

# Chapter 2: Rehospitalization

While there are 12 measures that determine payment adjustments under HHVBP, the broad focus is on patient improvement, care quality and rehospitalization. We'll spend time looking at each goal, with a focus on how the measures support these outcomes.

In announcing its expansion of HHVBP, CMS lauded the results of the model states, where there was a reduction in unplanned hospitalizations and skilled nursing facility stays when compared to the non-model states.

## Breaking down the measures

Preventing rehospitalization under the expanded HHVBP is the primary goal of three of the measures:

### Acute Care Hospitalization During the First 60 Days of Home Health Use

This is based on the number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay when compared to the total number of home health stays that began during the 12-month period. This accounts for 26.75% of your score, the most of any measure.

### Emergency Department Use without Hospitalization During the First 60 Days of Home Health

This is based on the number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay when compared to the total number of home health stays that begin during the 12-month period. This accounts for 8.75% of your score.

### Discharged to Community

Based on results of M2420 in the OASIS-E, this measure is determined by the number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge when compared to the number of home health episodes of care ending with discharge or transfer to an inpatient facility during the reporting period. This accounts for 5.83% of your score.

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## Prescreen patients to get ahead of issues

Having the intake person prescreen patients prior to admission ensures that the patient meets Medicare guidelines for coverage of home health services and lower hospitalization rates, because agencies will start each episode of care more informed about patients and their specific needs.

This step allows you to identify the skilled need for home health, the services needed, potential barriers to care and can also help with caregiver buy-in.

### Choose patients you're best fit to care for

The prescreening process should be catered to your agency's abilities to care for the patient at the time of admission. If no clinicians at your agency are trained in dementia care, it might be smart to avoid accepting patients with cognitive issues while short staffed.

In order to avoid "cherry picking" agencies should create a policy that outlines what type of patients to accept or decline. For example, if you can't provide adequate dementia care, be consistent when considering patients with dementia.

There are several best practices that apply to agencies when conducting pre-screening:

- **Review the patient record.** Thoroughly review the patient record and/or referral information provided.
- **Interview the referral source.** When possible, have an interview or conversation with the referral source or ordering physician's staff about the patient's needs.
- **Interview the patient or caregiver.** Consider conducting an in-person interview with patient and/or caregiver. If an in-person interview is not possible, a phone conversation with patient and/or caregiver will suffice.

### Look for this in the clinical record

Agencies should start the prescreening process by looking for the following information in the clinical record and referral information:

- **The diagnosis driving the need for home health.** Agencies need to first determine if the diagnosis is an acceptable primary diagnosis under PDGM.

### Hospitalization by clinical group

The PDGM clinical group with the highest 60-day acute care hospitalization rate is MMTA-Infectious, for Medicare FFS patients in the 12 months ending Sept. 30, 2022. The data are based on over 5.8 million patient stays, pulled from provider claims received by Strategic Healthcare Programs (SHP).

Clinical Group	60-Day ACH
Behavioral Health	10.6%
Complex Nursing	20.3%
MMTA - Cardiac	17.9%
MMTA - Endocrine	14.9%
MMTA - GI/GU	19.6%
MMTA - Infectious	22.8%
MMTA - Other	13.0%
MMTA - Respiratory	17.9%
MMTA - Surg After	12.9%
MS Rehab	6.6%
Neuro Rehab	11.6%
Wounds	18.1%
Overall	13.7%

- **Comorbidities.** All comorbidities and past medical history should be taken into account, including all hospitalizations.
- **Disciplines needed.** If a patient needs occupational therapy and your agency is short staffed in that area, it might not be a good idea to take the patient on.
- **The patient's home situation.** Consider who the patient lives with, what kind of support and assistance they have at home and what kind of community resources are available to them.

This will determine if the patient will be fully reliant on the home health agency, or if there will be other resources available.

Also think about whether the person living with the patient is capable of providing support and assistance to the patient. Consider whether there is someone else, such as a child or disabled individual, who also relies on that caregiver for support.

- **Transportation.** Think about whether the patient has reliable transportation available, or if you'd need to arrange it for doctors' visits, etc.
- **Resource needs and availability.** Look at what type of resources the patient might need upon discharge home, as well as what is already available to them. This can include community resources like Meals on Wheels, transportation assistance, medication management assistance and personal care assistance.
- **Durable medical equipment (DME).** If the patient will need any DME in the home, you'll need to decide how it will be provided or if your agency is able to provide it or arrange it.
- **Homebound status.** A patient's homebound status considerations should include whether or not the patient is able to leave the home or is dependent on assistance for grocery shopping and doctor's appointments.

## Have a conversation with the patient

During the prescreening conversation with the patient, caregiver, facility discharge planner or case manager, confirm the following:

- Patient's physician's name and contact information
- Where the patient will be staying at the time of discharge
- Patient phone numbers, both cell and landline (if applicable)
- Patient's emergency contacts including name, relationship and phone number that is not the same as patient's phone number
- Equipment needed in the home prior to the patient coming home (oxygen, hospital bed, etc.)

Additionally, when speaking with the patient or caregiver, discuss with the patient what they expect from home health services. Help them understand that home health does not mean 24-hour care in the home. Find out what is meaningful to the patient/caregiver in terms of care and goals.