ACHIEVING SUCCESS IN THE MEDICARE HOME HEALTH VALUE BASED PURCHASING PILOT PROGRAM

SUPPORTING FIRMS

- Special thanks goes to:

FACULTY

- Tim Ashe (Fazzi) tashe@fazzi.com
- Chris Attaya (SHP) cattaya@SHPdata.com
- Gary Bowers (CLA) garyrbowers@gmail.com
- Mary K. Carr mkc@nahc.org
- Ron Clitherow (CLA) RHCHEELS@aol.com
- Bill Dombi (NAHC) wad@nahc.org
- Mike Dordick (McBee) MikeDordick@McBeeAssociates.com
- Melinda Gaboury (HPS) mgaboury@healthcareprovidersolutions.com
- Rachel Hawkins (Simione) rhawkins@simione.com
- Christine Lang (OCS) Christine.Lang@ABILITYNetwork.com
- Diane Link Blacktree) dianelink@blacktreehealthcare.com
- Sandy Marshall (CLA) sgmarshall47@gmail.com
- Jeannee Parker Martin (Corridor) jpmartin@corridorgroup.com
- Laurie Salmons (McBee) LaurieSalmons@McBeeAssociates.com
- Nick Seabrook (Blacktree) nickseabrook@blacktreehealthcare.com
- Mark Sharp (BKD) msharp@bkd.com
- Kim Skehan (Simione) kskehan@simione.com
- Karen Vance (BKD) kvance@bkd.com

AN OVERVIEW OF THE CY2016 HHVBP RULE

ACHIEVING SUCCESS IN THE MEDICARE HOME HEALTH VALUE BASED PURCHASING PILOT PROGRAM

The 2016 Medicare Home Health Value Based Purchasing Pilot Program Rule

Rule: https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home

FAQ Site: https://innovation.cms.gov/initiatives/Home-Health-Value-Based-Purchasing-Model/faq.html

Value-Based Purchasing Pilot (VBP)

- CMS establishes piloted VBP:
  - Starting in 2016
    - Baseline year 2015
    - Performance year 2016
    - Payment year 2018
  - 9 states mandatory participation of all HHAs (Florida included - 20% of all HHAs nationally
  - 3-8% payment withhold for incentive payments
    - "greater upside benefit and downside risk"
    - Phase-in to 8%
  - Performance measures
    - Achievement and improvement
    - Process, outcomes, and patient satisfaction
  - Comparison based on "smaller-volume" and "larger-volume"
    - State-based comparison

Value-Based Purchasing Pilot: Structure

- Randomized state selection methodology
- Reporting framework
- Payment adjustment methodology
- Payment adjustment schedule
- Quality measure selection standards
  - Classification and weighting
  - Measures for performance year
  - Framework to adopt new measures
- Performance scoring method
  - Achievement
  - Performance improvement
- Review and recalibration period
- Evaluation framework
- Public reporting

Value-Based Purchasing Pilot

- Final states: MA, MD, NC, FL, WA, AZ, IA, NE, TN
  - 9 regions
  - Randomized selection w/in each region
  - Subject to change
- Factors considered in setting up regions
  - HHA size
  - Utilization levels
  - Rural
  - Dual-eligibles
  - Proportion of minorities

Value-Based Purchasing Pilot

- Payment Adjustment Timeline
  - 5 performance years beginning in 2016
    - 2016 > 2018 payment adjustment (3%)
    - 2017 > 2019 payment adjustment (5%)
    - 2018 > 2020 payment adjustment (6%)
    - 2019 > 2021 payment adjustment (7%)
    - 2020 > 2022 payment adjustment (8%)
  - May modify schedule beginning in 2019 with more frequent adjustments

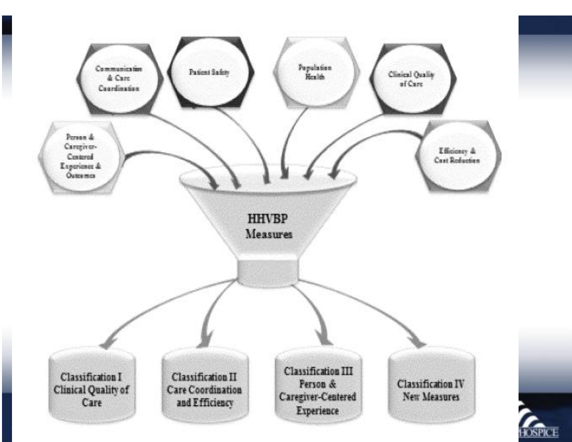
Value-Based Purchasing Pilot

- Measures
  - 6 Process; 15 Outcome; 3 New Measures
  - OASIS; Claims; HHCAPS
- Principles:
  - Broad set to capture HHA complexities
  - Flexibility to include IMPACT Act proposed PAC measures
  - Develop second-generation measures of outcomes, health and functional status, shared decision-making and patient activation
  - Balance of process, outcome, and patient experience
  - Advance ability to measure cost and value
  - Measures on appropriateness and overuse
  - Promote infrastructure investments

Classification of Measures

- Classification I - Clinical Quality of Care: Measures the quality of health care services provided by eligible professionals and paraprofessionals within the home health environment.
- Classification II - Care Coordination and Efficiency: Outcomes measure the end result of care including coordination of care provided to the beneficiary. Efficiencies measure maximizing quality and minimizing use of resources.
- Classification III – Person- and Caregiver-Centered Experience: Measures the beneficiary and their caregivers' experience of care.
- Classification IV – New Measures: Measures not currently reported by Medicare certified HHAs to CMS, but that may fill gaps in the NQS Domains not completely covered by existing measures in the home health setting.

Home Health Value Based Purchasing



Value-Based Purchasing Pilot: Measures

- Outcome
  - Improvement in ambulation-locomotion (OASIS)
  - Improvement in bed transferring
  - Improvement in Bathing
  - Improvement in Dyspnea
  - Discharged to community
  - Acute care hospitalization (unplanned w/in 60 days; during first 30 days)
  - Emergency Department use w/o hospitalization
  - Improvement in pain interfering with activity
  - Improvement in oral medication management
  - Prior functioning ADL/IADL
  - Care of Patients (CAHPS)
  - Communication between providers and patients (CAHPS)
  - Specific care Issues (CAHPS)
  - Overall rating (CAHPS)
  - Willingness to recommend the agency (CAHPS)

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Value-Based Purchasing Pilot: Measures

- Process (OASIS)
  - Influenza vaccine data collection
  - Influenza immunization received
  - Pneumococcal vaccine received
  - Reason Pneumococcal vaccine not received
  - Drug education
  - Care management/types and sources of assistance

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HOMECARE & HOSPICE

Value-Based Purchasing Pilot: Measures

- New Measures: HHA reporting through portal
  - Influenza vaccination of HH staff
  - Herpes zoster (shingles) vaccines for HHA patients
  - Advanced Care planning

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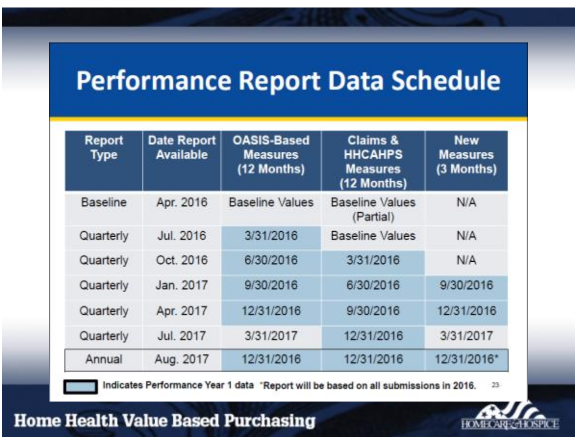
HOMECARE & HOSPICE



Performance Report Data Schedule

Report Type	Date Report Available	OASIS-Based Measures (12 Months)	Claims & HHCAHPS Measures (12 Months)	New Measures (3 Months)
Baseline	Apr. 2016	Baseline Values	Baseline Values (Partial)	N/A
Quarterly	Jul. 2016	3/31/2016	Baseline Values	N/A
Quarterly	Oct. 2016	6/30/2016	3/31/2016	N/A
Quarterly	Jan. 2017	9/30/2016	6/30/2016	9/30/2016
Quarterly	Apr. 2017	12/31/2016	9/30/2016	12/31/2016
Quarterly	Jul. 2017	3/31/2017	12/31/2016	3/31/2017
Annual	Aug. 2017	12/31/2016	12/31/2016	12/31/2016*

Indicates Performance Year 1 data *Report will be based on all submissions in 2016. 23

Value-Based Purchasing Pilot: Scoring

- Quarterly assessment
- Total Performance Score (TPS): higher of achievement or performance score in each measure
- All Outcome and Process measures have equal weight and account for 90% of TPS
- New Measure reported accounts for 10% and each has equal weight
- Points only for "applicable measures" (20 episodes per year)
  - 0 to 10 points on each Outcome and Process measure
  - 10 or 0 points on New Measures (report vs. no report)

Value-Based Purchasing Pilot: Scoring

- "Achievement threshold": <u>median</u> of all HHA performance in baseline period
- "Benchmark": <u>mean</u> of top decile of all HHA performance in baseline period
- State specific; separate "smaller" and "larger" HHAs
- Each measure is separately scored

Value-Based Purchasing Pilot: Scoring

- Achievement scoring
  - HHA with performance equal to or higher than benchmark receives 10 points
  - HHA with performance equal to or greater than achievement threshold receives 1-9 points based on formula:
    - 9 X (HHA performance score-achievement threshold) divided by (benchmark-achievement threshold) + 0.5
  - HHA with performance less than achievement threshold receives 0 points

Value-Based Purchasing Pilot: Scoring

- Improvement scoring
  - HHA with performance equal to or higher than benchmark receives 10 points
  - HHA with performance greater than its baseline period receives 1-9 points based on formula:
    - 10 X (HHA performance period score-HHA baseline period score) divided by (benchmark-HHA baseline period score) - 0.5
  - HHA with performance equal or less than baseline period score receives 0 points

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Scoring Illustration

Figure 7: Example of an HHA Earning Points by Achievement or Improvement Scoring

Measure: PN Pneumococcal Vaccination

Achievement Threshold
Benchmark
Achievement
. 474
.875
Achievement Range
Performance Year Score
.910
HHA A Score: 10 maximum points for achievement
Baseline Year Score
Performance Year Score
.212
.703
HHA B Improvement
Improvement Range
HHA B Score: the greater of 6 points for achievement and 7 points for improvement

EXAMPLE

Achievement Threshold – 0.474

Benchmark – 0.875

- **HHA B's performance on this measure went from 0.212 (which was below the achievement threshold) in the baseline period to 0.703 (which is above the achievement threshold) in the performance period. Applying the achievement scale, HHA B would earn 5.640 points for achievement, calculated as follows:**

  [9 x ((0.703 - 0.474)/(0.875 -0.474))] + 0.5 = 5.640

- **Checking HHA B's improvement score yields the following result: Based on HHA B's period-to-period improvement, from 0.212 in the baseline year to 0.703 in the performance year, HHA B would earn 6.906 points, calculated as follows:**

  [10 x ((0.703 -0.212)/(0.875 -0.212))] - 0.5 = 6.906

- **Because the higher of the achievement and improvement scores is used, HHA B would receive 6.906 points for this measure.**

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Value-Based Purchasing Pilot: Scoring

- **Total Performance Score (TPS)**
  - **Use only those measures out of the 24 with 20 or more episodes**
  - **Use higher of improvement or achievement score**
  - **Existing 21 measures (90% of TPS): Total possible points = 210**
    - **Divide total earned points by total possible points multiplied by 90%:**
    - **Example: 176 earned points/210max points = 83.810% x 90% = 75.429 points**
  - **Add New Measure points: 0, 10, 20, 30 points (points earned/possible points X 10%).**
    - **HHA only submits on 2 of the 3 measures = 20 points/30 points – 66.67% X 10% - 6.667 points**
  - **TPS = 75.429 + 6.667 = 82.096**

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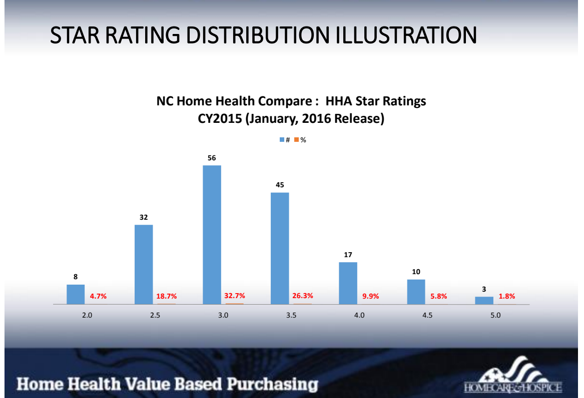
STAR RATING DISTRIBUTION ILLUSTRATION



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PAYMENT EFFECT

- Based on a Linear Exchange Function (LEF)
  - Arrays all HHA scores in the state on a curve and slope
  - HHAs above average will get increases and those below will get payment rate reductions
- 7 step process calculated by CMS not providers
  – Prior Year Aggregate HHA Payment Amount
  – % Payment Reduction Amount
  – Final TPS Adjusted Reduction Amount
  – LEF
  – Final TPS Adjusted payment Amount
  – Quality Adjusted Payment Rate
  – Final Percent Payment Adjustment

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Figure 9: 8-percent Reduction Sample

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
HHA	TPS	Prior Year Aggregate HHA Payment*	8-Percent Payment Reduction Amount (C2*8%)	TPS Adjusted Reduction Amount (C1/100)*C3	Linear Exchange Function (LEF) (Sum of C3/ Sum of C4)	Final TPS Adjusted Payment Amount (C4*C5)	Quality Adjusted Payment Rate (C6/C2) *100	Final Percent Payment Adjustment +/- (C7-8%)
	(C1)	(C2)	(C3)	(C4)	(C5)	(C6)	(C7)	(C8)
HHA1	38	$ 100,000	$ 8,000	$ 3,040	1.93	$ 5,867	5.9%	-2.1%
HHA2	55	$ 145,000	$ 11,600	$ 6,380	1.93	$ 12,313	8.5%	0.5%
HHA3	22	$ 800,000	$ 64,000	$ 14,080	1.93	$ 27,174	3.4%	-4.6%
HHA4	85	$ 653,222	$ 52,258	$ 44,419	1.93	$ 85,729	13.1%	5.1%
HHA5	50	$ 190,000	$ 15,200	$ 7,600	1.93	$ 14,668	7.7%	-0.3%
HHA6	63	$ 340,000	$ 27,200	$ 17,136	1.93	$ 33,072	9.7%	1.7%
HHA7	74	$ 660,000	$ 52,800	$ 39,072	1.93	$ 75,409	11.4%	3.4%
HHA8	25	$ 564,000	$ 45,120	$ 11,280	1.93	$ 21,770	3.9%	-4.1%
Sum			$ 276,178	$ 143,007		$ 276,002		

*Example cases.

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Value-Based Purchasing Pilot: Preview

- Opportunity to review quarterly quality reports
  – 30 days to request recalculation July 2016 first report
- Opportunity to review TPS and payment adjustment calculations
  – August 1, 2017 first notification
  – 30 days to request recalculation Final report no later than November 1, 2017

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CMS Secure Portals

- Enterprise Identity Management (EIDM) system
  - Register for User ID
  - Must submit the User ID and agency point of contact information to HHVBP helpdesk
    HHVBPquestions@cms.hhs.gov
- EIDM registration is the first step in accessing:
  - Innovation Center Portal
  - HHVBP Portal
    - New measure submission
    - Performance reports

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Value-Based Purchasing Pilot: Industry Concerns

- Generally supportive of VBP as a payment model reform
  - Details matter!
- Details here raise concerns
  - Amount at risk
    - 2% is max in other sectors
    - At risk levels may prevent improvements as resources depleted
  - Measures are complex, subject to manipulation, and leave out patient stabilization
    - Do not reflect population served in home health
  - Will congressional VBP overlap or replace?
  - Will overlap with bundling, ACOs, and other innovations

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Dates to Remember

- April 2016: CMS provides thresholds and benchmarks to each HHA based on 2015 data
- July 2016: Initial Quarterly performance reports sent to HHAs
- August 2017: Initial Annual report with expected "Quality Adjusted Payment Rate" provided to each HHA
  - Adjustments can be positive (increase) or negative (decrease)
  - Percentage Rate Adjustment applied to final payment amounts for paid claims in 2018 (determined by the fiscal intermediary) after each annual performance period.
  - 30-day appeals process

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CONCLUSION

- We've seen the future and it is here!
- Winners will come through effort
- Manipulators need to be exposed!
- While in just 9 states all should be attentive

How to Design and Implement Your HHVBP Strategic Plan

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Strategic Management Model

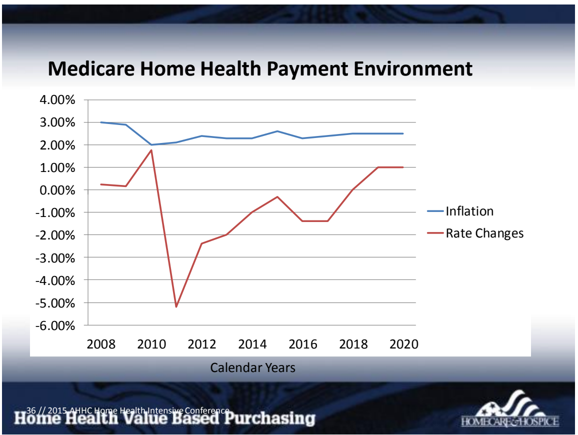
Direction from Leadership

- Define and communicate the vision
- Develop culture of change
- Establish the behavior and performance expectations
- Ensure access to necessary resources
- Identify known barriers and manage resistance

Establishing a VBP Team

- Purpose
  - Gather information and provide input via a multi-disciplinary team approach
  - Oversee and drive all phases of the project

Medicare Home Health Payment Environment



Establishing a VBP Team

- Selecting the right team members
  - Appoint a team leader
    - Committed to the vision, culture, and needed change
  - Determine appropriate size of team
    - Inclusive of:
      - Administrative/management
      - Performance improvement/quality assurance
      - Clinical, nursing and rehab
      - Information technology
      - Finance and/or billing
      - Outside vendors?

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Establishing a VBP Team

- Desired traits of the team members
  - Strong leadership skills
  - Understand scope of HHVBP transition
  - Great listeners and communicators
  - Positive attitude and change agent
  - Skills to implement change
  - Innovative and will contribute ideas
  - Ability to see the big picture but get in the details

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VBP Team Functions

- Through regular meetings and activities
  - Execute the vision
    - Culture of quality must be included in the mission and values of the organization
  - Identify gaps
  - Develop plan
  - Assess progress
  - Hold team accountable
  - Effective and concise agenda and activities

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VBP Team Functions

- Reinforce the vision and culture
- Perform gap analysis
- Develop implementation budget
- Identify and ensure involvement of key stakeholders
- Develop and adhere to well-defined implementation timeline
- Manage the change

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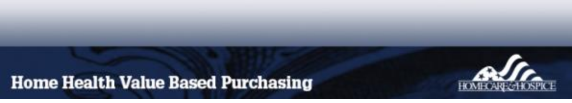
Gap Analysis

- Comparison of actual performance with potential/needed performance
- Foundation for measuring investment of time, money and other resources required to achieve a particular outcome



Gap Analysis

- VBP gap analysis should consider
  - Operations
  - Clinical
  - Financial
- Get out of the silos
- Look outside traditional Medicare FFS

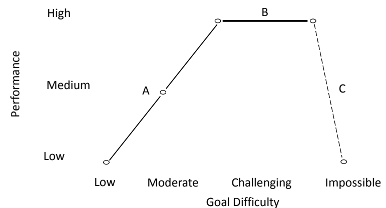
Gap Analysis Steps

- Identify the objectives
  - Where do we need to be
- Analyze the current situation
  - Where are we now
    - Current performance and processes
    - Problem areas
    - Responsible staff
    - Data required
    - Source of data

Gap Analysis Steps

- Identify how to “bridge the gaps”
  - Set your goals
  - How do we get there
    - The people
    - The processes
    - The technology
    - The time
    - The materials/equipment

Goals That Are Too Easy or Too Hard Fail



A: Performance of committed individuals with adequate ability
B: Performance of committed individuals who are working at capacity
C: Performance of individuals who lack commitment to high goals

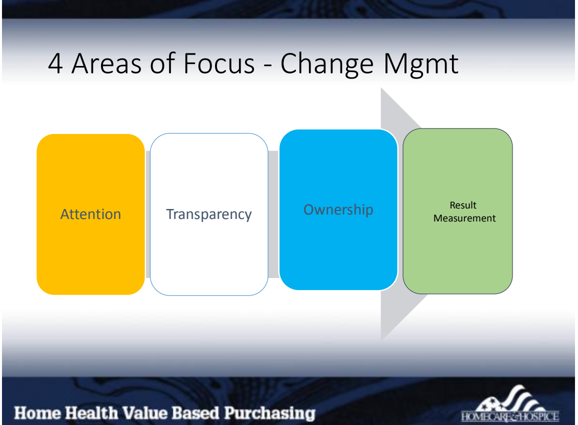
Gap Analysis Steps

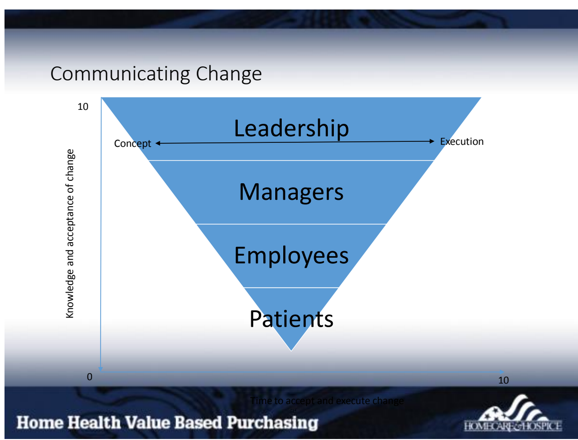
- **Define the necessary tasks**
- **Assign a responsible party**
- **Reconsider gaps/tasks periodically**

Through it all you need

to manage change.

4 Areas of Focus - Change Mgmt





Caution! Avoid Overload

Too Many Strategies Leads to Reduction in Application

Impact of Too Many Strategies

The Impact of Information Overload

Decision Accuracy

Information Overload

Information Load

Source: Eppler, Martin J., Mengis, Jeanne, A Framework for Information Overload Research in Organizations, Insights from Organization Science, Accounting, Marketing, MIS, and Related Disciplines, Paper # 1/2033, September 2003

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VBP Is a Marathon, Not a Sprint!

- Established as a 5 year model – changes are likely from CMS.
- **Sustaining** change, and continuous learning and improvement, as an organizational culture, will be critical for ongoing success.
  - Assuring operating systems are adequate and properly aligned to support the organization's vision, strategies and goals.
  - Alignment of employee (and contract staff) behaviors, practices, performance, and reward recognition are important for assuring long-term, sustainable change and improvement.
    - Cannot allow some to impede progress or not "to be on the bus."
  - What matters should be measured---what gets measured tends to improve over time! Critical for assuring ongoing sustainable change and continuous improvement as keys for VBP.
    - Clearly define "what matters" with key metrics to measure how we are going to "keep score"…avoid information overload.

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Summary

- Create the vision and goals that are both articulated <u>and</u> reinforced by top management
- Establish and empower a VBP team
- Perform a gap analysis and identify/address any perceived barriers to success
- Develop a plan for effective organizational transition and clearly quantified goals
- Follow the plan…but learn and adjust as indicated
- Hold the team accountable
- Manage change AND celebrate successes!

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Establishing Essential Data Dashboards for HHVBP

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Agenda

- Accessing Information, Working with your Vendor
- Assessing Performance—Identifying Strengths and Weaknesses
- Prioritizing Efforts
  - Selecting Measures/Areas for Focus
  - Identifying Opportunities for Improvement
- Monitoring Progress

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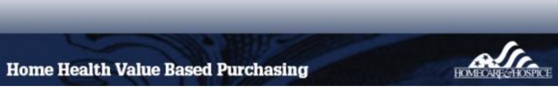
Part 1: Accessing Information



Sources of Information

- Lots of places to access information
- Varying requirements for cost—time and money
- Varying types and levels of value
- What do you already have available?
- What additional information do you need?
- What's the best way for your agency to get it?
- Concepts discussed today are to feed the conversation about what will work best for your organization, not necessarily a blueprint.

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Sources of Information

- Is the information already available to you? Take an inventory.
- CMS = Free
  - CASPER
  - HHVBP Secure Portal → Reports
  - Other Sources: HHVBP Connect, Innovation Center Web-site
- HHCAHPS Vendor
- EMR Vendor
  - Built-in Reports and/or
  - Accessing the data directly, if you have the right tools, people/skills, and time
- Performance/Reporting/Benchmarking Vendor

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What to Look/Ask For

- **Right Measures**
- **Right Benchmarks**
  - **2015 State median (coming from CMS in April & July)**
  - **2016 State performance for understanding positioning relative to payment impact**
- **Ease of Use**
- **Right Levels of Access**
- **Timeliness**
  - **(more on this as we talk about monitoring performance)**
- **Level of Granularity**
  - **(more on this as we talk about identifying opportunities for improvement)**

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Part 2: Assessing Performance

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Assessing Performance

Four Questions:

1. **What is your performance in the HHVBP measures?**
2. **How does that compare to applicable benchmarks?**
3. **What is your trend?**
4. **Why and how should you drill in?**

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HHVBP Measures

Outcome Measures	Home Health Compare	Star Rating
Imp. In Ambulation/Locomotion	✓	☆
Imp. In Transferring	✓	☆
Imp. In Bathing	✓	☆
Imp. In Management of Oral Meds	✓	
Imp. In Pain	✓	☆
Imp. In Dyspnea	✓	☆
60-Day ACH Rate	✓	☆
60-Day ED Use	✓	
Discharged to Home		
Prior ADL/IADL Functioning		

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HHVBP Measures

Process Measures	Home Health Compare	Star Rating
Flu Vaccine	✓	☆
Pneumococcal Vaccine	✓	
Drug Education	✓	☆
Reason PPV Not Received		
Flu Vaccine Data Collection Period		
Types and Sources of Assistance		

☆ *Star Rating also includes Timely Initiation of Care*

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HHVBP Measures

HHCAHPS Measures	Home Health Compare	Star Rating
Communication	✓	☆
Care of Patients	✓	☆
Specific Care Issues	✓	☆
Overall Rating	✓	☆
Would Definitely Recommend	✓	

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Importance of Benchmarks

- **Remember: Achievement Threshold and Benchmark for HHVBP are based on your cohort (large volume and small volume, if available) within your state**
  - **Variability between national and state performance**
- **The other important benchmark is your agency's 2015 baseline score for calculating improvement points**
- ***FYI: Star ratings based on national benchmarks, but your stars are compared against others in your state***

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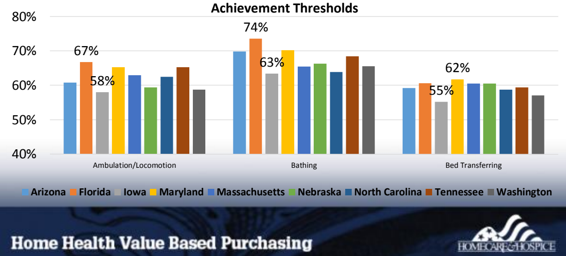
State Median Variability

- See handout with state Achievement Thresholds and Benchmarks
- *Based on HHC data released January 2016—2 quarters shy of CY2015*



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Trends Provide Additional Insight

- **Annual number used for measuring performance**
- **The trend tells you important information:**
  - **Is your performance going up or down? An above-benchmark score may not stay that way if you are on a downward trend.**
  - **Is there an element of seasonal variation**
- **Trended benchmarks: how are your peers changing?**
  - **TPS based on 2016 data compared to 2015 benchmarks**
  - **At-risk dollars determined based on performance year data—*everyone in the state could get above the threshold and positive points, but the reimbursement distribution will still be positive and negative*.**

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Drilling Into the Data Offers Insight

- **Data by clinician:**
  - **Are clinicians answering the OASIS at SOC and ROC to accurately describe the patients' characteristics to be able to demonstrate improvement?**
  - **Do staff understand the measure exclusions for those directly tied to HHVBP?**
  - **Are some staff struggling more or doing better than others?**
- **Data by patient:**
  - **Risk assessments provide useful data point(s) to help deliver consistent, predictable care and best outcomes**
  - **Track individuals in real time for data correction or course correction**
  - **Identifies which patients for investigating outcomes**

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Part 3: Prioritizing Efforts

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Where to Begin Quality Improvement Efforts?

- **Designate improvement team(s)**
- **Start with 2-3 outcomes for improvement**
- **Assign roles and responsibility for implementation of plan**
- **Set timeframes**
- **Aggregate results and compare against baseline**
- **Summarize and make results visible**

Home Health Value Based Purchasing

Priorities: Two Primary Questions

1. Which measures?
   - Which measures align with organizational priorities?
   - What measures offer multiple benefits?
   - Where is the greatest opportunity for improvement?
2. Where to focus for maximum improvement?
   - Are some clinicians or teams outperforming others?
   - Do we struggle with certain diagnoses/conditions?
   - Do we have patients who are high cost and have high utilization of services?
   - Do we have groups of patients that frequent the hospital or Emergency room? (chronic co-morbid diagnosis)

Which Measures? Data Perspective

- **Overlapping purposes**
  - **VBP and Star Ratings**
  - **Efforts that impact more than one measures**
    - **For example, medications→ improve the process measure, outcome measure, HHCAHPS measure, and avoid hospitalizations?**
    - **For example, episode management → improve multiple measures (including accurate reimbursement), appropriate utilization, and avoid hospitalizations?**

Which Measures?

- Biggest opportunity to improve
  - Smallest differences between 0 points and 10 points
  - For example, Drug Education (data source = HHC):

	AZ	FL	IA	MD	MA	NE	NC	TN	WA
Achievement Threshold - Below = 0 points	95.4%	97.3%	94.3%	95.5%	97.1%	97.4%	94.6%	95.5%	93.5%
Achievement Benchmark - At or above = 10 points	100%	100%	100%	100%	100%	100%	100%	100%	99%

- Example: In Florida:

Score	97%	98%	99%	100%
Points	0 points	2.833	6.167	10 points

Which Measures?

- **Biggest opportunity to improve**
  - **Negative TPS value—below state achievement threshold**
  - **Opportunity for improvement points over achievement points**
  - **Any outcome below last year's performance/trending downward**
  - **Closest to next star level**
  - **Easiest to improve**
    - **Process measures vs. outcome measures vs. patient experience**
    - **Items you've been working on but have stalled progress—time to move on??**

Home Health Value Based Purchasing

Where is Your Focus?

Sometimes there is opportunity to improve across the organization.

Sometimes there are weaknesses (or strengths) that are more narrow, and a specific focus of improvement efforts can be more effective.

- **Teams?**
- **Branches?**
- **Clinicians?**
- **Clinical Conditions? Diagnosis groups?**
- **High cost/High Utilization of services?**

Home Health Value Based Purchasing

Condition-Specific Differences

60-Day Hospitalization Rate, by primary diag. (Q4 '14-Q3 '15)

Procedures and Aftercare
Therapy Aftercare
Ortho Aftercare
Disorders of Muscle, Ligament, Fascia
Chronic Bronchitis
Heart Failure
Hypertension
Diabetes

0% 10% 20% 30%

Data source OCS/ABILITY Network

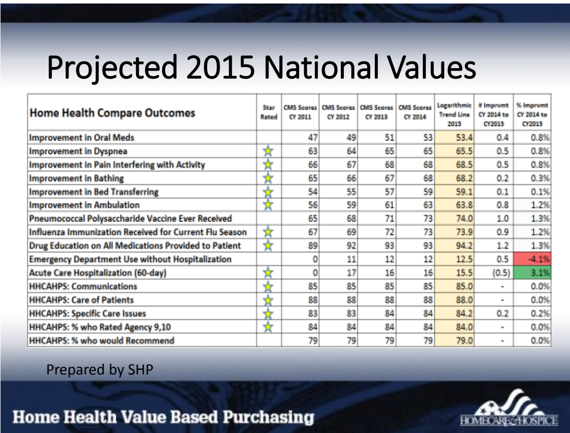
Home Health Value Based Purchasing

HOMECARE&HOSPICE

Branch/Team/Clinician Drill-Down

Goal Setting

- Important for goals to be realistic and sustainable
- Where do we expect performance to be in 2016?
- What improvement have we actually seen?



Projected 2015 National Values

Home Health Compare Outcomes	Star Rated	CMS Scores CY 2011	CMS Scores CY 2012	CMS Scores CY 2013	CMS Scores CY 2014	Logarithmic Trend Line 2015	# Imprvmt CY 2014 to CY2015	% Imprvmt CY 2014 to CY2015
Improvement in Oral Meds		47	49	51	53	53.4	0.4	0.8%
Improvement in Dyspnea	☆	63	64	65	65	65.5	0.5	0.8%
Improvement in Pain Interfering with Activity	☆	66	67	68	68	68.5	0.5	0.8%
Improvement in Bathing	☆	65	66	67	68	68.2	0.2	0.3%
Improvement in Bed Transferring	☆	54	55	57	59	59.1	0.1	0.1%
Improvement in Ambulation	☆	56	59	61	63	63.8	0.8	1.2%
Pneumococcal Polysaccharide Vaccine Ever Received		65	68	71	73	74.0	1.0	1.3%
Influenza Immunization Received for Current Flu Season	☆	67	69	72	73	73.9	0.9	1.2%
Drug Education on All Medications Provided to Patient	☆	89	92	93	93	94.2	1.2	1.3%
Emergency Department Use without Hospitalization		0	11	12	12	12.5	0.5	-4.1%
Acute Care Hospitalization (60-day)	☆	0	17	16	16	15.5	(0.5)	3.1%
HHCAHPS: Communications	☆	85	85	85	85	85.0	-	0.0%
HHCAHPS: Care of Patients	☆	88	88	88	88	88.0	-	0.0%
HHCAHPS: Specific Care Issues	☆	83	83	84	84	84.2	0.2	0.2%
HHCAHPS: % who Rated Agency 9,10	☆	84	84	84	84	84.0	-	0.0%
HHCAHPS: % who would Recommend		79	79	79	79	79.0	-	0.0%

Prepared by SHP

Year-to-Year: What's Possible?

For example, in 60-day hospitalization rates:

- Overall average change in scores = 0.11% point reduction in rates (15.3%→15.2%)
- 51% of agencies improved; their average = 3.2% point reduction (16.9%→13.7%)

Range of Improvement	% of Improvers	Avg. Original Rate	Avg. Improved Rate
Up to 1 point	23%	15.5%	15.0%
1-2 points	22%	15.9%	14.4%
2-3 points	16%	16.4%	14.0%
3-4 points	11%	17.2%	13.7%
4-5 points	8%	17.3%	12.9%
5 or more points	21%	19.9%	11.8%

Home Health Value Based Purchasing

Quality Imp. Program Design

Determine and document:

- Services and processes to be assessed
- Data to be collected and reported
- Frequency of data collection and analysis
- How findings will be used
- How you will implement action plan findings
- Method(s) of evaluating improvement
- Frequency with which you will report on performance

Home Health Value Based Purchasing

Quality Imp. Program Culture

- Overall commitment to performance improvement
- Move from a reactive approach to one of being proactive and able to anticipate data challenges
- Assess your information and approach and make adjustments along the way—consistent improvement in all things!

Home Health Value Based Purchasing

Perf. Imp. Data Timing

	Daily Data Capture	Weekly Review	Monthly Reporting	Quarterly Reporting	Annual Review
Patient Record Audit	X			X	X
Infection Control	X			X	X
Patient Safety Initiatives	X		X	X	X
Patient Risk Assessment	X	X	X	X	X
PAE (Potentially Avoidable Events)	X	X	X	X	X
Customer Concerns	X		X	X	X
Process Measures	X		X	X	X
Patient Outcomes	X		X	X	X
HHCAHPS			X	X	X

Home Health Value Based Purchasing

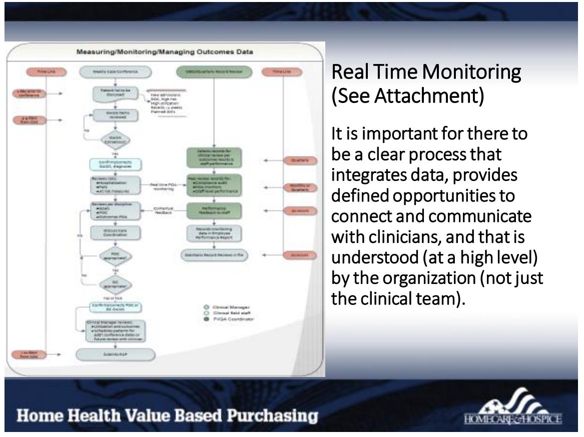
Measuring, Monitoring, Managing

- Clinical management structure to influence the following:
  - Most accurate data collection on each patient
  - Identify and monitor at-risk patients
  - Identify and monitor at-risk outcomes
  - Identify and monitor at-risk staff
  - Manage episodes
    - For clinical outcomes
    - For financial outcomes

Home Health Value Based Purchasing

Monitoring and Managing

- Must happen in real time
  - To identify at risk outcomes up front
  - To develop a Plan of Action at risk identification
  - To influence outcomes before they occur
- Must happen at a staff level
  - To identify who is responsible for what outcomes
  - To trend patterns
    - By outcome measures
    - By staff



Real Time Monitoring (See Attachment)

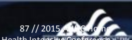
It is important for there to be a clear process that integrates data, provides defined opportunities to connect and communicate with clinicians, and that is understood (at a high level) by the organization (not just the clinical team).

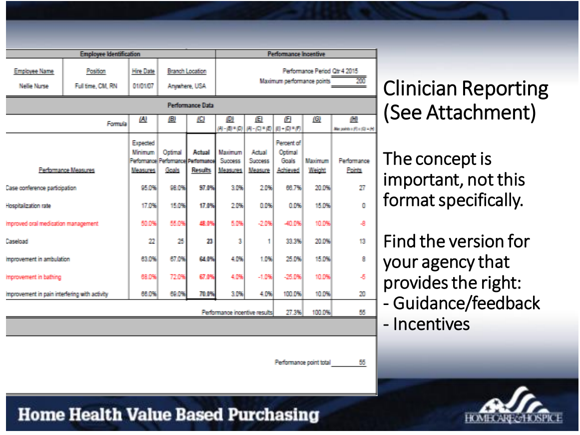
Trending

- Trending at an individual staff level
- Utilize the data for individual dashboards
- Utilize data to inform chart selection for clinical record review:
  - Poor performing staff
  - At risk outcome measures
- Provide individualized feedback targeted at those who are responsible for the numbers

Performance Report

- Use a Performance Report for individual focus on outcome improvement at an employee level
- Deliver the Performance Report to employees in a timely manner allowing for self-improvement
- Build it into annual performance evaluations or use dollars as an incentive plan, if your organization allows you to do so





Employee Identification				Performance Incentive
Employee Name	Position	Hire Date	Branch Location	Performance Period Qtr 4 2015
Nellie Nurse	Full time, CM, RN	01/01/07	Anywhere, USA	Maximum performance points 200

Performance Data

Formula	(A)	(B)	(C)	(D) (A) - (B) = (D)	(E) (A) - (C) = (E)	(F) (E) ÷ (D) = (F)	(G)	(H) Max points x (F) x (G) = (H)
Performance Measures	Expected Minimum Performance Measures	Optimal Performance Goals	Actual Performance Results	Maximum Success Measures	Actual Success Measure	Percent of Optimal Goals Achieved	Maximum Weight	Performance Points
Case conference participation	95.0%	98.0%	97.0%	3.0%	2.0%	66.7%	20.0%	27
Hospitalization rate	17.0%	15.0%	17.0%	2.0%	0.0%	0.0%	15.0%	0
Improved oral medication management	50.0%	55.0%	48.0%	5.0%	-2.0%	-40.0%	10.0%	-8
Caseload	22	25	23	3	1	33.3%	20.0%	13
Improvement in ambulation	63.0%	67.0%	64.0%	4.0%	1.0%	25.0%	15.0%	8
Improvement in bathing	68.0%	72.0%	67.0%	4.0%	-1.0%	-25.0%	10.0%	-5
Improvement in pain interfering with activity	66.0%	69.0%	70.0%	3.0%	4.0%	100.0%	10.0%	20
Performance incentive results						27.3%	100.0%	55

Performance point total 55

Part 4: Monitoring Performance

Make Results Visible—Demonstrate Valuation

- **Demonstrate the importance of these efforts**
- **Talk about it in meetings**
- **Show the data**
- **Recognize high performers**
- **Hold everyone accountable for improvement**
- **Tie initiatives back to the focus**

REMEMBER THE WHY. It's not just about scores. It's about quality patient care.

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Monthly Trends

Pros:

- Immediate feedback about the impact of PI efforts
  - For you to evaluate the ROI
  - For course-corrections, if necessary
  - For the team to be inspired/motivated
- Information to drive evaluation and refinement in real-time
- Real patients: improving or not improving, receiving or not receiving best practices (risk assessments, interventions, and timely care), going to the hospital

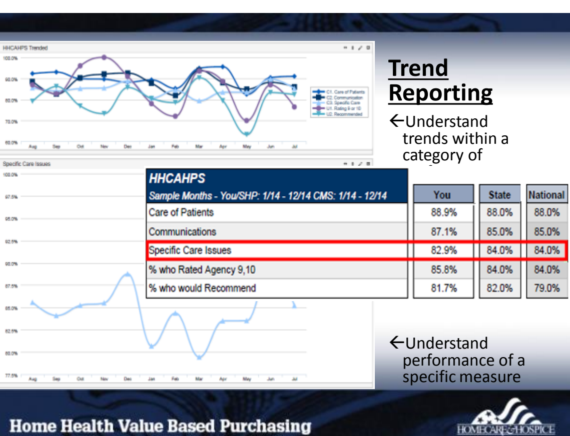
Home Health Value Based Purchasing

Monthly Trends

Cautions:

- Seasonality (especially for flu vaccines)—both positive and negative
- Data variations
  - What happens in one month is what happened in that month—it is real
  - It is not necessarily indicative of a trend, depending on the size of your organization; it should be interpreted with caution
  - Quarterly feedback offers a different perspective
  - Only one of twelve data points—each month builds upon the others in the year

Home Health Value Based Purchasing



HHCAHPS Sample Months - You/SHP: 1/14 - 12/14 CMS: 1/14 - 12/14	You	State	National
Care of Patients	88.9%	88.0%	88.0%
Communications	87.1%	85.0%	85.0%
Specific Care Issues	82.9%	84.0%	84.0%
% who Rated Agency 9,10	85.8%	84.0%	84.0%
% who would Recommend	81.7%	82.0%	79.0%

Trend Reporting

←Understand trends within a category of

←Understand performance of a specific measure

Home Health Value Based Purchasing

Performance in 2016

Quarterly Trends

- **Clear performance trends**
- **Stronger perspective around tracking data for the year**

"2016 Performance View"

- **YTD – What's going into the 2016 performance year**
- **Rolling year/Trailing 12 Months – More clear perspective of the eventual 2016 values?**

Home Health Value Based Purchasing

Example of Monthly Tracking vs. Quarterly Tracking vs. Impact on Annual Numbers

- Example Smaller Agency and month-to-month variability

Trended Improvement in Pain

Monthly Value Quarterly Rate CY Rate

75%
70%
65%
60%
55%
50%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2016

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Example of Monthly Tracking vs. Quarterly Tracking vs. Impact on Annual Numbers

- **Example Agency in North Carolina**
- **Improvement in pain**
  - **Performance threshold (based on current HHC data) = 65.1%**
  - **Performance benchmark = 82.0%**
  - **Agency's 2015 baseline = 65.0%**
  - **Goal = 69%**

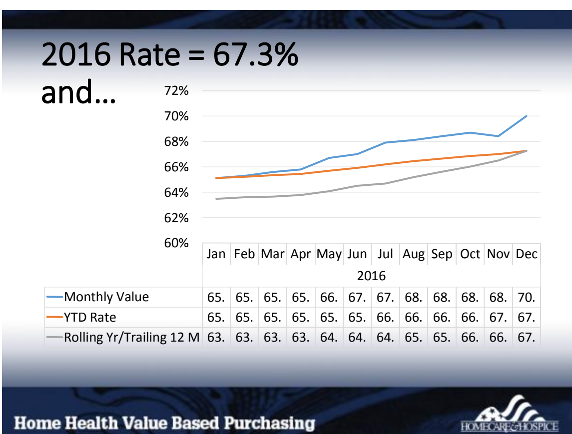
70%
65%
60%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2015

Home Health Value Based Purchasing

HOMECARE & HOSPICE



2016	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly Value	65.	65.	65.	65.	66.	67.	67.	68.	68.	68.	68.	70.
YTD Rate	65.	65.	65.	65.	65.	65.	66.	66.	66.	66.	67.	67.
Rolling Yr/Trailing 12 M	63.	63.	63.	63.	64.	64.	64.	65.	65.	66.	66.	67.

Wrap Up—Key Take-Aways

- Accessing Information: There are multiple sources of information available. Make a point to know the different sources that best meets your needs and includes the information and resources that best suit your organization, it goals and vision.
- Assessing Performance: Be knowledgeable of and be able to articulate and communicate your agency's baseline data and trends. Understand what drill down level will support your quality improvement efforts.
- Prioritizing Efforts: Choose only 2-3 outcomes for improvement. Use your data and drill down capabilities to clearly identify areas of focus for corrective action including remediation, retraining efforts, and process re-engineering as needed.
- Monitoring Progress: Be diligent in reviewing data and trends on a monthly and quarterly basis to identify your agency's progress and the impact on the projected annual results.

Home Health Value Based Purchasing

HOMECARE&HOSPICE

Home Health Value Based Purchasing: Clinical Operations

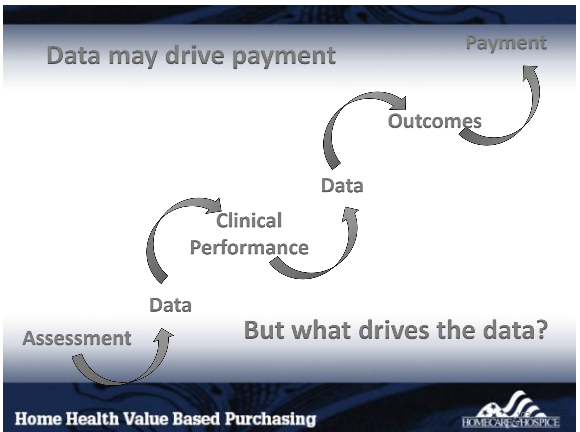
ACHIEVING SUCCESS IN THE MEDICARE HOME HEALTH VALUE BASED PURCHASING PILOT PROGRAM

Objectives

- Explain the importance of OASIS data accuracy in Value Based Purchasing
- Describe the phases of effective episode management to support Value-Based Purchasing program
- Describe clinical best practices for home health agency implementation to adapt to the reimbursement changes of home health value-based purchasing and continue to improve patient outcomes

Home Health Value Based Purchasing
Clinical Operations Strategies

Importance of OASIS data Accuracy
Episode management process improvement
Disease management and chronic care management



Data Accuracy is Dependent On…

- Clinician's assessment skills
- Clinician's understanding of the data elements and the response items
- Clinician's ability to translate:
  - Assessment results to data collection
  - Data results to a better informed plan of care and… better outcomes

Data Accuracy Must Be Influenced

- Use a case conference protocol that begins by reviewing the OASIS data with all who have laid eyes on the patient within the 5 day assessment period
- The case conference is facilitated by a designated clinical supervisor, manager, QA coordinator, PI person, any one who can:
  - Influence correct OASIS data
  - Influence a better informed plan of care by using the data correctly

Case Conference Objectives

- Ensure the patient's most accurate OASIS data
- Define each team member's role to reduce hospitalization and fall risks
- Establish patient's identified goal and readiness for engagement in plan of care
- Identify at risk or targeted outcome measures
- Review Plans of Action, disease management protocols, pathways, care paths, any best practices to include in patient's plan of care

Home Health Value Based Purchasing

Case Conference Objectives (cont.)

- Consider best mix of discipline skills with patient/caregiver skills to accomplish goals
- Determine most efficient use of resources to accomplish goals/targeted outcomes
- Discuss strategies for team collaboration on the patient's single plan of care
- Facilitate movement toward
  - Reducing hospitalization and fall risk
  - Targeted outcomes
  - Improved patient experience

Home Health Value Based Purchasing

Case Conference Structure

- Team Case Conference occurs weekly
- Choose the least worst day and time
- The number of patients discussed and the pace of the conference process is ***kept to a specified time frame,*** clinicians need to count on it to schedule their day
- Use peer pressure to keep it focused
  - Insist on prepared participants
  - No sidebar conversations or stories not contributing to better outcomes

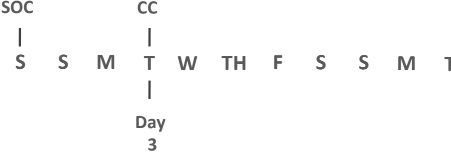
Home Health Value Based Purchasing

Case Conference Procedure

- ‘Post’ the list of patients 1-2 days prior to conference, prioritize as follows:
  - Admissions with multiple disciplines
  - Recerts (2 weeks out) with multiple disciplines
  - ROCs, high risk, high utilization
  - Discharges (2 weeks out)
  - Single discipline Admissions and Recerts, so if time is up, follow up with individuals after conference
- OASIS collaboration is BEFORE data transmitted
  - ‘Single clinician rule’ does not prevent collaboration as long as assessing clinician has last word

Home Health Value Based Purchasing

Case Conference Scenario One



- SOC discussed in earliest CC once all evals completed and data available in software

Home Health Value Based Purchasing

Case Conference Scenario Two

SOC (S) | CC (T) | Therapy Eval (W) | CC (T)

S S M T W TH F S S M T

Day 4 (W) | Day 10 (T)

- Evals completed after 5 day assessment window are not considered in OASIS review, but are for Episode Management
- *Assessment* must be done in 5 days from SOC, documenting or correcting data can occur up to 30 days without an error report
- Never delay past 2nd CC after SOC

Home Health Value Based Purchasing

Case Conference Procedure

- Assure all staff are prepared ahead of time, being familiar with own patients on list, loading in conference patients on to software as needed
- Have results handy from OASIS scrubber for decision support during conference
- Prepare for review:
  - Project OASIS on screen for all viewers if possible
  - Original assessor or case manager pulls up patient on own unit to make corrections as decided
  - Provide item guidance for those unfamiliar with OASIS

Home Health Value Based Purchasing

Case Conference Protocol

Review key OASIS data on Admissions & Recerts

(see OASIS Worksheet Handout)

- M1046
- M1051
- M1200
- M1242
- M1400
- M1610
- M1620
- M1630
- Risk assessments
- M1810
- M1820
- M1830
- M1840
- M1850
- M1860
- Integumentary items as needed
- Diagnoses sequencing discussed after POC review for possible adjustment

Home Health Value Based Purchasing

Conference Protocol for OASIS Review

- Assessing clinician runs through the key items and shares the response selected during the Comprehensive Assessment
- Reach consensus among all clinicians who saw the patient within the assessment window
- Facilitate to resolve discrepancies
  - Conclusion based on observation or interview?
  - Conditions present during assessment? (e.g. time of day, cueing, environmental issues, etc.)
  - Consult OASIS 'Item Guidance' as needed

Home Health Value Based Purchasing

Conference Protocol for OASIS Review

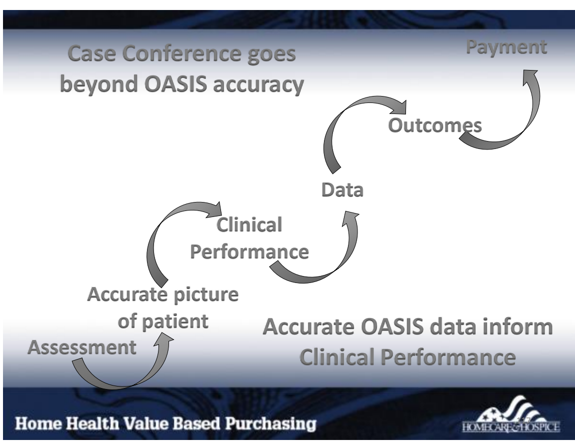
- Guide discussion regarding discrepancies:
  - What did the therapist see or the aide smell?
  - Do issues with routines affect scores differently than isolated observed activities (such as ADLs)?
- Discussion can serve three purposes:
  - Improve the accuracy of the data for that patient
  - Accidental knowledge for improved future assessments
  - Opportunity for item specific education
- Learning about specific OASIS items in the context of a known patient STICKS!

Home Health Value Based Purchasing

Conference Protocol for OASIS Review

- Best practice urges all disciplines to be in within 5 day assessment window
- Though input from evals past the 5 day window shouldn't be considered in OASIS review, other conference protocol items are still discussed re plan of care, frequencies, etc.
- Assessing clinician corrects OASIS during CC, no follow up audits or correction form needed
- Data locked and transmitted day after CC, so RAPs ideally are never later than day 11

Home Health Value Based Purchasing



Home Health Value Based Purchasing
Clinical Operations Strategies

Importance of OASIS data Accuracy
Episode management process improvement
disease management and chronic care management

Key Reasons for Episode Management

- Episode management is the process of applying best practice/evidence-based practice to the HH 60 day episode of care for best outcomes.
  - Reduce hospitalization rate
  - Improve patient and referral source satisfaction
  - Improve outcomes
    - Clinical
    - Operational
    - Financial

Episode Management

- Developing and implementing best practice processes in:
  - LUPA management
  - Therapy management
  - Discipline management
  - Other specialty programs that reduce hospitalization rate and improve outcomes

LUPA Management Implementation

- Episode management education to all staff: What is a LUPA and why are the outcomes of these episodes often poor?
- Process of episode review:
  - Weekly analysis of all episodes of care
  - Operational processes/triggers applied to these episodes
  - Weekly team conference calls where episodes are reviewed

Home Health Value Based Purchasing

Low Utilization (LUPA) Management

- Operational processes/best practice examples
  - Front loading of chronic disease- 3 times in first 7 days
  - Cancelled visits rescheduled and completed within 24-48 hours
  - Added disciplines in first week where clinical triggers apply

Home Health Value Based Purchasing

Therapy Management Implementation

- Therapy management education provided to all staff
  - Review functional need triggers and why therapy should be a "need to have" not a "nice to have"
- Process of therapy review:
  - Weekly analysis of episodes for falls risk and OASIS HHRG scoring triggers
  - Weekly team conference calls focusing on functional need at SOC, ROC and recertification

Home Health Value Based Purchasing

Therapy Management PT

Best Practice Examples: Physical Therapy (PT)

- Request orders for PT evaluation when HHRG score documents functional need (F2/F3)
- Front load episodes of care for total joint diagnoses, orthopedic aftercare, gait and mobility issues
- Request orders for nursing in a rehab only episode when patient HHRG score is C3

Therapy Management OT

Best Practice Examples: Occupational Therapy (OT)

- When utilizing HH aides, order OT and coordinate HH aide services to help patient improve independence in care
- Order OT on SOC for COPD/pneumonia primary diagnoses
- Order OT where there is any need for energy conservation education
- Add OT where Bathing score is at 3

Therapy Management ST

Best Practice Examples: Speech Therapy (ST):

- Swallowing/eating issues (but ***also***)
- Speech/language issues
- Cognitive issues
- Technology assisted communication
- Post- medication toxicity or drug overdose

Aide Supporting Therapy

Benefit Policy Manual §50.2(D)

- Assistance With Activities which are:
  - Directly supportive of skilled therapy services
  - But do not require the skills of a therapist to be safely and effectively performed such as
    - Routine maintenance exercises
    - Repetitive practice of functional [activities]
    - Repetitive practice of functional communication skills to support Speech-Language Pathology Services

(formatting added)

Home Health Value Based Purchasing

Interdisciplinary Management Implementation

- Interdisciplinary management education for all staff that focus on triggers adding disciplines to the plan of care as needed:
  - Registered Nurse
  - Therapists/Assistants (PT, OT, ST)
  - Medical Social Worker
  - Home Health Aides

Communication is vital between team members, no working in silos!

Home Health Value Based Purchasing

Interdisciplinary Management

Best Practice Examples:
- Therapy collaboration- OT and PT (analyze therapy eval only if they occur)
- Uses of HHA to support patient when there are refusals or delays of therapy
- Chronic disease visit guidelines for staff based on evidence-based practice (Disease Management)
- Enhanced use of MSW e.g., depression, PHQ-2 scoring

Home Health Value Based Purchasing

Advanced Phase of Episode Management

- Internal reporting, external reporting
- Scorecards for locations and teams
- Scorecards for clinicians
- Trending of ACH rates
- Trending of patient outcomes and completion of appropriate plan of care
- Trending of patient satisfaction scores

Episode Management Recommendations

- Operational triggers—MOST CRITICAL
- Always promote “episode management” and improvement in patient care not visit counts
- Consistent message to staff

Home Health Value Based Purchasing
Clinical Operations Strategies

Importance of OASIS data Accuracy
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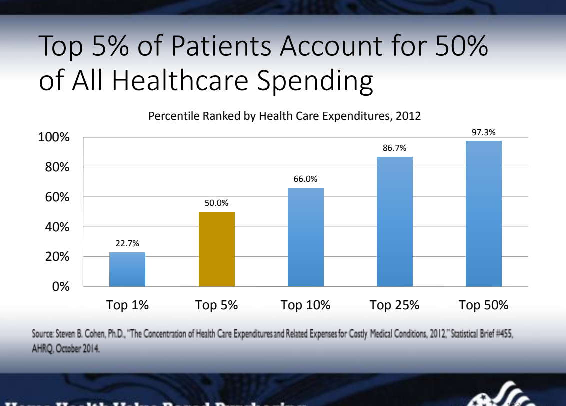
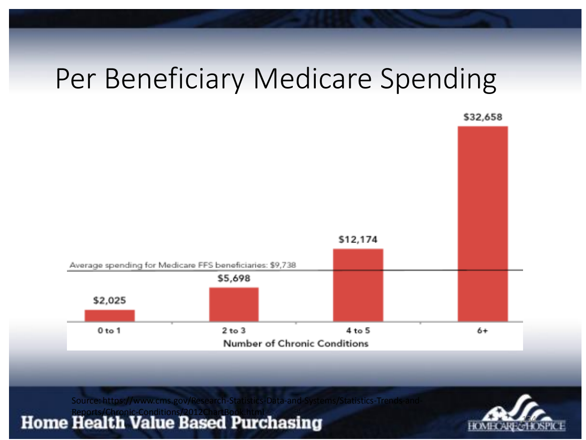
Disease management and Chronic care management





Top Five Most Costly Medical Conditions

1. Heart Disease
2. Trauma-Related Disorders
3. Cancer
4. Mental Health Disorders
5. COPD/Asthma

Disease Management (DM): Outcome-Based Home Care

- **Disease Management**: concept of reducing health care costs and improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of the **disease** through integrated care
- **Definition of disease management:** a system of healthcare interventions for populations with conditions in which self-care efforts are significant
- **Reasons for Disease Management:**
  - Improved clinical, operational, and financial outcomes
  - Effect on acute care hospitalization rate

Home Health Value Based Purchasing

Seven Key Elements in DM Programs

1. Identify specific appropriate populations
2. Apply evidence-based practice guidelines
3. Implement patient self-management education
4. Collaboration with all health care team member from physician to support services
5. Identify outcomes, evaluation, and management measures
6. Establish a Routine reporting mechanism
7. Develop a feedback loop

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Target Population = High Risk Patients

Patients May Have:
- Functional limitations
- Multiple chronic conditions
- Dementia
- Serious (life threatening) illness
- Uncontrolled symptoms
- Recent discharge from hospital
- Caregiver breakdown

Home Care May Involve:
- Home safety assessment
- Patient and family education
- Medication reconciliation
- Diet counseling
- What to do in crisis
- Planning – Care goals
- Visits
- Telephonic support or Telehealth

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Chronic Care Management

- Chronic care management encompasses the oversight and education activities conducted by health care professionals to help patients with chronic diseases and health conditions such as diabetes, high blood pressure, lupus, multiple sclerosis and sleep apnea learn to understand their condition and live successfully with it. This term is equivalent to disease management (health) for chronic conditions. The work involves motivating patients to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

Chronic Care Management (ICM)

- Established by Center for Integrated Care at Sutter Care
- An evidence and outcome-based approach to patient care that can be understood by the patient and caregivers and incorporates the shared decision making model
  - Person Centered
  - Evidence Based
  - Coordinated Care
- http://www.suttercenterforintegratedcare.org/

Integrated Chronic Care Management Competencies

- Person-centered approaches that build trust, shared understanding and strong provider-patient relationships
- Individualized assessment of patient needs, values and preferences
- Collaborative goal setting and action planning
- Skill building and problem solving
- Linkage to community resources and programs
- Repeated follow-up contacts
- Care Transitions
- Knowledge and actions for condition exacerbation
- Medication Management
- Physician follow up visits
- Initiation of a personal health record (PHR)
- Case management role and process with a strong emphasis on best practices in communication and coordination with the care team.

Source: Sutter Center for Integrated Care: www.suttercenterforintegratedcare.org/

CMS Quality Initiatives

Center for Innovation Demos-Examples:

- Frontier Health Integration Project Demo
- Private, For-Profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE)
- Independence at Home Demo
- Medicare Coordinated Care Demo
- Medicaid Incentives for the Prevention of Chronic Diseases Model
- Community Based Care Transitions Program (CCTP)
- Collaborative Joint Replacement Initiative
- Million Hearts

http://innovation.cms.gov/

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CMS Quality Initiatives Align with HHVBP

Home Health Quality Initiative

- Established in 2001
- Currently in 4th phase
- Resource for Home Health Agencies
- Align with:
  - Chronic Care Management
  - Care Transitions
  - Triple AIM

Best Practice Intervention Packages (BPIPs)

- Disease Management: Heart Failure
- Disease Management: Diabetes
- Cardiovascular Health
- Immunization and Infection Prevention
- Medication Management
- Underserved Populations
- Patient Self-Management
- Reducing Acute Care Hospitalizations
- Fall Prevention
- Cross Settings

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Basic Components of Chronic Care/ Disease Management Care Pathways

- Goal Setting:
  - Patient Centered
  - Evidence based
  - SMART Goals
- Prevention of Emergent Care/ Hospitalization
- Community/ Psychosocial Support Systems
- Teaching/Teach-Back* to Facilitate:
  - Self Care Management
  - Preventive Measures
  - Medication Management
  - Nutrition/Diet/Fluid Management
  - Functional Status/Exercise
- Symptom Management
  - Telehealth/Telephone Monitoring**
- Care Transitions and Care Coordination

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*10 Elements of Competence for Using Teach-back Effectively

1. Use a caring tone of voice and attitude
2. Display comfortable body language and make eye contact
3. Use plain language
4. Ask the patient to explain back, using their own words
5. Use non-shaming, open-ended questions
6. Avoid asking questions that can be answered with a simple yes or no
7. Emphasize that the responsibility to explain clearly is on you, the provider
8. If the patient is not able to teach back correctly, explain again and re-check
9. Use reader-friendly print materials to support learning
10. Document use of and patient response to teach-back

Source: www.homehealthquality.org

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**Telehealth and Telephone Monitoring

- Can be a key component in chronic disease management and patient experience efforts as long as telehealth and/or telephone monitoring is implemented with appropriate visit utilization/episode management.
- Conduct a feasibility and cost benefit analysis as well as a process for monitoring outcomes associated with telehealth and/or telephone monitoring implementation (i.e. reduction in acute hospital readmissions or ED visits).
- Define internal clinical staff members to monitor telehealth or conduct telephone monitoring and implement consistent processes, oversight and outcome measures.

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Strategies to Implement Best Practice Interventions

- Utilize existing, evidence-based tools and pathways (refer to resources)
- Work with the Patient to Set Individual Goals:
  - Evidence Based
  - Long Term Patient Centered
  - SMART Goals
- Implement care transitions/care coordination/ navigation programs to ensure communication between settings
- Integrate all components of disease/chronic care management into daily operations
- Monitor OASIS accuracy, outcomes and episode/visit utilization

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Examples of Best Practice Interventions

Heart Failure:
- Daily Weights, Dietary/Nutrition/Fluid management
- Symptom Management
  - Symptoms to report to the MD
  - Regularly scheduled MD appointments
- Medication Management
- SN: skilled assessment, teaching, medication management, symptom management, care coordination and case management
- PT/OT: Energy conservation, increasing endurance, home safety, 02 sats for biofeedback
- MSW: Long term planning, psychosocial support community resources

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BPIP Contents for Heart Failure

- General Resources
  - BPIP Comprehension Test
  - Bulletin Board content
  - Bulletin Board example
- Clinician Tools
  - Clinical Evidence-Based Practices for Heart Failure
  - Heart Failure Medication Reference for Clinicians
  - Review of the SBAR Technique
  - SBAR Worksheet
- Patient Tools
  - 6 Tips to Cut Sodium
  - Heart Failure Stoplight Tool
  - Heart Failure Zone Tool
  - Heart Talk: Living with Heart Failure (English, Polish, Spanish)
  - Managing My Heart Failure: I Know, I Can, I Will! (English, Spanish)

Source: www.homehealthquality.org

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Examples of Best Practice Strategies: Medication Management

- Medication Reconciliation
  - Beers Criteria
  - “Show Me” to assess medications in home
  - Send complete list to MD by next business day
  - Coordinate with pharmacy
- Medication Adherence
  - Ex/Morisky Medication Adherence Scale
- Medication Knowledge
  - Use scripts
  - Teach back
  - Tools

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Examples of Best Practice Strategies: Self Management

- Motivational Interviewing
- Patient Activation
- Problem Solving
- Action Planning
- Teach-Back
- Setting Goals:
  - Evidence Based
  - Long Term Patient Centered
  - SMART Goals

Home Health Value Based Purchasing

HHQI Self-Management Support Example

- Greg, RN, is working on self-management support to help his patients improve in self-management. He is looking for a tool or tools that will help motivate his patients. Sharon, the home health manager, has introduced two new resources to the staff, *My Action Plan* and *Patient Self-Hospitalization Risk Assessment*. Greg decides to try the *My Action Plan* with his 67-year-old patient, Brenda, newly diagnosed with type 2 diabetes. Brenda decides she wants to learn more about her diet. Greg explains that writing goals and actions could help. Brenda completes her action plan and rates learning about diet as *Somewhat Important* and she has *Little Confidence* on the ruler scales. She also identifies potential barriers that could cause her to not meet her dietary plan. Brenda says making a plan to overcome the barriers is beneficial, and states that acknowledging barriers actually helps her feel more convinced and more confident.

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HHQI Self-Management Support Example

- Greg is also using the *Patient Self-Hospitalization Risk Assessment* tool with many patients. He is finding that patients appreciate understanding their hospitalization risk. One patient said it was 'eye-opening'. Greg is finding that it also helps the patient understand what the health care team is doing to prevent rehospitalization. In fact, at a recent staff meeting, Greg shared that by understanding the risk of hospitalization and treatment plan, patients see themselves as a more active member of their own health care team.
- HHQI suggests the following toolkits from the Institute for Healthcare Improvement:
  - Self-Management Toolkit for People with Chronic Conditions and Their Families
  - Self-Management Toolkit for Clinicians

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Clinical Pathway Evidence Based Practice Resources

- Agency for Healthcare Research and Quality
  - http://www.ahrq.gov/
- Institute for Healthcare Improvement
  - www.ihi.org
- National Guideline Clearing House
  - http://www.guideline.gov/
- Home Health Quality Initiative
  - www.homehealthquality.org
- Integrated Chronic Care Management Model and Resources
  - http://www.suttercenterforintegratedcare.org/
- CMS Million Hearts Initiative:
  - http://millionhearts.hhs.gov/index.html

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Clinical Pathway Evidence Based Practice Resources

- DMAA-Disease Management Association of America www.ourcaresource.com
- WOCN- Wound Ostomy and Continence Nurses Society www.wocn.org/
- AHA- American Heart Association www.heart.org
- ADA- American Diabetes Association www.diabetes.org
- American Lung Association www.lung.org
- American Nurses Association www.ana.org
- American Physical Therapy Association www.apta.org
- American Speech and Hearing Association www.asha.org
- American Occupational Therapy Association www.aota.org
- NASW-National Association of Social Work www.nasw.org

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Putting it All Together

(follow along with Case Conference Protocol)

- This is a new admission scheduled for case conference after all the evaluations and initial visits are completed: SN, Aide, PT, OT
- Clinical Supervisor uses software for:
  - OASIS scrubber to access decision support
  - Comparing estimated payment and utilization cost including non routine supply costs and service utilization of all disciplines in utilization monitoring and in total cost/number of visits per episode
- All disciplines come prepared to answer all the questions, stay focused, no extraneous stories, and are familiar with the following patient so this information is NOT described in conference

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Case Study

- 68 year old female who lives with her husband
- Primary diagnoses are Congestive Heart Failure and Chronic Obstructive Pulmonary Disease
- Ambulates less than 10 feet with rolling walker and can't climb stairs due to weakness, dyspnea
- Requires assistance with medications and ADLs
- History of smoking and poor dietary habits resulting in repeated exacerbation of her illness
- Repeated hospitalization and ER visits

OASIS Review for Consensus

Key items for this patient	SN	AIDE	PT	OT
M1242 Pain interfering with activity	1	2	2	2
M1400 Dyspnea	2	3	2	3
M1615 Urinary Incontinence frequency	1	4	2	2
M1810 Dressing Upper Body	1	1	1	1
M1820 Dressing Lower Body	2	2	2	2
M1830 Bathing	2	3	2	3
M1850 Bed Transferring	0	0	1	1
M1860 Ambulation/Locomotion	2	2	3	3
M2020 Management of Oral Meds	1	1	1	2
M2200 Therapy Need (for Episode Mgmt)	?		6	5

OASIS Consensus Discussion

- M1242 – initial visits by Aide, PT and OT reveal OTC night time pain meds for discomfort changing positions and pain with orthopnea
- M1400 – Aide and OT discover dyspnea with minimal exertion as patient goes through ADL routine, not just isolated activities
- M1615 – Pt. tells RN she, "only dribbles a little", Aide discovers odor on sheets, PT/OT both hear husband c/o patient up frequently at noc due to Lasix and being fuzzy headed w/noc pain meds

OASIS Consensus Discussion

- M1830 – Aide and OT discover patient unstable standing during 20 minutes of warm, moist air and no shower bench yet
- M1850 – OT and PT observe patient is unsafe without use of walker and SBA
- M1860 – Even w/ walker, PT and OT feel patient is unsafe w/o SBA walking more than 10 feet on any surface
- M2020 – OT ADL eval reveals patient frequently forgets evening Carvedilol without husband reminding her

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Risk Identification/Reduction Plan

- **Risk:** hospitalization from inconsistency in taking meds, increased edema and dyspnea
- **Risk reduction:** all disciplines were scheduled so a visit was made every day of first week, all those in home check daily weights, meds taken, take vitals and notify RN if outside of stated parameters
- **Risk:** falls at night due to combination of night time pain meds and Lasix
- **Risk reduction:** bedside commode placed immediately

Home Health Value Based Purchasing

Goal Setting/Targeting Outcomes

- Patient Goal: wants to breathe better to last when grandkids are over, tired of hospitals
- At risk outcomes to target in POC:
  - Re-hospitalization… again
  - No improvement in dyspnea
- PI Coordinator reminds team of disease management protocols
  - CHF
  - COPD
  - All in home remind patient of CHF Management ZONE Tool, ask when she is to call agency

Home Health Value Based Purchasing

Heart Failure Management ZONE Tool

GREEN ZONE	YELLOW ZONE	RED ZONE
All Clear (GOAL) • No shortness of breath • No swelling • No weight gain ▪ Your goal weight: _________ pounds • No chest pain • Able to do usual activities	**Caution (Warning)** **If you have any of the following:** • Short of breath with activity • Extra pillows needed to sleep • More coughing • 2-3 pound weight gain in one day or 5 pounds in one week ▪ Other: ____________ • Swelling of feet, ankles, or legs • Extra tired	**Emergency** • Short of breath all the time • Wheezing at rest • Must sit up to breathe • Chest pain or tightness that does not go away • More than 5 pound weight gain in one week ▪ Other: ____________________ ▪ Swelling of hands or face • Confusion/anxiety
Doing Great! • Your symptoms are under control • Actions: ▪ Take medicines as ordered ▪ Weigh self every day ▪ Eat foods lower in salt ▪ Keep all doctor appointments	**Act Today!** • You may need your medicines changed • Actions: ▪ Call your **home health nurse** ____________________ *(agency's phone number)* • Or call **your doctor** ____________________ *(doctor's pone number)*	**Act NOW!** • You need to be seen by a doctor right away • Actions: ▪ **Call your doctor right away** ____________________ *(doctor's phone number)* ▪ **Or call 911**

References: www.homehealthquality.org; AHA, 2012; AHA, 2012; Yancy, et al, 2013

Home Health Value Based Purchasing

Plan of Care/Care Coordination

Primary focus of the POC and Frequency/Duration:

- One plan of care for the patient
- All disciplines working toward one set of common prioritized goals
- Frontloading care using care coordination
- Taper frequency
- Include use of evidence-based best practices into POC interventions and measurement of progress toward goals. Monitor/adjust visit utilization in conjunction with progress toward goals
- Utilize chronic disease management to strive for client self management

Home Health Value Based Purchasing

Plan of Care/Care Coordination

Primary Focus of POC and Frequency/Duration:

- SN: 2w2; 1w2; 3m1 – teach back on symptoms when not taking meds; identify patient behaviors contributing to weight gain
- PT: 2w1; 1w2; 2m1 – adaptive equipment, pursed lip breathing, 02 sats pre/post activity
- OT: 1w3; 2m1 – energy conservation, 02 sats pre/post activity, reinforce med ***routine***
- Aide: 1w1; 2w2; 1w2 – reinforce bathing safety, pursed lip breathing during ADLs

Always remind for tapered frequency

Patient Self-Management

- What will the patient do between visits to continue progress toward goals and what will everyone do to reinforce what each has asked the patient to do between visits?
- Taper frequency to allow patient to self-manage more as episode progresses
- Assess for patient's confidence in new skills
- Be prepared to reduce frequency earlier depending on how well the patient is self-managing

Case Conference Update Review: Resumptions of Care

- What was the reason for hospitalization?
- Was it related to a medication issue?
- What was the date of the last visit prior to hospitalization?
- Was the agency called first?
- What risk reduction interventions were being used by each discipline?
- Was ROC completed timely?

Case Conference Update Review: High Risk/High Utilization

- Is the patient making progress toward goals?
- Are the goals appropriate?
- Is the patient engaged in the plan of care?
- What can other team members do to reinforce what you've asked the patient to do?
- Does the POC, and frequency, need to be revised?
- Can care be better coordinated among disciplines?
- Would telehealth/telemonitoring be appropriate?
- Priority setting parameters for utilization monitoring activities include high cost, high volume, and high risk services or populations and variances to internal or external benchmark standards

Case Study Example Findings

- OASIS and HHCAHPS staff education:
  - Accurate OASIS assessments for Functional status, Dyspnea, Management of Oral Medications
  - Process Measures:
  - Avoidance of ER/hospital readmission
  - Utilization of regular case conferencing and Episode/service utilization management:
  - Improved care coordination
  - Improved overall care
  - Potential improvement in outcomes and HHCAHPS
- Implementation of Heart Failure BPIP

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Case Study Example Findings

- Improved Patient Outcomes:
  - Symptoms controlled
  - Patient remains at home
  - Patient is knowledgeable about disease process
- Improved OASIS Outcome and Process Measures
  - Improved OASIS scores
  - Potential Improvement in HH-CAHPS scores
- Better resource utilization and episode management:
  - Cost Savings
  - Effective Care Transitions/Care Coordination
- Potential increase HHVBP reimbursement:
  - Performance Measures: Dyspnea, Functional Status, Management of Oral Meds, ED Use, ACH, Drug Education, HH-CAHPS
  - Total Performance Score? *Depending on cohort results*

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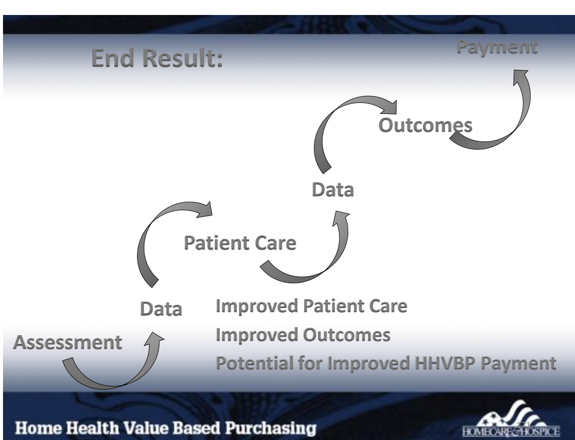
End Result:



Home Health Value Based Purchasing

Questions?

Value Based Purchasing Medicare Home Health Financial Impact Calculations

Overview

- Calculation
- Strategy
- Budgeting
- Dashboards
- Benchmarking

Calculation

- 21 Quality Measures
  - Data collected from OASIS, HHCAHPS, Medicare claims, and direct agency reporting to Medicare
    - 10 Outcome Measures
    - 6 Process Measures
    - 5 HHCAPS Measures
  - Calculated by $\frac{\textit{numerator value}}{\textit{denominator value}}$

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Quality Measures

- Process Measures
  - Care Management: Types & Sources of Assistance
    - Calculation: $\frac{\textit{Multiple Data Elements}}{\textit{Multiple Data Elements}}$
  - Influenza Immunization Received for Current Flu Season
    - Calculation:

#of HH Episodes in which patients a) received vaccine during episode from HHA or b) received vaccine during earlier episode or c) received vaccine from another provider

---

# of HH episodes of care ending with discharge or transfer to inpatient facility during reporting period

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Quality Measures

- Process Measures
  - Drug Education
    - Calculation:

#of HH episodes in which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects and how and when to report problems

---

#of HH episodes ending with a discharge or transfer to inpatient facility during reporting period

  - Pneumococcal Vaccine Ever Received
    - Calculation:

#of HH episodes in which the pneumococcal vaccine was determined to have ever been received by the patient

---

# of HH episodes of care ending with discharge or transfer to inpatient facility

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Quality Measures

- **Process Measures**
  - **Influenza Vaccine Data Collection Period**
    - **Calculation criteria not available**
  - **Reason Pneumococcal Vaccine Not Received**
    - **Calculation criteria not available**

Home Health Value Based Purchasing

Quality Measures

- Outcome Measures
  - Improvement in Ambulation/Locomotion
    - Calculation:

$$\frac{\text{\# of HH episodes where the value recorded on discharge assessment indicates less impairment in ambulation/locomotion at discharge than at start}}{\text{\# of HH episodes ending with a discharge during the report period}}$$

  - Improvement in Bed Transferring
    - Calculation:

$$\frac{\text{\# of HH episodes where the value recorded on discharge assessment indicates less impairment in bed transferring at discharge than at start}}{\text{\# of HH episodes ending with a discharge during the report period}}$$

Home Health Value Based Purchasing

Quality Measures

- Outcome Measures
  - Improvement in Bathing
    - Calculation:

$$\frac{\text{\# of HH episodes where the value recorded on discharge assessment indicates less impairment in bathing at discharge than at start}}{\text{\# of HH episodes ending with a discharge during the report period}}$$

  - Improvement in Dyspnea (Difficult Breathing)
    - Calculation:

$$\frac{\text{\# of HH episodes where the value recorded on discharge assessment indicates less dyspnea at discharge than at start}}{\text{\# of HH episodes ending with a discharge during the report period}}$$

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Quality Measures

- Outcome Measures
  - Discharged to Community
    - Calculation:

# of HH episodes where the value recorded on discharge assessment indicates the patient remained in the community after discharge
———
# of HH episodes ending with a discharge or transfer to an inpatient facility during the report period

  - Acute Care Hospitalization
    - Calculation:

# of HH stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of an HH stay
———
# of HH stays that begin during the 12-month observation ending with a discharge during the report period

Home Health Value Based Purchasing

HOMECARE&HOSPICE

Quality Measures

- Outcome Measures
  - Emergency Department use w/out Hospitalization
    - Calculation:

# of HH stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay
———
# of HH stays that begin during the 12-month observation ending with a discharge during the report period

  - Improvement in Pain Interfering with Activity
    - Calculation:

# of HH episodes where the value recorded on the discharge assessment indicates less frequent pain at discharge than at the start of the episode
———
# of HH episodes ending with a discharge during the reporting period

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Quality Measures

- Outcome Measures
  - Improvement in Management of Oral Meds
    - Calculation:

# of HH episodes where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at start of care
———
# of HH episodes ending with a discharge during the reporting period

  - Prior Functioning ADL/IADL:
    - Calculation:

# of a clinician's patients in an particular risk adjusted diagnostic category who meet a target threshold of improvement in ADLs
———
# of all patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care

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HOMECARE&HOSPICE

Quality Measures

- Outcome Measures – HHCAHPS Survey
  - Calculation criteria not available
  - Care of Patients
  - Communications between Providers and Patients on Specific Care Issues
  - Specific Care Issues
  - Overall Rating of Home Health Care
  - Willingness to Recommend Agency

Home Health Value Based Purchasing

Achievement Threshold and Benchmark

- For each Quality Measure a State Achievement Threshold value and a Benchmark value will be calculated
  - Achievement Threshold: Median value of all the Quality Measure scores for the state
  - Benchmark: Average of Quality Measure scores in the 90th percentile for the state

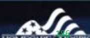
Home Health Value Based Purchasing

Achievement Threshold and Benchmark

- Example: Maryland – Drug Education Outcome
  - 52 agencies in the state – measures listed below

Drug Education Outcome Measure					
51.6	98.5	91.9	96.7	99.4	97.9
92.6	97.2	100	95.5	82.1	99.9
94.4	95.2	98.4	75.2	87.8	98.8
99.3	84.4	99.7	57.6	100	98.3
98.2	56	84.9	99.7	98.4	63.3
99.4	91.6	87.3	95	79.9	97.6
98.2	82.5	95.7	56.6	88.6	94.8
98.1	86.1	79.9	75.2	93.2	N/A
77.5	99.8	96.4	94.1	97	N/A

- Achievement Threshold = 95.1



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Achievement Threshold and Benchmark

- Example: Maryland – Drug Education Outcome

Drug Education Outcome Measure					
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94.4	95.2	98.4	75.2	87.8	98.8
99.3	84.4	99.7	57.6	100	98.3
98.2	56	84.9	99.7	98.4	63.3
99.4	91.6	87.3	95	79.9	97.6
98.2	82.5	95.7	56.6	88.6	94.8
98.1	86.1	79.9	75.2	93.2	N/A
77.5	99.8	96.4	94.1	97	N/A

- Benchmark = 99.85

Home Health Value Based Purchasing

Achievement Scores

- **Each quality measure will be awarded an achievement score**
  - **Achievement scores calculated by performance score comparison to state benchmark and achievement threshold**
  - **Quality Measure ≥ State Benchmark = 10 pts**
  - **Quality Measure < State Achievement Threshold = 0 pts**
  - **State Benchmark > Quality Measure < State Benchmark = Score between 0-10 pts**

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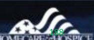


Achievement Scores

- Achievement Score Calculation:

$$9 \text{ x } \frac{HHA\ Perfomance\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold} + 0.5$$

- Example:

Agency Performance Score	Achievement Threshold	Benchmark
95.5	95.1	99.85

- **Achievement Score** $= 9 \text{ x } \frac{95.5-95.1}{99.85-95.1} + 0.5 =$ **1.258***

*rounding to the 3rd decimal point

Improvement Scores

- Each quality measure will also be awarded an improvement score in comparison to the baseline 2015 year outcome score
  - 2015 remains the baseline for improvement for 5 years
  - Performance Score ≥ State Benchmark = 10 pts
  - Performance Score < Baseline = 0 pts
  - Baseline > Performance Score < State Benchmark = Score between 0-10 pts

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Improvement Scores

- Improvement Score Calculation:

$$10 \times \frac{HHA\ Perfomance\ Score - HHA\ Baseline\ Score}{Benchmark - HHA\ Baseline\ Score} - 0.5$$

- Example:

HHA Performance Score	HHA Baseline	Benchmark
97.5	95.5	99.85

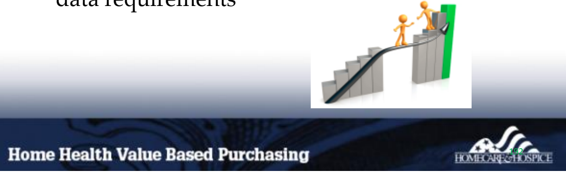
- **Improvement Score** = $10 \times \frac{97.5-95.5}{99.85-95.5} - 0.5 = \mathbf{4.098}$

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Total Performance Score (TPS)

- 90% of the score is determined by summing the higher of an HHA's achievement or improvement score for each quality measure
  - Each measure is equally weighted
- 10% of the score is from the submission of new data requirements



Home Health Value Based Purchasing

HOMECARE & HOSPICE

Total Performance Score (TPS)

Quality Outcome	Performance Score
Taught patient about meds	1.258
Received flu vaccine	0.622
Received pneumonia vaccine	0.000
Improved ambulation	1.478
Improved transfer in and out of bed	0
Improved bathing	0
Less pain when moving	2.030
Improved dyspnea	1.657
Improved taking meds	0
Urgent unplanned ER visit	0
ACH	0
Care in a Professional Way	0.500
Communication	0.500
Specific Care Issues	3.324
Agency Rating	2.079
Recommend	3.176
Total	**16.623**

TPS = $.9 \times (\frac{16.623}{160} \times 100) + 10 =$ **19**

Home Health Value Based Purchasing

HOMECARE&HOSPICE

Financial Impact

FIGURE 9—8-PERCENT REDUCTION SAMPLE

HHA	TPS	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
		Prior year aggregate HHA payment*	8-Percent payment reduction amount (C2*8%)	TPS adjusted reduction amount (C1/100)*C3	Linear exchange function (LEF) (Sum of C3/ Sum of C4)	Final TPS adjusted payment amount (C4*C5)	Quality adjusted payment rate (C6/C2) *100	Final percent payment adjustment +/− (C7–8%)
	(C1)	(C2)	(C3)	(C4)	(C5)	(C6)	(C7)	(C8)
HHA1	38	$100,000	$8,000	$3,040	1.93	$5,867	5.9 %	−2.1%
HHA2	55	145,000	11,600	6,380	1.93	12,313	8.5	0.5
HHA3	22	800,000	64,000	14,080	1.93	27,174	3.4	−4.6
HHA4	85	653,222	52,258	44,419	1.93	85,729	13.1	5.1%
HHA5	50	190,000	15,200	7,600	1.93	14,668	7.7	−0.3%
HHA6	63	340,000	27,200	17,136	1.93	33,072	9.7	1.7
HHA7	74	660,000	52,800	39,072	1.93	75,409	11.4	3.4
HHA8	25	564,000	45,120	11,280	1.93	21,770	3.9	−4.1
Sum			276,178	143,007		276,002		

*Example cases.

Home Health Value Based Purchasing

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Financial Impact

Step 1

- Prior year aggregate HHA payment
  - Sum of all final claim payments
    - Example: $100,000

Step #1 involves the calculation of the 'Prior Year Aggregate HHA Payment Amount' (See C2 in Figure 9) that each HHA was paid in the prior year. From claims data, all payments are summed together for each HHA for CY 2015, the year prior to the HHVBP Model.

Home Health Value Based Purchasing

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Financial Impact

Step 2

- Percent payment reduction amount
  - Percent will depend on year
    - CY 2018 = 3%
    - CY 2019 = 5%
    - CY 2020 = 6%
    - CY 2021 = 7%
    - CY 2022 = 8%
    - Example: $100,000 x 8% = **$8,000**

Home Health Value Based Purchasing

HOMECARE & HOSPICE

Financial Impact

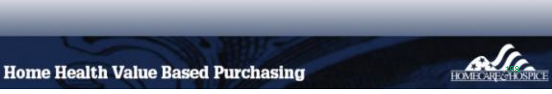
Step 3

- TPS adjusted reduction amount
  - = $\left(\frac{TPS\ Score}{100}\right)$ x Percent Payment Reduction Amount
    - Example: $\frac{33}{100}$ x $8,000 = **$3,040**

Financial Impact

Step 4

- Linear Exchange Function
  - Function used to translate the TPS score into the Value Based Purchasing payment percentage adjustment
  - Function is determined so the average TPS score in a cohort receives a 0% payment adjustment
  - Payment adjustments determined by the slope of the LEF
  - = $\frac{Cohort\ sum\ of\ Percent\ payment\ reduction\ amount}{Cohort\ sum\ of\ TPS\ adjusted\ reduction\ amount}$
    - Example **LEF = 1.93**



Financial Impact

Step 5

- Final TPS adjusted payment amount
  - =(LEF x TPS adjusted reduction amount)
    - Example: 1.93 x $3,040 = $5,867

Home Health Value Based Purchasing

Financial Impact

Step 6

- Quality adjusted payment rate
  - $=\left(\frac{Final\ TPA\ adjust\ payment\ amount}{Prior\ Year\ Aggregate}\right) \times 100$
    - Example: $\left(\frac{\$5,867}{\$100,000}\right) \times 100 = 5.9\%$

Financial Impact

Step 7

- Final percent payment adjustment
  - = (Quality adjusted payment rate – 8%)
    - Example: 5.9% - 8% = **-2.1%**

Home Health Value Based Purchasing

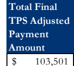
Payment Example

- Medicare Payment Adjustment
  - On episodes ending 1/1/18 and forward
  - Calculation = 2018 Base Rate (wage and case mix adjusted) x VBP adjustment
  - Sequestration separate
  - Adjustment on Final Payment only (not RAPs)

Note that the payment adjustment percentage is capped at no more than plus or minus 8-percent for each respective performance period and the payment adjustment will occur on the final claim payment amount.

Home Health Value Based Purchasing

VBP Example: CY 2018 at 3% max. adjustment



Calendar Year Reduction Percentage	Total Payment Percentage Reduction Amount	Total TPS Adjusted Reduction
3%	$ 103,567	$ 53,628

Total Final TPS Adjusted Payment Amount
$ 103,501

Agency	TPS	Prior Year Aggregate HHA Payment	Percentage Reduction Amount Based on CY	TPS Adjusted Reduction Amount	Linear Exchange Function (slope)*	Final TPS Adjusted Payment Amount	Quality Adjusted Payment Rate	Final Percent Payment Adjustment (+/-)
HHA1	38	$ 100,000	$ 3,000	$ 1,140	1.93	$ 2,200	2.2%	-0.8%
HHA2	55	$ 145,000	$ 4,350	$ 2,393	1.93	$ 4,618	3.2%	0.2%
HHA3	22	$ 800,000	$ 24,000	$ 5,280	1.93	$ 10,190	1.3%	-1.7%
HHA4	85	$ 653,222	$ 19,597	$ 16,657	1.93	$ 32,148	4.9%	1.9%
HHA5	50	$ 190,000	$ 5,700	$ 2,850	1.93	$ 5,501	2.9%	-0.1%
HHA6	63	$ 340,000	$ 10,200	$ 6,426	1.93	$ 12,402	3.6%	0.6%
HHA7	74	$ 660,000	$ 19,800	$ 14,652	1.93	$ 28,278	4.3%	1.3%
HHA8	25	$ 564,000	$ 16,920	$ 4,230	1.93	$ 8,164	1.4%	-1.6%

Dollar figures are rounded

Home Health Value Based Purchasing

Reframing VBP example for CY 2018

Taking a second look at potential financial impacts, consider HHA 8.
In CY 2018 it will have a penalty of -1.6%.

Agency	TPS	Prior Year Aggregate HHA Payment	Percentage Reduction Amount Based on CY	TPS Adjusted Reduction Amount	Linear Exchange Function (slope)*	Final TPS Adjusted Payment Amount	Quality Adjusted Payment Rate	Final Percent Payment Adjustment (+/-)	Potential Financial Impact
HHA1	38	$ 10,000,000	$ 300,000	$ 114,000	1.93	$ 220,020	2.2%	-0.8%	$ (79,980)
HHA2	55	$ 14,500,000	$ 435,000	$ 239,250	1.93	$ 461,753	3.2%	0.2%	$ 26,753
HHA3	22	$ 80,000,000	$ 2,400,000	$ 528,000	1.93	$ 1,019,040	1.3%	-1.7%	$ (1,380,960)
HHA4	85	$ 65,322,200	$ 1,959,666	$ 1,665,716	1.93	$ 3,214,832	4.9%	1.9%	$ 1,255,166
HHA5	50	$ 19,000,000	$ 570,000	$ 285,000	1.93	$ 550,050	2.9%	-0.1%	$ (19,950)
HHA6	63	$ 34,000,000	$ 1,020,000	$ 642,600	1.93	$ 1,240,218	3.6%	0.6%	$ 220,218
HHA7	74	$ 66,000,000	$ 1,980,000	$ 1,465,200	1.93	$ 2,827,836	4.3%	1.3%	$ 847,836
HHA8	**25**	**$ 56,400,000**	**$ 1,692,000**	**$ 423,000**	**1.93**	**$ 816,390**	**1.4%**	**-1.6%**	**$ (875,610)**

**rounded to 2 decimal places as per CMS example*
*** CMS rounds this number by rounding to whole dollars only*
Payments were increased by a factor of 100

Home Health Value Based Purchasing

Inaction will result in negative financial impacts

The table below shows HHA 8 making no relative improvement within its cohort, resulting in a -4.1% penalty by CY2022.

Agency	Prior Year Aggregate HHA Payment	PY 2016 CY 2018 3%	PY 2017 CY 2019 5%	PY 2018 CY2020 6%	PY 2019 CY 2021 7%	PY 2020 CY 2022 8%	Total Financial Impact
HHA8	$ 56,400,000	-1.6% $ (875,610)	-2.6% $ (1,459,350)	-3.1% $ (1,751,220)	-3.6% $ (2,043,090)	-4.1% $ (2,334,960)	$ (8,464,230)

Same model utilized by CMS with no relative changes over pilot years

Home Health Value Based Purchasing

Strategy

- Budgeting
  - Analysis
  - Staffing
  - Technology
  - Models
- Dashboards
- Benchmarking

Home Health Value Based Purchasing

Budgeting

- Analysis: Agencies should identify measures of greatest potential financial impact
- Identify the VBP Quality Measure Areas that will provide the greatest opportunity for improvement
- Interdisciplinary Operational Team assessment to determine forecasted range of opportunity

Home Health Value Based Purchasing

Higher performance does not guarantee a higher TPS

In the example below HHA 1's PY1 score is lower than HHA 2's, but the score earned towards the TPS is higher due to a greater improvement score*.

Agency	Measure Title	Source	Achievement Threshold (50th Percentile) 2016	Benchmark (~95th percentile) 2016	HHA CY2015 Baseline	HHA Performance PY1 (2016)	HHA Achievement Score PY1 (2016)	HHA Improvement Score PY1 (2016)
HHA 1	Improvement in Ambulation-Locomotion	OASIS (M1860)	60	75	20	50	0	4.955
HHA 2	Improvement in Ambulation-Locomotion	OASIS (M1860)	60	75	60	65	3.500	2.833

*final earned points towards to TPS are weighted at 90% for this measure

Home Health Value Based Purchasing

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Opportunities exist for HHAs with low baseline year scores in subsequent years

The example below shows the same HHAs in PY2 (2017). The Achievement Threshold has increased from PY1, and while HHA1 has improved the same number of points as HHA 2, the score earned towards the TPS* is still higher for HHA 1!

Agency	Measure Title	Source	Achievement Threshold (50th Percentile) 2017	Benchmark (~95th percentile) 2017	HHA CY2015 Baseline	HHA Performance PY2 (2017)	HHA Achievement Score PY2 (2017)	HHA Improvement Score PY2 (2017)
HHA 1	Improvement in Ambulation-Locomotion	OASIS (M1860)	65	85	20	55	0	4.885
HHA 2	Improvement in Ambulation-Locomotion	OASIS (M1860)	65	85	60	70	2.750	3.500

*final earned points towards to TPS are weighted at 90% for this measure

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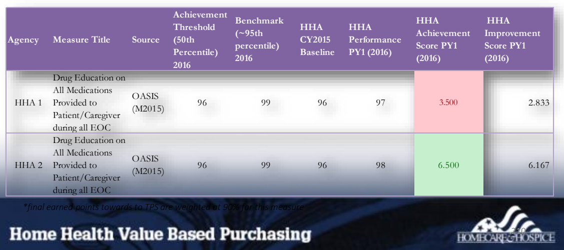
Every point counts when the Achievement Threshold and Benchmarks are close

The example below shows a measure where the window between the Achievement Threshold and Benchmarks are very close. One point difference in PY1 results in a 3 point gap in earned points towards the TPS*.



Agency	Measure Title	Source	Achievement Threshold (50th Percentile) 2016	Benchmark (~95th percentile) 2016	HHA CY2015 Baseline	HHA Performance PY1 (2016)	HHA Achievement Score PY1 (2016)	HHA Improvement Score PY1 (2016)
HHA 1	Drug Education on All Medications Provided to Patient/Caregiver during all EOC	OASIS (M2015)	96	99	96	97	3.500	2.833
HHA 2	Drug Education on All Medications Provided to Patient/Caregiver during all EOC	OASIS (M2015)	96	99	96	98	6.500	6.167

Home Health Value Based Purchasing

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Budgeting

- Staffing
- Create dedicated VBP Accountability Team
  - Clinical education
  - Quality & patient experience team
  - Strict financial & budget model oversight
  - Consider third-party clinical and financial consulting
- Know your metrics, know your cohort's metrics
- Strategically target measures with the greatest improvement opportunity
- Identify measures of greatest risk

Home Health Value Based Purchasing

Strategize to minimize VBP related exposure

- Utilize the formed VBP Accountability Team to be responsible for the following:
  - Develop key assumptions for improved VBP measurement scores that will drive future revenue loss exposures required to be budgeted for future budget years
  - Meet regularly to closely monitor progress (at a minimum with quarterly data submissions)
  - Constantly update financial statement impact based on most recent information
  - Establish concrete targets and operational action plans

Home Health Value Based Purchasing

Budgeting Strategy Considerations

- Utilize your VBP Accountability Team to identify and forecast the improvements in identified VBP measurement areas
- Simulate the CMS formula in forecasting estimated future budget year TPS scores
- Model your current VBP Impact and forecast overall Financial Risk Ranges to 2018 and future budget year annual Medicare Revenues

Home Health Value Based Purchasing

Strategies to Achieve VBP Budget Targets

- Utilize the same VBP Accountability Team that supported the Budget Modeling to:
  - Meet regularly to closely monitor progress (at a minimum with quarterly data submissions)
  - Constantly update financial statement impact based on most recent information
  - Establish concrete targets and operational action plans

Budgeting

- **Technology**
- Invest in technology and systems
  - Dashboards
  - Data metric management
  - Reporting

Home Health Value Based Purchasing

Budgeting for years prior to VBP impact year

- Model your future budget year(s) estimated range of financial risk exposure based on the most recent actual VBP TPS performance scores
- Consider adjusting current and near-term budget operational expenses to mitigate any modeled unfavorable future year financial impact from VBP
  - Example that follows shows HHA 8 will be penalized roughly 1.6% in CY 2018 – budget 0.8% savings between budget years CY17/CY18
- Budget additional dollars now for dedicated VBP team resources
- Budget for outsourcing services that require support to improve efficiency
  - Billing
  - Clinical compliance
  - Training

Home Health Value Based Purchasing

Investing in improvement helps minimize exposure

Investing in strategic initiatives can lead to significant turn-arounds during the VBP pilot phase. In the hypothetical example below, HHA 8 has worked to improve its relative TPS score modestly each year, resulting in a positive net financial impact over the course of the VBP pilot.

Agency	Prior Year Aggregate HHA Payment	PY 2016 CY 2018 3%	PY 2017 CY 2019 5%	PY 2018 CY2020 6%	PY 2019 CY 2021 7%	PY 2020 CY 2022 8%	Total Financial Impact
HHA8	$ 56,400,000	-1.6% $ (875,610)	-2.6% $ (1,459,350)	-3.1% $ (1,751,220)	-3.6% $ (2,043,090)	-4.1% $ (2,334,960)	$ (8,464,230)
Relative TPS Improvement Over Previous Year			50%	40%	30%	20%	Total Financial Impact
HHA8	$ 56,400,000	-1.6% $ (875,610)	-1.5% $ (853,050)	-0.4% $ (221,652)	1.1% $ 632,667	2.7% $ 1,548,338	$ 230,693

Relative TPS improvement numbers are illustrative only and do not factor in changes in other cohort member's changes

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Important considerations for the hypothetical models

- **The considerations used to build the hypothetical model exclude many of the complexities that will impact final TPS scoring. These include, but are not limited to:**
  - **Annually shifting benchmarks and thresholds**
  - **Sensitivity of low or high scores based on the number of scoring categories**
  - **Overall TPS distribution within the cohort**

Home Health Value Based Purchasing

Dashboards

- Definitions
  - **Corporate** – a part of **enterprise performance management;** dashboard provides alignment, visibility & collaboration across organization by allowing business users to **define, monitor & analyze** business performance **via key performance indicators**

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Performance Management

Decide & Act
Set Goals
Monitor Dashboard
Analyze

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The Business Fact Gap

- Inaccurate & incomplete information
- Too much data to sift through – or not enough
- Difficulty locating necessary information
- Inability to analyze data for details & root causes

The result: Decisions Not on Fact – But Gut Feel

Source: The Fact Gap, Business Week Research Services

Home Health Value Based Purchasing

What Gets Measured Gets Managed

Take Ownership

- YOU have to take ownership
- Champion the process
- Identify the sources
  - Internal
  - Outside vendors
- Facilitate the production of the dashboards
- Support the need for more detail

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Key Dashboard Concepts

- Short & concise
- Drill-down capabilities
- Keep it simple
- Not a perfect science

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Establishing a Dashboard

- Identify performance area
- Identify audience
- Aggregate all measures within area
- Identify those critical for success
- Determine a reporting schedule

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Benchmarking

- **Performance measurement tool used in conjunction with improvement initiatives to measure comparative operating performance data & identify best practices**

  - Health Care Benchmarking Association

Benefits of Benchmarking

- **Helps develop performance targets**
  - **Tells what's possible**
  - **Make targets aggressive & achievable**
  - **Involve staff to promote buy in**
- **Identify & implement best practices**
  - **Determine possibilities**
  - **Challenge traditional thinking**

Measure Only What You're Going to Manage; Manage Only What Matters

Home Health Value Based Purchasing

Questions

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