Home Health Value Based Purchasing: Where Does Stabilization Fit?

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Objectives

Assess
- Assess the impact of Home Health Value Based Purchasing care delivery

Examine
- Examine how outcome measures create opportunities for interdisciplinary care.

Discuss
- Discuss the role of therapy in reducing risk for higher cost care.

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HHVBP Expansion

Home Health Value Based Purchasing

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Home Health Value-Based Purchasing Model Evaluation of the First Four Performance Years (2016-2019)

May 2021

CMS Summary Report

For more information and to download the fourth annual evaluation report, visit: https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model

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Impact on Medicare Spending

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

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Impact on Quality and Utilization

- Results through the fourth year of the model and second year of HHVBP payment adjustments suggest **modest gains** in quality of care and **declines in utilization** for some types of services due to HHVBP:
  - Total Performance Scores were **8% higher** among HHAs in HHVBP states than HHAs in non-HHVBP states in 2019
  - Decrease in unplanned hospitalizations, ED visits **leading to inpatient admission**, and skilled nursing facility use by FFS beneficiaries using home health
  - Continued trend toward **improvement in functional status**, including two new composite measures
- Offset by modest unintended changes due to HHVBP:
  - 2.6% increase in outpatient ED visits
  - 0.3% decrease in two of five measures of patient experience: communication and discussion of care with patients

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Impact on Home Health Agency Operations

- Agencies continue to view the model as complementary to other CMS quality initiatives and report leveraging data analytics in coordination with staff training to improve performance and care delivery.
- No effect on overall agency entries or closures, use of home health services, or access to home health care.

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VBP Quality Measures

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

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TNC = 75% of OASIS Items Impacting HHVBP

TNC Mobility (3)

- M1840 - Toilet Transferring
- M1850 - Bed Transferring
- M1860 - Ambulation/Locomotion

TNC Self-Care (6)

- M1800 - Grooming
- M1810 - Ability to Dress Upper Body
- M1820 - Ability to Dress Lower Body
- M1830 - Bathing
- M1845 - Toileting Hygiene
- M1870 - Eating

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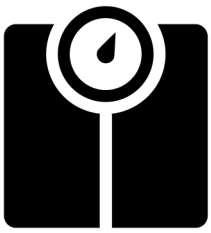
OASIS Data Collection

OASIS Is:

- Discipline Neutral
- Data Collection

OASIS Is Not:

- Thorough Assessment
- Creating Care Plans



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Who is Driving Outcomes?

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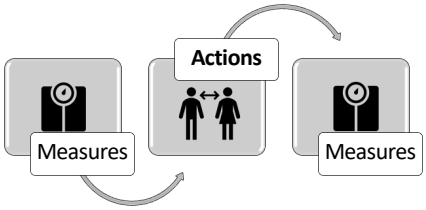
How Outcomes are Created



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M1860 - Ambulation

(M1860)	Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	
Enter Code ☐	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, unable to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is unable to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.

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

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Making Improvement Happen

- Determine "why" the impairment is present
  - Weakness, balance, environment, cognition, pain, medications
- Continuous vs Intermittent Assistance
  - Consistent level of understanding across disciplines (LPN/PTA/OTA)
- Translate into goal setting and care planning
  - Focus on intentional strategies to improve / stabilize OASIS response

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M1830 - Bathing

(M1830)	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).
Enter Code ☐	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 Unable to participate effectively in bathing and is bathed totally by another person.

- *If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then enter Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3").*
- *If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, enter Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.*

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Making Improvement Happen

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

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

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

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M2020 – Management of Oral Medication

(M2020)	Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)
Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.

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

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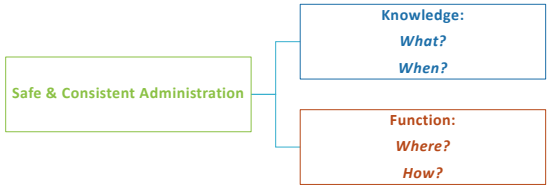
Assessing Ability



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Making Improvement Happen

- Determine "why" the impairment is present
  - Weakness, balance, environment, cognition, pain, lack of medications
- Administration errors vs Drug Regimen Review
  - Consistent level of understanding across disciplines (LPN/PTA/OTA)
- Translate into goal setting and care planning
  - Focus on intentional strategies to improve / stabilize OASIS response

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Managing Rehospitalization Risk

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Defining Hospital-Associated Deconditioning

- Multi-system decline in function partially avoidable occurrence resulting from prolonged immobility during period(s) of hospitalization
  - Decline in ADL performance
  - Prolonged periods of bed rest/relative inactivity
    - Older adults spend ~83% of hospital stay in bed
    - Older adults spend ~12% of hospital stay in chair

Falvey,JR, et.al. Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

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Exercise Prescription: The Issue of Underdosing

- Functional Reserve (def): the capacity for older adults to handle additional stressors or illnesses without loss of independence
- Older adults discharged with poor physical function have 3x the odds of being re-hospitalized within 30 days as compared to:
  - Older adults with medically complex conditions, &
  - Older adults with high physical function
- Most common PAC physical therapists choose low-intensity exercises ("safer")

Falvey,JR, et.al. Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

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Exercise Prescription: Paradigm Shift

Figure 2.
Current rehabilitation hierarchy for older adults with hospital-associated deconditioning (HAD) and hierarchy of an updated treatment approach for older adults with HAD. RT=resistance training, ADL=activities of daily living, GCAs=general conditioning activities.

- Focus of Interventions in HAD:
- High intensity resistance training
- Mod to high intensity motor control-based gait, balance, ADLs
- Mod intensity aerobic training
- General conditioning activity

Falvey,JR, et.al. Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift. Phys Ther. 95:9, pp 1307-1315, 2015.

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Service Utilization: SN, PT & Function

- At the threshold dose of 1 PT or 2 SN visits/week, higher visit intensity significantly reduced the hazard of rehospitalization in these patients by up to 82% for PT
  - The effect of PT on reducing the risk of rehospitalization was more pronounced in patients with low versus high functional limitation
    - Threshold: 1 PT visit/week
    - Risk lowered: up to 82%
  - SN was only effective in reducing the hazard of rehospitalization in the low functional limitation, but not in the high functional limitation group
    - Threshold: 2 SN visits/week
    - Risk lowered: 48%

Wnag, J, et.al. Inverse Dose-Response Relationship Between Home Health Care Services and Rehospitalization in Older Adults. JAMDA 20, pp 736-742, 2019.

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Research: Did You Know??

- Hospital **readmission rates** after acute care discharge are **3x higher** if physical therapist discharge recommendations are replaced with less intensive interventions.
- Declines in self-reported ADL ability is **strongly linked** to poor outcomes following hospitalization.
- Older adults who return home with **unmet needs for ADL assistance** have a **66% increase** in the odds of hospital readmission when compared to those whose needs are adequately addressed after discharge.
- Older adults who walk < 4,691 steps per day over the 1st week post discharge are ~6x more likely to be readmitted within 30 days.

Falvey,JR, et.al. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. Phys Ther. 96:8, pp 1125-1134, 2016.

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Where does Stabilization Fit?

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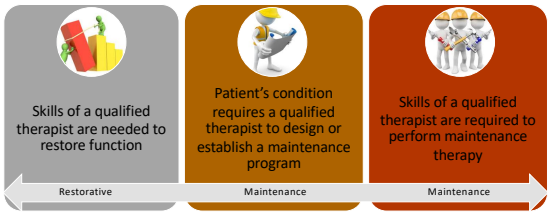

Coverage Criteria for Therapy

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Patient is responding to therapy and can meet the goals in a predictable period of time	**The maintenance program must be established by a qualified therapist**	**The unique clinical condition of a patient may require the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient's specific illness or injury**	**Must include the program design, instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a PT, SLP, or OT is required**

Condition #2: Maintenance

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Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist *or* by a qualified therapist assistant under the supervision of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program.

Condition #3: Maintenance

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What About the Caregiver?

The presence or absence of a caregiver DOES NOT define the intervention provided as "skilled"

IF someone OTHER THAN a therapist can do the intervention THEN it would NOT be considered "skilled"

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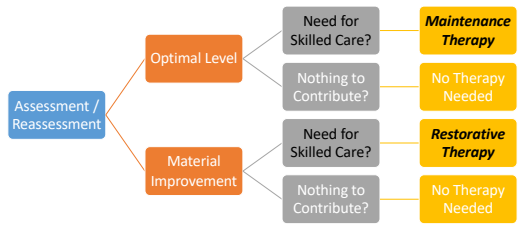

Choosing a Course of Care

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Defining Key Concepts

Skill
- proficiency, facility, or dexterity that is acquired or developed through training or experience

Reasonable
- governed by or being in accordance with reason or sound thinking; not excessive or extreme

Necessary
- Absolutely essential; needed to achieve a certain result or effect; requisite

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"Choosing" Maintenance

Providing maintenance therapy is NOT an "option" for beneficiaries that qualify

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Looking Ahead

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Mission:
Empower home health agencies with revenue protection strategies.

Core Values:
Innovation / Trust / Integrity

K&K HEALTH CARE SOLUTIONS
OUTSOURCING ◆ AUDITING ◆ COMPLIANCE

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