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.

Measures beginning in 2025

Preventing rehospitalization under the expanded HHVBP is the primary goal of two claims-based measures:

Home Health Within-Stay Potentially Preventable Hospitalization (PPH)

This risk-adjusted measure is based on the number of patients with at least one potentially preventable hospitalization. or observation stay during the home health stay. It accounts for 26% of your score, the most of any single measure.

Discharge to Community — Post Acute Care

This risk-adjusted measure is based on the number of patients who are discharged to the community and do not have an unplanned admission to an acute care hospital or long-term care hospital in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. This accounts for 9% of your score.

Measures for 2024 results

When reviewing 2024 results, keep in mind that the following three measures were used in calculating scores. All three have been removed in 2025.

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.

Start strong on new PPH measure

Beginning with 2025 results, PPH will have the biggest impact on your HHVBP scores.

Agencies already succeeding on this new measure are thinking ahead with good case management.

Plan ahead for patient needs

Proactive case management puts a focus on disease management, communication management and empowering the patient and the home health clinician by ensuring you're planning ahead to get the right tools in the tool belt before they're needed.

By anticipating needs, you can obtain orders that fill the gaps and allow a more expedited response, such as PRN or "as needed" orders for visits or labs, or PRN medication orders for anticipated symptoms associated with the patient's higher risk disease processes.

A patient with heart failure, for example, would require planning to ensure the agency had the ability to get out to the patient as soon as possible if there are troubling symptoms.

The nurse would ensure they have obtained orders to visit as needed when increased weight, edema or shortness of breath occurred.

The nurse will also want to have tools to use, such as ordering extra furosemide PRN when these symptoms occur.

The physician must still be notified of the change in condition, but these tools allow the agency to respond quickly — which is imperative in reducing preventable hospitalizations.

Climbing to the top

Those agencies looking to improve their score should start with a root cause data analysis of all acute care hospitalizations.

To do this, the agency must first understand how the measure is calculated, including the exclusions, which diagnoses are considered potentially preventable and the factors that go into the calculation. All of this information is available at the Home Health Quality Reporting Program website.

Once this is understood, the agency should then initiate a root cause data analysis. Some of the questions that agencies should think about when performing this analysis include:

- Look for trends in the timing of the hospitalizations. For example, is there a day of the week with more hospitalizations? Is there a pattern in the number of days since the Start of Care (SOC)?

- Look for other trends in the data. This could include:
  - hospitalizations in specific clinical groupings;
  - the reason for the hospitalization; or
  - the CMS-identified "potentially preventable" diagnosis.
- Consider issues during the period. For example, where there missed visits? Was the agency able to front-load visits and bring in other disciplines? Could these services have impacted the resulting hospitalization?

Learn what top agencies are getting right

Some of the proactive steps you can take to mitigate preventable hospitalizations include:

- Act on any trends identified in data analysis with process and performance improvement plans.
- Institute check-in calls for patients who have infrequent visits, such as monthly catheter patients.
- Implement a touchpoint care pathway for patients with high-risk diagnoses such as CHF or COPD, or for patients who are at high risk for hospitalization based on the agency's risk assessment.
- Add appropriate secondary disciplines to the plan of care such as a medical social worker to assist with Social Determinants of Health (SDoH).

Keep a close eye on red flags

There are some factors that routinely come up in hospitalization reviews.

For example, agencies with a high rate of observation stays among their patient populations should note that observation stays are a hospitalization red flag and are included in the PPH measure.

Other red flags for hospitalization include:

- **Difficult patients.** This could include patients who are resistant to accepting home health services, have frequent missed visits or refuse additional disciplines.
- **Issues with medication management.** This could include medications missing from the home, expired medications or having no caregiver willing or available to assist with medication management.
- **SDoH challenges.** This could include patients with low income, poor health literacy, lack of support system or lack of transportation.
- **Pain management.** Patients with poorly controlled pain are more likely to end up in the hospital.
- **Patient history.** This can be identified in OASIS results for history of falls (2 or more falls or any fall with injury); unintentional weight loss; multiple hospitalizations or ER visits; decline in mental, emotional or behavioral status; and reported or observed history of difficulty complying with any medical instructions.