Home Health Value Based Purchasing

Performance Improvement Strategies from the VNAA Blueprint for Excellence

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Presenters

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Agenda for Today

- A look at performance requirements in VBP
- Voices from the field: Norwell VNA & Hospice
- VNAA Blueprint for Excellence: cross-cutting strategies to improve performance
- VNAA Blueprint for Excellence: measure specific strategies to improve performance
- Questions: please use chat box

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Why Performance Improvement for VBP?

Baseline:

- Home Health Compare
- Star Ratings for Quality and Patient Experience
- National benchmarks

VBP

- 21 OASIS, Claims and HHCAHPS Measures (not all on HHC)
- Reimbursement tied to performance: improvement and achievement
- 3 New Measures (scored on reporting only)
- Quarterly feedback to HHAs starting July 2016
- Annual public reporting of quality reports

HHVBP Measures by NQF Domain*

Domain	Measure	Measure Type	Source
1	Communications between Providers and Patients	Outcome	CAHPS
1	Specific Care Issues	Outcome	CAHPS
1	Overall rating of home health care	Outcome	CAHPS
1	Willingness to recommend the agency	Outcome	CAHPS
2	Improvement in Ambulation-Locomotion	Outcome	OASIS (M1860)
2	Improvement in Bed Transferring	Outcome	OASIS (M1850)
2	Improvement in Bathing	Outcome	OASIS (M1830)
2	Improvement in Dyspnea	Outcome	OASIS (M1400)
2	Drug Education on All Medications Provided to Patient/Caregiver during all EOC	Process	OASIS (M2015)
3	Discharged to Community	Outcome	OASIS (M2420)
3	Care Management: Types and Sources of Assistance	Process	OASIS (M2102)
4	Influenza Vaccine Data Collection	Process	OASIS (M1041)
4	Influenza Immunization Received for Current Flu Season	Process	OASIS (M1046)
4	Pneumococcal Polysaccharide Vaccine Ever Received	Process	OASIS (M1051)
4	Reason Pneumococcal vaccine not received	Process	OASIS (M1056)
5	Acute Care Hospitalization:	Outcome	CCW (Claims)
5	Emergency Department Use without Hospitalization	Outcome	CCW (Claims)
6	Improvement in Pain Interfering with Activity	Outcome	OASIS (M1242)
6	Improvement in Management of Oral Medications	Outcome	OASIS (M2020)
6	Prior Functioning ADL/IADL	Outcome	OASIS (M1900)
6	Care of Patients	Outcome	CAHPS
			Total

DOMAINS

1) Patient and Caregiver centered experience
2) Clinical Quality of Care
3) Communication & Care Coordination
4) Population Health
5) Efficiency and cost reduction
6) Safety

* From SHP webinar

VBP Measures not on HHC

5 of 21 OASIS, HHCAHPS and Claims measures are collected but not currently reported on HHC:

- Discharge to community
- Care Management – Types and Sources
- Prior Functioning ADL/IADL
- Influenza Vaccine Data Collection
- Reason Pneumococcal Vaccine not received

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New Measures

- 3 measures are completely new and will be reported by the HHAs via CMS Web Portal starting with Q3 data

Measure	Measure Type	Notes
Influenza Vaccination Coverage for Home Health Care Personnel	**Process**	**% HHA personnel received or documented not received – medical condition, received elsewhere, declined, unknown. Need to have worked 1 day Oct 1 to March 31st**
Herpes zoster (Shingles) vaccination: Has the patient ever received the shingles vaccination?	**Process**	**# of Medicare beneficiaries over 60 that ever received shingles vaccine**
Advanced Care Plan	**Process**	**Patients over 18 with plan or discussed with patient (no surrogate or plan made)**

Some Context – All HH Quality Measures!

	Measure	Data Source	VBP	Patient Experience Star Rating	Quality Care Star Rating	HHC	IMPACT Act (under development)
1.	Communications between providers and patients	CAHPS					
2.	Specific care issues	CAHPS					
3.	Overall rating of home health care	CAHPS					
4.	Willingness to recommend the agency	CAHPS					
5.	Improvement in ambulation-locomotion	OASIS					
6.	Improvement in bed transferring	OASIS					
7.	Improvement in bathing	OASIS					
8.	Improvement in dyspnea	OASIS					
9.	Drug education on all medications provided to the patient/caregiver during all EOC	OASIS					
10.	Discharged to community	OASIS					Specs not final
11.	Care management types and sources of assistance	OASIS					
12.	Influenza vaccine data collection	OASIS					
13.	Influenza immunization received for current flu season	OASIS					
14.	Pneumococcal polysaccharide vaccine ever received	OASIS					
15.	Reason pneumococcal vaccine not received	OASIS					
16.	Acute care hospitalization	claims					
17.	Emergency department use without hospitalization	claims					
18.	Improvement in pain interfering with activity	OASIS					
19.	Improvement in management of oral medications	OASIS					
20.	Prior functioning ADL/IADL	OASIS					
21.	Care of patients	CAHPS					
22.	Flu vaccine for HHA Staff	HHA report					
23.	Herpes zoster vaccine for patient	HHA report					
24.	Advance Care Plan	HHA report					
25.	Timely initiation of care	OASIS					
26.	Heart failure symptoms addressed	OASIS					
27.	Diabetic foot care and patient education implemented	OASIS					
28.	Pain assessment conducted	OASIS					
29.	Pain interventions implemented	OASIS					
30.	Depression assessment conducted	OASIS					
31.	Multifactor fall risk assessment for all pts who can ambulate	OASIS					
32.	Pressure ulcer risk conducted	OASIS					
33.	Pressure ulcer prevention in POC	OASIS					
34.	Pressure ulcer intervention implemented	OASIS					
35.	Improvement in status of surgical wounds	OASIS					
36.	Rehospitalization during the first 30 days of home health	Claims					
37.	Emergency department use without hospital readmission within the first 30 days of home health	Claims					
38.	Estimated Medicare Spending Per Beneficiary	Claims					
39.	All cause potentially preventable readmissions	Claims					
40.	Skin integrity and changes in skin integrity	new OASIS					
41.	Medication reconciliation / drug regimen review	new OASIS					
42.	Incidence of major falls	unknown					
43.	Communicating and transferring care preferences and health information	unknown					
44.	Functional status, cognitive function, and changes in function and cognitive status	unknown					

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What is the Blueprint?

- Expert recommendations from VNAA member Work Group
- Based on evidence, but evidence is not available on every topic
- Work in progress – knowledge continues to evolve
- Identifies multiple options for improvement
- Blueprint ideas are used in conjunction with Clinical Pathways, accreditation, electronic tools, regulatory compliance and other requirements for home health agencies
- Users identify strategies that work in their organization, given size, workforce availability, caseload, customer needs

For Live Links, Case Studies, Resources and More Information

VNAA Blueprint for Excellence

Vnaablueprint.org

5-Star Best Practices

(Members only)

Home | Home Health | Hospice and Palliative | About | Contact search

VNAA Blueprint for Excellence
PATHWAY TO BEST PRACTICES

Background for Payers | Policymakers | Providers

Home Health

Hospice and Palliative

VNAA Presents a Blueprint for Best Practices in Home Health, Hospice and Palliative Care.

The VNAA Blueprint for Excellence is a quality improvement and workforce training resource for home health, hospice and palliative care providers. It advances the use of best practices by gathering into one virtual location curriculum and training tools, as well as the relevant research supporting those tools. The VNAA Blueprint and its best practices demonstrate the value of home health, hospice and palliative care--both in lowering the overall cost of care and in improving health outcomes.

	Measure	Data Source	VBP	Patient Experience Star Rating	Quality Care Star Rating	HHC	IMPACT Act (under development)
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Patient Experience

Improving function

Symptom management

Immunizing pt and staff

Admissions and ED use

Foundations of Quality

Cross-cutting strategies that influence all measures:

1) Adopt a quality improvement model
2) Use your data strategically
3) Educate and train staff to improve reliability
4) Ensure accurate OASIS assessment and documentation

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Quality Improvement Models

Institute for Healthcare Improvement

- Plan-Do-Study-Act-Sustain
- Improve consistency of practices
- Make the right thing to do the easy thing to do – build the processes into tools and documentation systems
- Evaluate new programs to ensure the achieve desired goals

Other programs and models available from HRSA, AHRQ, HHQI

Best Practice Tip

Adopt cross cutting quality steps to improve all measures:

- Staff training specific to the measure
- OASIS training and auditing
- Matching staff to patient need
- Patient-defined goal setting
- Always events to improve reliability
- Data review and accountability at all clinician and management levels

Use Data Strategically

Best practices:

- Use electronic alerts for gaps in care or documentation
- Use predictive alerts for patients at risk of care gaps
- Routine review of data trends; daily review of readmissions and ED data
- Performance targets specific to star ratings or VBP measures
- Benchmark agency data to risk adjusted state and national data
- Partner with a data analytics vendor if needed
- If you’ve got it, flaunt it! Make sure your customers know you can deliver high performance in the areas they care about

Best Practice Tip

Data and Analytics:

- Generate measurement reports weekly or at minimum, monthly to be reviewed by team members, including clinicians.
- Develop criteria for improvement directly related to key measures: VBP, Home Health Compare and Star Ratings.
- Understand which measures are driving your performance and address them first in quality improvement.

Educate and Train Staff

Consistency is the goal!

- Train specific to priority measures and the ‘big picture’
- Use simulations and scenarios to help adult learners make the connections
- Reinforce OASIS skills with regular updates and tips
- Recognize high performing staff
- Teach skills needed to manage patient experience
- Use mentors and preceptors
- Recognize different education needs for nursing and therapy
- Provide monthly and quarterly scorecard and feedback on staff performance specific to metrics

Accurate OASIS Assessment and Documentation

- Train staff on big picture links between assessment, patient care, documentation, and reimbursement
- For functional status, observation is key
- Conduct 100% review before submitting OASIS
- Assign same clinician at SOC and discharge
- Train for inter-rater reliability of assessments and documentation
- Support continuing OASIS education and certification of staff

Measure-specific Strategies to Improve Performance

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Managing Daily Activities

Barriers to high performance:

- Patient depression
- Patient cognitive impairment
- Not all staff engaged in care plan goals
- Rehabilitation staff not involved (shortages, lack of MD referral)
- Some patients have limited improvement opportunity

Managing Daily Activities

Best Practice Recommendations

- Screen all patients for cognitive problems and depression
- Involve therapists early – Occupational therapy (OT)
- Develop plan of care with emphasis on functional status
- Improve consistency of care plan implementation - assign agency staff with knowledge of patient's plan (POC)
- Educate referral sources on need for rehab services
- Develop sources for supplemental rehab staff, and processes to ensure they practice according to agency performance standards

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Managing Pain and Treating Symptoms

Barriers to High Performance

- Inconsistent assessment and documentation
- Inconsistent physician prescribing and responsiveness
- Patient factors (fear, non-adherence, home environment)
- Lack of access to / use of palliative care specialists

Managing Pain and Treating Symptoms

Best Practice Recommendations

- Agency level Nurse Council develops, endorses and oversees use of agency specific pathways for pain and dyspnea management
- Pain and dyspnea standardized assessment conducted with vital signs
- Adopt pain management ‘always event’
- Adopt symptom management checklists in EMR
- Consistent use of clinical pathways with numeric thresholds for contacting physician
- Develop and use relationships with palliative care nurse consultants
- Enhance clinician training with ELNEC or other targeted information
- Adopt SBAR communications
- Educate referral sources on need for pain, dyspnea protocols and need to involve rehab staff

Case Example: Managing Pain and Treating Symptoms

Agency Example:

- Re-educate all clinical teams on pain screening and pain assessment in cognitively impaired patients
- Increase referrals to PT to manage pain and dyspnea with movement
- Review SHP data and hospitalization data on regular basis
- Implement High Risk protocol (frontloading visits, etc.)
- Standardize patient education materials with hospital
- Implement Better Breathing program overseen by PT

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Preventing Harm - Interventions

Barriers to Best Practices – Flu Shot

- Lack of coordination with other practitioners
- Lack of documentation or difficulty locating records
- Lack of clarity regarding the ‘current flu season’ and HH episode
- Patient refusal
- Provider’s not prioritizing

*recommendations target the Star Ratings Measure

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Preventing Harm - Interventions

Best Practice Recommendations – Flu Shot

- Include flu shot status in referral info and/or initial assessment
- Incorporate into health record as mandatory field
- Develop protocols for follow up where shot is missing – may be standing orders, referral to PCP, referral to other site
- Obtain standing orders in states where allowed
- Designate specific staff to follow up with providers and/or query for missing data
- Traveling shot clinics
- Educate staff on agency protocols and annual initiatives
- Tap into Centers for Disease Control and Prevention resources for patient and provider information

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Preventing Unplanned Hospital Care

Barriers to Best Practices – Preventable readmissions:

- Early hospital discharge without adequate planning
- High risk patients needing additional intensity
- Physician referral to the emergency department
- Lack of access to outpatient urgent care
- Patient / caregiver lack of knowledge or fear

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Preventing Unplanned Hospital Care

Best Practice Recommendations – preventing readmissions

- More effective identification of high risk patients
- Offer intensive home health services for high risk patients, including frontloaded visits, link with private duty
- Arrangements with physician or nurse practitioner for home visits
- Improve relationships with hospitals – liaison teams, participation on discharge planning team
- Using SBAR communications for more rapid response
- Track, monitor ED and admission data, and develop targeted interventions
- Develop transition of care protocols
- Improve planning and education with patients on what to do in emergencies. "Call me first" education tools.
- Use technology to monitor, engage with patients

Improving Patient Experience

Barriers to Best Practice:

- Lack of consistent practice
- Lack of customer service perspective
- High demands
- Cognitive barriers

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Improving Patient Experience

Best Practice Recommendations:

- Create an ‘always event’ practice to ask patients about their goals
- Understand customer needs more effectively: routine outbound call at 1 week and after any complaint
- Designate agency leader for customer service
- Implement customer service QI in areas of frequent complaints: scheduling, return calls, staff turnover
- Develop formal process for effective handoffs when there are staff turnovers
- Offer customer service training for all employees with scripting, roll playing
- Document patient goals in the home, use them for discussion with patients and refer to them when discussing progress

Improving Patient Experience

Top Tip: Make it an ‘always event’ to ask about the patient’s personal goal for each specific visit: “what can I do for you today?”

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Takeaways

- Know your data and USE it!
- Address the fundamentals – OASIS, training, patient experience, then drill down
- Prioritize your activities
- Stay focused in spite of competing priorities
- Keep the patient at the center

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More Details

- **VNAABlueprint.org**
- VNAA Leading Innovation Annual Meeting – VBP Preconference workshop
- vna@vnaa.org | www.VNAA.org

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Next webinar
March 17, 2-3 EST

Customizing Your QAPI to Meet Strategic and Operational Objectives in a VPB Environment

Margherita Labson, The Joint Commission