CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPANDED HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

Strategies for Success Self-Assessment Tool

March 2023

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: *This information has not been publicly disclosed and may be privileged and confidential. It is for internal government and home health agencies subject to the expanded Home Health Value-Based Purchasing Model use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information.*

LEWINGROUP
Part of OptumServe

University of Colorado
Anschutz Medical Campus

OASISanswers

Introduction

The expanded Home Health Value-Based Purchasing (HHVBP) Model uses the results achieved by home health agencies (HHAs) to establish quality measure benchmarks. These benchmarks reflect the average performance of the top 10% of HHAs nationally, within each volume-based cohort.[1] HHAs can achieve performance at or approaching published benchmarks through consistent application of available clinical science and best practices in home health care.

Additional resources about the expanded HHVBP Model are available on the Expanded HHVBP Model webpage. Questions can be sent to the HHVBP Help Desk at HHVBPquestions@lewin.com.

This resource introduces a self-assessment process and tool that HHA teams can use in conjunction with other Quality Assessment and Performance Improvement (QAPI) methods to identify specific strategies that have the potential to improve quality performance results. These strategies were drawn from such sources as health service research, home health nursing standards of practice, Medicare Home Health Conditions of Participation (CoP), and the Medicare Benefits Policy Manual. The self-assessment is designed to review these strategies and the systems in place for your agency that support consistent and reliable use. HHA teams can use the results from this self-assessment to prioritize, plan, and track progress on implementation of home health quality improvement (QI) strategies over time.

Instructions for Use

Below is a summary of each step in the assessment process that HHAs can consider including in their QAPI activities.

1. ***Plan your QAPI activity.*** To make efficient use of the QAPI team's time, it may be helpful to designate a facilitator. The facilitator should familiarize themselves with the self-assessment and action plan template provided in this resource; schedule QAPI team time for the activity; provide materials required for team review; and facilitate the group self-assessment process.
2. ***Assess strategies using the Strategies for Success Self-Assessment form.*** Any staff familiar with the HHA's quality improvement activities can complete an initial self-assessment, but results should be reviewed by the QAPI team and discussed before moving forward. More details on each strategy can be found in the **Briefing Cards.**
3. ***Identify up to three (3) strategies to target for performance improvement.*** After completing the assessment, analyze the results. In which areas do you see strength? Which areas may need improvement? Considering these results and the overall performance goals of your HHA, select up to three (3) strategies that would benefit from improvement and that the QAPI team considers to be high priority.
4. ***Develop an action plan, with scheduled check-ins to assess progress.*** The goal of self-assessment is informed and effective action. After completing the self-assessment and analyzing the results, the QAPI team should convert findings into action. Effective action plans include the specific changes needed, who is responsible, and timelines for completion. HHAs may already have planning forms used for quality improvement activities. If not, they can consider using the ***Action Plan for QAPI Activities*** template.

[1] For more information about the expanded HHVBP Model, benchmarks, this tool, and other quality improvement resources, please visit the expanded HHVBP Model webpage (https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model).

5. ***Review progress periodically.*** As with all quality improvement activities, it is important to monitor and review results. The self-assessment activity itself should be repeated periodically to track progress over time.

Strategies for Success Self-Assessment Form

Using the strategies listed in the assessment tool below, review their level of integration into the current management strategies used at your HHA (i.e., *Is the strategy included in staff orientation and training? Is it incorporated into your procedures, protocols, and tools? Is it included in performance monitoring?*). Circle the highest score (from 0 to 3) that applies. For an example, see **Exhibit 1** in the **Appendix.**

	Strategies for Success *See **Briefing Cards** for more information on each strategy listed.*	**Not specifically addressed**	**Included in staff orientation and training**	**Incorporated into procedures, protocols, tools**	**Included in performance monitoring**
1	**Assessment** – Clinical assessments include appropriate observation of patients' functional abilities.	0	1	2	3
2	**Assessment** – Clinical assessment involves all required disciplines. This includes: HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.	0	1	2	3
3	**Assessment** – Medication review practices and procedures reliably identify potential adverse effects and drug reactions for all patients.	0	1	2	3
4	**Assessment** – Patients who want and continue to require HHA services that can be provided safely are not discharged until measurable outcomes and goals set forth in their plan of care have been achieved.	0	1	2	3
5	**Care Planning** – HHA has established clinical protocols or pathways for conditions common to the HHA's patient population.	0	1	2	3
6	**Monitoring** – HHA has established protocols for monitoring for and responding to signs of deterioration in clinical status, including monitoring outside of in-person visits.	0	1	2	3
7	**Patient Engagement** – Written care plan and associated education and training is usable and understood by the patient and caregivers.	0	1	2	3
8	**Patient Engagement** – Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths.	0	1	2	3
9	**Maintenance Coverage** – HHA has established clinical protocols or pathways for eligible patients needing skilled care to maintain function or prevent or slow decline in function.	0	1	2	3
	Subtotal:				

Sum of all scores (range zero (0) to 27): _____

Select up to three (3) high priority strategies to prioritize for QAPI activities and record them here:

1. _____

2. _____

3. _____

Action Plan for QAPI Activities

Next, develop an action plan based on the results of the self-assessment. In the table below, fill in the three (3) strategies your HHA thinks are high priority. Next, identify the specific changes needed, who is responsible, and timelines for completion for each of the strategies selected. For an example, see **Exhibit 2** in the **Appendix.**

Strategies for Success	What changes will we make?	Who is responsible?	When will this be completed?
1.	*In our orientations & trainings…*		
	In our procedures, protocols, & tools…		
	In our performance monitoring…		
2.	*In our orientations & trainings…*		
	In our procedures, protocols, & tools…		
	In our performance monitoring…		
3.	*In our orientations & trainings…*		
	In our procedures, protocols, & tools…		
	In our performance monitoring…		

Briefing Cards

The briefing cards provided below give greater detail on the strategies that an HHA might prioritize for performance improvement. Each card follows an SBAR (situation, background, assessment, and recommendation) format, leading to a recommendation on how an HHA can address the identified opportunity for improvement from the self-assessment process. These strategies were drawn from such sources as health service research, home health nursing standards of practice, Medicare Home Health Conditions of Participation (CoP), and the Medicare Benefits Policy Manual.

Assessment:	***Clinical assessments include appropriate observation of patients' functional abilities.***
Situation	Clinicians new to home health care, charged with completing assessment data collection, may be over-reliant on patient reported data and fail to systematically and reliably collect data based on direct observation of patient functional abilities or incorporate such data into their assessment.
Background	Comprehensive patient assessment, providing a complete picture of the patient's status and abilities is an essential home health function, necessary for care planning.
Assessment	Over-reliance on patient reported data can significantly and negatively impact patient outcomes and HHA operations.
Recommendation	HHAs should establish procedures to ensure patient assessments include direct observation of functional abilities, as appropriate. Staff should be supported in the use of this strategy, including: • Allocating the time required to complete assessments. • Monitoring performance. • Providing positive feedback on desired performance.

Assessment:	***Clinical assessment involves all required disciplines. This includes: HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.***
Situation	Patients may have needs for skilled care beyond those included in their care plan that are either not identified by home health clinicians or not accessed through care coordination efforts with the referring physician.
Background	Through interactions with patients in their homes, home health clinicians gain a unique perspective on the patient's health and care needs. Home health clinicians – including nurses and therapists – are in an ideal position to identify potential needs for skilled care from other disciplines beyond those included in the original physician referral.
Assessment	Unmet skilled care needs can significantly and negatively impact patient outcomes and HHA operations.
Recommendation	HHAs should establish procedures to ensure that initial and ongoing patient assessments identify needs for skilled care beyond those included in the current care plan. This should include: • Interdisciplinary orientation and education that promotes understanding the roles and functions of other clinical disciplines. • Assessment procedures that include identification of potential unmet skilled care needs. • Care coordination procedures to effectively communicate assessment findings to referring physicians to approve additions or modifications to the care plan.

Assessment:	***Medication review strategies and procedures reliably identify potential adverse effects and drug reactions for all patients.***
Situation	Medication review for home health patients may not reliably identify potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, and duplicate drug therapy.
Background	HHA patients, including those with multiple chronic conditions and complex care needs, who may be under the care of multiple prescribing clinicians, and who experience frequent care transitions are at significant risk for adverse drug effects (ADEs). In this population, ADEs are a common cause of emergency department visits, hospitalization, and treatment failures.
Assessment	Failure to identify potential ADEs can significantly and negatively impact patient outcomes and HHA operations. With the modern pharmacopeia, identifying potential ADEs in this patient population is an exceptionally challenging cognitive task – even for experienced HHA nurses.
Recommendation	HHAs should establish procedures to ensure that, during medication review, the HHA nurse considers the potential for ADEs of each medication the patient is taking and for their medication regimen as a whole. This review for potential ADEs should be documented in the clinical record. Medication review procedures should include or consider: • Orientation and education on the standards and expectations for medication review. • Tools and decision aids to support HHA nurses in this task. • Care coordination procedures to effectively communicate medication review findings of potential ADEs to referring physicians.

Assessment:	***Patients who want and continue to require HHA services that can be provided safely are not discharged until measurable outcomes and goals set forth in their plan of care have been achieved.***
Situation	Home health care patients may be discharged from care even though they want home health services, remain homebound, have a qualifying skilled need, and the measurable outcomes and goals set forth in their plan of care have not been achieved.
Background	A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, is to be considered in deciding whether skilled services are needed. Unless there is some other specific justification for discharge, discharge is only appropriate when the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.
Assessment	The discharge of eligible patients from home health care can deny patients benefits to which they are entitled and significantly and negatively impact patient experience, post-discharge outcomes, and HHA operations.
Recommendation	HHAs should establish procedures to ensure that eligible patients who have not met the measurable outcomes and goals set forth in their plan of care are not discharged from care. This would include: • Orientation and education on the standards for home health care discharge. • Assessment procedures with documentation of plan of care goals and progress toward those goals. • Care coordination procedures to effectively communicate assessment findings and continuing care needs to referring physicians.

Care Planning:	***HHA has established clinical protocols or pathways for conditions common to the HHAs patient population.***
Situation	Reliable individual and interdisciplinary team performance, and improved patient and caregiver communication can be achieved though standardization of common tasks and clinical activities.
Background	While every patient's care needs are unique, an HHA's patient population will have common conditions, with aspects of care that can be standardized.
Assessment	Failure to use clinical protocols or pathways can negatively impact patient outcomes, patient experience, and HHA operations.
Recommendation	HHAs incorporate clinical protocols or pathways for conditions seen in their patient population and institutionalize their use. This would include: • Development or adoption of clinical protocols or pathways. • Orientation and education on clinical protocols or pathways and expectations for their use. • Incorporation of clinical protocols or pathways into procedures, tools, and patient education and training resources.

Monitoring:	***HHA has established protocols for monitoring for and responding to signs of deterioration in clinical status, including monitoring outside of in-person visits.***
Situation	Home health patients may experience delays in care because signs of deterioration in clinical status are not detected or because monitoring occurs at times of limited availability of care resources.
Background	Home health patients are at risk for emergency department visits and hospitalization due to, for example, their underlying and recognized health conditions, fragmentation of care and care transitions, exacerbation of previously well-managed conditions, and even new diagnoses that can arise. Responding to signs of deterioration in clinical status may involve coordination of care with other providers. Care plans must include interventions, such as monitoring, that address these underlying risk factors. Monitoring scheduling should consider patient-specific risk and the availability of other care providers.
Assessment	Failure to establish and use protocols for monitoring for and responding to signs of deterioration in clinical status or pathways can negatively impact patient outcomes, patient experience, HHA operations, and increase risk for emergency department visits and hospitalizations.
Recommendation	HHAs should establish protocols for monitoring for and responding to signs of deterioration in clinical status. This would include: • Development or adoption of monitoring protocols. • Orientation and education on monitoring protocols and expectations for their use. • Ensuring that responsible staff have the time to perform expected monitoring activities, according to schedules provided in protocols. • Incorporating monitoring protocols into procedures, tools, and patient education and training resources. • Performance monitoring and feedback.

Patient Engagement:	***Written care plan and associated education and training is usable and understood by the patient and caregivers.***
Situation	Home health patients who are provided with a plan of care they don't understand may experience anxiety and dissatisfaction with home care services. Patient outcomes are impacted by the clarity and usability of written resources as well as the knowledge, skills, and attitudes patients and caregivers develop through associated education and training.
Background	The home health individualized plan of care is intended not only as a care coordination tool, but also to communicate expectations for home care services and for the use of the patient and their caregivers. The information in the plan of care must be organized and presented such that it can be understood and used by patients and caregivers. Development of the care plan and associated teaching should employ methods appropriate to the patient and caregiver's developmental level, learning needs, readiness to engage in self-care activities, and culture.
Assessment	Failure to provide a usable plan of care with appropriate teaching method can negatively impact patient outcomes, patient experience, HHA operations, and increase risk for emergency department visits and hospitalizations.
Recommendation	HHAs should review the design of written care plans for usability. HHAs should establish protocols for teaching activities for all staff, to promote development of knowledge, skills and attitudes necessary for patient and caregivers' active engagement in self-care activities. This includes the use of activities such as the involvement of patients in goal-setting, incorporating patient preferences into care plans, identifying patients' individual educational and health promotion needs, and health promotion teaching methods. Implementation of teaching activities protocols would include: • Identification of effective health teaching and health promotion methods and tools. • Orientation and education on teaching protocols and expectations for their use. • Ensuring that responsible staff have the time to perform expected health teaching and health promotion interventions. • Incorporating teaching protocols into procedures, tools, and patient education and training resources. • Performance monitoring and feedback.

Patient Engagement:	***Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths***
Situation	Assessment processes that focus exclusively on functional limitations and care needs or that don't include an opportunity for a patient to affirm their own strengths can leave patients feeling un-empowered to take an active role in their own care. Patients who are un-empowered may experience anxiety, negative affect, and dissatisfaction with home care services; the effectiveness of health promotion teaching can be negatively impacted for such patients; they may be less likely to participate in self-care activities; and more likely to experience negative outcomes of care.
Background	Consistent with the principles of patient-centered care, the intent in identifying patient strengths is to empower the patient to take an active role in his or her care. To promote a sense that the patient is respected as an active partner in the delivery of care, the HHA should ask the patient to identify her or his own strengths and independently identify the patient's strengths to inform the plan of care and to set patient goals and measurable outcomes.
Assessment	Failure to consistently identify patient strengths, and have those strengths affirmed by the patient themselves, can negatively impact patient outcomes, patient experience, and HHA operations.
Recommendation	HHAs should establish protocols identifying patient strengths and documenting those strengths in their comprehensive assessment. The interdisciplinary team should consider patient strengths in care plan development. Implementation of patient strengths identification protocols would include: Identification of effective strengths identification methods and tools. • Orientation and education on strengths identification protocols and expectations for their use. • Ensuring that responsible staff have the time to perform strengths identification interventions. • Incorporating strengths identification protocols into procedures, tools, and patient education and training resources. • Performance monitoring and feedback.

Maintenance Coverage:	***HHA has established clinical protocols or pathways for eligible patients needing skilled care to maintain function or prevent or slow decline in function.***
Situation	Home health providers and clinical staff may believe that the Home Health Benefit of the Medicare program covers nursing and therapy services only when a beneficiary is expected to improve. This is not always true. HHAs may not have established clinical protocols or care pathways that guide goals in the plan of care, decision making, documentation, care coordination, and appropriate discharge.
Background	The Home Health Benefit of the Medicare program is not based on the presence or absence of a beneficiary's potential for improvement, but rather (when all other coverage criteria are met) on their need for skilled care.
Assessment	Establishing clinical protocols or care pathways for home health patients with maintenance goals can potentially positively impact beneficiary access to care, patient outcomes, patient experience, and HHA operations.
Recommendation	HHAs incorporate clinical protocols or care pathways for eligible patients needing skilled care to maintain function or prevent or slow decline or deterioration and institutionalize their use. This would include: • Development or adoption of clinical protocols or pathways. • Orientation and education on clinical protocols or pathways and expectations for their use. • Incorporation of clinical protocols or pathways into procedures, tools, and patient education and training resources. • Care coordination procedures to effectively communicate assessment findings and care plans for patients with maintenance goals to referring physicians.

Appendix: Completed Self-Assessment & Action Plan Example

Exhibit 1 shows how a fictional HHA might complete self-assessment. **Exhibit 2** provides an example of an action plan based on the results of the self-assessment.

Exhibit 1. Completed Strategies for Success Self-Assessment

	Strategies for Success *See **Briefing Cards** for more information on each strategy listed.*	Not specifically addressed	Included in staff orientation and training	Incorporated into procedures, protocols, tools	Included in performance monitoring
1	Assessment – Clinical assessments include appropriate observation of patients' functional abilities.	0	1	**2**	3
2	Assessment – Clinical assessment involves all required disciplines. This includes: HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.	**0**	1	2	3
3	Assessment – Medication review strategies and procedures reliably identify potential adverse effects and drug reactions for all patients.	0	1	2	**3**
4	Assessment – Patients who want and continue to require HHA services that can be provided safely are not discharged until measurable outcomes and goals set forth in their plan of care have been achieved.	0	1	**2**	3
5	Care Planning – HHA has established clinical protocols or pathways for conditions common to the HHA's patient population.	0	1	2	**3**
6	Monitoring – HHA has established protocols for monitoring for and responding to signs of deterioration in clinical status, including monitoring outside of in-person visits.	0	**1**	2	3
7	Patient Engagement – Written care plan and associated education and training is usable and understood by the patient and caregivers.	0	1	2	**3**
8	Patient Engagement – Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths.	**0**	1	2	3
9	Maintenance Coverage – HHA has established clinical protocols or pathways for eligible patients needing skilled care to maintain function or prevent or slow decline in function.	0	1	2	**3**
	Subtotal:	0	1	4	12

Sum of all scores (range 0 to 27): _____**17**_____

Select up to three (3) high priority strategies to prioritize for QAPI activities and record them here:

1. (1) Assessment – Clinical assessments include appropriate observation of patients' functional abilities.
2. (2) Assessment – Clinical assessment involves all required disciplines. This includes: HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.
3. (8) Patient Engagement – Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths.

Exhibit 2. Completed Action Plan: Strategies Selected for QAPI Activities

Strategies for Success	What changes will we make?	Who is responsible?	When will this be completed?
(1) Assessment – Clinical assessments include appropriate observation of patients' functional abilities.	***In our orientations & trainings…*** For managers and supervisors – how to monitor staff performance on clinical assessment, especially observation of patients' functional abilities. ***In our procedures, protocols, & tools…*** Incorporate observation and feedback of staff performance into assessment procedures. ***In our performance monitoring…*** Observe a sample of current staff performance, monitor periodically to determine whether additional action is required.	Manager	30 days (XX/XX/XX)
(2) Assessment – Clinical assessment involves all required disciplines. This includes: HHA has established procedures for initiating request for orders for needed nursing or rehabilitation therapy assessment when not included in physician referral.	***In our orientations & trainings…*** Identify best practices for involving all required disciplines; integrate into orientation and training; update current staff. ***In our procedures, protocols, & tools…*** Work with staff to add consideration of other disciplines into assessment tools; develop SBAR tool for communicating with ordering physicians; incorporate interdisciplinary approach messaging into provider relations communications. ***In our performance monitoring…*** Incorporate consideration of other disciplines into assessment and care planning quality assurance activities; monitor to determine whether additional action is required.	Manager	90 days (XX/XX/XX)
(8) Patient Engagement – Assessment protocols ask patients to identify their own strengths and independently identify the patient's strengths.	***In our orientations & trainings…*** Identify best practices for patient strengths identification; integrate into orientation and training; update current staff. ***In our procedures, protocols, & tools…*** Work with staff to integrate patient strengths identification into assessment tools and documentation. ***In our performance monitoring…*** Incorporate patient strengths identification into assessment and care planning quality assurance activities; monitor to determine whether additional action is required.	Manager	90 days (XX/XX/XX)