Best Practices to Reduce Re-Hospitalization

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HOME HEALTH STRATEGIC MANAGEMENT (HHSM)

- Home Health Consultants (30+ years HH experience)
- Developed from PAC Clinical Practice – Acute, SNF,HH
- Arnie Cisneros PT – President - HHSM
- Kimberly McCormick RN BSN – Exec Clinical Dir
- Utilization Review Model for Home Health
- CMS Bundled Payment Pilot for CJR reforms
- Post-Acute PPS Trial for Episodic Models
- Operational Solutions for PDGM, VBP Success

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Best Practices to Reduce Re-Hospitalization

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Readmission lessons learned via Impact Act trials
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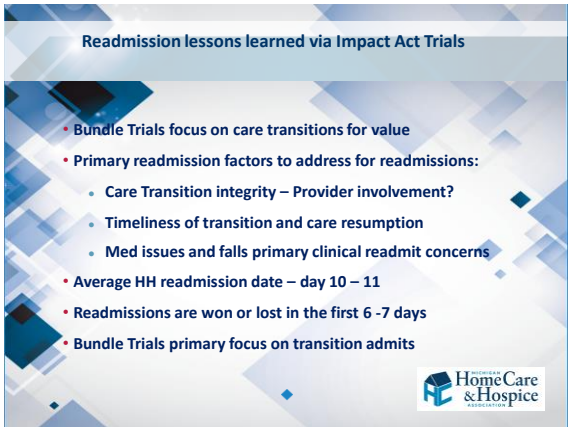
Readmission lessons learned via Impact Act Trials
Bundle Trials focus on care transitions for value
Primary readmission factors to address for readmissions:
Care Transition integrity – Provider involvement?
Timeliness of transition and care resumption
Med issues and falls primary clinical readmit concerns
Average HH readmission date – day 10 – 11
Readmissions are won or lost in the first 6 -7 days
Bundle Trials primary focus on transition admits
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Readmission lessons learned via Impact Act Trials
Bundle Trials managed admission SOC for readmit declines
Specifics of Bundle mandated 24-hour SOC for ALL clients
ALL subsequent disciplines within 24 – 48 hours for POC
POC completion essential for Day 1-7 care delivery
Our focus is on average readmit pattern of Day 10 – 11
Immediate SOC & matches other Post-Acute Providers
IRF – SNF – 24-hour SOC & POC completion w care delivery
Let's discuss staff and patient response to these items
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Readmission lessons learned via Impact Act Trials

- Specifics for Post-Acute Providers in Bundle readmits
- Timeliness of Post-Acute admit – 24 HOURS!!!
- POC development – for value-based POC
- POC Freq/Dur approval w prospective LOS only!!
- NO MVs – SOC delays – non-compliance
- DOCUMENTATION FOR COVERAGE (DFC) determined LOS
- DFC managed IRF/SNF patients heading to HH
- Hardwiring process led to 10+ yrs of single-digit readmits

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Employing Impact Act Bundle lessons for VBP Single-digit Readmissions

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Employing Impact Act Bundle lessons for Single-digit Readmits

- Bundle lessons employed for HH readmission reduction
- HH Single-digit readmission model with an eye on VBP
- All elements of Bundle Care transitions employed
- Initial intervention is at Intake level – referral management
- Referrals intake must be complete for 24-hour SOC
- Complete referrals at intake promote 24-hr scheduling
- Scheduling must have knowledge of staff schedules
- Real-time management of staff schedules for admits

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Employing Impact Act Bundle lessons for Single-digit Readmits

- 24-hour SOCs scheduled – preferably before 1:00 pm
- Assure OASIS accuracy for SOC clinical acuity profile
- OASIS accuracy requires OASIS walk and OASIS Guidance
- Scrubbers don't provide OASIS accuracy in current form
- Involve CGVR and HH agency in SOC OASIS for accuracy
- HH Providers assist in POC Freq/Dur MD order
- Value-based Freq/Dur order – How fast to reach goals
- Remember POC freq/Dur are prospective – may be changed

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Employing Impact Act Bundle lessons for Single-digit Readmits

- Home programs established at SOC and Eval visits
- Compliance must be demoed in documentation asap
- No MVs – missed visits compromise value and outcomes
- Non-compliance must be identified and reported
- Agency interventions in response to non-compliance
- Ongoing non-compliance results in Discharge
- Focus after readmission model thru rehospitalization audits
- Rehospitalization audits hardwire readmit reduction

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2025 VALUE BASED PURCHASING (VBP) UPDATES

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2025 VBP UPDATED CATEGORIES IN DETERMINING HHA FINAL TPS

- Starting in 2025 the following 3 OASIS-based measures, 2 claims-based measures along with HHCAHPS will determine VBP success.
- OASIS-Based Measures:
  - Improvement in Management of Oral Medication – Weighted measure=9%
  - Improvement in Dyspnea – Weighted measure=6%
  - Discharge Function Score (DFS) – Weighted measure=20
- Claims-Based Measures:
  - Discharge to Community – Weighted measure=9%
  - Potentially Preventable Hospitalization (PPH)=26%
- HHCAHPS – 5 Weighted measures=30%

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2025 VBP UPDATED CATEGORIES IN DETERMINING HHA FINAL TPS

- PPH relies on the previously developed conceptual framework that for:
  - Certain diagnosis
  - Proper management of the patient's condition
  - Care of the condition by the HHA
  - Combined with the appropriate, clearly explained and implemented D/C instructions, and accurate referrals can prevent rehospitalization
- Medicare states the PPH is directly affected by:
  - Inadequate management of chronic conditions or infections
  - Inadequate management of other unplanned events
  - Inadequate injury prevention
- Risk goes up in male/female statistically after age 65 (men and women independent of diagnosis)

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2025 VBP DISCHARGE FUNCTION SCORE (DFS)

The DFS determined by assessing and scoring the below 10 GG measured as SOC then at D/C

CMS takes the total SOC "actual score from the below GG questions and runs a risk adjustment to determine an "expected" DFS score that CMS is expecting the patient to achieve by D/C

- GG0130A – Eating
- GG0130B – Oral Hygiene
- GG0130C – Toileting Hygiene
- GG0170A – Roll Left and Right
- GG0170C – Lying to Sitting on Side
- GG0170D – Sit to Stand
- GG0170E – Chair/Bed-to-Chair Transfers
- GG0170F – Toilet Transfers
- GG0170I – Walk 10 Feet
- GG0170J – Walk 50 Feet with 2 Turns
- GG0170R – Wheel 50 Feet with 2 Turns

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2025 VBP DISCHARGE FUNCTION SCORE (DFS)

- 10 GG Measures
- Calculated into an Expected Score at Start of Care
  - The measure is met if you meet or exceed the expected score
  - Team coordination and communication is key throughout episode to achieve
  - Avoid any use of ANA (Activities Not Attempted)
- HHSM – The use of Outcome Patient Detailed Reports in SHP need to be used to drill into any episodes not achieving DFS
  - Teaching all client who have SHP on the use of this report is Key!

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2025 VBP POTENTIALLY PREVENTABLE HOSPITALIZATION (PPH)

- The PPH score is risk adjusted
- It represents the number of unplanned, potentially preventable hospital admissions or observation stays at the HHA divided by the expected number of observation stays for the same patients if treated by the average HHA (Home Health Agency)
  - This included traditional and FFS Medicare
- Hospitalizations are costly and often preventable
- 17-20% of all patients discharged from hospital are re-admitted in 30 day
  - 76% are considered potentially avoidable readmissions
  - Cost of this is appx 12 billion dollars in Medicare expenditures

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2025 VBP POTENTIALLY PREVENTABLE HOSPITALIZATION (PPH)

- Following are excluded from PPH outcomes
  - <18 years old
  - HH stay where patient is NOT continuously enrolled in Part A FFS Medicare for 12 months prior to admission
  - LUPAs
  - Stays where the patient services were received from multiple agencies during the HH stay
  - Stays where the information required for risk adjustment are missing
    - DOB
    - Male/Female
    - HIPPS code
  - Planned inpatient admissions or observation stays

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2025 VBP POTENTIALLY PREVENTABLE HOSPITALIZATION (PPH)

- A patient home health stay is included in the PPH outcome when a potentially preventable condition results in a hospital observation stay or inpatient admission.
- Planned admissions are not counted For the PPH measure.
- Criteria for PPH
  - Clinical condition – *Only certain conditions classified as potentially preventable are included*. These typically relate to health issues that are chronic but can be effectively managed in the community or through home healthcare services
  - Exacerbations or complications – Hospital admissions due to exacerbations of chronic diseases, lack of medication management, or insufficient care

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2025 VBP UPDATED CATEGORIES IN DETERMINING HHA FINAL TPS

- Measures INCLUDED in PPH one year prior to admission to HH
  - Functional impairment level
  - # of post acute admissions
  - # of outpatient ED visits
  - # skilled nursing admissions
  - # inpatient rehab admissions
  - # long term care admissions
  - Hierarchical Conditions Categories (HCC) comorbidities
  - CCS Diagnosis groups – see the attachment everyone
- https://www.cms.gov/files/document/hh-qrp-specificationspotentiallypreventablehospitalizations.pdf

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Rehospitalization Audits to hardwire Single-digit readmits

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Rehospitalization Audits to hardwire Single-Digit Readmits

- Rehospitalization Audits held to drill down per readmit
- Rehosp Audits used to hardwire readmit reduction
- Audits include Clinical Manager, Front-line clinical staff
- Held in response to ALL readmits – daily in large agencies
- Seeking reasons for readmissions to prevent re-occurrence
- Manager performs chart review prior to audit meeting
- Rehospitalization audit tool used for objective findings
- Clinical changes required post Rehosp audit findings (?)

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Rehospitalization Audit DEMO

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Rehospitalization audit DEMO

- Focus on readmission to outline reduction opportunity
- Rehospitalization Audit occurs within 48 hrs of readmit
- Chart review initiates rehosp audit with readmit team
- Readmit team consists of Manager/Supervisory staff
- SOC date, primary dx, CGVR, readmit date and reason
- Per Discipline intervention Chart review & breakdown
- Vitals, CGVR/patient report, response to clinical issues
- Final determination – was this readmission preventable

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