



Texas Association for  
Home Care & Hospice  
*Leading ★ Advancing ★ Advocating*

## Winter Conference

Wednesday, February 18, 2026

11:45am-12:45pm

# 2a. The FY2026 Home Health Final Rule: Quality Counts: HHQRP, CAHPS Evolution & HHVBP Changes

Presented by:

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Thank you to our Partners:



# The FY2026 Home Health Final Rule: Quality Counts: HHQRP, CAHPS Evolution & HHVBP Changes

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## Learning Objectives

- The learner will identify the FY2026 quality measures being added, removed, or modified and how these changes will affect quality performance and compliance.
- The learner will understand the changes to HHCAHPS and the effect on HHVBP and patient experience outcomes.
- The learner will identify strategies to optimize quality performance, improve patient experience scores, and mitigate reimbursement risk in response to the FY2026 HHQRP, HHCAHPS, and HHVBP changes.

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## HH QRP Changes

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## HH QRP - OASIS

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Beginning with the CY 2026 Home Health Quality Reporting Program (HHQRP):

- Remove the “COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date” (O0350)
  - Remove from OASIS April 1, 2026 – submit any valid answer until that time
- Remove Four Standardized Patient Assessment Data Elements set to be collected on the OASIS in 2027 – Social Determinates of Health (SDoH) category
  - Living Situation (R0310)
  - Two items for Food (R0320A and R0320B)
  - Utilities (R0330)

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## HH QRP - OASIS

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- Other OASIS changes with OASIS E2 – Effective April 1, 2026
  - A1255 Transportation item will replace A1250 Transportation
    - A1255: Transportation – In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting the things needed for daily living?
      - 0. Yes
      - 1. No
      - 7. Patient declines to respond
      - 8. Patient unable to respond
  - A0810 Sex will replace M0069 Gender
  - B1000 Hearing, B0200 Vision, and A1110 Language added to ROC assessment
  - OASIS Q&A Guidance added on some items

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## HH QRP - All-Payer OASIS Data Submission

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Updates to Medicare Conditions of Participation (CoP) to align with all-payer OASIS data submission:

- “Beneficiary “ replaced with “patient” at §484.45(a)
  - §484.45(a) Standard: Encoding and transmitting OASIS data. An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each **beneficiary patient** with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.
- Update §484.55(d)(1)(i) to remove the term “beneficiary”
  - §484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status, but not less frequently than-
    - (1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a-
      - (i) **Beneficiary Patient** elected transfer;
      - (ii) Significant change in condition; or
      - (iii) Discharge and return to the same HHA during the 60-day episode.

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## HH QRP – Home Health Consumer Assessment of Providers and Systems (HHCAHPS)

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3 new questions beginning with April 2026 sample month:

- In the last 2 months of care, how often have the services you received from this agency helped you take care of your health? (Q13)
- In the last 2 months of care, did home health staff from this agency provide your family or friends with information or instructions about your care as much as you wanted? (Q12)
- In the last 2 months of care, how often did you feel that home health staff from the agency cared about you as a person? (Q11)

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## HH QRP – Home Health Consumer Assessment of Providers and Systems (HHCAHPS)

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Beginning with April 2026 sample month:

- Remove multiple questions:
  - When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking? (Q5)
  - In the last 2 months of care, did you take any new prescription medicine or change any of the medicines you were taking? (Q11)
  - In the last 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines? (Q12)
  - In the last 2 months of care, did home health providers from this agency talk with you about when to take these medicines? (Q13)

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## HH QRP – Home Health Consumer Assessment of Providers and Systems (HHCAHPS)

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Beginning with April 2026 sample month:

- Remove multiple questions:
  - When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get? (Q2)
  - In the last 2 months of care, did you and a home health provider from this agency talk about pain? (Q10)
  - When you contacted this agency's office, how long did it take for you to get the help or advice you needed? (Q23)
  - In the last 2 months of care, did you have any problems with the care you got through this agency? (Q24)
- Minor text changes to selected existing questions to help clarify the question or response options, based on feedback from patients.

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HHVBP Changes

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## OASIS-Based Measures

OASIS-Based Measures	Weight Distributions			
	CY2025		CY2026	
	Larger Cohort	Smaller Cohort	Larger Cohort	Smaller Cohort
Improvement in dyspnea	6.00%	8.57%	7.00%	8.75%
Improvement in management of oral medications	9.00%	12.86%	11.00%	13.75%
DC Function	20.00%	28.57%	15.00%	18.75%
Improvement in bathing (M1830)	---	---	3.50%	4.38%
Improvement in upper body dressing (M1810)	---	---	1.75%	2.19%
Improvement in lower body dressing (M1820)	---	---	1.75%	2.19%
<b>Sum of OASIS-Based Measures</b>	<b>35.00%</b>	<b>50.00%</b>	<b>40.00%</b>	<b>50.00%</b>

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## Claims-Based Measures

Claims-Based Measures	Weight Distributions			
	CY2025		CY2026	
	Larger Cohort	Smaller Cohort	Larger Cohort	Smaller Cohort
Potentially Preventable Hospitalization (PPH)	26.00%	37.14%	15.00%	18.75%
Discharge to Community (DTC-PAC)	9.00%	12.86%	15.00%	18.75%
Medicare Spending Per Beneficiary – Post Acute Care (MSPB-PAC)	---	---	10.00%	12.50%
<b>Sum of Claims-Based Measures</b>	<b>35.00%</b>	<b>50.00%</b>	<b>40.00%</b>	<b>50.00%</b>

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## HHCAHPS Survey-Based Measure Weights

HHCAHPS Survey-Based Measures	Weight Distributions			
	CY2025		CY2026	
	Larger Cohort	Smaller Cohort	Larger Cohort	Smaller Cohort
Care of Patients	6.00%	0.00%	---	---
Communication Between Providers and Patients	6.00%	0.00%	---	---
Specific Care Issues	6.00%	0.00%	---	---
Overall Rating of Home Health Care	6.00%	0.00%	10.00%	0.00%
Willingness to Recommend the Agency	6.00%	0.00%	10.00%	0.00%
<b>Sum of HHCAHPS Survey--Based Measures</b>	<b>30.00%</b>	<b>0.00%</b>	<b>20.00%</b>	<b>0.00%</b>

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Measure	2026 Weight (Larger Cohort)
DC Function (Multiple GG items)	15.00%
Potentially Preventable Hospitalization (PPH)	15.00%
Discharge to Community (DTC-PAC)	15.00%
Improvement in management of oral medications (M2020)	11.00%
Medicare Spending Per Beneficiary – Post Acute Care (MSPB-PAC)	10.00%
Overall Rating of Home Health Care (HHCAHPS)	10.00%
Willingness to Recommend the Agency (HHCAHPS)	10.00%
Improvement in dyspnea (M1400)	7.00%
Improvement in bathing (M1830)	3.50%
Improvement in upper body dressing (M1810)	1.75%
Improvement in lower body dressing (M1820)	1.75%
<b>Total</b>	<b>100.00%</b>

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## Strategies

OASIS-Based Measures

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## M1400: When is the patient dyspneic or noticeably Short of Breath?

### Assessment Strategies:

- Incorporate into functional assessment – what level induces dyspnea?
  - Orthopnea - when laying flat (day or night)? Sitting? Watching TV? Reading? – **Code 4- At rest**
  - While eating? Talking? Brushing teeth? When agitated? – **Code 3 - Minimal Exertion**
  - Walking shorter distances of < 20 feet? Dressing or Toileting? - **Code 2 - Moderate Exertion**
  - Ambulating 20, 50 or 150 feet? Climbing stairs? – **Code 1 – Walking more than 20 feet or climbing stairs**
  - Patient is not short of breath even after all functional items are assessed - **Code 0- Patient is not short of breath**
- Code based on the patient's actual use of oxygen, not what is ordered

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## M1400: When is the patient dyspneic or noticeably Short of Breath?

### Improvement Strategies:

- What is the cause(s) of dyspnea or exacerbation? (Asthma, COPD, Heart failure, Respiratory infection, Obesity, Anxiety, Smoking, ??)
- Targeted interventions specific to patient:
  - Encourage treatments of underlying cause (asthma, COPD, heart failure, etc)
  - Medication compliance (diuretics, bronchodilators, steroids, antibiotics)
  - Therapy and exercise (encourage increasing activity, moderate exercise to strengthen respiratory muscles and improve endurance)
  - Breathing techniques (pursed-lip breathing, diaphragmatic breathing, improving breathing efficiency)
  - Oxygen therapy (encourage use if ordered, discuss need with provider)
  - Avoid triggers (identify and reduce allergens, smoking cessation)
  - Goal is to improve from baseline – not all patients will have no dyspnea

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## M1400: When is the patient dyspneic or noticeably Short of Breath?

### Improvement Strategies:

- Implement measurable interventions/goals specific to patient. Examples:

- Intervention: 'SN will encourage patient to walk at least 10 minutes every day and keep a diary of minutes walked to increase endurance and improve breathing efficiency.'

- Goal: 'Patient will walk at least 10 minutes daily for the next 30 days as evidenced by diary entries and stated increase in endurance by patient.'

- Intervention: 'SN will teach breathing exercises to include pursed-lip breathing and diaphragmatic breathing to be performed for 10 minutes, three times a day to increase level of exertion required to produce dyspnea.'

- Goal: 'The patient will experience less dyspnea as evidenced by the ability to walk 20 feet before experiencing episodes of dyspnea by XX/XX/XXXX.'

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## M2020: Management of Oral Medications

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### Assessment Strategies:

- Best to observe the patient – reliability for every medication, every time:
  - Obtain meds from where they are routinely stored
  - Read the label or identify the medication another way
  - Open the container
  - Select the correct dosage
  - Take at the correct time(s)
- Interview the patient/caregiver:
  - Ask questions to confirm understanding of meds
  - Ask about the need for reminders (in-person, call, text, calendar, etc)
  - Who sets reminders?
  - “What do you do if you miss a dose?”

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## M2020: Management of Oral Medications

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### Assessment Strategies:

- During comprehensive assessment:
  - Look for pill minders, drug diaries/lists
  - Assess for confusion, forgetfulness
  - Manual dexterity (grooming, dressing, buttons, etc)
  - Ambulation difficulty – could affect obtaining meds
  - Vision problems
  - Pain – can they open containers?
- Environmental concerns:
  - Difficulty accessing meds or water
  - Poor lighting, fall hazards

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## M2020: Management of Oral Medications

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### Improvement Strategies:

- Targeted interventions specific to patient:
  - Modify the environment for easier access to meds
  - Facilitate modifying containers if needed for dexterity problems
  - Educate on medications for knowledge deficit(s)
  - Pill minders to prepare doses – teach family/caregiver
  - Facilitate reminders – in-person, call, phone, text, etc
  - Develop drug diary/list with schedule
  - Goal is to improve from baseline – all patients will not be independent with medications

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## M2020: Management of Oral Medications

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### Improvement Strategies:

- Implement measurable interventions/goals specific to patient. Examples:

- Intervention: 'SN will teach patient about her medication dose changes and newly prescribed medications so she can manage her oral medications independently.'

- Goal: 'The patient will be able to manage her oral medications independently as evidenced by identifying all her medications and taking them safely and reliably by XX/XX/XXXX.'

- Intervention: 'SN will teach caregiver to fill medication organizer and set reminders in patient phone to improve compliance with medication regimen.'

- Goal: 'Caregiver will show competency in filling patient pill organizer as evidenced by return demonstration to the nurse by XX/XX/XXXX.'

- Goal: 'Patient will improve in management of oral medications when pill organizer and reminders are set up by the caregiver as evidenced by taking all oral medications at the correct times reliably and safely by XX/XX/XXXX.'

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## Discharge Function Score (DC Function)

### Overview

- Assessing functional status provides insight into the quality of care provided by agencies
- The DC Function score:
  - Helps determine how successful the HHA is at achieving the expected level of functional ability at DC
  - Promotes patient wellness and encourages adequate nursing and therapy services to help prevent adverse outcomes
  - Is measured across other post-acute settings

Only One

	Item	Item Description
<b>Self-Care</b>		
1	GG0130A	Eating
2	GG0130B	Oral Hygiene
3	GG0130C	Toileting Hygiene
<b>Mobility</b>		
4	GG0170A	Roll Left and Right
5	GG0170C	Lying to Sitting on Side of Bed
6	GG0170D	Sit to Stand
7	GG0170E	Chair/Bed-to-Chair Transfer
8	GG0170F	Toilet Transfer
9	GG0170I	Walk 10 Feet
10	GG0170J	Walk 50 Feet with 2 Turns
10	GG0170R	Wheel 50 Feet with 2 Turns*

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## Discharge Function Score (DC Function)

### Overview

- Observed** DC Function Score is the sum of individual function items at discharge
  - If the code is between 1 and 6 – the code is the score for the item
  - If the code is 7, 9, 10, 88, dashed, skipped, or missing – statistical imputation is used for that item based on patient characteristics from the OASIS assessment and codes assigned to other GG activities
  - A separate statistical imputation is used for each GG activity for the DC function score at SOC/ROC and discharge
  - Add scores for all items for the total observed DC Function score

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## Discharge Function Score (DC Function)

### Overview

- **Expected** Discharge Function Score:
  - Estimates an expected discharge function score by using risk-adjusted OASIS data from SOC/ROC
  - Is calculated by risk adjusting the observed DC Function score for each quality episode
  - Risk adjustment controls for SOC/ROC function score, age, and clinical characteristics (i.e. prior surgery, prior function/device use, pressure ulcers, cognitive function, incontinence, availability of assistance, admission source, BMI, hospitalization risk, confusion, vision, medication management needs, supervision and safety sources of assistance, comorbidities)
  - Applies the same statistical imputation to items that are coded 7, 9, 10, 88, dashed, skipped, or missing

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## Discharge Function Score (DC Function)

### Assessment Strategies:

- Accurate initial scoring is critical - do not consider assistive devices for GG items
- Avoid the use of activity not attempted codes unless that is the ONLY option
- Consider cognitive impairment (confusion, forgetful, etc)
- Score “prior to the benefit of services” by agency that would result in more independent coding
- Direct observation is best (patient should perform as independent as possible, consider similar activities when feasible, collaborate)
- Interview the patient/caregiver (ask about patient’s ability – not what caregiver does, are there barriers?, what needs are there? Devices? DME?)

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## Discharge Function Score (DC Function)

### Improvement Strategies:

- Targeted interventions specific to patient:
  - Interventions to fix any barriers to functional ability
  - Modify the environment for safety, access to supplies, implements, etc
  - Facilitate obtaining assistive devices/adaptive equipment/DME
  - Educate on self-management practices and patient involvement
  - Therapy to address and improve functional needs
  - Focus on progress to goals
  - Goal is to improve function of all patients – CMS determines ‘expected’ score

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## Discharge Function Score (DC Function)

### Improvement Strategies:

- Implement measurable interventions/goals specific to patient. Example:
  - Intervention: ‘PT will facilitate obtaining 4-wheel walker for patient and teach on use to improve functional mobility in transfers and ambulation.’
  - Goal: ‘Patient’s ability to transfer will improve as evidenced by the ability to safely chair/bed to chair transfer independently with the use of walker by XX/XX/XXXX.’
  - Goal: ‘Patient’s ambulation will improve as evidenced by the ability to safely ambulate 50 feet with 2 turns independently with the use of walker by XX/XX/XXXX.’

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## M1810 & M1820 Current Ability to Dress Upper/Lower Body

### Assessment Strategies:

- Best to observe the patient
  - Ask them to demonstrate if already dressed
  - Must be able to obtain, put on, and remove upper/lower body clothing
  - Assess whatever clothing is routinely worn
  - Manage zippers, buttons, and snaps if routinely worn
- Collaborate
  - Patient/caregiver: Who helps with dressing? What did patient wear prior? Will they return to that style of dressing?
  - Therapist(s): Balance problems? Dressing aides? Established goals?
  - Home Health Aide – How much assistance required?

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## M1810 & M1820 Current Ability to Dress Upper/Lower Body

### Assessment Strategies:

- During comprehensive assessment:
  - Look for where clothing is stored
  - Ambulation difficulty – could affect accessing clothing/shoes
  - Balance problems – could affect accessing clothes or bending over to put on pants, socks, shoes
  - Range of motion and manual dexterity (dressing, buttons, zippers, etc)
  - Pain – can they raise arms, place feet in underwear or pants, etc?
  - Ensure accurate initial scoring – “before the benefit of services”
- Environmental concerns:
  - Difficulty accessing clothing/shoes
  - Poor lighting, fall hazards
  - Lack of place to dress safely – where is dressing taking place?

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## M1810 & M1820 Current Ability to Dress Upper/Lower Body

### Improvement Strategies:

- Targeted interventions specific to patient:
  - Modify the environment for easier access to clothing/shoes
  - Facilitate modifying style of clothing if needed for balance or dexterity problems
  - Educate on pain management
  - Facilitate initiation of therapy for mobility, balance, strengthening
  - Dressing aides
  - Goal is to improve from baseline – all patients will not be independent with dressing the upper and lower body

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## M1810 & M1820 Current Ability to Dress Upper/Lower Body

### Improvement Strategies:

- Implement measurable interventions/goals specific to patient. Examples:

• Intervention: 'SN will assist the patient to modify clothing and shoe storage so he can access his clothing and shoes independently.'

• Goal: 'The patient will be able to access his clothing and shoes independently as evidenced by gathering all needed dressing items prior to dressing by XX/XX/XXXX.'

• Intervention: 'SN (or PT/OT) will teach patient in the use of adaptive equipment to include long-handle shoehorn, sock aide, button hook, and zipper pull to facilitate independence in upper and lower body dressing.'

• Intervention: 'SN will teach caregiver to facilitate the use of adaptive equipment and allow ample time to dress the upper and lower body to increase independence.'

• Goal: 'Patient will improve in dressing the upper body with the use of adaptive equipment as evidenced by completing the majority of dressing tasks with only minimal assistance from the caregiver by XX/XX/XXXX.'

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# M1830: Bathing

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## Assessment Strategies:

- Best to observe the patient
  - Ask them to simulate the bathing process
  - **Excludes** washing hands/face and shampooing hair
  - **Excludes** accessing bathing supplies and preparing the water
  - **Includes** accessing the tub/shower, getting in and out, washing the entire body
  - **Includes** washing back and difficult to reach areas (feet, legs, perineum, etc)
- Collaborate
  - Patient/caregiver: Who helps with bathing currently?
  - Therapist(s): Ambulation, balance, transferring, range of motion?
  - Home Health Aide – How much assistance required?

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# M1830: Bathing

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## Assessment Strategies:

- During comprehensive assessment:
  - Have patient show you the tub/shower
  - Ambulation difficulty, balance issues, limited range of motion, pain – all can affect ability to bathe
  - Does the patient have grab bars, shower bench/chair, handheld shower, non-slip mat, long-handled sponge, etc?
  - Facilitate getting needed equipment/supplies to enhance independence
  - Ensure accurate initial scoring – “before the benefit of services”
- Environmental concerns:
  - Difficulty accessing clothing/shoes
  - Poor lighting, fall hazards
  - Lack of place to dress safely – where is dressing taking place?

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# M1830: Bathing

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## Improvement Strategies:

- Targeted interventions specific to patient:
  - Modify the environment – grab bars, shower bench/chair, handheld shower, non-slip mat, long-handled sponge, etc
  - Educate on energy conservation, sitting when bathing, and pacing steps with rest periods
  - Facilitate initiation of therapy for mobility, balance, strengthening, range of motion
  - Facilitate aide services for temporary assistance
  - Goal is to improve from baseline – all patients will not be independent with bathing

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# M1830: Bathing

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## Improvement Strategies:

- Implement measurable interventions/goals specific to patient. Examples:

- Intervention: 'SN will teach patient about energy conservation to include pacing herself so she can bathe her entire body with the intermittent assistance of another person.'
- Goal: 'The patient will demonstrate energy conservation techniques as evidenced by the ability to bathe in the shower with the intermittent assistance of another person safely by XX/XX/XXXX.'

- Intervention: 'SN will facilitate obtaining adaptive equipment/supplies to modify the bathing environment to include grab bars, shower chair, non-slip mat, hand-held shower, and long-handled sponge to allow more independence with bathing tasks.'
- Goal: 'The patient will improve in the ability to bathe in the tub/shower with the use of adaptive equipment/supplies as evidenced by the ability to bathe in the shower with the intermittent assistance of another person safely by XX/XX/XXXX.'

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## Overall Strategies for Improvement

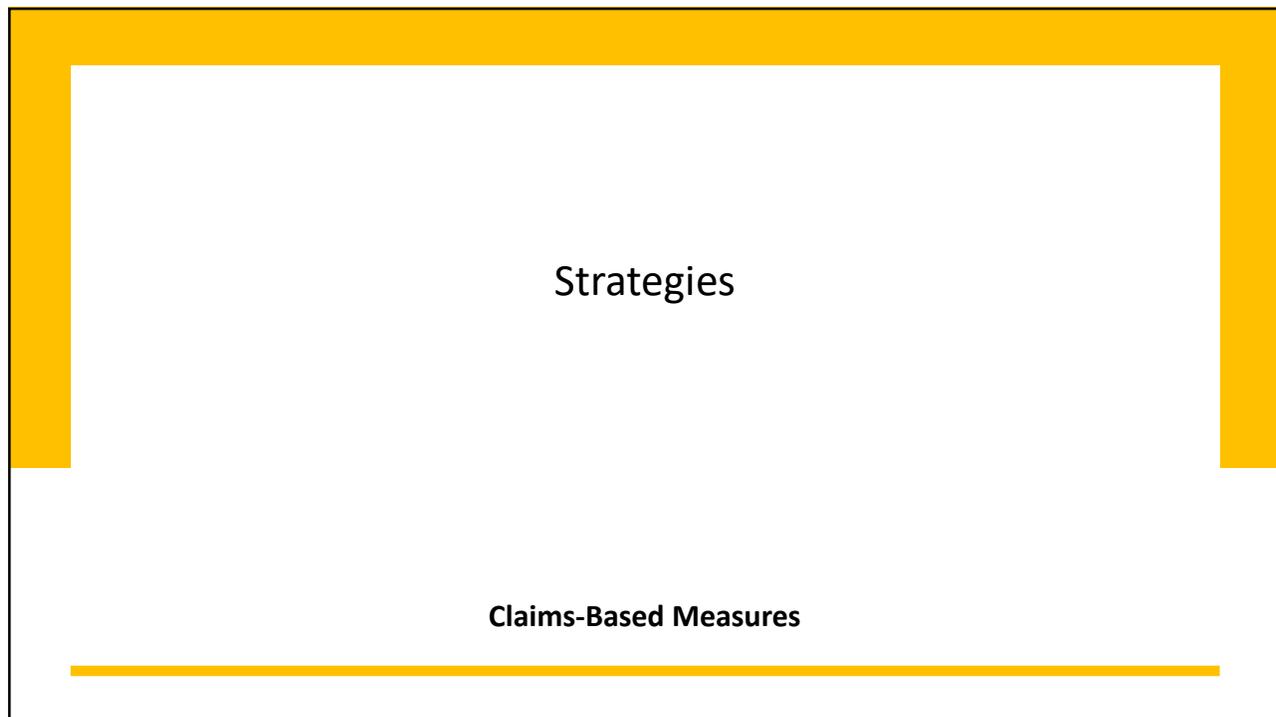
- Understand 'improvement'
  - Only needs to improve by 1 level
  - Patients who stay the same did not 'improve' and count negatively for HHVBP
  - Accurate initial assessment is critical
- Accurate and timely documentation
  - Document at the time of service
  - Understand the intent of each item and the guidance
  - Collaborate
- Focused clinical interventions
  - Comprehensive plan of care individualized to the patient
  - Interventions and goals targeted at improvement in outcomes
  - Begin planning for discharge on initial assessment
  - Patient involvement – patient goals and ownership in improving

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## Overall Strategies for Improvement

- Patient-centered care and robust patient education
  - Clinical pathways, self management tools
  - Focus on outcome improvement in all areas
  - Progress to goals
  - Case conference/outcomes conference – focus on outcomes and patient progress
- Staff training and development
  - Ongoing education – OASIS, best practices, scenarios, case studies
  - Shadowing, audits
  - Quality review with feedback
- QAPI involvement
  - Analyze data
  - Focus on high-impact measures
  - Performance improvement projects (PIPs)
  - Celebrate high-performers and share best practices and strategies

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## Potentially Preventable Hospitalization (PPH)

- Home Health Within-Stay Potentially Preventable Hospitalization (PPH) Measure:
  - HHA-level rate of risk-adjusted potentially preventable hospitalization (PPH) or potentially preventable observation stays (PPOBS) that occur within a home health (HH) stay
  - Potentially preventable conditions determined by if hospitalization could have potentially been prevented with good outpatient care and early intervention - considering:
    - Inadequate management of infections (i.e., septicemia, influenza, pneumonia, skin/subcutaneous infections, UTI)
    - Inadequate management of other unplanned events (i.e., dehydration, arrhythmia, aspiration, pressure ulcers, intestinal impaction, deficiency/other anemia, thrombosis/embolism)
    - Inadequate management of chronic conditions (i.e., diabetes, heart failure, HTN, COPD, asthma)
    - Inadequate injury prevention (i.e., head injury, fractures)

[Specifications for the Home Health Within-Stay Potentially Preventable Hospitalization Measure for the Home Health Quality Reporting Program](#)

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## Potentially Preventable Hospitalization (PPH)

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### Overview:

- Measured by home health stay - a sequence of payment episodes separated by 2 or fewer days. If there are more than 2 days between payment episodes – it starts a new ‘stay’
- Potentially preventable is determined by diagnosis codes - more than 9200 ICD-10 codes included as potentially preventable
- Based on the discharge date – HH stays with a DC date in the observation window
- Uses 1 year of data (Baseline year is CY2023)
- PPH Measure is heavily weighted (26% for 2025 and 15% for 2026) **and** is part of the Quality of Patient Care Star Rating

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## Potentially Preventable Hospitalization (PPH)

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### Strategies:

- Comprehensive and individualized plan of care and teaching
  - Chronic disease management and robust teaching
  - Medication management – thorough assessment and medication reconciliation
  - Focus on teaching patient/caregiver self-management of chronic diseases
  - Risk assessments and targeted interventions to mitigate all risks
  - Coordination of care among disciplines/family/providers
  - Fall prevention program
  - Telehealth services
  - Tuck-in calls/Friday calls
  - Preventive care – immunizations, handwashing, regular checkups with provider

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## Potentially Preventable Hospitalization (PPH)

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### Strategies:

- Patient and family/caregiver engagement
  - Call agency first
  - Zone tools or decision support tools
  - Education on signs/symptoms to report
  - Management of chronic diseases and medication management intense teaching
  - Focus on healthy lifestyle and improving overall health
  - Enlist support systems
  - Home safety – prevent falls/accidents – good lighting, grab bars, assistive devices, remove tripping hazards
- Visit management (front-load, stagger discipline visits, additional disciplines for safety or resources – HHA or social work)

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## Potentially Preventable Hospitalization (PPH)

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### Strategies:

- Incorporate into QAPI
  - Analyze every hospitalization/observation/ED visit – could it have been avoided?
  - Set goals and celebrate wins
- Coordination with community providers
  - Collaboration with all providers (avoid “send to ED”, consider PRN orders, etc)
  - Chronic disease management orders
  - Communication - health maintenance strategies
- Would you be surprised if the patient went into the hospital or to the ED?
  - As yourself after assessing
  - What are you going to do about it?

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## Discharge to Community – Post Acute Care (DTC-PAC)

- Discharge to Community – Post Acute Care (DTC-PAC):
  - Percentage of home health stays in which patients were discharged to the community and:
    - Do not have an unplanned admission to an acute care hospital or LTCH in the 31 days
    - Remain alive in the 31 days following discharge to community
  - “Community” for this measure, is defined as home/self-care, without home health services, based on Patient Discharge Status Codes 01 and 81 on the Medicare FFS claim
  - Measured by home health stay - a sequence of payment episodes separated by 2 or fewer days. If there are more than 2 days between payment episodes – it starts a new ‘stay’
  - Discharged to hospice or to another home health agency are excluded
  - Uses two years of claims data
  - Aligned across PAC settings for risk-adjustment, exclusions, numerator, and intent
  - DTC Measure is weighted heavier for 2026 – 15% (was 9% in 2025)

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## Discharge to Community – Post Acute Care (DTC-PAC)

### Strategies:

- Comprehensive and individualized plan of care
  - Begin discharge planning at admission
  - Identify barriers and anticipated needs before discharge (support network, socioeconomic status, financial concerns, social isolation, transportation, etc)
  - Focus on self-management as the goal with robust teaching
  - Consider social work for community resources/needs
- Patient and family/caregiver engagement
  - Have an agreement (engagement, DC visit – avoid unplanned discharges)
  - Management of chronic diseases
  - Medication management
- Identify and coordinate with hospice when needed

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## Discharge to Community – Post Acute Care (DTC-PAC)

### Strategies:

- Coordination with community providers
  - Plan for discharge – communicate before discharge
  - Outpatient chronic disease management (Diabetes management, heart failure clinic, falls prevention, medication management, lifestyle modification, etc.)
  - Regular PCP/specialist visits for health maintenance
- Post-discharge
  - Facilitate Community resources (meals on wheels, check-in calls, life alert, etc)
  - Social services before discharge to plan (as needed)
  - Consider following patient after DC (calls at one week, two weeks, 30-days)
- Incorporate into QAPI
- Set goals and celebrate wins

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## Medicare Spending Per Beneficiary (MSPB)

- **Medicare Spending Per Beneficiary – Post Acute Care (MSPB-PAC):**
  - Includes Medicare spending for most Part A and B services during the episode of care, as well as up to 30 days after the end of the home health treatment period
  - Agency score is the average risk-adjusted Medicare cost per beneficiary divided by the national median for all home health providers
  - A score higher than “1” means the agency has Medicare costs greater than the national average
  - Intended to incentivize providers to redesign care systems to provide coordinated, high-quality, and cost-efficient care
  - Uses **two** years of claims data
  - MSPB Measure is weighted at 10% for 2026

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## Medicare Spending Per Beneficiary (MSPB)

### Strategies:

- Comprehensive and individualized plan of care
  - Build a robust plan of care with targeted interventions and goals
  - Identify high-risk patients and focus on interventions to prevent facility use
  - Accurate initial assessment and resource utilization
- Patient and family/caregiver engagement
  - Teach strategies for management of chronic diseases
  - Have an agreement (engagement, DC visit – avoid unplanned discharges)
  - Medication management
- Analyze data
  - Review current data reports and identify patients with high cost – are there opportunities?

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Strategies

HHCAHPS Survey-Based Measures

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## HHVBP and HCAHPS Survey Measures

- Home Health Quality Reporting Program (HH QRP) is removing multiple questions beginning with April 2026 sample month
- Affects the HHVBP composite items by removing:
  - Care of Patients
  - Communication between Providers and Patients
  - Specific care issues
- Remaining measures for HHVBP:
  - Overall rating of home health care – 10%
  - Willingness to recommend the agency – 10%
- Total HCAHPS percentage for HHVBP is 20% for 2026 (was 30% for 2025)

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## Strategies for Success

## HCAHPS Survey Measures

- Provide staff with questions
- Let patients know they will get a survey
- Person answering phone - always pleasant/helpful
- Track all patient calls and follow until resolved
- Educate staff on complaints/how to document
- Investigate every complaint/incident
- Respond to any patient question/issue same day
- Make customer service a top priority – educate
- Cultivate a positive culture
- Schedule visits in a 30-minute window and update
- Listen carefully and never interrupt

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## Strategies for Success

### HHCAHPS Survey Measures

- At SOC and throughout care explain how to contact the office/administrator/clinical director
- Inform patient/caregiver with any change in care
- Use terms that are easy to understand and avoid acronyms and medical terms
- Ask the patient/caregiver if they understand and explain again if needed
- Always be respectful of the patient/caregiver, they are vulnerable and may be feeling a loss of control
- Involve all staff
- Set expectations and monitor
- Review publicly reported results with staff
- Address concerns and celebrate wins

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Resources

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## Resources

- CMS expanded HHVBP model: [Expanded Home Health Value-Based Purchasing Model | CMS](#)
  - Provider Data catalog: [Home health services data archive | Provider Data Catalog](#)
  - 2026 Home Health Final Rule: <https://www.federalregister.gov/documents/2025/12/02/2025-21767/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate>
  - Home Health Quality Reporting Program: [Home Health Quality Reporting Program | CMS](#)
  - OASIS Manual/Q&As: [home-health-agency-hha-providers Reference & Manuals | QIES Technical Support Office](#)
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## Questions?

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