Home Health Value-Based Purchasing: Lessons learned and strategies to improve patient outcomes

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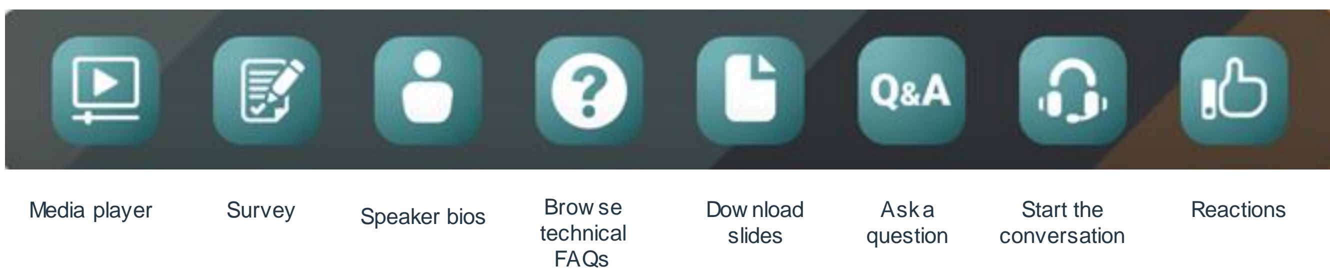
A few notes before we begin…

- The windows on your screen can be resized and moved. Set it up how you like it!

- The icons at the bottom of your screen open tools that let you ask for help and download slides.



- We will send you a link to re-watch and share the webinar on-demand.

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About the presenters

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Learning objectives

- Explain the concept of whole person care and why this is not an option but a necessity to meet quality expectations of home health care in the future
- Describe the three key success factors of whole person care: a patient-centered focus, a dynamic risk-based approach and an iterative learning model
- Discuss the process of root cause analysis, within the context of HHVBP

Agenda

- HHVBP 2023 recap
- Looking forward to 2025
- Whole person care

CMS Home Health Value-Based Purchasing: Reflections on 2023

Measures & Weights (current through CY2024)

Source	Quality Measure	All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS
OASIS-based	Dyspnea	5.83%	8.33%	8.98%	16.67%
	Discharged to Community	5.83%	8.33%	8.98%	16.67%
	Management of Oral Medications	5.83%	8.33%	8.98%	16.67%
	Total Normalized Composite Change in Mobility	8.75%	12.50%	13.46%	25.00%
	Total Normalized Composite Change in Self-Care	8.75%	12.50%	13.46%	25.00%
	Total %	**35%**	**50%**	**54%**	**100%**
Claims-based	Acute Care Hospitalization	26.25%	37.50%	0.00%	0.00%
	Emergency Department Use without Hospitalization	8.75%	12.50%	0.00%	0.00%
	Total %	**35%**	**50%**	**0%**	**0%**
HHCAHPS Survey-based	Professional Care	6.00%	0.00%	9.23%	0.00%
	Communication	6.00%	0.00%	9.23%	0.00%
	Team Discussion	6.00%	0.00%	9.23%	0.00%
	Overall Rating	6.00%	0.00%	9.23%	0.00%
	Willingness to Recommend	6.00%	0.00%	9.23%	0.00%
	Total %	**30%**	**0%**	**46%**	**0%**

Total Performance Score example

Scoring

Quality Measure	HHA Baseline Year (2022) Improvement Threshold	Model Baseline Year (2022) Achievement Threshold	Model Baseline Year (2022) Benchmark	Weight%	Agency Performance Year	Achievement Score	Improvement Score	Weighted Care Points
OASIS Measures								
TNC Self-Care	2.016	2.096	2.693	8.75%	2.435	5.678	5.570	4.969
TNC Mobiliity	0.875	0.734	0.995	8.75%	0.867	5.096	0.000	4.459
Oral Medications	92.1%	80.3%	97.7%	5.83%	91.3%	6.318	0.000	3.683
Dyspnea	85.3%	85.7%	98.3%	5.83%	89.2%	2.795	2.709	1.630
Discharge to Community	79.8%	72.7%	84.4%	5.83%	81.6%	7.605	3.564	4.434
Claims Measures								
60-Day Hopitalization	15.5%	13.8%	7.7%	26.25%	15.2%	0.000	0.338	0.887
60-Day ED Use	11.4%	11.6%	4.6%	8.75%	9.3%	3.347	2.822	2.929
HHCAHPS Measures								
Care of Patients	88.0%	89.0%	94.4%	6.00%	88.0%	0.000	0.000	0.000
Communication	88.0%	86.4%	93.0%	6.00%	88.0%	2.460	0.000	1.476
Specific Care Issues	74.0%	81.8%	91.1%	6.00%	74.0%	0.000	0.000	0.000
Willing to Recommend	81.0%	79.7%	90.8%	6.00%	81.0%	1.158	0.000	0.695
Overall Rating	88.0%	85.6%	94.2%	6.00%	88.0%	2.768	0.000	1.661
Total Performance Score								26.822

Significant challenges for agencies

- Patients have higher acuity and comorbidity levels
- Variable Patient Activation level
- Rural areas and access to clinical resources
- Clinician shortage
- Health-related social needs are impacting outcomes

Successful strategies for agencies

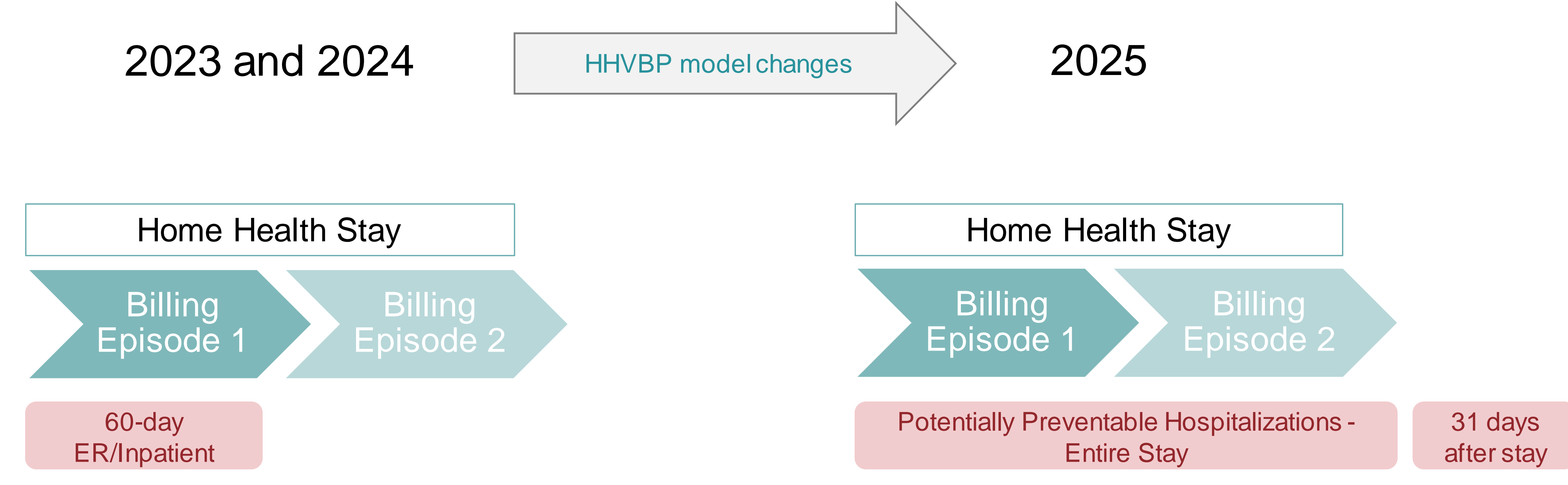
- Bringing the entire agency team into achieving quality
- Check-in calls for high hospitalization risk patients
- Integrating telehealth visits within care plans
- Integrating and leveraging predictive analytics throughout the home health stay
- Advanced care planning aligned with patient goal and prognostic status
- Level-setting clinical-practice knowledge through focused education of the IDT
- Educating teams on customer service and rewarding clinicians for delivering an excellent patient experience
- Small group training

CMS Home Health Value-Based Purchasing: 2025 shift

Measures & weights (Beginning CY 2025)

Source	Quality measure	All measures	No HHCAHPS
OASIS-based	Dyspnea	6.00%	8.571%
	Management of Oral Medications	9.00%	12.857%
	DC Function	20.00%	28.571%
	Total %	35%	50%
Claims-based	DTC-PAC	9.00%	12.857%
	Home Health Within Stay Potentially Preventable Hospitalization (PPH)	26.00%	37.143%
	Total %	35%	50%
HHCAHPS survey-based	Professional Care	6.00%	0%
	Communication	6.00%	0%
	Team Discussion	6.00%	0%
	Overall Rating	6.00%	0%
	Willingness to Recommend	6.00%	0%
	Total %	30%	0%

Hospitalization accountability time shift



Meet Susan

70-year-old widow with 4 grandchildren and a small dog named Chloe

Socioeconomic factors

Susan lives alone in a food desert and unfortunately does not have local family support.

Goals and priorities

Stay home – stop revolving door ER visits

Physical environment

Small, tidy, apartment within an increasingly high-risk neighborhood.

Clinical assessment

Susan has co-morbid, chronic disease: CHF, NIDDM, DJD. She has experienced multiple ER visits due to exacerbation of her CHF, with occasional associated rehospitalization. She is tired and knows she isn't getting better.

Health behaviors

Susan used to smoke, quit 25 years ago. She sometimes skips her evening diuretic. Otherwise, no at-risk health behaviors.

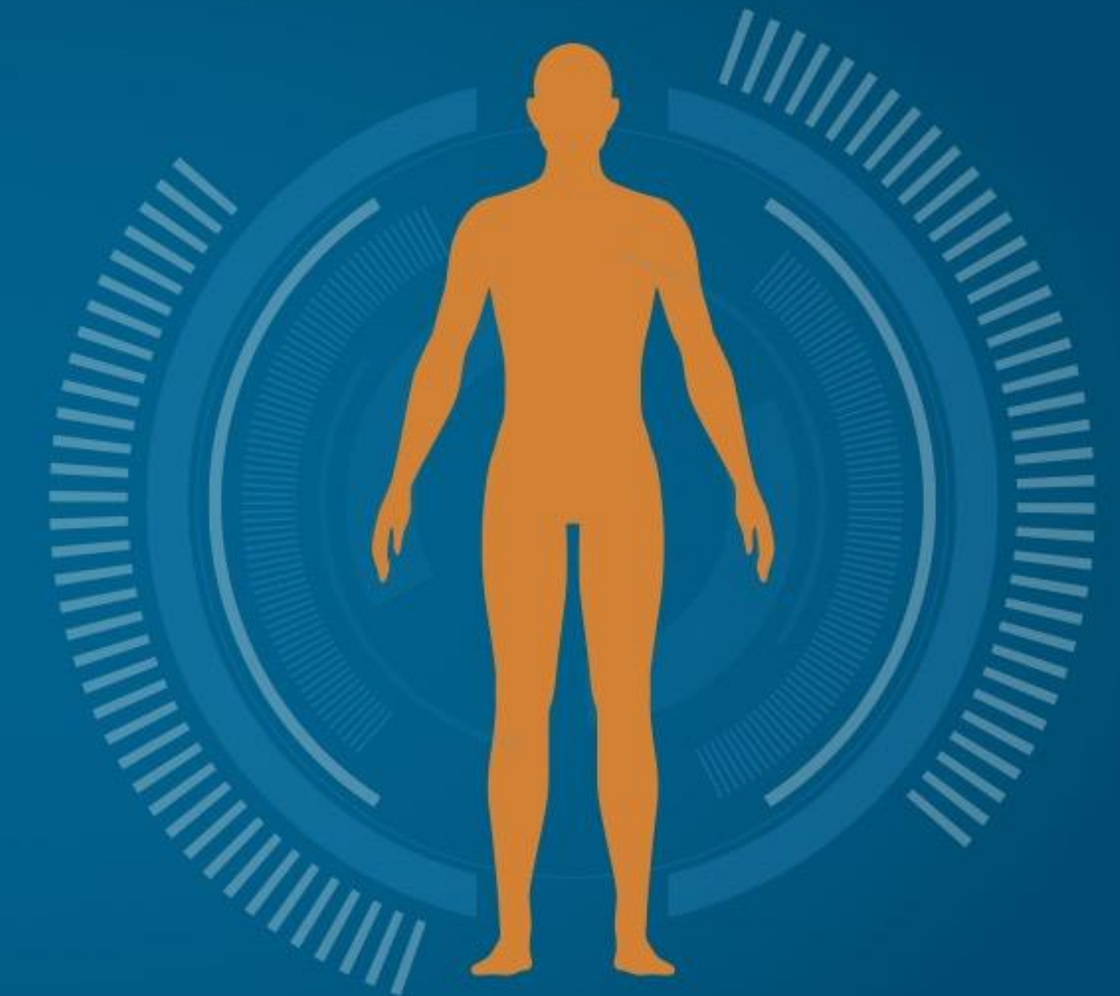
Health care

Over the next year, she will need home health therapy, skilled nursing services, palliative and hospice care.

Reframing whole person care:
Home Health

Whole person care

- Patient-centered focus
- Dynamic risk-based approach
- Iterative learning model



Keys to patient-centered focus

1

Key #1
Patient goals

- The place to start

2

Key #2
Patient needs

- Emotional
- Psychological
- Health-related social

3

Key #3
Individualized Care Plan

- Comprehensive SOC assessment
- Predictive risk analytics

4

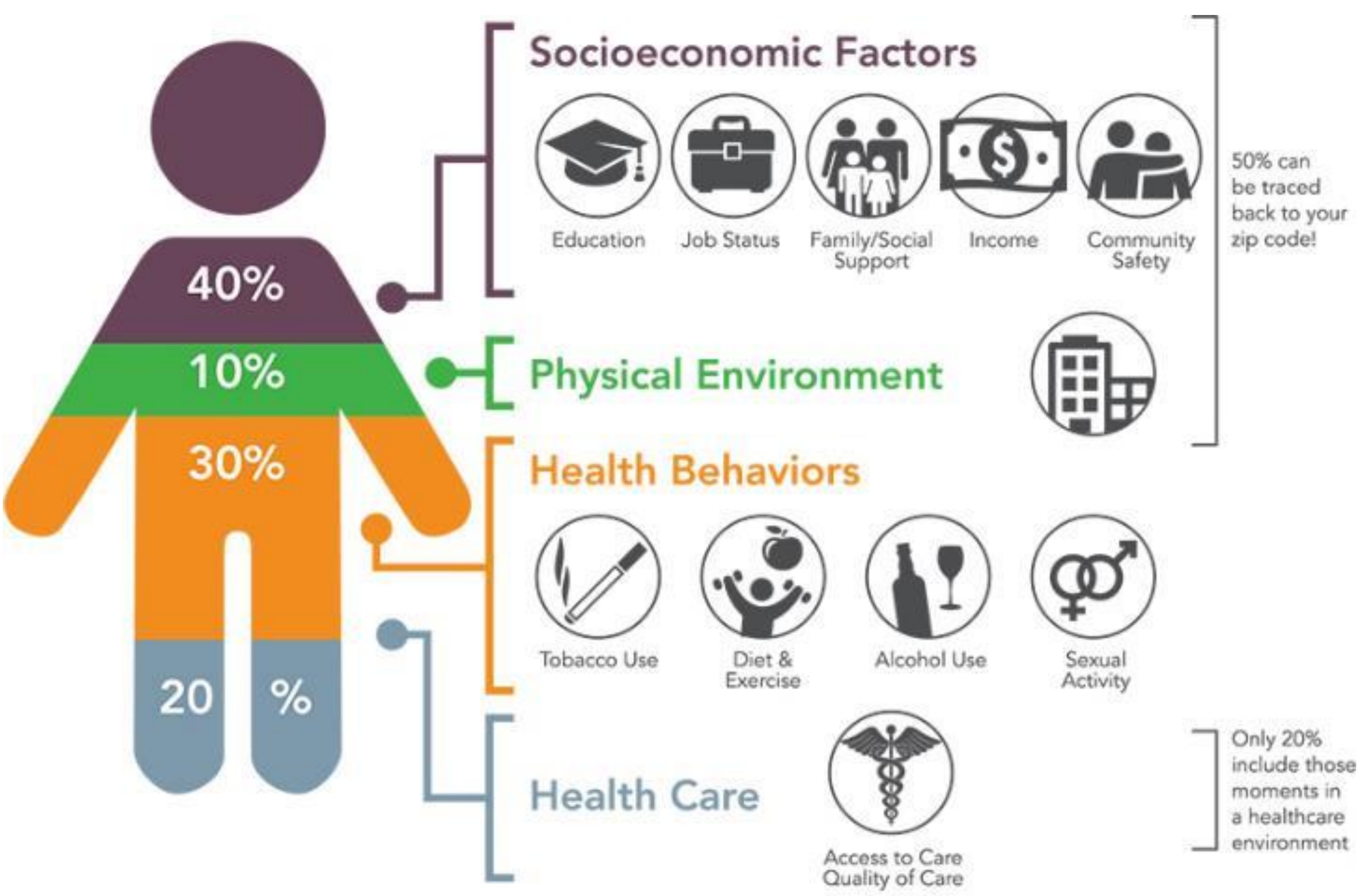
Key #4
Advanced care planning

Grow your census & revenue

Health-related social needs

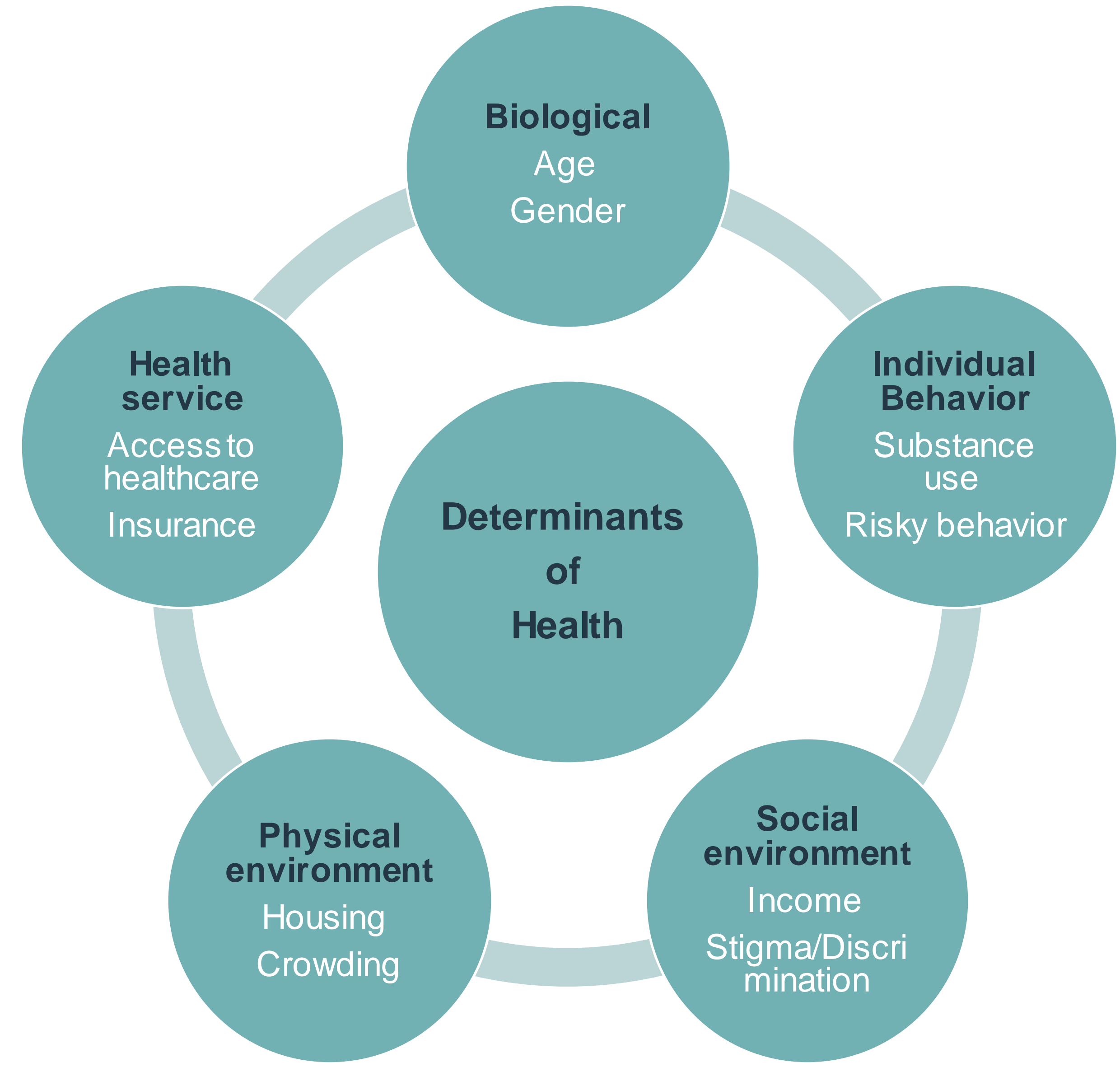
The social determinants of health are the **conditions in which people are born, grow, live, work and age**. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are **mostly responsible for health inequities** - the unfair and avoidable differences in health status seen within and between countries.

http://www.who.int/social_determinants/sdh_definition/en/



Trends: Human services as preventative

- Creating clinical strategies to identify health related social needs will drive better health outcomes
- Integration of care and sharing of data are essential components of managing determinants of health.
- Ignoring any pillar can lead to diminished outcomes
- Requires building in a common set of data around determinants of health upon which advanced business intelligence and predictive analytics can be based



Build patient activation and engagement

Activation essentials

Friendly and professional

- Utilize Motivational Interviewing
- Empower each patient in their care
- Be cognizant of how the patient will feel about each interaction especially the first
- Build patients' self-efficacy

Set the tone for the entire patient experience

Engage your patient in a friendly, confident, and professional way

- Start conversations guiding patient self-assessment of status
- Smile. How you interact with the patient is as important as what you do with the patient.
- A patient may not remember what you did, but they will remember how you made them feel
- Review **patient centered goal** – tie in how work to be done in the visit supports what matters most to them

Motivational Interviewing – integrating patient-centered goal and O.A.R.S :

- Open-ended questions
- Affirmations
- Reflective Listening
- Summarize

(Integrated teach-back methodology)

Empowerment

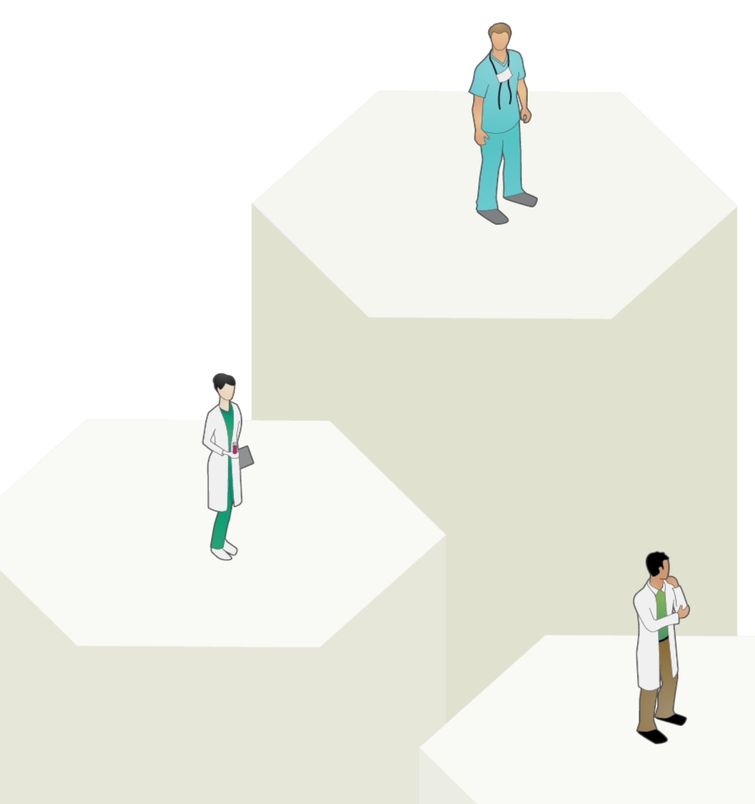
- Emphasize the patient's central role in his/ her care

Promoting Self Efficacy

- The belief a patient has in his/her ability to take control of his/her health

Meeting a continuum of clinical need in home health

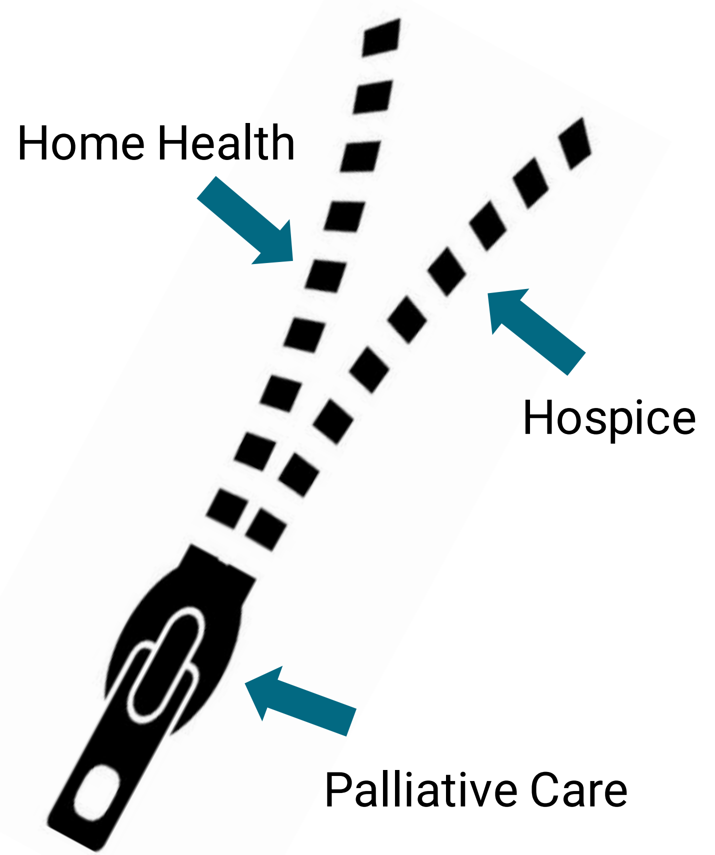
- Often a "gap" between home health, palliative care, and hospice
  - Too often identified on admit to hospital while in HH, and DC to hospice
- Silos reinforced by disparity in regulatory language
- Home health, mind-set: often a curative focus
  - Given outcome pressure, clinician cultural perception can become "we have to get you better"
- Where we miss it?
  - We may not understand/integrate progression of disease
  - Death is a "progress to goal" - how do we help upstream journey when indicated?
- Palliative care services can provide an umbrella of support within the care continuum – helping to navigate upstream **gaps in the journey**
- **The goal is peaceful death – transitions are imperative!**
  - **This is not a failure**



“Ownership” of the patient

SILOS - they deepen when the patient is 'mine’

- **My patient isn’t ready”** ….doesn’t want hospice, a new team, different people in their home, etc.
- Person-centered care cannot transition unless you see patient-centered continuum of advancing need
- Important to break the cycle of ‘my patient’ and shift to organization’s/continuum's patient
- Think of the continuum as a ZIPPER
- Enhance team member knowledge:
  - Increase awareness of each other’s practice framed within progression of need (HH, personal care, palliative care, hospice)
  - Increase training on advance care planning and having the end-of life-conversation



Let's look again at Susan

70-year-old widow with 4 grandchildren and a small dog named Chloe

Socioeconomic factors

Susan lives alone in a food desert and unfortunately does not have local family support.

Goals and priorities

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Physical environment

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Clinical assessment

Susan has co-morbid, chronic disease: CHF, NIDDM, DJD. She has experienced multiple ER visits due to exacerbation of her CHF, with occasional associated rehospitalization. She is tired and knows she isn't getting better.

Health behaviors

Susan used to smoke, quit 25 years ago. She does love sodium-rich foods. She sometimes skips her evening diuretic.

Health care

Over the next year, she will need home health therapy, skilled nursing services, palliative and hospice care.

Dynamic risk-based approach

- Daily Huddle
- Every Visit Preparation
- 1:1 Manager and Clinician
- Small Team Case Conference by exception

Susan starts Home Health

Fundamental shift from discontinuous check-in to dynamic risk monitoring and patient engagement

START HERE: 87 y.o. with advancing Heart Failure recently hospitalized 4 days ago with CHF exacerbation

Sunday: hospital DC- Shift from controlled to uncontrolled setting

Monday: Admission- ask questions for functional assessment- CHF controlled

Tuesday: Patient really craving good night sleep – starts to skip evening diuretic

Wed 11 am: Late documentation – partial submit, QAPI/Coding-heavy-cascade of correction

Wed: Managing own diet – cannot wait to 'hit the pickle juice'

Thursday: BP starts to rise, edema as well as hemodynamics change

Friday: Increased dyspnea, poor sleep, never wants to 'bother anyone'

Thursday QA /POC complete – 2X week to scheduling.

Saturday: Pt's dtr calls 911, found mom on floor – hospitalized with CHF exacerbation and fall

Empowering IDT responsibilities

- **Mandatory IDT Deep Dive**: stacking skills, iterative education, method and discipline, cadence – monthly

- **IDT SBARG Care Coordination**: ~1 week prior to 30-day period end, or recertification:
  - Active IDT summarize SBARG:
    - Current situation, background, assessment, recommendations supported by goal progression.
    - Summary supports decision to continue with care plan, providing evidence for payment rationale in the clinical record
  - QAPI to monitor IDT SBARG documentation adherence

- **Identify complex patients:** When identified in daily team huddle, call out any complicated patients with the need for a 'mini case conf' (virtual) with patient's active IDT and manager

Daily huddle

Team huddle essentials

Risk-focused and *data-Informed*

- Identify patients with high and/or rising risk, service need
- Prioritize scheduling of aligned resources
- Re-align discipline need to best coordinated care
- Review new admits from day before, reinforce risk-aligned initial care plan
- Confirm discharges/recertifications
- Identify complex patients requiring SBARG

WellSky | CareInsights for Home Health

Population Performance

Hospitalization Risk

Very High	4
High	3
Elevated	19
Guarded	127
Low	0

0 20 40 60 80 100 120

60-Day ACH and ED Rates

200% 150% 100% 50% 0%

Apr Jul Oct

Acute Care Hospitalization
Emergency Department Rate

Performance Improvement Measures

Timely Initiation of Care

100%

+ 0%

100% 80% 60% 40% 20% 0%

Jan Jan

FILTER

Export CSV

1 – 50 of 155

Visit Utilization Insights

Last Name	First Name	Hospitalization Risk	Change	Primary Dx	Comorbidities	Referral Type	Hospice Suitability	Payment Period	PDGM Median	Assessment	LUPA Risk
Parsons	Bruno		→			Community	Potentially Suitable	-	-		Not enough data to determine LUPA Threshold
Paul	Dakota		→	Z4733: Aftercare following exp...	Low	Community	Marginally Suitable	1	5	Under	0/2
Bueller	Ferris		→			Community		-	-		Not enough data to determine LUPA Threshold
Noland	Roger		→	A1884: Tuberculosis of heart		Community		1	3	Under	1/2
Keith	Gordon		→	I10: Essential (primary) hypert...	Low	Community		13	12	In Line	4/4
Wilson	Wilma		→			Community		-	-		Not enough data to determine LUPA Threshold
Anderson	Adams		→			Community		-	-		Not enough data to determine LUPA Threshold
Wheeler	Ferris		→			Community		-	-		Not enough data to determine LUPA Threshold

Every visit preparation with *"Take 5 in the drive"*

Visit preparation essentials

Virtual and *data-informed*

- Review predictive analytics
- Hospice suitability
- ACH risk
- Current orders
- Last visit team notes
- Patient goal

Help frame observations within light of predictive and social risks

Supports agile care delivery and empowers clinicians to deliver the best care

Episode Manager : View: Nursing
Keith, Gordon (11989)

01/01/2024 - 02/29/2024

January 2024

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Scheduled Visit

February 2024

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

Frequency Dates	Frequency Description	Alert Time Frame	Alert
01-25-2024 - 02-29-2024	2 visits a week for 6 weeks	02-04-2024 - 02-10-2024	Overs

Episode Day   Scheduled Task   Completed Task

Nursing | All Therapy | PT | OT | ST | HHA | MSW | Orders

Task	Assigned	Target Date	Visit Date	Status
1. OASIS-E Start of Care	A. Staggs	01/01/2024	01/01/2024	Returned for Review
2. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/03/2024	01/03/2024	Completed
3. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/05/2024	01/05/2024	Submitted with Signatur
4. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/11/2024	01/11/2024	Submitted with Signatur
5. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/12/2024	01/12/2024	Submitted with Signatur
6. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/13/2024	01/09/2024	Saved
7. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/15/2024	01/14/2024	Submitted with Signatur
8. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/17/2024	01/17/2024	Submitted with Signatur
9. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/19/2024	01/19/2024	Submitted with Signatur
10. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/21/2024		Not Started
11. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/22/2024		Not Started
12. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/24/2024		Not Started
PRN 13. LPN/LVN - Skilled Nursing Visit	A. Staggs	01/25/2024		Not Started

VIEW EPISODIC FREQUENCIES

Gordon Keith

Primary DX: Essential (primary) hypertension

Patient Overview | Patient Timeline

START VIDEO VISIT

AI Risk Alerts 2
- High Hospitalization Risk
- High Hospitalization for Cardiac

Hospitalization Risk High
1. M1033 Hospitalization Risk Factors
2. M1000 14 Day Discharge: None
3. M1860 Ambulation

Hospice Suitability Not Likely Suitable

Utilization Assessment In Line

Comorbidity Low

Social Risks

Clinician 1:1 with Clinical Manager

Clinician 1:1 essentials

Virtual and *data-informed*

- Regular touch-base cadence per your scheduling realities – best in person, could be virtual
- Provides one-on-one support
  - Reinforce ability to use data to help make risk-informed decisions, tied to goal-directed care (patient and IDT)
  - Provide support, answer any questions – address need for any focused training
  - Reinforce feedback – celebrating progress in impacting outcomes of care
  - Acknowledge the effort to make changes, advancing their clinical craft.

Building confidence and competence in risk and data informed care planning.

Population View > Gordon Keith | Moderate Nutrition | Poor Social Support | Good Housing

Vitals

Body Temp 100 | Blood Pressure 120/80 | Pulse 54 | Pain 6 | Weight 165 | Respirations 28 | O2 Sat 96

Patient Overview

Name: Gordon Keith
Primary Clinician: Andy Staggs
Primary Diagnosis: Essential (primary) hypertension
Referring Physician: Andy Andrews
Secondary Diagnosis: Diab d/t undrl cond w hyprosm w/o nonket hyprgly-hypr...
Referral Source: BAYLOR SCOTT & WHITE MEDICAL CENTER
Episode Day: 26
Insurance: Palmetto GBA

Utilization Insights

1st Payment Period | 2nd Payment Period | LUPA Assessment 4/4

Visit Type	Total	Completed	25th Percentile	PDGM Median	75th Percentile	Assessment
SN	13	5	3	5	6	Over
PT	0	0	3	6	8	Under
OT	0	0	0	0	4	In Line
ST	0	0	0	0	0	In Line
MSW	0	0	0	0	0	In Line
HHA	0	0	0	0	0	In Line
OVERALL	13	5	8	12	16	In Line

Hospitalization Risk — High

Top Risk Factors
1. M1033 Hospitalization Risk Factors
2. M1000 14 Day Discharge: None
3. M1860 Ambulation
4. M0150 Medicare Fee-For-Service payment
5. ACH within 1 year

Hospitalization Risk Likelihood Trend

Care Plan for Jan 07, 2024 - Feb 10, 2024

Upcoming Visits
- SN VISIT — JAN 26, 2024
- SN VISIT — JAN 30, 2024
- SN VISIT — FEB 1, 2024
- SN VISIT — FEB 6, 2024

Five-Week Care Overview

Su	Mo	Tu	We	Th	Fr	Sa
07	08	09	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	01	02	03
04	05	06	07	08	09	10

Hospice Suitability — Not Suitable

Top Risk Factors
1. Respirations: 30 Day Median
2. Pain: 3 Day Median
3. M1600 UTI within 14 days
4. M1000 14 Day Discharge: LTCH
5. Systolic BP: Max Value

Hospice Suitability Likelihood Trend

Primary Diagnosis and Comorbidities

Primary Diagnosis: Essential (primary) hypertension

Secondary Diagnosis: Diab d/t undrl cond w hyprosm w/o nonket hyprgly-hypro... Amyotrophic lateral sclerosis Pneumonia, unspecified organism

PDGM Comorbidities: Low Adjustment | Neurological 4

Small IDT Case Conference by exception

Small IDT Conference essentials

By exception and *Data-Informed*

- Daily huddle/triage - identify need for a team case conference, involving IDT members r/t specific case
  - Virtual meeting, at discretion of manager to help align goals and care plan direction
- Regular coordination of care can be achieved via EMR communication utilizing SBARG reports, by discipline:
  - Tight report of Situation, salient Background, current Assessment, Recommendations and Goal progression.
  - Build reliable, robust process for payment period and episode management

Demonstrate both regulatory compliance for coordination of care, as well as defensive documentation for claim.

Informing SBARG, a regular rule for care coordination

Patient Timeline: Gordon Keith

FILTERS

Episode: Jan 01, 2024 - Jan 26, 2024

Jan 26, 2024

Jan 11, 2024
Time In: 9:00 AM
Time Out: 10:00 AM
Andy Staggs, RN

LPN/LVN - Skilled Nursing Visit — Submitted with Signature

Temperature	Pulse	Blood Pressure	Respirations	O2 Saturation	Pain	Weight
100	54	120 / 80	28	N/A	6	165

Jan 9, 2024
Time In: 11:11 AM
Time Out: 12:12 PM

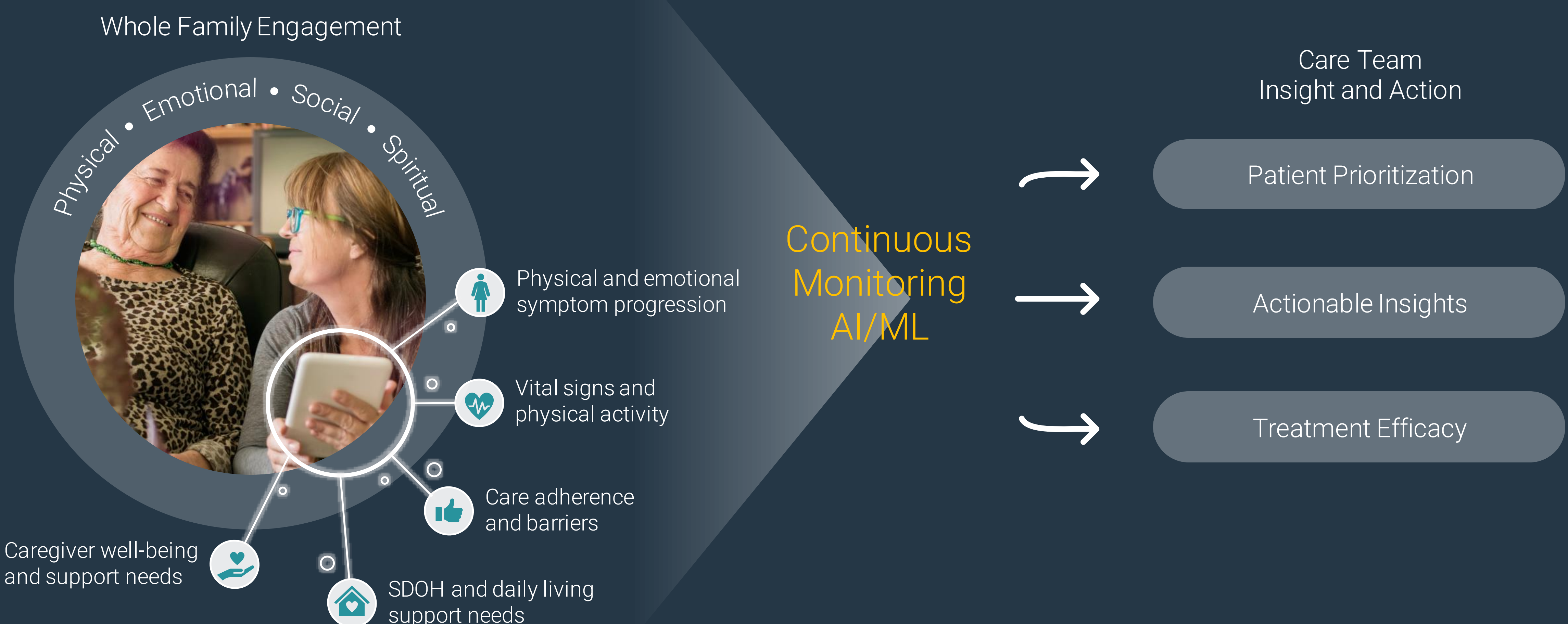
LPN/LVN - Skilled Nursing Visit — Saved

Temperature	Pulse	Blood Pressure	Respirations	O2 Saturation	Pain	Weight
101	54	120 / 80	22	N/A	6	165

Jan 5, 2024
Time In: 12:12 PM
Time Out: 1:13 PM
Andy Staggs, RN

LPN/LVN - Skilled Nursing Visit — Submitted with Signature

Patient & family engagement in home-based care helps us all stay and feel connected to who we serve



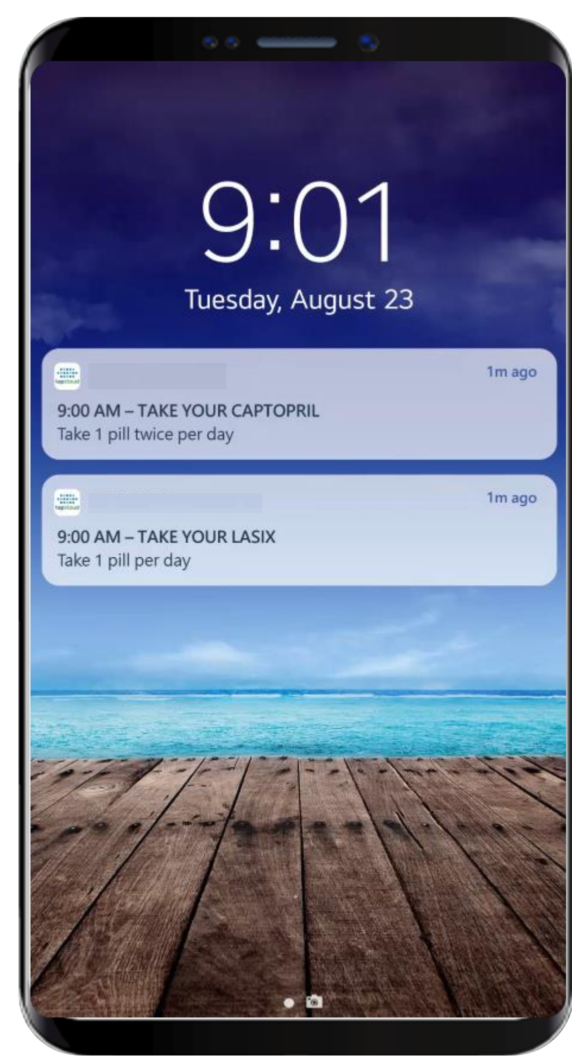
Continuous Patient Engagement

Continuous Engagement essentials

Experience-improving and *Data-Informed*

- Check-in calls for patients within 5 days of admission and prn
- Friday afternoon calls
- Calls to discuss nutrition and changes in health-related social needs

Prioritize the highest risk patients



Technology can enable:

- Daily care reminders
- Automated check-ins to share her symptoms
- Personalized education
- Updates for family to stay connected to care

With no impact to your team's workload

Remote Patient Monitoring: Increasing our "presence" while improving outcomes

Most Common Diagnosis Groups	% HH Readmitted 30 Days[1]	% of Medicare HH Patients[1]
Kidney & Urinary Tract Diagnoses	14.9%	1.2%
Renal Failure	19.6%	1.1%
Heart Failure	**21.0%**	**4.6%**
COPD	19.5%	0.9%
Respiratory Infection	15.3%	5.9%

Example: Heart Failure Readmissions with RPM

Providers proven to drop **CHF readmission < 50%[2]**

Estimated HH TAM:

- $13,500 savings per heart failure admission (source: AHA), multiplied by
- **per year = 6,850 admissions prevented**
- **$92+ million annual savings** opportunity for CHF in HH (Medicare FFS only)

Heart Failure ED Visits reduced 25% with RPM

- $2,500 savings per heart failure ED Visit
- ED usage rate: 13% reduced to 9.75%
- **per year = 2,200 ED visits prevented**
- **$5.5M annual savings** for CHF in HH (Medicare FFS only)

Total savings ~ $100M/yr for CHF HH Cohort

1. Home Health Chartbook. KNG Health. (2022).
2. Can telemonitoring reduce hospitalization and cost of care? A health plan's experience in managing patients with heart failure. Pop Health Management. (2014)
3. https://www.jacc.org/doi/10.1016/j.jchf.2023.02.018#:~:text=Heart%20failure%20(HF)%20affects%20an,the%20course%20of%20their%20disease.

Home Health Outcomes

CareInsights Users Achieve Performance Improvement and Differentiation

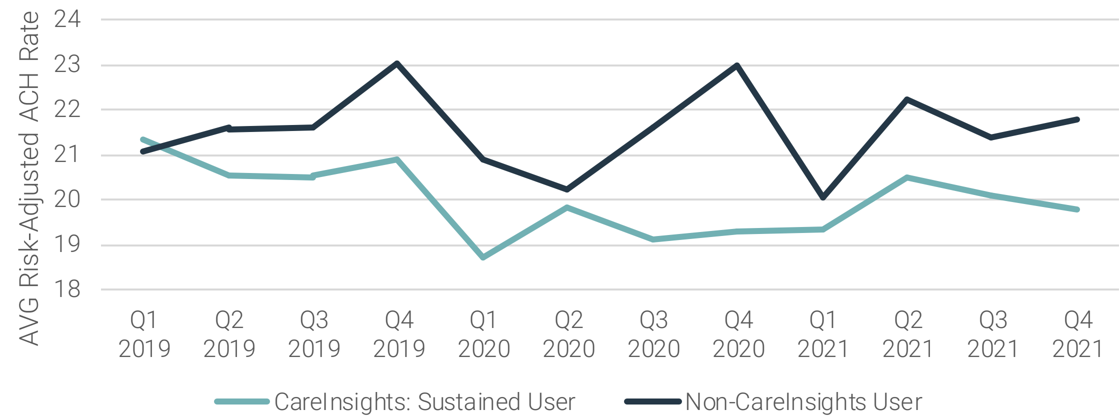
Care performance improved, even with increased patient acuity and decreased visit utilization

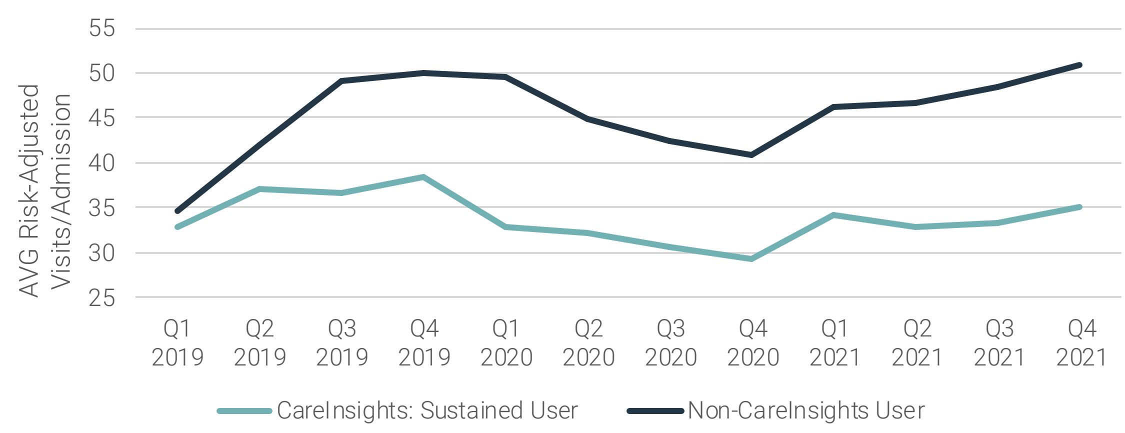
Improvement: Average Results, 12-Months Before vs. 12-Months After CareInsights Activation

Client Segment	60-Day ACH Rate	Visits/Admission
All agencies using CareInsights	▼12%	▼8%

Differentiation: Average Results, CareInsights Users vs. Non-Users, 2019-2021

Client Segment	60-Day ACH Rate	Visits/Admission
Agencies with 1,000+ Medicare admissions per year	▼12% than non-users	▼32% than non-users
Top 100 agencies using WellSky Insights*	▼26% than non-users	▼45% than non-users

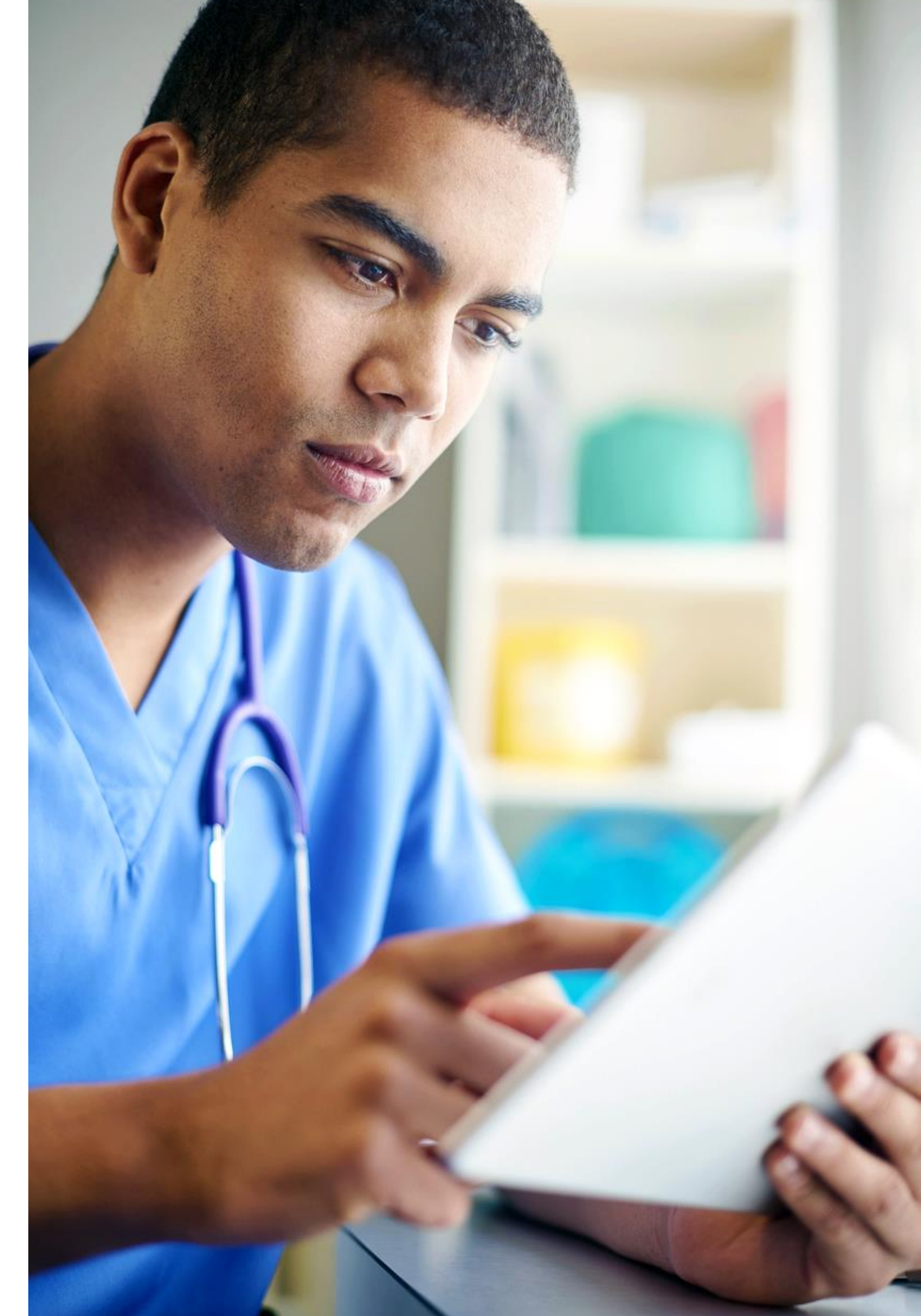




*Based on solution usage

Iterative Learning Model

- Learning Model Architecture
- Root Cause Analysis
- Monthly IDT Deep Dive



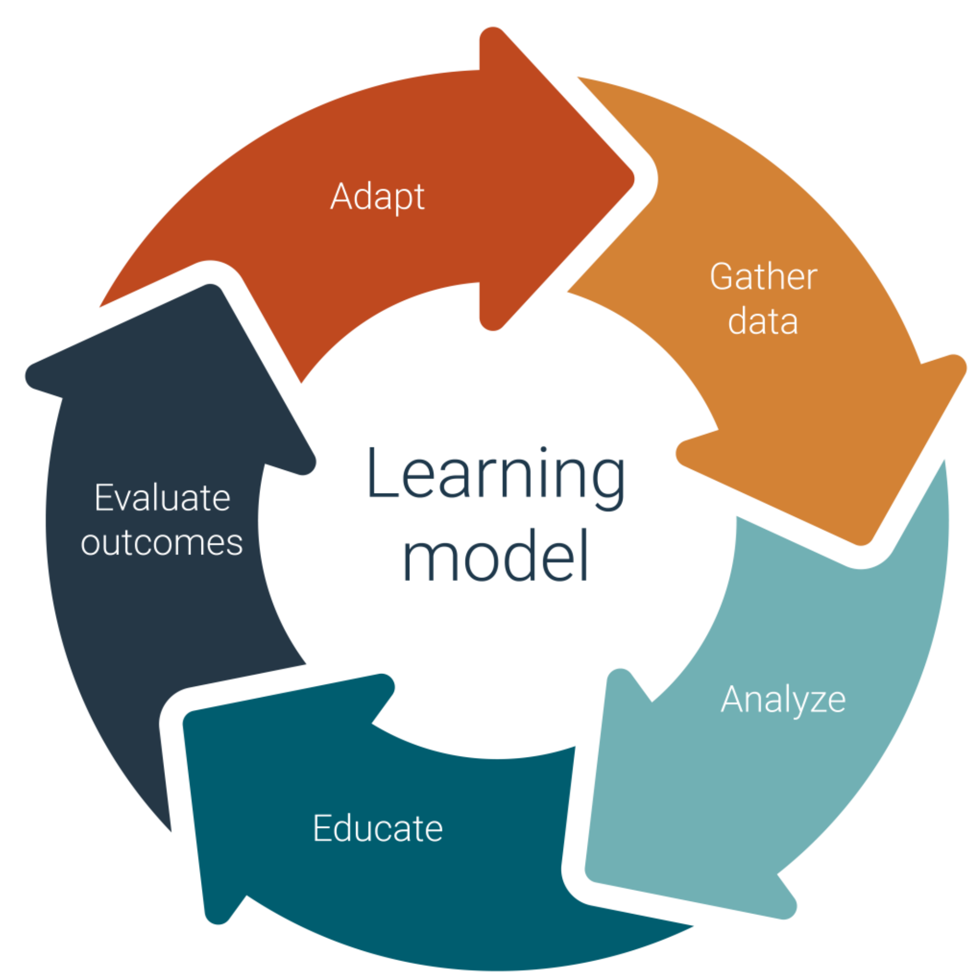
Iterative Learning Architecture

Learning Model essentials

Iterative and *Data-Informed*

- Cadence of gathering relevant data
- Clinician performance and coaching
- Comprehensive education including clinical, process and customer service
- All-agency participation
- Root Cause Analysis applied intentionally
- Small group training
- Monthly IDT meeting

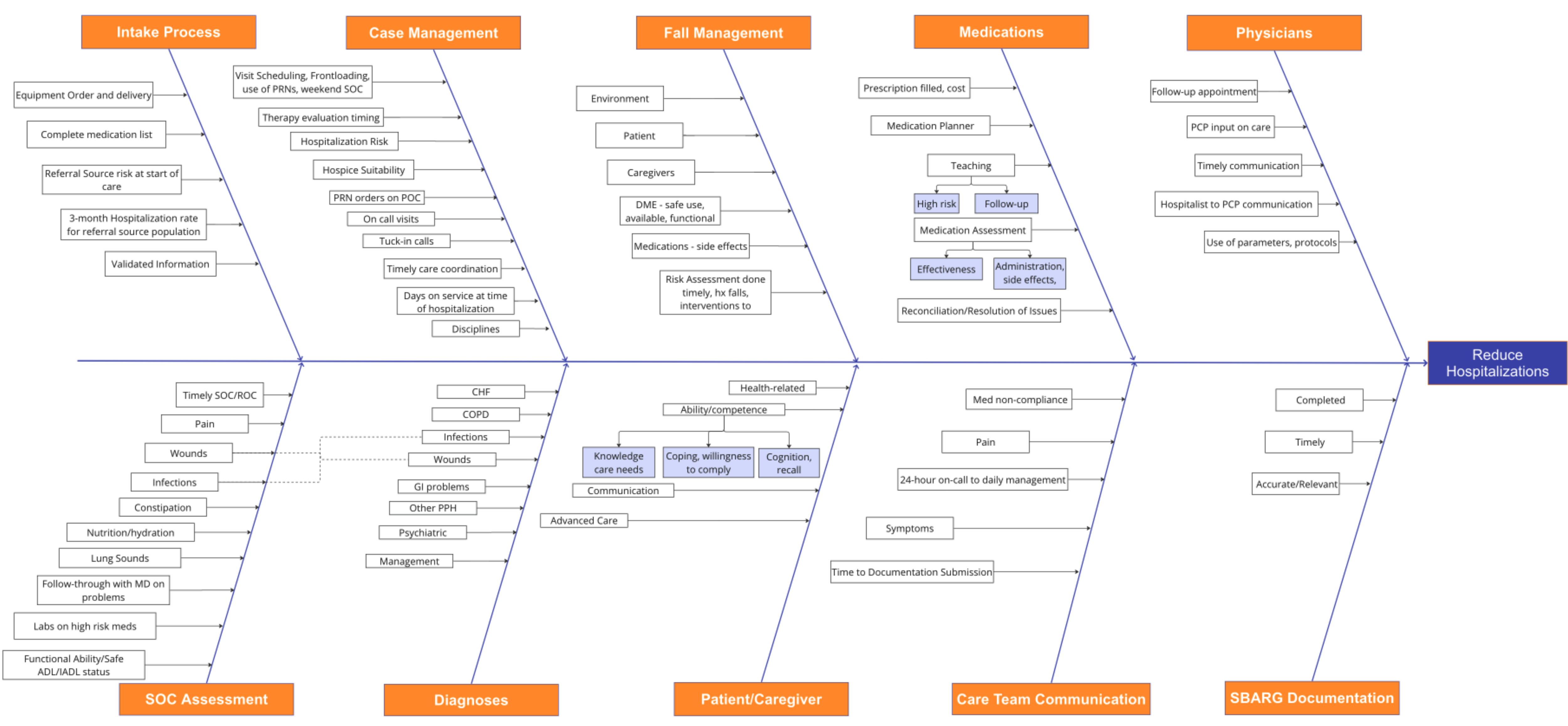
Culture of continuous learning and improvement



Root Cause Analysis

- As defined by CMS: Structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions.
- This comprehensive process provides agencies with a way to identify breakdowns in processes and systems that could be eliminated for the future.
- Goal: Find out what happened, why it happened, and determine what changes need to be made.
- CMS resource:

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf



Intake Process
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Complete medication list
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3-month Hospitalization rate for referral source population
Validated Information
Case Management
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Physicians
Follow-up appointment
PCP input on care
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Hospitalist to PCP communication
Use of parameters, protocols
Reduce Hospitalizations
Timely SOC/ROC
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Nutrition/hydration
Lung Sounds
Follow-through with MD on problems
Labs on high risk meds
Functional Ability/Safe ADL/IADL status
SOC Assessment
CHF
COPD
Infections
Wounds
GI problems
Other PPH
Psychiatric
Management
Diagnoses
Health-related
Ability/competence
Knowledge care needs
Coping, willingness to comply
Cognition, recall
Communication
Advanced Care
Patient/Caregiver
Med non-compliance
Pain
24-hour on-call to daily management
Symptoms
Time to Documentation Submission
Care Team Communication
Completed
Timely
Accurate/Relevant
SBARG Documentation

Monthly IDT Deep Dive

Monthly IDT meeting

Leadership Led and Data-Informed

- Data-informed IDT case presentation/team learning
- PIP-aligned education; risk and goal focused best practice
- Reinforce discipline-specific value of IDT collaboration
- Actively involve team in collective QAPI and PIPs

Bring PIPs to life through examples of the care of known patients

- Culture that values excellence and is willing to shift gears to achieve it
- Lose wasted effort and time – focus on what is needed
- Convey the value of each clinician and the collaborative IDT, including the integrated use of machine-learned data, predicated on excellence in assessment skill and accurate data capture
- Dig deeper into the diagnosis piece, build better understanding in how to focus education to meet continuum-based-need (disease cascade)
- What is your risk strategy for patients?
  - What should be looked at in the five mins per day?
  - How do specific team members use alerts in analytics to support their goals?
  - Does this align with your general QAPI strategy?
- Evaluate the data tools you are using to drive your actions/performance today

Example: IDT deep dive

1x month education strategy serves PIP of lowering ACH: trend found with CHF and HRSN risk

Team review heart failure progression, impact/interventions for HRSN and focus on prognostication, combined with Susan's goal of "just wanting to stay home and be comfortable"

Set the stage for expectations of performance, provide tools to meet the expectations

Susan's care planning - integrates

- Front loaded visits
- Predictive analytics
- OT for cardiac/pulmonary sparing on ADL/IADL
- Consider HH Aide front loaded to reinforce OT concepts in ADLs – taper down
- Social Services, potential collaboration with programs supporting personal care
- RPM and Patient Satisfaction technology, building increased connectivity & risk management
- Predictive diuretic protocol embedded into care plan – anticipate the ER visit...prevent it
- Advance care planning and palliative consult

- Stack skills/level-set efficient and effective approach to care – building engagement
- Achieve high value outcomes for higher acuity patients

Susan's journey

SHIFT to whole person care along continuum of need

START HERE: Susan discharged home, again, with advancing Heart Failure

Shift from controlled to uncontrolled setting

Monday: ROC with frontloaded visit plan – Patient satisfaction technology with RPM ordered- Personal care consult

Tuesday – devices arrive and visit made to orient Susan to how we will work to stay connected

Susan still craves pickle juice and wants to get good sleep – so skipping PM diuretic

Thursday – RPM flags weight increase, slightly decreased O2 Sat. Call from Central Monitor nurse triggers Susan to reveal she knows she isn't going to get better

Predictive diuretic protocol initiated – nursing visit scheduled for same day

Thursday afternoon-RN visit made to discuss conversation had about Susan's goals for her care

RN initiated advanced care planning conversation

Friday – Palliative consult initiated after discussion with Susan, as well as her MD

Weekend monitoring the result of diuretic – RPM continues

Monday – Social work visit from cross-trained HH/Hospice clinician

Susan's decision? Admit to Hospice – Susan's goal? Met.

A framework for Whole Person Care

Within home health care

Patient-centered focus

- Patient activation and engagement
  - Patient Goals
  - Patient Needs
  - Individualized Care Plan
  - Advanced Care Planning

Dynamic risk-based approach

- Daily Huddle
- Every Visit Preparation
- 1:1 Manager and Clinician
- Small Team Case Conference, by exception

Iterative learning model

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Analytics enablement

Leadership leaning into innovation

Thank you!

Questions?

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WellSky CareInsights helps providers **improve patient outcomes** through **fewer, more efficient visits.**

A recent study found that top users of WellSky CareInsights for Home Health experience:

- **26% lower** 60-day acute care hospitalization rates*
- **45% lower** visits per admission*

**Compared to non-users*

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WellSky solutions overview:

WellSky CareInsights
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Handouts

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Analytics Enablement

Leadership leaning into innovation

Build concrete method and discipline for strategic data use

Establish an iterative cadence of relevant data use

- Clinical manager and team: Virtual daily triage, data and risk informed (hospitalization and hospice suitability/aligned utilization)
- Clinician: Every visit check of dynamic, predictive risk, patient goal, orders
- Clinical manager and QAPI, 1x mo. deep dive, skill stacking, data & risk informed IDT
- Level-set skills to manage today's patient acuity and keep patients home

Build competence and confidence to increase clinician engagement

High engagement yields retention, which helps your agency grow ... for all the right reasons

Enabling Analytics in Care

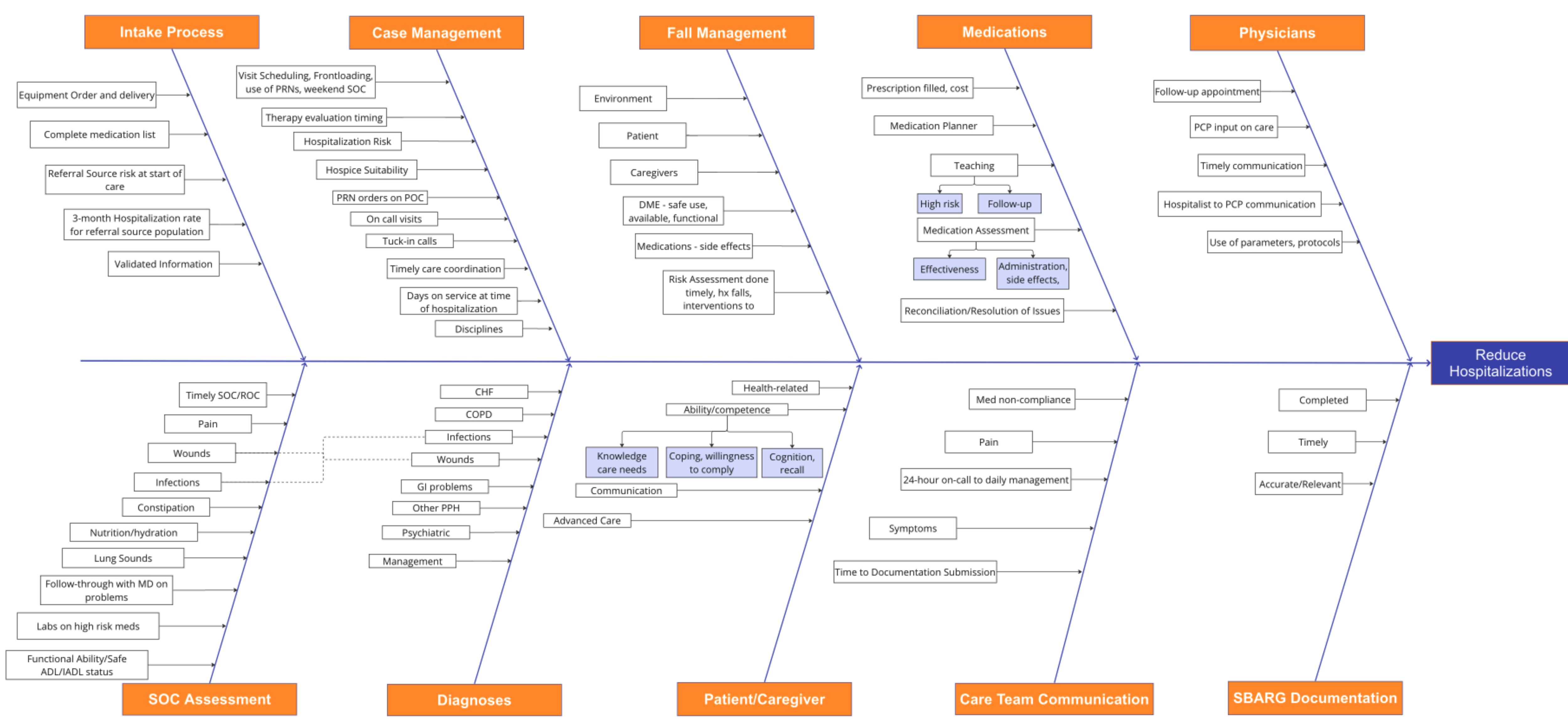
01 Daily Huddle

02 Every Visit Preparation

03 Clinician 1:1

04 Small Team Case Conference (by exception)

05 Patient Engagement



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