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

Winter Conference
Wednesday, February 18, 2026
3:30pm-4:30pm

4a. Home Health Value Based Purchasing: Determining and Monitoring What Measures Matter

Presented by:

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Home Health Value Based Purchasing

Determining and Monitoring What Measures Matter

J'non Griffin, RN MHA HCS-D, HCS-C, HCS-H, HCS-O, COS-C
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Agenda

1. Discuss VBP Overview
2. Discuss the proposed changes to HHVBP
3. Discuss items to review to improve your outcomes

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HHVBP Overview

3

Payment Impact

- Home Health agencies can receive payment adjustments ranging from -5% to +5% of Medicare fee-for-service payments based on quality performance

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Current and Proposed VBP Measures

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VBP Current Measures (2025)

Measure Type	Measure Name	Category	% of TPS
OASIS Based *Risk-Adjusted	Dyspnea	35%	6.00%
	Management of Oral Medications		9.00%
	Discharge Function Score		20.0%
Claims Based *Risk-Adjusted	Potentially Preventable Hospitalizations	35%	26.0%
	Discharge to Community (Post Acute Care)		9.00%
HHCAHPS *Risk-Adjusted	Care of Patients	30%	6.00%
	Communications Between Providers/Pts		6.00%
	Specific Care Issues		6.00%
	Overall Rating		6.00%
	Willingness to Recommend		6.00%

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VBP Measures Removal - Starting CY 2026

Measure Type	Measure Name	Category	% of TPS
OASIS Based *Risk-Adjusted	Dyspnea	~~35%~~	~~6.00%~~
	Management of Oral Medications		~~9.00%~~
	Discharge Function Score		~~20.0%~~
Claims Based *Risk-Adjusted	Potentially Preventable Hospitalizations	~~35%~~	~~26.0%~~
	Discharge to Community (Post Acute Care)		~~9.00%~~
HHCAHPS *Risk-Adjusted	~~Care of Patients~~	~~30%~~	~~6.00%~~
	~~Communications Between Providers/Pts~~		~~6.00%~~
	~~Specific Care Issues~~		~~6.00%~~
	Overall Rating		~~6.00%~~
	Willingness to Recommend		~~6.00%~~

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VBP New Measures / Re-weighting Starting CY 2026

Measure Type	Measure Name	Category	% of TPS
OASIS Based *Risk-Adjusted	Dyspnea	40%	7.00%
	Management of Oral Medications		11.00%
	Discharge Function Score		15.00%
	Improvement in Bathing		3.50%
	Improvement in Upper Body Dressing		1.75%
	Improvement in Lower Body Dressing		1.75%
Claims Based *Risk-Adjusted	Potentially Preventable Hospitalizations	40%	15.00%
	Discharge to Community (Post Acute Care)		15.00%
	Medicare Spending Per Beneficiary-Post-Acute Care (MSPB-PAC)		10.00%
HHCAHPS *Risk-Adjusted	Overall Rating	20%	10.00%
	Willingness to Recommend		10.00%

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The Whys

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Revisions

HHCAHPS

- CMS is implementing a revised HHCAHPS survey beginning April 2026 sample month. Three measures are being removed because the survey questions are changing, making it not feasible to maintain measure specifications

Why Add M1800 ADL Items?

- Complement DFS: While DFS focuses on GG items, M1800 items provide additional functional assessment perspectives.
- Well-established measures: Bathing and dressing have been tracked in Home Health for quite a long time.
- Patient-centered: These activities are fundamental to independence and quality of life
- Fill Gaps: Address functional domains not fully captured by current measures

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Revisions

Why Add MSPB-PAC?

- Resource Use Domain: Addresses efficiency and cost effectiveness of care.
- IMPACT Act Mandate: Required standardized measure across all PAC settings.
- Holistic View: Evaluates total Medicare spending during and after home health episode
- Incentives coordination: Encourages efficiency care delivery and resource utilization

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Let's Break It Down

OASIS

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M1810-Upper Body Dressing

- Audit Objective: Verify accurate assessment and documentation of patient's ability to dress upper body safely and independently.
- Step 1: Review SOC/ROC Documentation
  - M1810 code selected appropriately
  - Comprehensive assessment describes dressing ability
  - Specific clothing types mentioned (pullover vs button-up)
  - Ability to manage fasteners documented (zippers, buttons, snaps)
  - Range of motion limitations documented
  - Fine motor skills assessed and documented
  - Adaptive equipment documented (button hook, zipper pull)
  - Orthotics/Prosthetics documented

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M1810-Upper Body Dressing

- Step 2: Documentation Validation
  - Code 0: Must document complete independence including getting clothes from closet/drawers and managing all fasteners.
  - Code 1: Must specify that clothes must be laid out/handed to patient, but then patient can dress safely and independently.
  - Code 2: Must document that someone helps/should help put on clothing (not just lays it out), even if for safety
  - Code 3: Must document that someone performs the majority of tasks for safety of the patient

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M1810-Upper Body Dressing

- Step 3: Episode Review
  - OT evaluation and interventions for UE function and dressing
  - PT interventions addressing shoulder ROM/strength
  - Nursing assessment for skin integrity, hygiene
  - Documentation of orthotics/prosthetics used
  - Patient education on dressing techniques documented
  - Adaptive equipment ordered and training provided
  - Progress notes show improvement trajectory
- Step 4: DC Review
  - Current dressing ability clearly described
  - Specific improvements documented
  - Remaining limitations identified
  - Patient/CG can demonstrate current status

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M1810-Upper Body Dressing

- Common Errors
  - Not documenting fastener management ability
  - Confusing "laying out/handing clothes" to patient vs "helping put on clothes"
  - Not considering adaptive equipment in scoring
  - Not considering majority of tasks in determining dependence
  - Inconsistent scoring between disciplines
  - Overlooking shoulder/UE ROM limitations

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M1820-Lower Body Dressing

Audit Objective: Verify accurate assessment and documentation of patient's ability to dress lower body safely, including footwear.

Step 1: Review SOC/ROC Documentation:

- Ability to put on pants/underwear documented
- Ability to put on socks/stockings documented
- Ability to put on shoes documented
- Balance and safety considerations documented
- Hip/knee flexibility assessed
- Adaptive equipment documented (sock aid, shoehorn, reacher)
- Weight-bearing restrictions noted (if applicable)
- Orthotics/prosthetics documented

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M1820-Lower Body Dressing

Step 2: Key Documentation Elements

- Can patient bend to reach feet safely?
- Can patient maintain balance while dressing?
- Does patient need to sit vs stand while dressing?
- Are there hip precautions or ROM limitation?
- What type of footwear does patient use?

- Code 0-Fully independent
  - Can get clothes from closet/drawers
  - Can put on all lower body clothing including shoes
  - Can remove clothing independently
  - No assistance needed at any step

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M1820-Lower Body Dressing

- Code 1-Setup Only
  - Can get clothes from closet/drawers
  - Can put on all lower body clothing including shoes
  - Can put on all prosthetics/orthotics independently
  - Can remove clothing independently
  - No assistance needed at any step
- Code 2-Hands on Assistance
  - Helper must physically assist with putting on clothing
  - May help with pants, socks OR shoes
  - May help with prosthetics/orthotics
  - Patient does some but not all of the tasks

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M1820-Lower Body Dressing

- Code 3-Total Dependence:
  - Another person does all (or majority) of lower body dressing
  - Include all tasks included with lower body dressing.

Step 3: Episode Review:

- PT/OT interventions for LE dressing documented
- Hip precautions education provided (if applicable)
- Adaptive equipment ordered and training completed
- Balance training interventions documented
- Patient demonstrates safe technique

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M1820-Lower Body Dressing

Step 4: Discharge Review:

- Reassessment completed at discharge
- Current ability clearly documented including all components
- Improvements or lack thereof explained
- Safety recommendations provided

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M1820 Common Errors

- Forgetting footwear: Assessing only pants/underwear but not shoes/socks
- Safety oversight: Not documenting balance/fall risk during LE dressing
- Hip precautions ignored: Not considering total hip replacement precautions
- Code confusion: Confusing "laying out" (code 1) with physical assistance (code 2)
- Adaptive equipment: Not documenting use of sock aids, reachers, long shoehorns
- Incomplete assessment: Documenting only pants but not full lower body
- Position not considered: Not noting if patient must sit or can stand while dressing

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M1830-Bathing

- Audit Objective-Verify accurate assessment and documentation of patient's ability to bathe entire body safely at SOC/ROC and discharge. **Note:** Excludes grooming (washing face, hands, shampooing hair). Focus is on washing entire body safely.
- Step 1: Documents needed to review
  - SOC/ROC OASIS Assessment
  - DC OASIS Assessment
  - SOC Comprehensive assessment narrative
  - PT/OT evaluation(if applicable)
  - Clinical notes throughout episode
  - DC summary

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M1830-Bathing

- Step 2: SOC/ROC Assessment Review
  - M1830 code is selected
  - Comprehensive assessment describes bathing ability in detail
  - Documentation specifies bathing method(shower, tub, sponge bath)
  - Documentation identifies WHO provides assistance (if needed)
  - Documentation describes WHAT assistance is needed
  - Safety concerns documented (fall risk, balance, endurance)
  - Assistive devices documented (grab bars, shower chair, long-handles sponge)
  - Environmental factors documented (tub vs shower, bathroom setup

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M1830-Bathing

- Step 3: Documentation Validation Checklist
- Code 0- Independent
  - Must document patient bathes completely independently and safely
  - Can get in/out of tub or shower without help safely
  - Can wash all body parts including back, feet, between toes, etc.
- Code 1- Independent with devices:
  - Must specify which devices used (grab bars, shower chair, long handled brush)
  - Patient is independent once devices are in place.
- Code 2- Intermittent Assistance
  - Specify if assistance is for supervision OR getting in/out of tub/shower, OR washing difficult areas
  - Document that patient can perform most of the body independently
- Code 3-Presence throughout
  - Document that caregiver must be present entire time for safety
  - Patient participates by needs continuous assistance

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M1830-Bathing

- Step 3: Documentation Validation Checklist
- Code 4-Uses sink/bathes independently
  - Does patient have access to working shower/tub
  - Documentation that patient is safe in performing bathing at sink or bedside/Chair/BSC independently, because they do not have a shower/tub available.
- Code 5-Uses sink/needs assistance
  - Does patient have access to working shower/tub?
  - Documentation that the patient participates but needs assistance or supervision from another for safe performance.
- Code 6-Dependent
  - Documentation that patient is dependent on bathing from someone else no matter the location.

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M1830-Bathing

- Step 4: Episode Documentation
  - Visit Notes: Review all visit notes for bathing references
    - Nursing assessment of hygiene and skin
    - PT/OT interventions for bathing safety and independence
    - Patient/CG education on bathing techniques
    - Progress toward independence documented
  - Interventions: Verify appropriate interventions documented
    - Safety assessment completed
    - DME ordered (if needed)
    - Training provided to patient/caregiver
    - Home modifications discussed/completed

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M1830-Bathing

- Step 5: Discharge Assessment Review
  - M1830 code reassessed at discharge
  - Current bathing ability clearly documented
  - Comparison to admission status documented (improvement or decline)
  - Specific improvements or lack thereof explained
  - Ongoing needs and recommendations documented
  - Patient/CG education at discharge documented

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M1830-Bathing

- Common Documentation Errors
  - Vague documentation
  - Grooming confusion
  - Inconsistent information
  - Missing safety assessment
  - No device documentation
  - Overlooking environmental factors
  - Assumption of independence
  - Not reassessing at discharge
- Red Flags During Audit
  - No improvement or decline without explanation
  - No bathing interventions documented despite deficit at SOC/ROC
  - Conflicting information between disciplines
  - Sudden improvement not supported by visit notes
  - Missing discharge bathing assessment

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Improvement in Dyspnea (M1400)

- Ensure accurate assessment and documentation of patient's breathing status at SOC/ROC and discharge
- Step 1: Review Respiratory Assessment:
  - Do they have respiratory diagnosis?
  - Comprehensive assessment respiratory section complete
  - Lung sounds documented
  - Oxygen use documented (if applicable)
  - Baseline vital signs including O2 saturation
  - Specific description of WHEN SOB occurs
  - Examples of activities that cause SOB
  - Patient/caregiver interview documented

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Improvement in Dyspnea (M1400)

- Step 2: Documentation Requirements by Code:
  - Code 1 (moderate exertion): Must specify activities like walking across room, climbing stairs, household chores
  - Code 2 (minimal exertion): Must specify activities like dressing, bathing, walking to bathroom
  - Code 3 (at rest): Must clearly state "at rest" –sitting, lying down, no activity
- Step 3: Episode Review
  - Track respiratory status in each visit note
  - Interventions related to breathing documented
  - Medication changes documented (inhalers, diuretics, etc.)
  - Patient education on breathing techniques
  - Changes in oxygen requirements
  - Response to interventions documented.

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Improvement in Dyspnea (M1400)

- Step 4: Discharge Review
  - Discharge note reassesses breathing status
  - Specific documentation of current dyspnea level
  - Comparison to admission documented
  - Reasons for improvement or lack thereof explained
  - Ongoing plan documented
- Common Errors
  - Vague: "patient has trouble breathing"
  - No examples of what causes SOB
  - Conflicting information between assessment and visit notes
  - Not reassessing at discharge
  - Confusing patient anxiety with dyspnea
  - Not documenting oxygen use

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Improvement in Oral Medications (M2020)-11% of 40%

Audit Objective: Verify accurate assessment of patient's ability to self-manage oral medications.

Step 1: Review medication list

- Complete medication reconciliation at SOC
- Prescription and OTC medications listed
- Dosages, frequencies, routes documented
- Medication changes during episode tracked

Step 2: Assess Medication Management Ability:

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Improvement in Oral Medications (M2020)-11% of 40%

Step 2: Assess Medication Management Ability:

- Can patient name their medications?
- Can patient identify what each medication is for?
- Does patient know when to take each medication?
- Can patient physically take medications (open bottles, read labels)?
- Does patient use pillbox or organizing system?
- WHO fills/prepares medications documented
- Cognitive ability to manage meds assessed
- Can patient access or need assistance in accessing liquids to take medications?
- Does patient have physical impairments (limited manual dexterity)
- Emotional/cognitive/behavioral impairments (memory deficits, impaired judgment, fear
- Sensory impairments (impaired vision, pain)
- Environmental barriers (access to kitchen or med storage area, stairs, narrow doorways)

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Improvement in Oral Medications (M2020)-11% of 40%

Step 3: Documentation Validation by Code:

- Code 0-Independent
  - Must document patient demonstrates ability to take correct medications at correct times WITHOUT assistance
  - Patient can retrieve medications independently
  - Patient knows purpose and timing of each medication
- Code 1-Independent but needs setup/drug chart
  - Another person must prepare individual doses in advance-Must specify WHO prepares medications (fill pillbox)
  - Another person in home must modify the original medication container to enable patient access
  - Another person must develop a drug diary/chart
- Code 2- Needs setup/reminders
  - WHO provides reminders (family, alarm, phone call)
  - Once prepared/reminded, patient can take independently
- Code 3 (Administered by another):
  - Must document another person physically administers medications to patients
  - Patient cannot manage medications even if prepared
- Code NA- No oral medications (G tube, injectables, etc)

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Improvement in Oral Medications (M2020)-11% of 40%

Step 4: Review Education

- Medication education in visit notes
- Patient/caregiver understanding assessed
- Return demonstration documented (if appropriate)
- Written medication list provided
- Side effects discussed

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Discharge Function Score-Accounts for 15% of the 40%

- DFS=Actual Discharge Function Score/Expected Discharge Function Score
- Expected score is risk-adjusted based on patient's SOC/ROC functional status, age, and clinical characteristics.
- Statistical imputation used for missing data
- Risk adjustment accounts for patient differences

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GG items Used in DFS Calculation

Self-Care Items (GG0130)

- GG0130A: Eating
- GG0130B: Oral hygiene
- GG0130C: Toileting hygiene

Mobility Items (GG0170)

- GG0170A: Roll right to left
- GG0170C: Lying to sitting
- GG0170D: Sit to stand
- GG0170E: Bed-to-chair transfer
- GG0170F: Toilet transfer
- GG0170I: Walk 10 ft.
- GG0170J: Walk 50 ft with 2 turns
- GG0710R: Wheel 50 ft.

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DFS Audit Procedure

- Step 1: Document review
  - Pull SOC/ROC OASIS Assessment
  - Pull DC OASIS Assessment
  - Pul comprehensive assessment narrative
  - Pull ALL visit notes during the episode
  - Pull DC summary/final visit note

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DFS Audit Procedure

- Step 2: SOC/ROC Item review
  - Review all DFS related GG items are coded-Note any NA (CMS imputed)
  - Narrative description of each activity in comprehensive assessment
  - Clinician observed or assessed each activity during visit
  - OASIS code matches documented functional level
  - Assistive devices documented
  - WHO provides assistance documented (if applicable)
  - WHAT assistance is provided documented
  - HOW MUCH assistance documented (percentage of effort)

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DFS Audit Procedure

- Step 3: DC Assessment review
  - Compare discharge codes to SOC codes
  - Validate improvement with documented progress
  - Verify visit notes show functional gains
  - Confirm therapy/nursing interventions align with outcomes
  - Check for complete reassessment of all GG activities

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DFS Audit Procedure

- Common Errors
  - Overscoring: Coding higher than documentation supports
  - Vague documentation: "Patient needs some help" without specifics
  - Inconsistent Scoring: Different clinicians scoring same activity differently
  - Missing Activities: Dashed items without valid reason
  - Confusing Setup (05) vs Supervision (04): Very different levels of assistance
  - Not accounting for assistive devices
  - Not documenting percentage of effort

- Red Flags
  - No change or decline in function without explanation
  - Sudden improvement not documented in visit notes
  - Missing discharge visit note
  - Discharge scores don't align with discharge summary

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Let's Break It Down

Claims Data

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Discharge to Community-PAC

Percentage of patients discharged to community who remain there for 31 days without acute care hospitalization or SNF stay.

Audit Objective: Review discharge planning and care management to identify factors impacting successful community discharge

Step 1: Discharge planning documentation

- Discharge planning initiated at SOC
- Patient's discharge destination documented
- Patient/family preferences documented
- Barriers to community discharge identified
- Appropriate referrals made (DME, outpatient PT, etc)
- Follow-up appointments scheduled

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Discharge to Community-PAC

Step 2: Discharge readiness

- Patient met goals for community discharge
- Safety concerns addressed
- Caregiver support adequate
- Environmental modifications completed
- Patient/caregiver educated on warning signs
- Communication with physician

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Potentially Preventable Hospitalization

Measure Definition: Within-stay measure tracking hospitalization and outpatient care during home health episode that could have been prevented with appropriate care.

PPH Conditions:

- Diabetes complications
- Heart failure exacerbations
- Bacterial pneumonia
- UTI
- COPD/Asthma exacerbations
- Dehydration
- Electrolyte imbalances
- Pressure ulcer/wounds

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Potentially Preventable Hospitalization

Audit Objective: Evaluate care management strategies and early intervention protocols to prevent hospitalizations.

- Step 1: Review Risk Assessment at SOC
  - High risk diagnoses identified
  - Recent hospitalizations documented
  - Fall risk assessment
  - Medication reconciliation is thorough
  - CG support assessed

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Potentially Preventable Hospitalization

- Step 2: Review Plan of Care
  - Visit frequencies appropriate for acuity
  - Goals focused on preventing complications
  - Interventions specific to high-risk conditions
  - Patient/CG education-comprehensive
- Step 3: Review Monitoring
  - Vital signs monitored appropriately
  - Weight monitoring for CHF patients
  - Blood sugar monitoring for diabetics
  - Symptom changes identified early.

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Potentially Preventable Hospitalization

- Step 4: Communication and Escalation
  - Timely physician communication when status changes
  - Escalation protocols followed
  - After-hours coverage documented
  - Patient/CG knows when to call
  - Warning signs education documented
- Step 5: If Hospitalization Occurred
  - Root Cause Analysis
    - Was hospitalization potentially preventable
    - Were early warning signs documented but not acted upon?
    - Was physician notified of changes?
    - Was visit frequency adequate?
    - Were there missed visits?
    - What interventions could have prevented admission?
    - What will agency do differently next time?

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Potentially Preventable Hospitalization

- Prevention Best Practices
  - Document baseline status clearly at SOC
  - Document changes in status promptly
  - Document all physician communications
  - Proactive patient education on warning signs

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Medicare Spending Per Beneficiary-PAC

Measure: Assess Medicare spending by the HHA and other healthcare providers during an MSPB episode, evaluating efficiency relative to national median.

Key Features:

- Data Source: Medicare Claims
- Episode Window: Treatment period + Associated services
- Risk Adjusted: Patient characteristics and case mix
- Payment standardization: Removes geographic variations
- IMPACT Act Mandate: Standardized across all PAC setting

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Medicare Spending Per Beneficiary-PAC

What is included?

- Home Health Services
- Part A&B services during and after HH Episode
- Inpatient care
- Outpatient care
- SNF stays
- DME
- Physician Services
- Other PAC Services

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Timeline

HH Admit and new claim

Figure 1. MSPB-PAC Episode Window

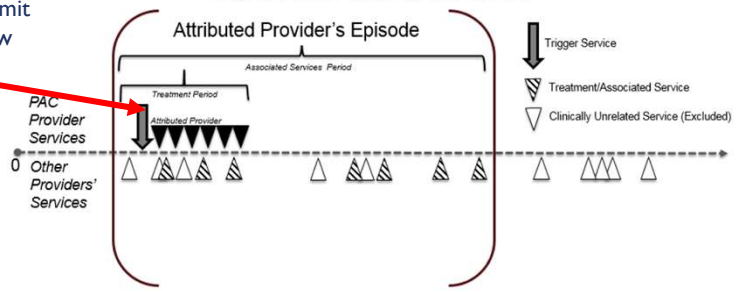

Table 2. MSPB-PAC Episode Windows

MSPB-PAC Episode Type	Treatment Period	Associated Services Period
HHA Standard HHA LUPA	• Begins at trigger • Ends 60 days after trigger	• Begins at trigger • Ends 30 days after the end of the treatment period
HHA PEP	• Begins at trigger • Ends at discharge	• Begins at trigger • Ends 30 days after the end of the treatment period

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Medicare Spending Per Beneficiary-PAC

Calculation Formula

Step 1: MSPB-PAC Amount = (Observed Spending ÷ Expected Spending) × National Average
Step 2: Final Score = HHA's MSPB-PAC Amount ÷ National Median MSPB-PAC Amount

Score < 1.0 = Below average spending (BETTER) ✓
Score = 1.0 = Average spending
Score > 1.0 = Above average spending (WORSE)

Risk Adjustment Factors:

- Age and gender
- Principal diagnosis
- Comorbidities
- Functional status
- Prior utilization
- Disability status

Important: HHAs only compared to other HHAs (not to SNFs, IRFs, etc.)
Goal: Lower total episode spending while maintaining quality

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Medicare Spending Per Beneficiary-PAC

Audit Objective: Review care management, coordination, and resource utilization to identify opportunities to reduce Medicare spending while maintaining quality

- Step 1: Comprehensive Admission Assessment
  - All patient conditions identified
  - Appropriate case mix captured in OASIS
  - High-risk conditions flagged
  - Recent utilization documented
  - Complete medical history
- Step 2: Appropriate Care Planning:
  - Plan addresses all identified needs
  - Visit frequency appropriate for acuity
  - Right discipline at right time
  - Goals specific and measurable
  - Evidence-based interventions

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Medicare Spending Per Beneficiary-PAC

- Step 3: Care Coordination Documentation
  - Regular physician communication
  - Medication reconciliation at each recert
  - Lab/diagnostic results reviewed and acted upon
  - Specialist communication when needed
  - DME orders appropriate and timely
  - Referrals to other services coordinated
  - Transitions of care managed effectively

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Medicare Spending Per Beneficiary-PAC

- Step 4: Resource Utilization Review
  - Evaluate Appropriateness of:
    - Visit frequency matches patient needs
    - No excessive or unnecessary visits
    - Skilled services clearly documented
    - DME orders medically necessary
    - Lab tests ordered appropriately
    - Timely discharge when goals met (not too early or late)
    - Use of telehealth when appropriate

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Medicare Spending Per Beneficiary-PAC

- Hospital Readmission Prevention
  - Medication management optimal
  - Patient/CG education thorough
  - Early warning signs addressed
  - Timely physician notification
  - Monitoring of high-risk conditions
- ER Visit Prevention
  - After-hours coverage documented
  - Patient knows when to call agency
  - Fall prevention strategies in place
  - Pain management adequate
  - Wound care appropriate

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Strategies to Improve MSPB-PAC

- Proactive Care Management:
  - Address issues before they escalate
- Excellent Care Coordination:
  - Communicate with ALL providers (internally and externally)
- Efficient Resource Use:
  - Right care at right time
- Patient Empowerment:
  - Education for self-management
- Timely Interventions
  - Don't wait for problems to worsen

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Do You Love Me?

HHCAHPS

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HHCAHPS Patient Experience

Revised HHCAHPS Survey

Beginning **April 2026** sample month, CMS will implement a revised HHCAHPS survey.

Measures Being REMOVED

- ❌ Care of Patients
- ❌ Communication Between Providers and Patients
- ❌ Specific Care Issues

Reason: Survey questions being revised; infeasible to maintain current measure specifications

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HHCAHPS Measuring

Focus on Excellent Communication and Care

Step 1: Communication Documentation

- Patient education in each visit
- Teach-back or return demonstration
- Patient questions addressed
- Patient/CG understanding assessed
- Barriers to learning identified and addressed
- Clear explanations documented

Step 2: Pain Management

- Pain assessed at each visit
- Pain management plan documented
- Non-pharmacological interventions
- Effectiveness evaluated
- Patient education on pain management

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HHCAHPS Measuring

Step 3: Medication Education

- All medications discussed with patient
- Purpose of each medication explained
- Side effects discussed
- When to call physician documented
- Medication changes explained

Step 4: Professional Conduct

- Respectful care documented
- Patient preferences considered
- Privacy maintained
- Punctuality noted (on-time arrivals)
- Professional appearance

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Best Practices for HHCAHPS

Use HHCAHP language

- Train staff to use survey language naturally

Create good first impressions

- Initial visit sets the tone

Communication is key

- Explain, listen, confirm understanding

Manage expectations

- Be clear about visit schedules, goals

Close the loop

- Follow through on commitments

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Miscellaneous

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Documentation Standards for All OASIS Measures

- Specific description of current ability
- WHO provides assistance
- WHAT assistance is provided
- HOW MUCH assistance (percentage/level)
- Assistive devices used
- Safety consideration
- Environmental factors
- Physical limitations (ROM, strength, pain)
- Cognitive factors (memory, sequencing)
- Basis for assessment (observation vs report)

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Key Success Factors for 2026

1. **Prioritize OASIS education**
2. **Enhance the Audit Processes (more frequent, more detailed)**
3. **Engage all disciplines**
4. **Improve care coordination**
5. **Focus on prevention**
6. **Empower patients**
7. **Monitor performance**
8. **Continuous improvement**

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What area of patient care do you think needs the most improvement under the new measures?

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Audit Tool

https://hhvbp-arkansas.tiiny.site/?mode=suggestions

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> Quality is never an accident; it is always the result of intelligent effort.
>
> — John Ruskin

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Let's Stay Connected

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