing Overview Series

Prepare front line clinicians and leaders for VBP

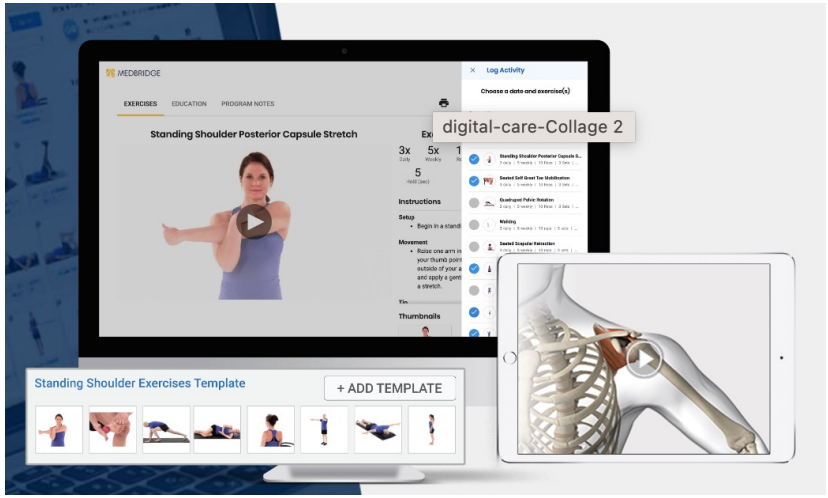
Change Management Leadership Training

Drive successful quality improvement initiatives with leadership tips and strategies

Readmission Reduction Podcasts

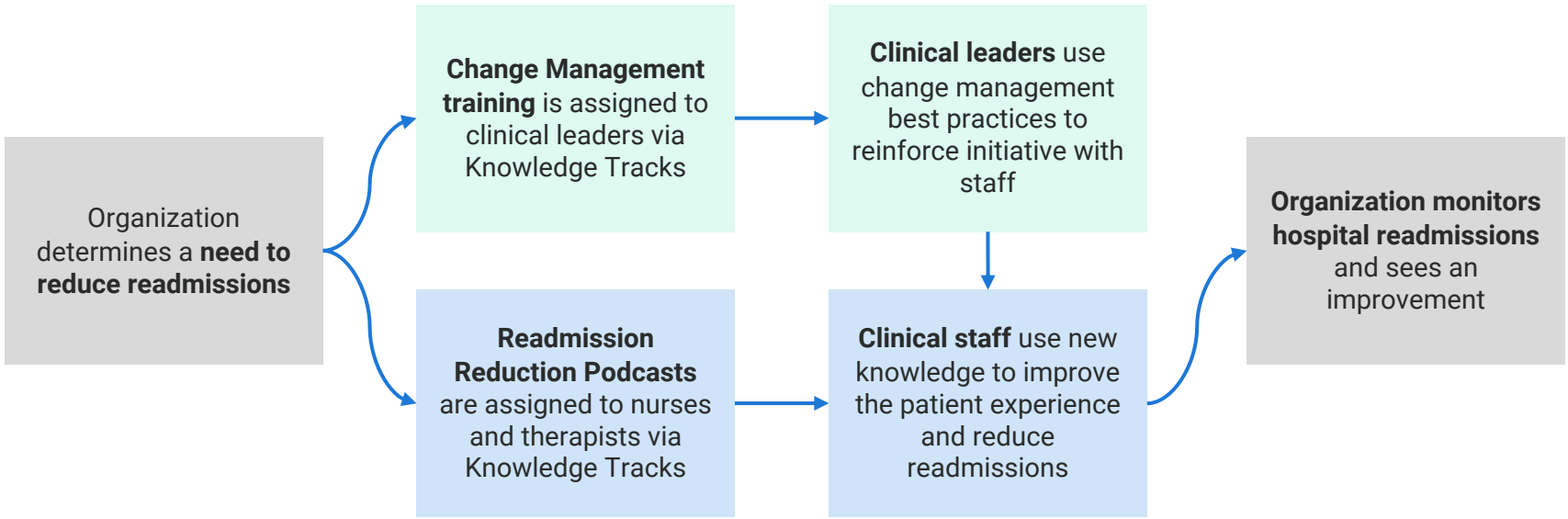
Reduce hospital and ER visits with motivational interviewing techniques

2b. Implement Process and Technology to Open your Patients' Digital Front Door



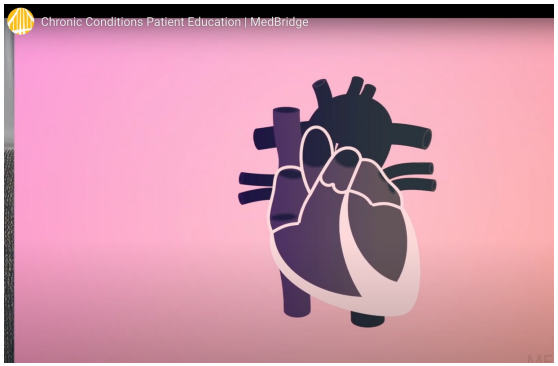
Step 2a:
Better (Chronic) Condition Management

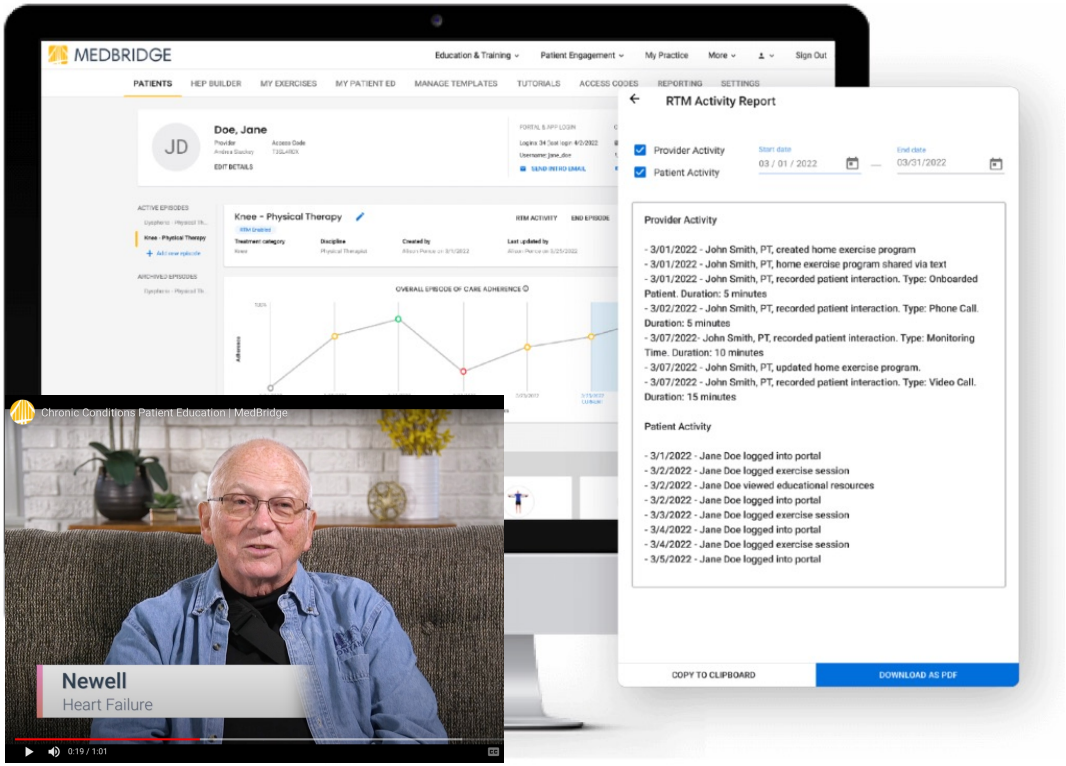
Implement a Multi-Tier Strategy to Enhance Knowledge of Your People



Step 2b:
Better (Chronic) Condition Management

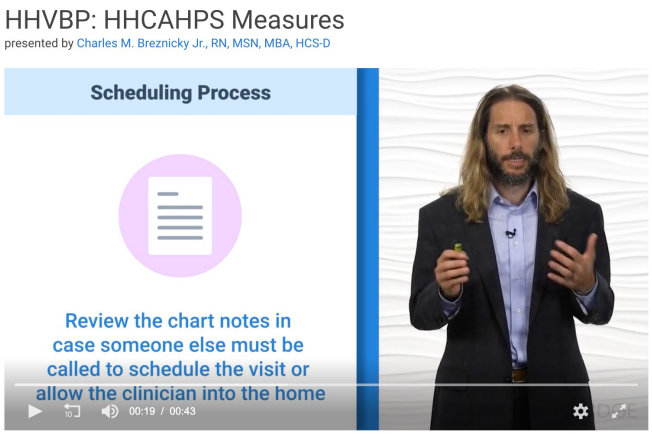
Open the Digital Front Door by Implementing the Right Process and Technology



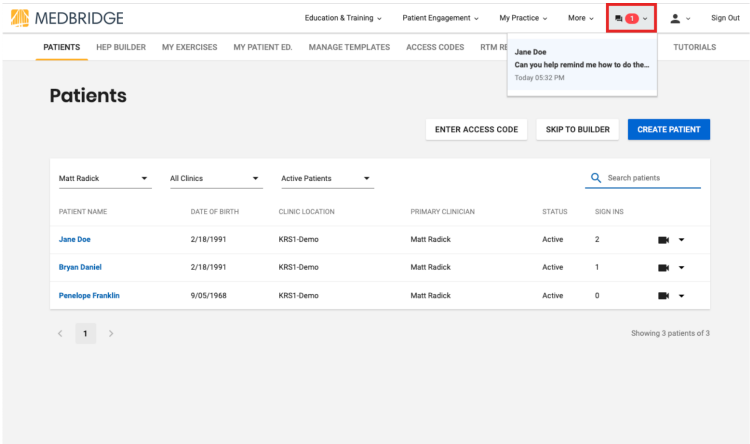


Step 3:
HHCAHPs and Customer-First Approaches

Foundational Education



Digital Patient Care Technology



Customer-First Training

From clear communication to creating an environment of accountability, quickly equip employees with critical management skills.

Soft Skills: Setting a Strong Foundation

Conflict Management and Resolution: Words, Tone, and Body Language

Coaching for Development: Giving Effective Positive Feedback

Managing for Accountability: Setting Expectations

1a. Case Scenario Example

Questions

We Help Home-Based Care Teams Improve Lives

Deliver quality care at a lower cost with a solution that combines powerful staff and patient engagement tools.

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