Balancing Efficiency & Quality: Keeping Things "Copacetic" for Roaring Success in Value-Based Care Delivery

Carissa L. McKenna, RN BSN COS-C, HCS-D

Senior Clinical Consulting Manager, McBee

Sparkle Sparks, PT MPT COS-C
AHIMA Approved ICD-10-CM Coding Instructor

Home Health Education Program Manager,
Sutter Health Care at Home

mcbee

Balancing Efficiency & Quality: Keeping Things "Copacetic" for Roaring Success in Value-Based Care Delivery

Carissa McKenna
Senior Clinical Consulting Manager, McBee

Sparkle Sparks
Home Health Education Program Manager
Sutter Care at Home

Copyright ©2022 McBee, All rights reserved.

mcbee

Objectives

- Review strategies for success under HHVBP
- Review common trends in LUPA and utilization based on CMS claims data
- Identify best practices for mitigating avoidable LUPA and enhancing quality patient care which ultimately spells success in HHVBP
- Describe successful strategies implemented at Sutter Care at Home for managing and mitigating avoidable LUPA, enhancing quality care delivery and positioning them to best address key indicators for HHVBP

mcbee

Value-Based Purchasing

Key Components and Best Practice Strategies for Success

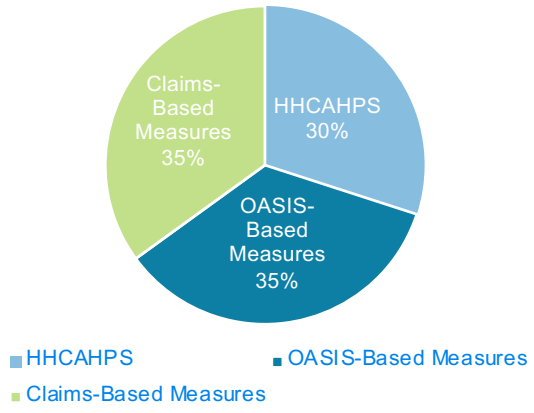
mcbee

Home Health Value Based Purchasing (HHVBP)

Quality Measures

- Claims-Based Measures:
  - Acute Care Hospitalization during the 1st 60 days of home health use
  - Emergency department use without hospitalization during 1st 60 days of home health use
- OASIS-Based Measures:
  - Improvement in Dyspnea
  - Discharged to Community
  - Improvement in Management of Oral Medications
  - Total Normalized Composite (TNC) Change in Mobility
  - Total Normalized Composite (TNC) Change in Self-Care
- HHCAHPS Survey

Quality Measures Used for VBP



mcbee 5

HHVBP Measure Weighting

Breakdown

Measure Category	Quality Measures	Weight % within Category	Individual weight in Entire weighting
	OASIS		**35**
OASIS	TNC self Care	25	8.75
	M1800	4.2	1.45
	M1810	4.2	1.45
	M1820	4.2	1.45
	M1830	4.2	1.45
	M1845	4.2	1.45
	M1870	4.2	1.45
	TNC Mobility	25	8.75
	M1840	8.33	2.9
	M1850	8.33	2.9
	M1860	8.33	2.9
	Other OASIS Items	50	17.49
	Dyspnea (M1400)	16.67	5.83
	Oral Medications (M2020)	16.67	5.83
	Discharge to Community (M2420)	16.67	5.83
	Claims		**35**
Claims	ACH	75	26.25
	ED Use	25	8.75
	HHCAHPS Survey Measures		**30**
HCAHPS Survey	Professional Care	20	6
	Communication	20	6
	Team Discussion	20	6
	Overall Rating	20	6
	Willingness to Recommend	20	6

mcbee 6

OASIS

Risk Adjustment Items

- Age
- Gender
- Payment Source
- SOC/ROC and Admission Source
- Post-Acute Care Facility
- Risk for Hospitalization
- Availability of Assistance & Living Arrangements
- Pressure Ulcers
- Stasis Ulcers
- Surgical Wounds
- Dyspnea
- Urinary Status
- Bowel Incontinence
- Cognitive Function
- Confusion
- Anxiety
- Depression Screening
- Behavioral Symptoms
- Disruptive Behavior Frequency
- Grooming
- Upper Body Dressing
- Lower Body Dressing
- Bathing
- Toilet Transferring
- Toilet Hygiene
- Transferring
- Ambulation
- Feeding or Eating
- Oral Medications
- Supervision and safety assistance
- Home Care Conditions

mcbee

Social Determinants of Health

Risk Areas

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

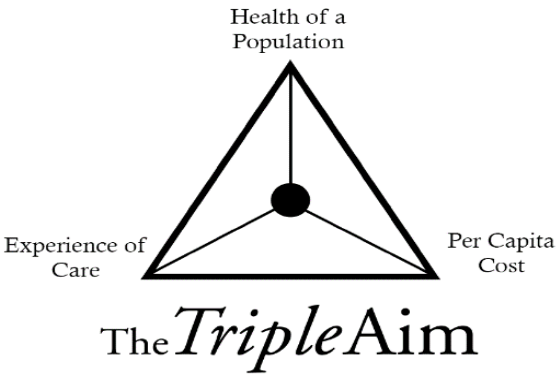
Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

mcbee

Medicare's Triple Aim Mandate

Episode Management is the Way to Achieve That



Episode Management Best Practices

Goals of Care

- Identify and document specific, measurable, ***patient*** stated goal(s) that is truly meaningful to them:
  - Helps identify additional discipline needs
  - Helps identify and prioritize interventions needed on the POC
  - Improves patient buy-in and adherence to the home health plan of care
- Build clinical goals into the POC based on the comprehensive assessment and OASIS responses that will support the patient's wishes:
  - Helps clinicians focus interventions on measurable improvement in outcomes
- Focus discharge planning on goals of care:
  - Helps to estimate length of the POC
  - Sets expectations for outcomes at discharge

Episode Management Best Practices

Plan of Care

- Reflects the primary focus of care
- Includes patient-stated goal
- Includes interventions related to patient-stated goal and clinical goals
- Includes interventions based on results of Risk Assessments:
  - Fall Risk (MAHC-10, TUG, Tinetti, etc.)
  - Pressure Ulcer Risk (Braden)
  - Depression Screening (PHQ-2/PHQ-9)
  - CAM (Confusion Assessment Method)
  - BIMS (Brief Interview for Mental Status)
  - Hospitalization/ER Risk

Episode Management Best Practices

Plan of Care

- Includes interventions based on the following OASIS assessment items:
  - M1033 Risk for Hospitalization
  - M1400 Dyspnea
  - M1800 Grooming
  - M1810 Upper Body Dressing
  - M1820 Lower Body Dressing
  - M1830 Bathing
  - M1840 Toilet Transferring
  - M1845 Toilet Hygiene
  - M1850 Transferring
  - M1860 Ambulation
  - M1870 Feeding/Eating
  - M2020 Management of Oral Medications

Episode Management Best Practices

Missed Visits and Front Loading

- Reschedule missed visits within the same Medicare week:
  - Ensures adherence to the patient's individualized care plan
  - Allows clinicians to continue progress toward patient goals
  - Prevents gaps in care
- Front Load care for patients with chronic/newly diagnosed disease and patients on services for surgical aftercare:
  - Keep in mind that front loading visits should be shared by all disciplines who are needed to address patients' deficits, not just nursing
  - Allows for assessment and monitoring of patients when they are most vulnerable to:
    - Medication errors
    - Disease exacerbation
    - Impaired functional abilities
    - Rehospitalization

Episode Management Best Practices

Visit Utilization

- Frequency orders should be coordinated among the interdisciplinary team, customized according to patient goals, and scheduled through the 60-day episode:
  - Prevents underutilization
  - Prevents overutilization
  - Prevents multiple visits from several disciplines in a single day
    - Prevents gaps in care created from this
    - Prevents visit refusals due to patients being overwhelmed

Episode Management Best Practices

Discipline Utilization

- Identify additional discipline needs through use of:
  - Comprehensive assessment
  - Patient stated goal
  - Risk Assessments
    - Fall Risk (MAHC-10, TUG, Tinetti, etc.)
    - Pressure Ulcer Risk (Braden)
    - Depression Screening (PHQ-2, PHQ-9)
    - Hospitalization/ER Risk
- Appropriate discipline involvement:
  - Helps address barriers to care
  - Improves likelihood of goal achievement

Episode Management Best Practices

Documentation

- Clearly identify the primary focus of home health care:
  - Connects to primary diagnosis/Clinical grouping
  - Establishes the main issue driving home health
  - Applies to all disciplines involved in the home health plan of care
- Document progression towards goals of care (patient and clinical):
  - Demonstrates skilled need and progress as required in the Medicare Benefit Policy Manual
  - Ensures continued focus on POC goal achievement
  - Helps identify barriers to care/progress
  - Prevents discharge without all goals being met

Common Trends in LUPA and Utilization Based on CMS Claims Data

mcbee

Subsequent 30-day Period

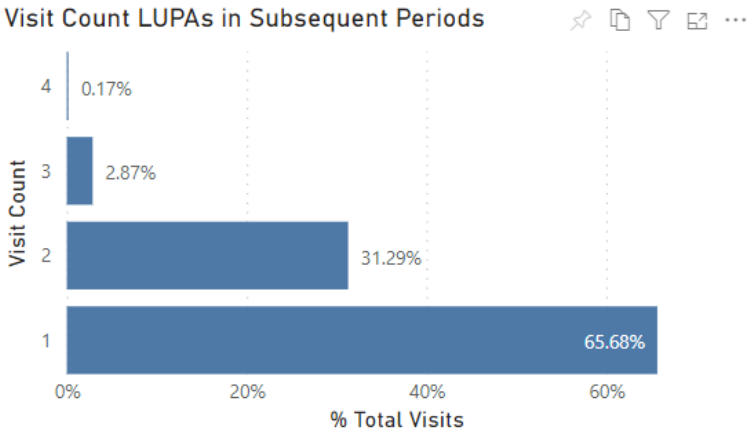
LUPA Trends - National

mcbee

Common Trends in Subsequent 30-day Period LUPA

Visit Utilization

- Almost 66% of subsequent 30-day period LUPAs had only 1 visit made in the period



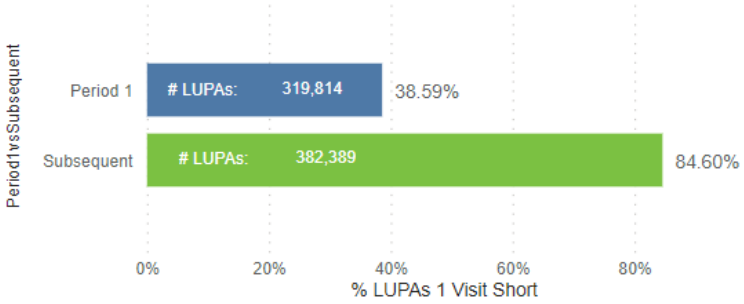
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Visits Made Compared to LUPA Threshold

- Approximately 85% of subsequent 30-day period LUPAs were only 1 visit short of meeting the LUPA threshold



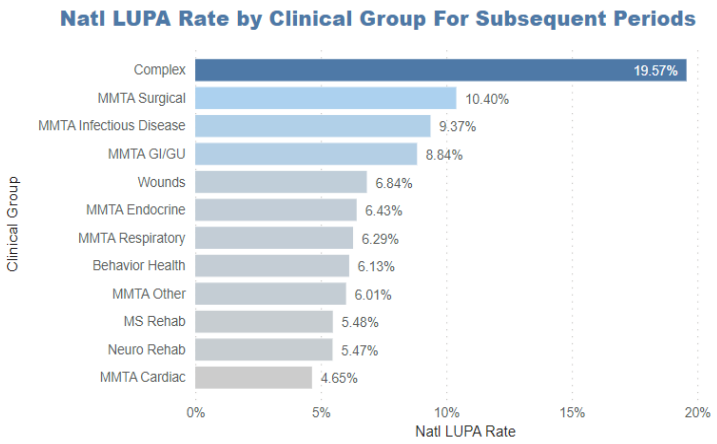
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Clinical Grouping

- The most common clinical groupings resulting in subsequent 30-day period LUPA were:
  - Complex
  - MMTA Surgical
  - MMTA Infectious Disease



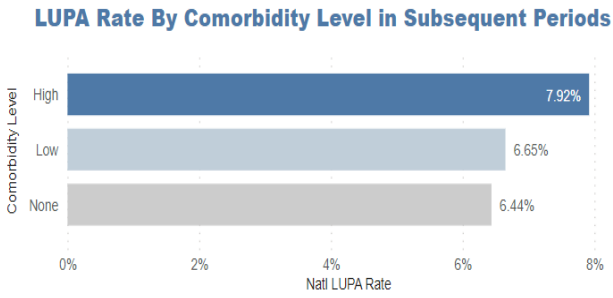
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

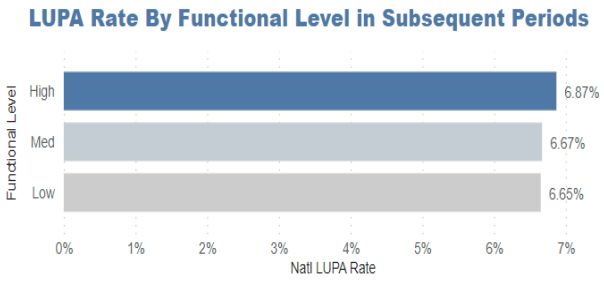
mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Comorbidity Adjustment and Functional Level

- Subsequent 30-day period LUPAs most commonly had high comorbidity adjustments and high functional impairment levels





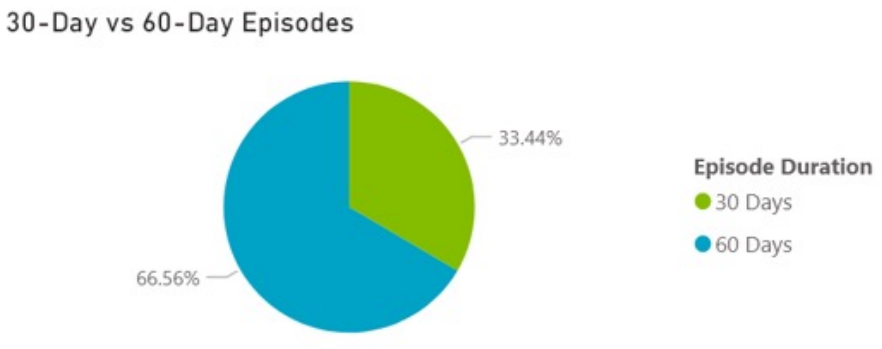
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

mcbee INSIGHT2022

30-day Periods vs 60-day Episodes

National Averages

- 33% of episodes ended in only 30 days



Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

Common Trends in Subsequent 30-day Period LUPA

Putting It Together

- The majority of subsequent 30-day period LUPA:
  - Had only 1 visit made in the period
  - Missed the LUPA threshold for the period by only 1 visit
- Additionally, subsequent 30-day period LUPA have been found to have higher:
  - Comorbidity adjustment
  - Functional impairment levels
- In general, there is higher utilization in the first 30-day period as opposed to subsequent 30-day periods with approximately 33% of periods ending in only 30 days, never making it into the subsequent 30-day period
- Bottom line:
  - Subsequent 30-day period LUPA patients tend to be sicker (high comorbidities) with increased need for assistance with functional activities indicating that these patients would likely benefit from additional visits in the subsequent 30-day period

Subsequent 30-day Period

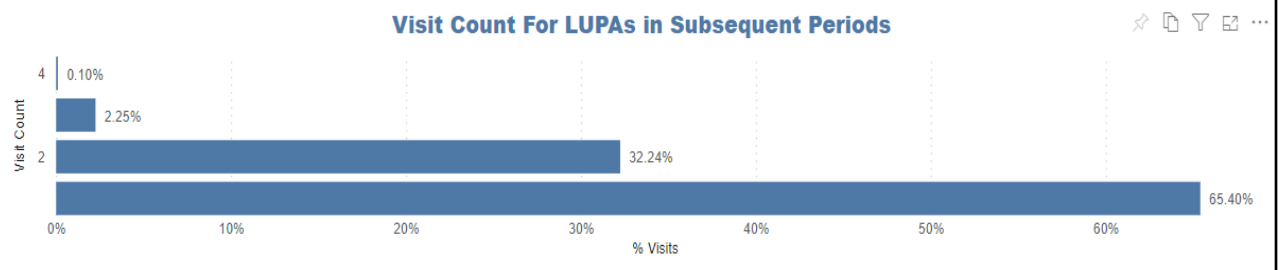
LUPA Trends - Florida

mcbee

Common Trends in Subsequent 30-day Period LUPA

Visit Utilization

- Almost 66% of subsequent 30-day period LUPAs had only 1 visit made in the period



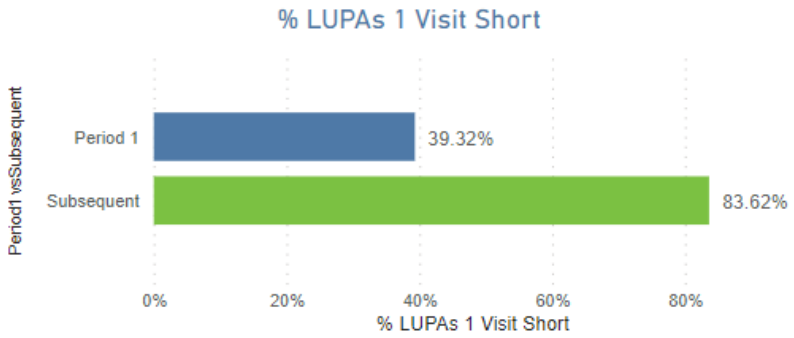
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Visits Made Compared to LUPA Threshold

- Approximately 84% of subsequent 30-day period LUPAs were only 1 visit short of meeting the LUPA threshold



Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

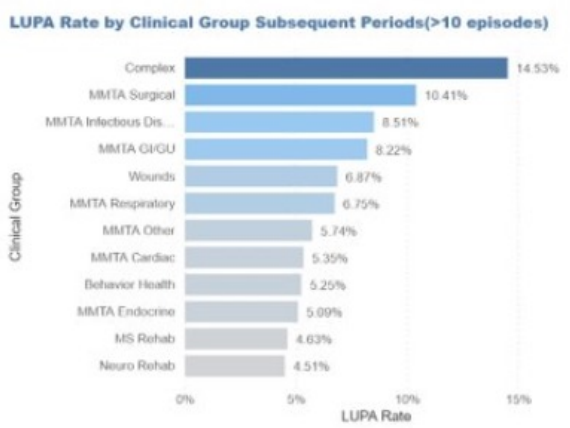
27

mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Clinical Grouping

- The most common clinical groupings resulting in subsequent 30-day period LUPA were:
  - Complex
  - MMTA Surgical
  - MMTA Infectious Disease



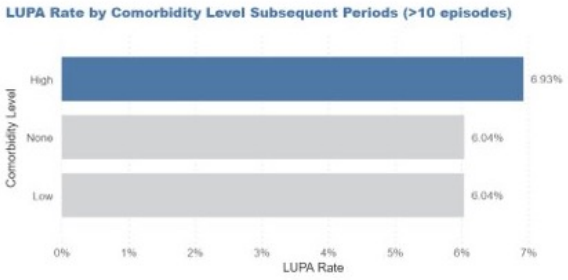
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

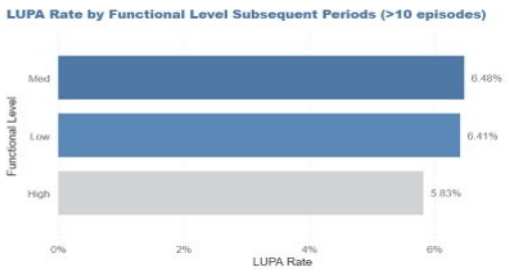
mcbee INSIGHT2022

Common Trends in Subsequent 30-day Period LUPA

Comorbidity Adjustment and Functional Level

- Subsequent 30-day period LUPAs most commonly had high comorbidity adjustments and medium functional impairment levels





Source: McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data

29

mcbee INSIGHT2022

Managing Subsequent 30-day Billing Period LUPA

Best Practice Strategies

mcbee

Managing Subsequent Period LUPA

Key Concepts to Remember

- One 60-day episode with one 60-day Plan of Care (POC)
- Two 30-day billing periods each with their own LUPA threshold based on HIPPS code (varying between 2 to 6)
- Adequate POC development is key
  - Consideration must be given to:
    - Clinical Grouping/Primary Focus of Care
    - Functional Level
    - Disciplines referred/involved
    - Patient goals
    - Missed visits
    - Patient tracking

60-day Episodes

Period Start and End Dates

- Important to know when one billing period ends and the next begins
  - Moving a discharge visit from one day to the next day can mean moving from period one into period two for a discharge visit only
- Educate clinicians where to find this information in the EMR
  - Patient calendar
  - Scheduler calendar
  - Frequency order entry
  - Other
- Calculate it by adding 30-days to the SOE/SOP date

LUPA Threshold

30-day Billing Periods

- LUPA threshold for each of the 30-day periods
- What is a LUPA threshold?
  - The number of visits that need to be met in order to qualify for a full 30-day period payment under PDGM
- Thresholds range from 2 to 6 under PDGM depending on HIPPS code
  - Final LUPA threshold information will not be available until all coding and OASIS review has been locked and completed
- Each of the two 30-day billing periods has its own LUPA threshold
- Educate clinicians where to find this information in the EMR
- Pull the most updated data from the CMS PDGM Case Mix Weights and LUPA thresholds file and look up the patient's HIPPS code:
  - https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1730-f

mcbee

Building the Plan of Care

Bridging the Billing Periods

- Build the POC for the full 60-day episode based on the clinical and functional assessment of the patient
- Interdisciplinary collaboration is critical to prevent overwhelming the patient
  - Spread care out between disciplines through the 60-day episode
  - Taper visits
- Determine, based on the primary focus of care, which discipline(s) are needed more heavily in the first 30-days vs which disciplines may start out slower and taper up later on
  - Tip: Patients referred following a recent acute hospitalization should focus on recovery from the acute illness in the first 30-days and then focus on long-term management
- Re-evaluate long-term patients for changes in status including need for therapy re-evaluations. Educate clinicians in maintaining a holistic view of patients and performing weekly check-in calls in the off-visit weeks to assess for new/changing needs of the patient.

mcbee

Clinical Grouping

Primary Focus of Care

- Defines the primary issue/reason for home health
- Helps identify which discipline(s) are most critical at initiation of the episode
  - Thoughtful utilization of disciplines is a driver of success
- Helps determine the frequency of visits needed
- Helps determine the focus of the plan of care
- Educate clinicians where to find this information in the EMR
  - Referral information
  - Face to Face
  - SOC/ROC/Recertification narrative
  - Plan of Care (485)

All of these should substantiate one another

Functional Level

Assistance Needed

- Identifies the patient's functional impairment level
  - How much assistance is needed to safely complete ADL/IADLs
- Helps to identify whether therapy involvement may be required
- High functional impairment indicates the possibility of a higher level of care needed
- **Review the functional level to identify whether:**
  - Disciplines ordered/referred appear adequate
  - Additional resources are necessary to the patient's long-term success
  - There are any safety concerns for the patient

Building the Plan of Care

Patient Goals

- Helps frame the POC by identifying:
  - Interventions needed to meet goals
  - Barriers impacting ability to meet goals
  - Additional resources needed in order to meet goals
    - Home Health: Therapy: PT, OT, ST; MSW, HHA
    - Community resources: Personal care, Homemaking, Travel, Meals, Medication Administration
    - Psychiatric Services
    - Other
  - Estimated time frame for POC completion
  - Best practice recommendation:
    - Agencies should clearly identify a specific area within the EMR for documenting patient stated goals and provide education to all clinicians on this process

Building the Plan of Care

Patient Goals

- Utilize patient goals to identify the necessary POC interventions
  - What is needed to achieve the goal?
  - What are the steps needed to move the patient from where they are now to where they need to be in order to achieve the goal?
  - How long will it take?
  - What is the best way to spread the visits out in order to successfully achieve the goals?

Building the Plan of Care

Managing Bumps in the Road: Missed Visits

- **Being aware and rescheduling missed visits helps to:**
  - Ensure best practice front-loading guidelines are met
  - Prevent gaps in care
  - Allow for service recovery to mitigate ongoing disruptions to the POC
- **Missed visits that are not rescheduled can lead to:**
  - Spill over into the subsequent 30-day period resulting in a LUPA for period one, period two or both periods
  - Poor clinical outcomes and patient satisfaction
- **Educate clinicians where to find this information in your EMR**
  - Patient/Scheduler calendar
  - Most EMRs have a missed visits report that can be run

Building the Plan of Care

Managing Bumps in the Road: Missed Visits

- Run missed visit reports daily and:
  - Identify patterns with clinicians who frequently miss visits
    - Provide one-on-one education to those clinicians
  - Identify patterns with patients who are missing multiple visits
    - Perform service recovery calls to those patients to identify barriers to POC adherence
- Educate clinical staff in:
  - Front-loading expectations
  - Expectations for rescheduling of missed visits within the Medicare week
  - Appropriate use of Telehealth/Virtual visits to meet POC goals, balancing with necessary in-person visits not replacing necessary in-person visits

Urgent/Emergent Care and Acute Care Hospitalizations

Managing Bumps in the Road

- Urgent/Emergent care visits, observation stays, Acute Care Hospitalizations (ACH) and other inpatient facility stays may disrupt an episode of care
- A well-organized patient tracking process is essential to:
  - Mitigating gaps in care created by poorly tracked urgent/emergent care or observation stays
  - Ensuring timely Resumption of Care (ROC) following ACH or other inpatient facility stays
- Identify where this information can be found within your EMR
  - Most EMRs have some sort of hospitalization report for tracking patients once a transfer OASIS has been generated
  - Best practice recommendation is for agencies to develop a process for weekly tracking of patients who have been transferred or are being held under observation or in urgent/emergent care. The process should include clear documentation of patient status within the patient chart.

Urgent/Emergent Care and Acute Care Hospitalizations

Patient Tracking

- Develop and maintain a well-organized patient tracking process
  - Include weekly follow up on all patients who have been transferred
  - Include daily follow up on all patients being held under observation or in urgent/emergent care
  - Ensure documentation in the clinical record, weekly for hospitalized patients and daily for patients under observation or urgent/emergent care, on the status of these patients (i.e. Admitted inpatient to xyz hospital on *date* with *diagnosis*; Remains inpatient at xyz hospital; Transferred to abc SNF)
- Ensure timely clinician follow up, within 24 hours, for patients returning home from observation or urgent/emergent care stays
  - Educate clinicians to re-evaluate the POC, including frequency orders and secondary discipline involvement, following observation or urgent/emergent care stays
- Ensure timely ROC, within 48 hours, following inpatient stays
  - Educate clinicians to re-evaluate the POC, including frequency orders, front-loading and secondary discipline involvement following inpatient stays

Sutter Care at Home

Trends in Subsequent Period LUPA

LUPA Rate Baselines

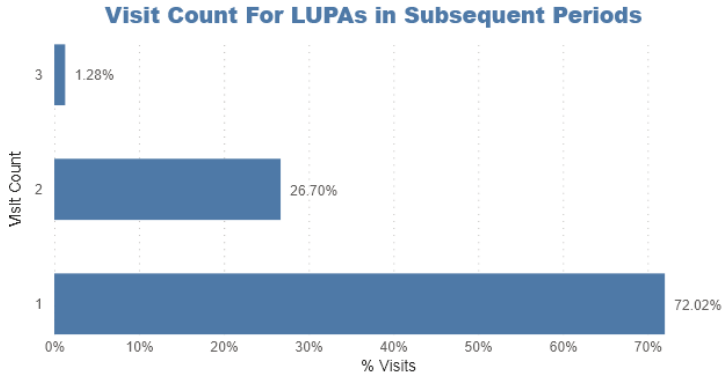
Prior to Episode Management Initiatives

- 12-month Baselines 7/1/2018 through 6/30/2019
  - Overall LUPA Rate Baseline: 12.80%
  - Period 1 LUPA Rate Baseline: 9.1%
  - Subsequent Period LUPA Rate Baseline: 16.8%

Sutter Trends in Subsequent 30-day period LUPA

Visit Utilization

- 72% of subsequent period LUPAs had only 1 visit made in the period

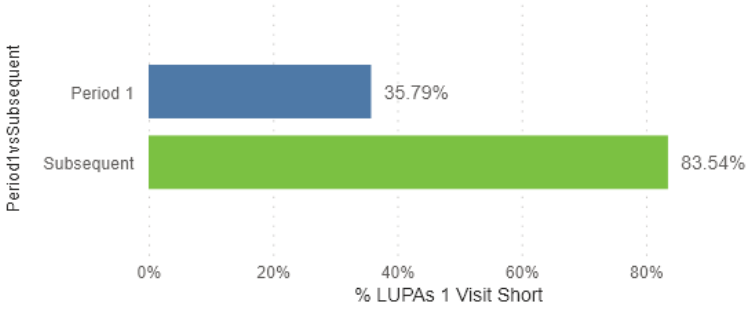


Source: McBee Market Reporting analysis of CMS Q1through Q4 2020 PDGM claims data

Sutter Trends in Subsequent 30-day period LUPA

Visits Made Compared to LUPA Threshold

- Approximately 84% of subsequent period LUPAs were only 1 visit short of meeting the LUPA threshold

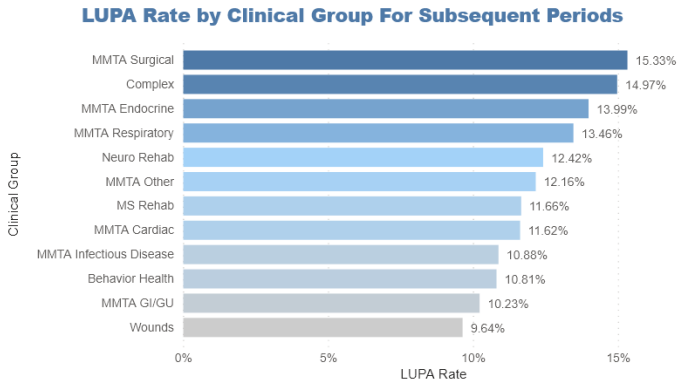


Source: McBee Market Reporting analysis of CMS Q1 through Q4 2020 PDGM claims data

Sutter Trends in Subsequent 30-day period LUPA

Clinical Grouping

- The most common clinical groupings resulting in subsequent 30-day period LUPA were MMTA Surgical, Complex and MMTA Endocrine



Top Clinical Grouping Diagnoses Examples:

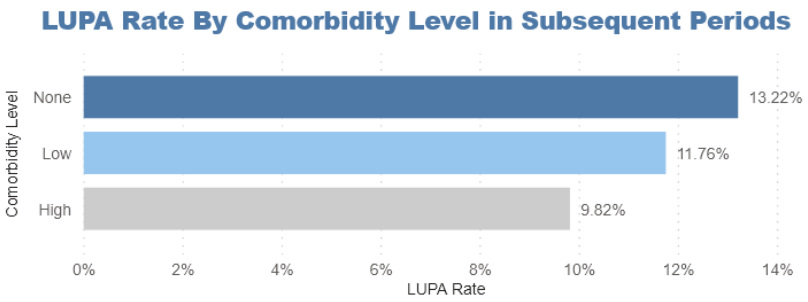
- **Complex:** Ostomy Care
- **MMTA Surgical:** Aftercare following surgery on body systems (GI, GU, Respiratory, Circulatory, etc.), Aftercare following organ transplant, Aftercare following surgery for Neoplasm
- **MMTA Endocrine:** Diabetes

Source: McBee Market Reporting analysis of CMS Q1 through Q4 2020 PDGM claims data

Sutter Trends in Subsequent 30-day period LUPA

Comorbidity Adjustment

- Subsequent 30-day period LUPAs most commonly had no comorbidity adjustments

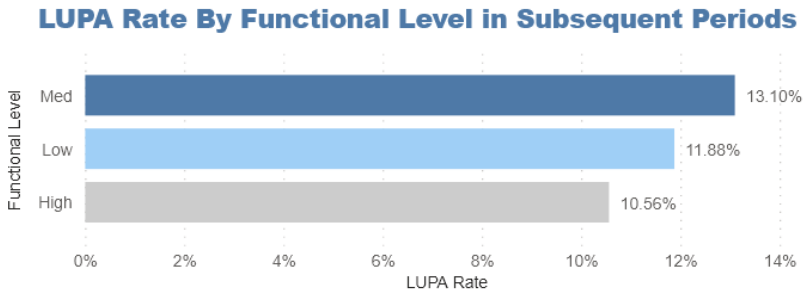


Source: McBee Market Reporting analysis of CMS Q1 through Q4 2020 PDGM claims data

Sutter Trends in Subsequent 30-day period LUPA

Functional Level

- Subsequent 30-day period LUPAs most commonly had medium functional impairment levels



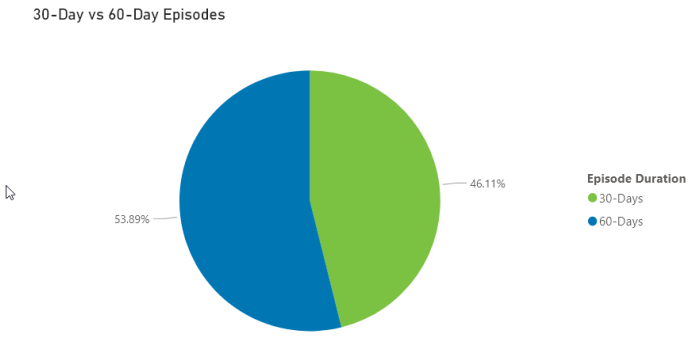
Source: McBee Market Reporting analysis of CMS Q1 through Q4 2020 PDGM claims data

mcbee

30-day Periods vs 60-day Episodes

Sutter Averages

- 46% of episodes ended in only 30 days



Source: McBee Market Reporting analysis of CMS Q1 through Q3 2020 PDGM claims data

mcbee

Sutter Care at Home

LUPA Trends

- Data analysis completed over the first few weeks of the McBee engagement revealed trends in:
  - Short 30-day plans of care with frequent order extension requests being sent to the ordering physicians
  - High subsequent period LUPA rates
    - Trend in discharges with 1 visit in the subsequent period
  - Weak, non-specific/measurable patient stated goals
  - Missed triggers for secondary disciplines, in particular
    - MSW
    - Therapy
  - Tendency towards one time OT evaluation only visits

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPA

- Root cause analysis of LUPA
  - Identified clinician misconception that, under PDGM, plans of care could only be written for 30-days at a time
  - Field clinicians frequently not aware of the LUPA thresholds and not always aware of how to distinguish the change in 30-day periods
  - Education was needed on how to identify and develop meaningful, measurable patient stated goals
  - Education was needed on secondary discipline triggers
  - Education was needed on OT scope of practice and identification of patient need for continued OT services

Managing Subsequent 30-day Periods

Strategies Implemented by Sutter Care at Home (SCAH) to Mitigate Avoidable Subsequent 30-day Period LUPAs

Result in Better Patient Care =

Better Positioning for HHVBP

mcbee

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- Education was rolled out to clinicians regarding scheduling care through the 60-day episode rather than focusing only on 30-day periods
  - Included review of 3 different patient scenarios with interactive discussion focused on visit frequency, coordinating frequencies between all disciplines involved, and front-loading care

Visit/Plan	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10
Dates	1/25	1/26-2/1	2/2-2/8	2/9-2/15	2/16-2/22	2/23-2/29 2/24=end of first 30-day period	3/1-3/7	3/8-3/14	3/15-3/21	3/22-3/28
SN	1	3	2	1	1	1	0	1	0	1
PT	0	2	2	3	3	1	1	0	0	0
OT	0	1	0	1	2	2	1	1	0	0
ST	0	0	0	0	0	0	0	0	0	0
MSW	0	0	1	0	0	0	0	0	0	0
HHA	0	1	2	2	1	1	1	0	0	0
Total	1	7	7	7	7	5	3	2	0	1

- Education was provided to the clinicians on how to identify, within the EMR, the transition between each of the 30-day periods

mcbee

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- A new report was developed to allow the clinical managers to easily identify patients with periods ending in the next 7 days
  - Clinical managers monitored the report to help identify patients with:
    - No visits planned into the subsequent 30-day period
    - Visits planned into the subsequent 30-day period that were less than the LUPA threshold
  - These patients were then discussed with the case manager
- Clinical managers began to educate the case managers in LUPA thresholds
- Clinical managers also implemented a practice to include discussion on patients nearing the end of the first 30-day period during their interdisciplinary team meetings

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- Another report was created to allow clinical managers to:
  - Identify trends in missed visits
  - Identify missed discipline evaluation visits to ensure those visits were appropriately rescheduled
- Education was provided to clinicians and schedulers around the expectation for missed visits to be rescheduled within the same Medicare week

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- Education was provided to clinicians on development of meaningful, measurable patient stated goals
  - Education on use of open-ended questions and motivational interviewing
  - Scenario based education with interactive discussion
  - Examples of weak and more specific, measurable, patient stated goals
- Education was provided to clinicians on triggers for secondary disciplines with a focus on MSW and Therapy triggers
  - Clinicians were provided with and educated on use of a tool called the MAHC-10 Guide for Building an Appropriate POC
  - Education was done during team meetings on disciplines scope of practice

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- Implementation of SOC huddles
  - SOC huddles were implemented between clinical managers and SOC clinicians
    - Initial focus on primary focus of care, visit frequency orders, MAHC-10 and disciplines ordered/referred and refused
    - An Interdisciplinary Case Conference tool was provided for use as a guide for these huddle discussions
- Recertification Rounds
  - Upcoming recertifications were already discussed during case conferences
  - A Recertification Rounds tool was provided to help streamline these discussions to ensure continued Medicare eligibility as well as continue clinician education around POC development including visit frequency orders and necessary discipline involvement

Sutter Care at Home

Strategies Implemented to Mitigate Avoidable LUPAs Result in Better Patient Care

- Caseload Reviews
  - Clinical managers have begun to perform caseload reviews with case managers on a weekly or biweekly basis
  - Focused discussion is held on any patients pending discharge
- Case management education
  - Ongoing during one-on-one with clinical managers, education sessions, team meetings
- Episode management education
  - Case managers have now begun to join weekly episode management review calls to present one of their patients
    - Education is provided during the call on best practice episode management strategies and case management
    - Real-time patient-specific feedback is given including any follow up needing to be completed by the case manager

mcbee

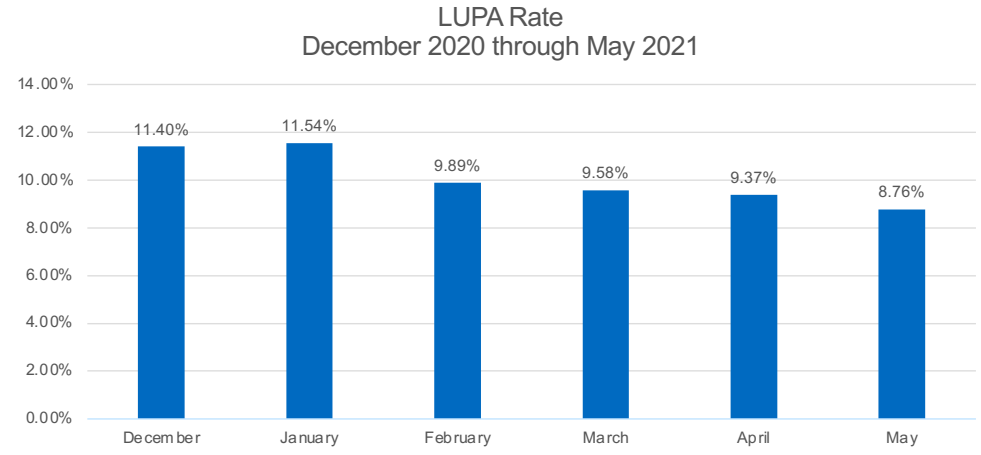
Sutter Care at Home Results

Trends in LUPA Improvement Reflect a Brighter Future in the HHVBP World

mcbee

2020-2021 Trended LUPA Rate

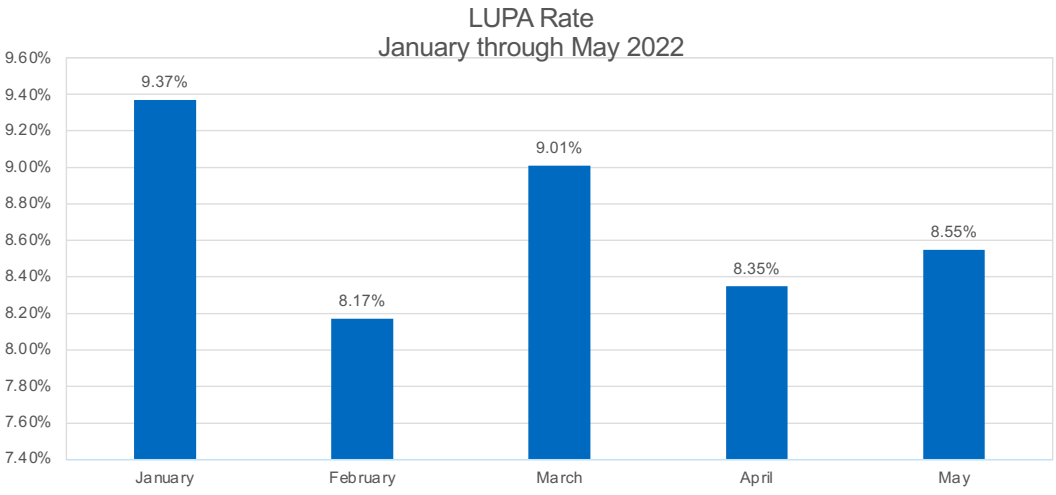
- Improvement from 11.40% down to 8.76%



Source: McBee Episode Management Data December 2020 through May 2021

2022 Trended LUPA Rate

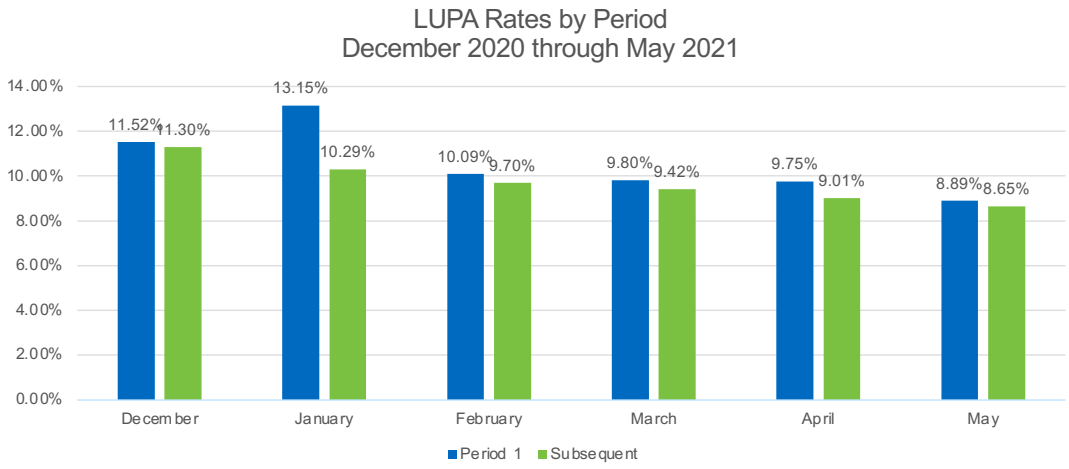
- Sustained improvement in 2022



Source: McBee Episode Management Data January through May 2022

2020-2021 Trended LUPA Rates by Period

- Improvement in subsequent period LUPA rates from 11.30% down to 8.65%

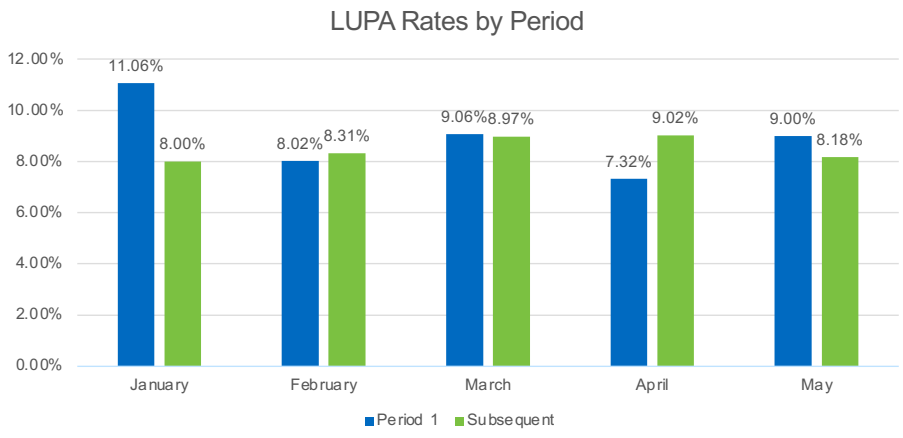


Source: McBee Episode Management Data December 2020 through May 2021

mcbee

2022 Trended LUPA Rates by Period

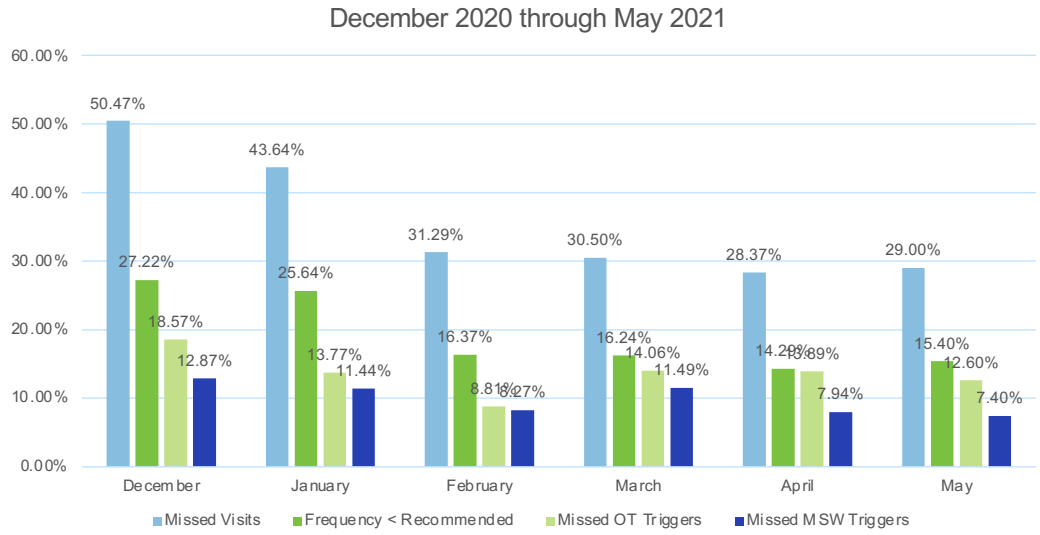
- Sustained improvement in subsequent period LUPA rates



Source: McBee Episode Management Data January through May 2022

mcbee

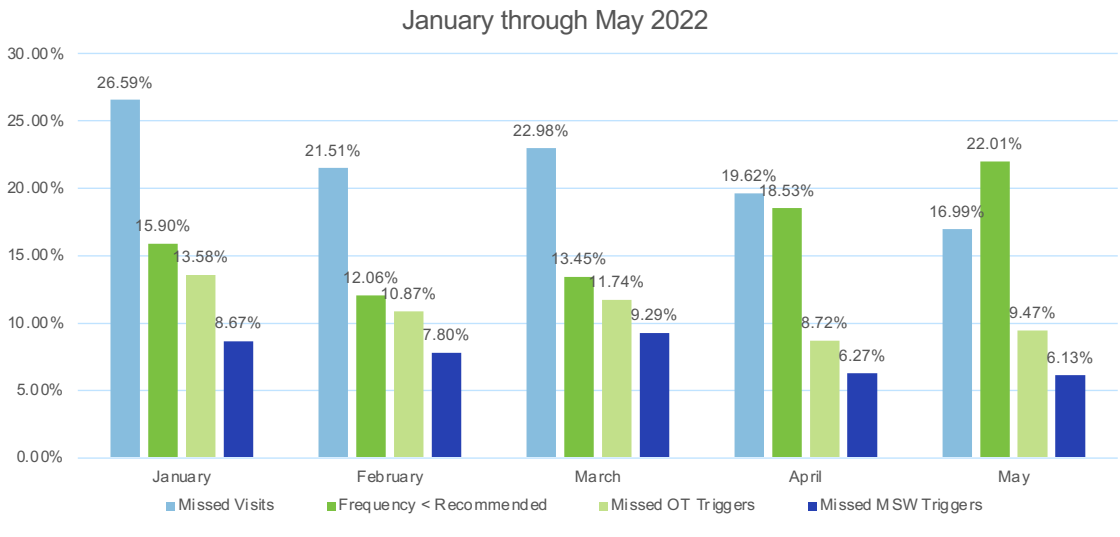
Sutter Care at Home Trended Improvements



Source: McBee Episode Management Data December 2020 through May 2021

mcbee

Sutter Care at Home Sustained Improvements



Source: McBee Episode Management Data January through May 2022

mcbee

Summary

Summary: LUPAs & Episode Management

- 66% of subsequent 30-day period LUPAs had only 1 visit made in the period
- 85% of subsequent 30-day period LUPAs missed the threshold by only 1 visit
- The majority of subsequent 30-day period LUPAs had higher comorbidity adjustments and functional impairment levels, meaning CMS anticipated these patients to require more care
- Clear oversight of patient plans of care is necessary to ensure:
  - Appropriate utilization through the 60-day episode
  - Appropriate discipline involvement
  - Adherence to best practice standards of care
  - Holistic view of patients, including long-term catheter patients
- Well defined processes for tracking missed visits and observation, urgent/emergent, and inpatient admission stays will help to reinforce best practice patient care management
- Application of best practice strategies and optimal use of your EMR will aid in mitigation of avoidable subsequent 30-day period LUPAs
- Analysis of trends impacting episode management can help to identify areas of focus for mitigating avoidable LUPAs
- Once trends are identified, best practice episode management process improvement strategies should be developed and implemented
- Implementing best practice episode management process improvement strategies helps to reduce avoidable LUPAs and improve overall patient care

Summary: Successful Episode Management = Success in HHVBP!

- Knowledge of the VBP scoring methodology, including weighting of each measure, will improve your ability to prioritize focus areas
- Success with VBP goes beyond OASIS improvement, VBP relies heavily on clinical outcomes and patient satisfaction to measure performance, an exceptional Episode Management program is crucial to maximizing your reimbursement
- Successful Episode Management includes processes and protocols to enhance patient care through application of evidence based clinical best practices for successful home health plans of care
- Episode Management promotes individualized, patient-centered care, enhances patient satisfaction, and leads to successful clinical outcomes resulting in quality care delivery and success under VBP

Resources

- CY 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements (6/23/2022). https://www.federalregister.gov/documents/2022/06/23/2022-13376/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home
- CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements. (11/04/2020). Retrieved February 8, 2021. https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1730-f
- McBee Market Reporting analysis of CMS Q1 through Q4 2021 PDGM claims data
- https://www.cms.gov/files/document/risk-adjustment-technicalspecifications508cfinal.pdf
- https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Home-Health-Outcome-Measures-Table-OASIS-D-11-2018c.pdf
- http://www.hhvna.com/files/CorporateCompliance/Education2018/VNA/7_20_18_HHVBP_Acute_Care_Hospitalization_and_Emergency_Department_Use_Handout.pdf
- https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Questions?

- **Carissa McKenna,** RN, BSN COS-C, HCS-D
  Senior Clinical Consulting Manager, McBee
  - CarissaMcKenna@McBeeAssociates.com
  - (863) 353-9304
- **Sparkle Sparks,** PT MPT COS-C AHIMA-Approved ICD-10-CM Coding Trainer
  Education Program Manager – Home Health, Sutter Care at Home
  - sparkssa@sutterhealth.org
  - (415) 613-7730

Contact us: 610.964.9680 | **Visit us:** McBeeAssociates.com

mcbee 72