Delivering Care in the Home in 2022 and Beyond - Part 2

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Objectives

Assess

• Assess the impact of Home Health Value Based Purchasing on therapy utilization.

Examine

• Examine how cross setting outcome measures create opportunities for therapy.

Discuss

• Discuss the role of therapy in facilitating effective care transitions between post-acute providers.
Thinking Beyond the Visit Count / CPT Codes

ADD VALUE

- Become better patient managers
- Embrace technology
- Monitor and ensure patient progress
- Optimize cost effectiveness
- Proactive readmission reduction
- Collaborate

Demonstrating the Value of Therapy

- Impact on Publicly Reported Outcomes
  - Self-Care, ADLs
  - Mobility/Locomotion
- Reduction in the Use of Higher Cost Centers of Care
  - Urgent, Emergent Care Centers
  - Unplanned Physician Office Visits
  - ED, (re-) Hospitalizations
- Positive Patient Experience

Quality Care
Patient Centered
Reduced Cost
HHVBP Expansion

Home Health Value Based Purchasing
Impact on Medicare Spending

• Overall, there was a decline in total Medicare spending in HHVBP states during and 30 days after home health episodes of care as measured by the average spending per day among fee-for-service (FFS) beneficiaries receiving home health services.
  • $604.8 million (1.3%) reduction in cumulative Medicare spending, 2016-2019 relative to the 41 non-HHVBP states
• Driven by:
  • $381.4 million (2.4%) reduction in inpatient hospitalization stay spending
  • $164.9 million (4.2%) reduction in skilled nursing facility services spending
• Offset by:
  • $65.3 million (6.1%) increase in outpatient ED & observation stay spending
• No effect on Medicare spending for home health care
Impact on Quality and Utilization

• Results through the fourth year of the model and second year of HHVBP payment adjustments suggest modest gains in quality of care and declines in utilization for some types of services due to HHVBP:
  • Total Performance Scores were 8% higher among HHAs in HHVBP states than HHAs in non-HHVBP states in 2019
  • Decrease in unplanned hospitalizations, ED visits leading to inpatient admission, and skilled nursing facility use by FFS beneficiaries using home health
  • Continued trend toward improvement in functional status, including two new composite measures

• Offset by modest unintended changes due to HHVBP:
  • 2.6% increase in outpatient ED visits
  • 0.3% decrease in two of five measures of patient experience: communication and discussion of care with patients

Impact on Home Health Agency Operations

• Agencies continue to view the model as complementary to other CMS quality initiatives and report leveraging data analytics in coordination with staff training to improve performance and care delivery.

• No effect on overall agency entries or closures, use of home health services, or access to home health care.
## VBP Quality Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quality measures</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-based</td>
<td>Improvement in Dyspnea</td>
<td>M1400</td>
</tr>
<tr>
<td>(weighted 35%)</td>
<td>Discharged to Community</td>
<td>M2420</td>
</tr>
<tr>
<td></td>
<td>Improvement in Management of Oral Meds</td>
<td>M2020</td>
</tr>
<tr>
<td></td>
<td>Total Normalized Composite (TNC) Change in Mobility</td>
<td>M1840, M1850, M1860</td>
</tr>
<tr>
<td></td>
<td>Total Normalized Composite (TNC) Change in Self-Care</td>
<td>M1800, M1810, M1820, M1830, M1845, M1870</td>
</tr>
<tr>
<td>Claim-based</td>
<td>Acute Care Hospitalization During the First 60 Days of Home Health Use</td>
<td>NQF 0171</td>
</tr>
<tr>
<td>(weighted 35%)</td>
<td>Emergency Department Use without Hospitalization During the First 60 Days of Home Health</td>
<td>NQF 0173</td>
</tr>
<tr>
<td>HHCAHPS Survey-based (weighted 30%)</td>
<td>Professional Care, Communication, Team Discussion, Overall Rating, Willingness to Recommend</td>
<td>NQF 0517</td>
</tr>
</tbody>
</table>

\[
\text{TNC} = 75\% \text{ of OASIS Items Impacting HHVBP}
\]

### TNC Mobility (3)
- M1840 - Toilet Transferring
- M1850 - Bed Transferring
- M1860 - Ambulation/Locomotion

### TNC Self-Care (6)
- M1800 - Grooming
- M1810 - Ability to Dress Upper Body
- M1820 - Ability to Dress Lower Body
- M1830 - Bathing
- M1845 - Toileting Hygiene
- M1870 - Eating
OASIS Data Collection

OASIS Is:
- Discipline Neutral
- Data Collection

OASIS Is Not:
- Thorough Assessment
- Creating Care Plans

Who is Driving Outcomes?

CLINICIANS
How Outcomes are Created

M1860 - Ambulation

- Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment.
- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3").
- If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps and uneven surfaces, then Response 2 is the best response (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).
Making Improvement Happen

Determine “why” the impairment is present
- Weakness, balance, environment, cognition, pain, medications

Continuous vs Intermittent Assistance
- Consistent level of understanding across disciplines (LPN/PTA/OTA)

Translate into goal setting and care planning
- Focus on intentional strategies to improve / stabilize OASIS response

M1830 - Bathing

- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then enter Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3").

- If the patient’s ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, enter Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.
Making Improvement Happen

Determine “why” the impairment is present
- Weakness, balance, environment, cognition, pain, medications

Continuous vs Intermittent Assistance
- Consistent level of understanding across disciplines (LPN/PTA/OTA)

Translate into goal setting and care planning
- Focus on intentional strategies to improve / stabilize OASIS response

M2020 – Management of Oral Medication

- Enter Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely.
Assessing Ability

Safe & Consistent Administration

Knowledge:
What?
When?

Function:
Where?
How?

Making Improvement Happen

Determine “why” the impairment is present
- Weakness, balance, environment, cognition, pain, lack of medications

Administration errors vs Drug Regimen Review
- Consistent level of understanding across disciplines (LPN/PTA/OTA)

Translate into goal setting and care planning
- Focus on intentional strategies to improve / stabilize OASIS response
Cross Setting Measures

LTAC, IRF, SNF, HH

Addressing Quality

Long Term Care Hospital  Inpatient Rehabilitation Facility

Skilled Nursing Facility  Home Health

Common Ground
Measure Development Timeline

- **2014**
  - IMPACT Act signed

- **2015**
  - Change in Mobility Among LTCH Patients Requiring Ventilator measure adopted for LTCH QRP

- **2016**
  - Process measure introduced in LTCH, IRF, SNF and 4 Functional Outcome measures finalized for IRF

- **2018**
  - Process measure added for HH and 4 Functional Outcome measures finalized for SNF

  - Currently
  - Refining functional measures for application across all four settings

Current Measurement Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>GG0170A</td>
<td>Roll Left and Right</td>
</tr>
<tr>
<td>GG0170B</td>
<td>Sit to Lying</td>
</tr>
<tr>
<td>GG0170C</td>
<td>Lying to Sitting on Side</td>
</tr>
<tr>
<td>GG0170D</td>
<td>Sit to Stand</td>
</tr>
<tr>
<td>GG0170E</td>
<td>Chair/Bed-to-Chair Transfer</td>
</tr>
<tr>
<td>GG0170F</td>
<td>Toilet Transfer</td>
</tr>
<tr>
<td>GG0170I</td>
<td>Walk 10 Feet</td>
</tr>
<tr>
<td>GG0170J</td>
<td>Walk 50 Feet with 2 Turns</td>
</tr>
<tr>
<td>GG0170K</td>
<td>Walk 150 Feet</td>
</tr>
<tr>
<td>GG0170R</td>
<td>Wheel 50 Feet with 2 Turns</td>
</tr>
<tr>
<td>GG0170S</td>
<td>Wheel 150 Feet</td>
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</tbody>
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Resources


Setting-specific QRP Websites

- HH: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits

Care Transitions

More than Making a Referral
Refocusing the “Hand Off”

Looking Ahead

The future depends on what you do today!

Mahatma Gandhi
Housekeeping: Asking Your Questions

- Please use the Q&A box to type in any questions you have regarding today’s programming.

- Those listening to a recorded version may ask questions by using the email address provided in this handout.

Our Mission:
Empower home health agencies with revenue protection strategies.

Our Core Values:
Innovation / Trust / Integrity

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