HCAF VBP - Part 1

Overview & Updates to Value Based Purchasing

PREVENTING UNPLANNED HOSPITAL CARE:

Emergency Room - Acute Care Hospitalization - Discharge to Community

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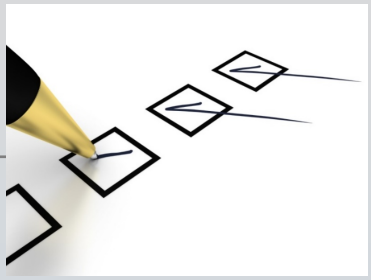
Objectives



Participant will Understand:

- Overview of VBP
- CASPER and Home Health Compare reports
- Outcomes that contribute to VBP
- Best practice strategies to enhance outcomes
- The key indicators to incorporate into QAPI for enhancing outcomes
- How to involve staff in enhancing outcomes

Refresher- What is VBP?

The Home Health Value-Based Purchasing (VBP) Model is expected to improve patient outcomes in home health, while lowering costs.

Required as part of the Affordable Care Act (ACA) and a part of IHI (Institute for Health Improvement)

Transitions home health from fee-for-service payment models toward value-based purchasing

Rewards HHAs that provide better quality care per outcomes

States:
- Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee

VBP Began January 1, 2016 with a 2015 baseline year on performance and payment adjustment beginning in year 2018

Payment model for incentive payments for the 1st year -3% (2018) to 8% (2022)

Budget Neutral….SO, Rewards improved quality and penalizes poor **performance**

Melinda G, HPS, at HCAF Winter Warm Up - FLORIDA SAMPLE RESULTS (71)

Largest Payment Adjustment -2.08%

Highest +Payment Adjustment +0.03%

ONLY ONE HHA in the sample had a positive payment adjustment!

Achievement points (AP)

The achievement threshold for each measure used in the Model is calculated as the median of all HHAs' performance on the specified quality measure during the baseline period (CY 2015).

The benchmark is calculated as the mean of the top decile of all HHAs' performance on the specified quality measure during the baseline period (CY 2015).

For each measure a HHA with performance equal to or higher than the benchmark could receive the maximum of 10 points for achievement.

For each measure - equal or greater than the achievement threshold (but below the benchmark) could receive 1-9 points for achievement.

With performance less than achieve thresh could receiver 0 points for achievement.

Improvement points (IP)

HHA could earn IP based on how much its performance has improved from its performance during the baseline period (2015), for each measure

An improvement range for each measure will be established for each HHA that is difference between HHA's baseline period score and the same state benchmark.

Equal to or higher than the benchmark score, HHA could receive an improvement score of 10 pts

Greater than its baseline period score but below the benchmark (within the improvement range), the HHA could receive 0-10

Equal to or lower than baseline HHA could receive 0 pts.

New Report Measures - 3

- 10% of TPS
- All or nothing score
- Each worth 10 pts for submission, if not submitted 0

So if miss submitting you can only earn up to 90% of the total points for the TPS

Total Performance Score (TPS)

Equals Numeric score ranging from 0-100 awarded to each competing HHA based on its performance in VBP

HHA's TPS determined using the higher of an HHA's achievement or improvement score For Each Measure

Using higher of the 2 scores recognizes HHAs that have made great improvements , even if their measured performance score may still be relatively lower when compared to other HHAs.

TABLE 24:
Measure Set for the HHVBP Model

Page 146 of 338 – Final Rule

How each is measure is calculated

Example: Improvement in Ambulation:

Numerator- # HH episodes where value recorded on DC assessment indicates less impairment in ambulation at DC than at SOC or ROC.

Denominator- # HH episodes ending with a DC (other than those covered by generic or measure specific exclusions).

VBP PILOT FINAL UPDATE 2017
Measures

- 14 Outcome Measures
- 3 Process Measures
- 3 New

Measures - source
- OASIS (10)
- Claims (2)
- HHCAHPS (5)

4 Removed

VBP PILOT FINAL UPDATE 2017
Measures

Outcome Measures

Improvement in pain interfering with activity (OASIS – M1240)

Improvement in Dyspnea (OASIS – M1400)

Improvement in Bathing (OASIS – M1830)

Improvement in Bed Transferring (OASIS – M1850)

Improvement in Ambulation-locomotion (OASIS – M1860)

Improvement in oral medication management (OASIS – M2020)

Discharged to Community (OASIS – M2420) (Not on Home Health Compare)

VBP PILOT FINAL UPDATE 2017
Measures

Process Measures

Influenza immunization received (OASIS – M1046)

Pneumococcal vaccine ever received (OASIS – M1051)

Drug education for all medications (OASIS – M2015)

Claims Based Outcomes:

Acute Care hospitalization (unplanned within 60 days)

Emergency Department use w/o hospitalization

VBP PILOT FINAL UPDATE 2017
Measures

CAHPS

Care of Patients

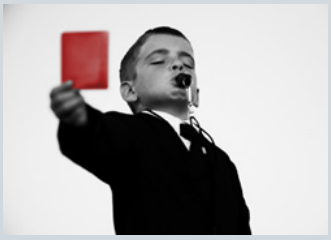
Communication between providers and patients

Specific Care Issues

Overall rating of home health care

Willingness to recommend the agency

New Measures- REPORT ONLY
Penalized if do not report



- Each of these new measures need to be reported by HHAs through a HHVBP Web Portal
- Reporting of influenza vaccination for HHA staff now only required annually rather than quarterly - first annual submission in April 2017 for PY2.
- Final rule to allow 15 days vs. 7 for submitting the data following the end of the reporting period.

New Measures- REPORT ONLY
Penalized if do not report

Influenza Vaccination of HH staff

- % of personnel received or documented not received due to medical condition, received elsewhere, declined or unknown Oct 1- March 31

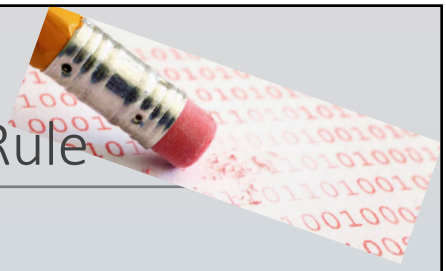
Herpes Zoster (shingles) vaccination for HHA patients

- # of Medicare beneficiaries over 60 that ever received shingles vaccine

Advanced care planning

- Patients over 18 with a plan or discussed and documented with patient

Measures removed in Final Rule



Prior functioning ADL/IADL (OASIS – M1900)

Influenza vaccine data collection period (OASIS – M1041)

Reason Pneumococcal vaccine not received (OASIS – M1056)

Care management: Types and sources of assistance (OASIS – M2102)

How to Improve Your Scores? Key areas of focus:

OASIS – Accuracy and Consistency

Care Management Model (Case Management)

CASPER Outcome Reports

QAPI

Engaging ALL HHA staff

Education…..Education…..Education….

OASIS Accuracy

If this is lacking, your work on improving outcomes will not be successful!

Steps:

OASIS Audit of all of your clinicians completing OASIS time points

Trend results- identify if common problem or individuals

Develop Education Plan- Tailored education

ex: if common problem with 3 outcomes, educate all OASIS clinicians on those;

ex: if individuals that don't understand OASIS- do full education for those staff

However, a FULL OASIS training class needs to be done annually for all OASIS Clinicians

- To update on CMS Q&A's , etc.
- TO Review CMS OASIS MANUAL chapter 3 INTENT and Guidelines – as many clinicians forget all of the caveats that can assist in increasing outcomes!

Audit Again! Drop frequency and amount of Best Performers

OASIS Consistency

Are all of your clinicians performing the comprehensive OASIS assessment in the same manner ?

If not, your Outcomes WILL be skewed! And your work to improve Outcomes will not succeed!

Mock Assessment In-services with all work wonderfully to engage staff!

Clinicians must walk with patient around the house to "SEE" how the patient does and have patient SHOW you activities.

Examples:

- Transfer to toilet
- Go down 2 steps to go outside
- Take off shoes and socks and put back on
- Read Meds to you and describe them

MUST do Assessments in this manner on DISCHARGE OASIS VISIT AS WELL!

Care Management

Care Management

Now in our new CoPs
Case Management , Integrated Care Coordination.....etc.

The patient care team MUST work together to improve the patient's outcomes

Start by setting up geographic Care Teams to include all disciplines

Continuity of Care- with a Care Management approach, this will happen!

- Put a back up for each discipline on the team to cover for days off
- Ex: May have Case Manager RN and an LPN and prn RN as the nurses on one team dependent on duties of the RN Case Manager in your HHA.
- Lack of continuity could destroy your chance at increasing the pt outcomes

Care Management

Have the team share a patient case load

The team must "TALK TO EACH OTHER"!

- Document All of the Communication!

Identify 2-3 outcomes to work on together for a patients over the course of the episode

Working towards outcome enhancement for a patient helps the Team be Goal oriented -

- The staff feel rewarded and have more purpose than just going visit to visit for tasks.
- And the Patient buys in and outcomes improve!

CASPER Reports

Assign someone to look in system monthly to see if reports have been updated

When updated, do an analysis of the data, focusing on the statistically significant areas

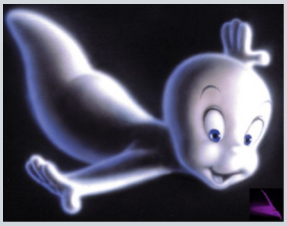
Write an action plan for needed areas

Incorporate into your QAPI plan- have an indicator for those selected to initially focus (cant do all! Pick 3 to start)

Share with all staff! That is how you get improvement!

Plan the episode of care for the patient in order to focus on improving outcomes as a team!

All of this information comes from what YOU PUT IN OASIS!!!



CASPER Outcome Reports

Compiled OASIS data of every certified HHA at 2 time points

Example: SOC to DC, or ROC to DC gives the outcome reports:

Agency Patient Related Characteristics (Many Risk Adjustment)

Risk Adjusted Outcome Report (Including ER & Hosp Outcomes)

Potentially Avoidable Events (Adverse Events including reasons for ER)

Process Based Quality Improvement (Process Measures)

3 Bar is most meaningful - your current %, your prior period % and national current %

Asterisks mean it is statistically significant data- Focus First on these!

Potentially Avoidable Events – PAE Related to ER visits

Emergent care for:

- Falls
- Wound infections or deteriorating wound status
- Improper medication administration or medication side effects
- Hypo/hyperglycemia

- Any significantly statistic should be addressed.
- These are not in real time, but recommend to review the clinical record to ascertain what the HHA could have done to prevent the visit
- This can be used for education now to prevent those ER visits in future
- Add any significantly statistic outcomes related to ER as QAPI indicators

Home Health Compare

Some of the outcomes from CASPER reports are on this website, separated into categories:

- Managing Daily Activities
- Managing & Treating Pain
- Treating Wounds and Preventing Pressure Wounds
- Preventing Harm
- Preventing Unplanned Hospitalization TODAY'S TOPIC

Variances to CASPER –agency compared to state and nation and timeframe

Star Ratings and CAHPs on HHC too

www.https//Medicare.gov/homehealthcompare/search.aspx

Remember, VBP will be public too in future!

QAPI

From the analysis of CASPER develop Indicators to Monitor in your QAPI program.

Develop indicators for QAPI from:

- VBP reports of your agency
- Statistically significant outcomes
- Vulnerabilities identified on mock or real surveys
- High volume/ high risk/ problem prone areas

Specifics will be shown for the Outcomes we review today and going forward!

Preventing Unplanned Hospital Care

Hospitalization (unplanned within 60 days)

Emergency Department use w/o hospitalization

Discharged to Community

Preventing Unplanned Hospital Care

Common Goals:

Keep the Home care patient in the home and/or community during the episode and at discharge

What do we do to impact change in our outcomes?

- Care Management Model as discussed above
  - Continuity of Care
  - Team Goals to improve patient outcomes
  - Be each others Eyes & Ears
  - Excellent Communication between team, patient/cg and physician

Identifying Patients at High Risk for ER or Hospitalization

On Admission, perform a Risk Assessment

- Past frequent ER visits and admissions
- "Frequent flyer" to home health
- Non compliance
- Socioeconomic and/or Psychosocial factors
- Share with Care Team prior to their initial visits!

Plan- Individualize per patient

- Front load visits by scheduling visits on alternating days so patient is seen by someone most days following the SOC for the first 7-14 days
  - Frequent ER or Hospitalization in these first 2 weeks
- Be each others eyes and ears – COMMUNICATE to each other!
- Communicate with On Call staff on high risk patient with pertinent data

On Call

Assess your On Call process to ensure staffing is adequate for coverage, skill level

Ensure escalation process is appropriate, i.e., when is supervisor notified to discuss if visit should be made

Develop scenarios and scripts per disease process and/or procedures

Provide additional training to On-Call staff

- Regarding new On Call procedures and process
- Goal that the On Call staff must understand is to avoid ER visits and Hospitalizations

Audit ALL ER visits and hospitalizations that are after hours

Physician Notification – Early and Timely!

With First changes in patient

- **All disciplines!**
  - Communicate in Real Time to appropriate members of the patient's care team, and then appropriate clinician contacts physician promptly

Examples:

- Is patient more fatigued when OT is working with them?
- Did patient cough frequently with aide?
- Is BP up when PTA with patient?
- Is there more pain not relieved appropriately with current pain meds?
- Any new or worsening symptoms!

- Often when clinical record reviews are done after an ER visit or hospitalization, these types of issues are documented……often with NO coordination with the other disciplines and NO Physician Notification !
- This alone can prevent ER visits and Hospitalizations!

Communication with Patient Between Visits- Telehealth & Patient/Caregiver Communication to Agency

Telehealth very important to:

- Continue with patient compliance
- Determine if there are any changes in patient
- Maintain a good rapport with your patient and family
- Identify risks !

This is an excellent method to prevent ER visits and hospitalization!

Communication with Patient Between Visits- Telehealth & Patient/Caregiver Communication to Agency

Methods:

Frequent Telephone Calls – in between visit days, including evening and weekends for high risk patients

- Have a script individualized for patients (by risk and/or disease)
- Patient / Family Communication to Agency
- Tell patient **EVERY VISIT** to call the HHA before going to the ER unless emergencies!
- Again explain to them what types of things to call HHA for- even minor changes that you have discussed with them. Ex: A CHF patient notes increased edema in feet and ankles.
- Also inform them to contact HHA right away after ER visit, or if hospitalized.

Telehealth Units - customize peripherals to pt risk and/or disease

Video Conferencing- many agencies planning to use Skype/other video technology "to speak with patients

- For high risk patients, should consider this!
- Great for wounds, CHF, COPD, CVA, post surgery, etc.
- Ensure HIPAA compliance

Proper Utilization of Services

Can Increase Patient Outcomes in Many Areas and Keep Patient Out of ER & Hospital

- Is OT in appropriately? – Great discipline to help increase outcomes!
- MSW if any issues identified by the team – Valuable discipline to have involved on any high risk patients! Plan dc to community when able with resources to keep patient at home.
- Aide - low usage today! Aides can be with your patients more frequently for a longer time and be able to "SEE" important issues! Be Sure the Aide communicates ALL to supervisor (RN on team and after COPs, can be therapist!)

Watch Frequencies! 1w9 wont keep your patients out of the ER and hospital!
After frontloading first 2 weeks, wean down → *Example: 3w2, 2w2, 1w5.*
ALL Disciplines can Front Load! Shows Pt Improvement and progress to goals!

Patient Education

On Call Services → 24/7 call HHA Before going to ER (unless Emergency)

Medication Management→ Ongoing & In Depth
- Are all disciplines paying attention to patient's compliance to meds?
- Are clinicians teaching the patients Every Visit?
- Are medications not relieving issues reported to the physician

Disease Management → Specific teaching plan for visits for all of the Care Team
- in order to coordinate the teaching together have a greater impact on outcomes

Potentially avoidable events → Specific frequent teaching
- ER for Falls with injury, hypo/hyperglycemia, wounds, medications

Patient education tools → Discuss frequently . . .not just at admission

Leave patients detailed tools that are easily accessed, be creative – flyers, magnets, magazines related to disease

Agency Action Plan for High Risk Patients

Care Team to take Action from results of patient education

- Communicate within team – come up with a revised plan as needed

Scheduling – Care team schedules with schedules / management oversight

- To avoid long weekend gap and see patients frequently:
  - Staff more patient visits on Mondays
  - Have weekend staff – all disciplines - doing routine visits and/or phone calls

(M2420) Discharge Disposition

Where is the patient going after discharge from your agency?

Patient remained in community (without formal assistance)

Patient remained in community (with formal assistance)

Patient transferred to non-institutional hospice

Unknown-patient moved to geographic area not serviced by HHA

Other unknown (go to M0903)

(M2420) Discharge Disposition

Where is the patient going after discharge from your agency?

If the agency can identify that they have a high rate of hospital admissions that are avoidable, it will help improve this, depending on when the admission occurs.

This measure looks at # of episodes where the DC indicates DC to community (numerator) over the # of episodes where the number of episodes end in a DC to inpatient facility (denominator)

Example: If your HHA has 35 DC to community and 7 Inpatient facility admissions, then you are sending 5 x more pts to community than to the hospital

Therefore, all of the Actions to decrease ER visits and Hospitalization are used for this VBP outcome

Pending - Implementation of the **Impact Act** where the indicator for Discharge to the Community will be utilized to track hospital readmits **following discharge for 60 days from home health-** separate from VBP outcome of M2420

ER Visit Without Hospitalization

BEST PRACTICE: Have a nursing visit prior to an ER visit!

Note: If patient goes to ER and isn't hospitalized, that may indicate that homecare could have prevented the ER visit!

Audit all ER visits without hospitalization in Real Time to ascertain if agency could have done something that may have prevented this:

- Physician Notification
- Additional Visit from telehealth call or information
- Increased medication education
- Education re contacting HHA prior to going to ER unless emergency
- Care team not reporting signs and symptoms to each other

How to Select QAPI Indicators

VBP reports from your Agency for your State

Statistically Significant outcomes from CASPER –especially Star & VBP outcomes

Items that are below National Averages on CASPER

Clinical, multidisciplinary, each discipline, service

- ***Example:*** dyspnea-clinical, pain-multi, improve in ambulation- therapy, improvement in bathing- aide and OT
- IV services – high risk and problem prone

Develop an indicator to incorporate in QAPI to assist in identifying if there is an OASIS understanding deficit, or if an actual care issue.

When choosing Indicators to develop:

Task force of stakeholders to brainstorm areas to improve care to increase outcomes.

Develop Audit Tools for each Indicator

Continue OASIS Education on specific M items identified in knowledge deficit.

Educate task force on clinical record reviews on how to review with focus on M items to improve

Assessing Agency Performance Levels:

Closely monitor the agency measure ratings in the HHVBP reports and share with all agency staff

Evaluate the agency ratings in comparison to applicable state benchmarks and other reports such as the Star Ratings, CASPER

Analyze trends for both patients and clinicians
- Drill down to disease types
- Drill down to Care Teams and Disciplines

Develop and WORK the Action Plans that need to be taken in order to improve

This is NOT BUSY WORK! Viability of your agency depends on this!

Assessing VBP with QAPI

Identify if VBP scores are based on Achievement or Improvement?

If Improvement – can we improve more?
- Continue QAPI indicator for further improvement
- Gather team to determine if other criteria to include

If not based on Improvement, why aren't we improving?
- Review the QAPI indicator
- Did we ascertain if an OASIS issue or a Care Issue?
- Did we drill down to disease type? To Care Team?
- Gather team to brainstorm and develop New plan

Definition of Insanity is doing the Same Thing Over and Over and Expecting a Different Result!

QAPI INDICATOR EXAMPLE:
ER visit for Falls with Injury

The QAPI coordinator or designee will audit 100% records of patients with ER visits for falls with injury per quarter to audit criteria with expected threshold 90%.

Potentially Avoidable Event – ER for Falls with injury will be below ___%

(State &Ntl Benchmark)

ER visit for Falls with Injury

Criteria for Audit tool

- Was fall assessment complete on SOC?
- Was fall assessment completed on ROC and Recert?
- Were interventions documented if risk was medium or high?
- Were interventions appropriate for the patient?
- Was there documentation of patient/ caregiver education?
- Was the physician notified of the fall?
- Was there anything the Agency could have done to prevent the fall?

QAPI Indicator and Audit Tool Example:
The QAPI Coordinator or designee will review 100% patients going to the ER without hospitalization quarterly to ascertain if there was anything the HHA could have done to prevent the ER visit.

Goal: 90% to audit criteria Goal to Outcome : ___%

Criteria	Pt
Was assessment on SOC complete	
Were appropriate disciplines ordered based on OASIS	
Was frequency and duration appropriate	
Were visits front loaded	
Was MD notified of any changes in pt condition	
Was visit frequency increased if necessary after change in condition	
Did disciplines communicate with each other re: pt change	
If pt/cg called RN after hours, did on call RN make visit	
If pt was non compliant with orders, was MD called	
Was appropriate patient/cg teaching documented re when to call 911, go to ER, call HHA RN, or call MD?	
Was response to patient teaching documented	
TOTAL COMPLIANCE: _____	
NOT SCORED: Was there anything agency could have done to prevent hospitalization	

QAPI Indicator Example: Reason for Emergent Care- Audit Tool

Outcome Reports (CASPER):

Other respiratory – 38% / 25% prior / 11% national

Uncontrolled pain – 25% / 0 prior / 5.5% national

Indicator: QI coordinator or designee will review 100% of patient OASIS - reason for emergent care quarterly.

If 'other respiratory' or 'uncontrolled pain' is the reason for emergent care, then a clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences.

Goal: CASPER data: other respiratory reason- 15%, uncontrolled pain reason- 10%

Audit criteria met on clinical record review when reason respiratory or pain – Goal: 90%

Criteria	Pt-	Pt	Pt	Pt	Pt
Respiratory:					
Not scored – does pt have resp diagnosis?					
Did the respiratory assessment correlate with the M item for dyspnea?					
Was physician notified for all resp signs and symptoms?					
Was resp education documented ?					
Was understanding of education by pt/cg documented?					
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?					
If yes, did the nurse call the physician and / or make a visit?					
Was there anything the HHA could have done to prevent emergent care for respiratory reasons?					
Total per pt:					
Total compliance : _____					

Criteria	Pt-	Pt
Pain		
Did the pain assessment correlate with the M item for pain on OASIS?		
Was physician notified for all pain signs and symptoms?		
Were all pain assessments complete and thorough?		
Was pain education documented ?		
Was understanding of education by pt/cg documented?		
Not Scored- Did the patient /cg contact the HHA prior to going to the ER?		
If yes, did the nurse call the physician and / or make a visit?		
Was there anything the HHA could have done to prevent emergent care for uncontrolled pain ?		
Total per pt:		
Total compliance : _____		

QAPI Indicator Example Re-hospitalizations

A primary goal of having a patient receive homecare services is to keep that patient in the home, and to prevent hospitalizations.

Agency goal is to have less than ___% (based on Agency VBP report as well as CASPER outcomes) of our patients be hospitalized during an episode of care.

The QAPI coordinator or designee will review 100% of patient records that are hospitalized during an episode of care every quarter. The goal is for a 90% compliance to the audit criteria.

Conclusion

Don't Allow yourself to be caught up in all of the New Regulations and Terms because:

- Most all comes down to how you perform the Comprehensive OASIS Assessment, how the OASIS is scored, and what your patients think and report about you!
- These are the SAME items we have been doing for decades!
- CASPER and Home Health Compare reports have been here since 2003!
- Be Sure to Read and Understand your VBP Reports so you can put outcomes into action!
- Have a great QAPI program to focus and formalize your efforts
- Educate and Involve your clinicians! THIS TAKES A VILLAGE!
- You will Find that your Outcomes will improve by keeping it simple!!!!!!!!!!!!!

Resources

HHQI- http://www.homehealthquality.org/Education/Best-Practices/BPIPs/Fundamentals-of-Reducing-Hospitalizations-BPIP.aspx

Initiative of the Centers for Medicare & Medicaid Services (CMS). Since 2007, the Home Health Quality Improvement (HHQI) National Campaign has been dedicated to improving the quality of care provided to America's home health patients

https://www.hsag.com/en/medicare-providers/home-health-agency

Health Services Advisory Group- hsag

Thank You

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