



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

## Winter Conference

Thursday, February 19, 2026

10:15am-11:30am

### 5a. Connecting the Dots from Orientation to VBP Success

Presented by:

Tammy Ross, MHA, BSN, RN, CCM, EVP Professional Services

Mike Carr, PT, Senior Director of Training and Education, Axxess

Thank you to our Partners:



# Connecting the Dots from Orientation to HH VBP Success

**Tammy Ross, MHA, BSN, RN, CCM**  
Axxess, EVP Professional Services

**Mike Carr, PT**  
Axxess, Sr. Director of Training and Education

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## Objectives

- Identify Workforce Trends
- Identify Key Components of an Effective Orientation Program
- Define Key Metrics and Performance Measures Used in HH VBP
- Develop Strategies to Align Staff Education with HH VBP Success
- Apply Best Practices for Continuous Improvement



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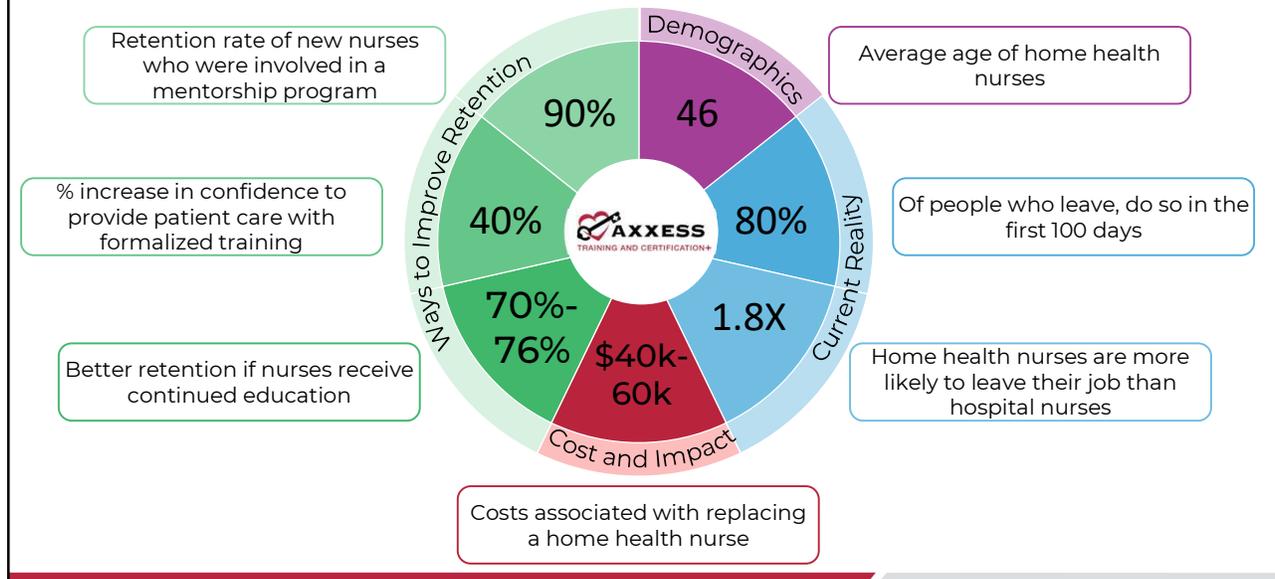
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### STRUGGLES FACED BY HOME HEALTH AGENCIES

				
<b>POST-COVID BURNOUT</b>	<b>STAFFING SHORTAGES</b>	<b>RUSHED ONBOARDING</b>	<b>RISING COSTS</b>	<b>REGULATORY CHANGES</b>

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## Training is Critical for Better Outcomes



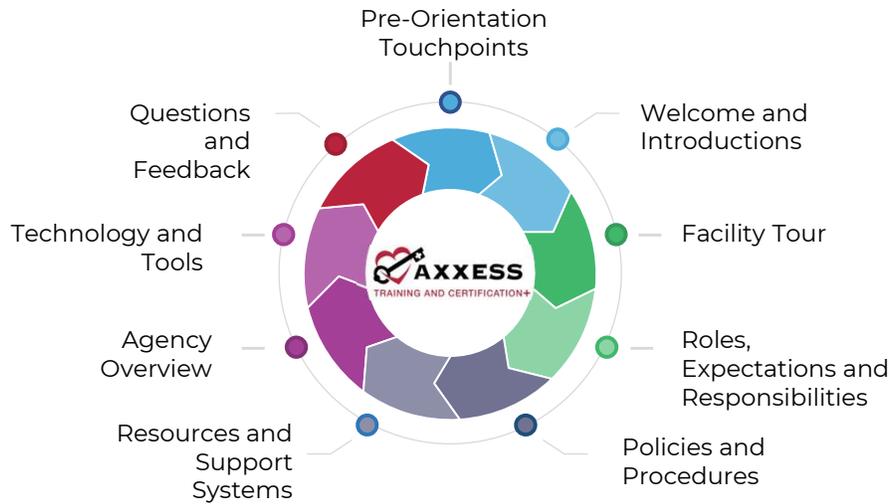
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## Orientation As A Strategic Lever

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## Elements of A Strong Orientation

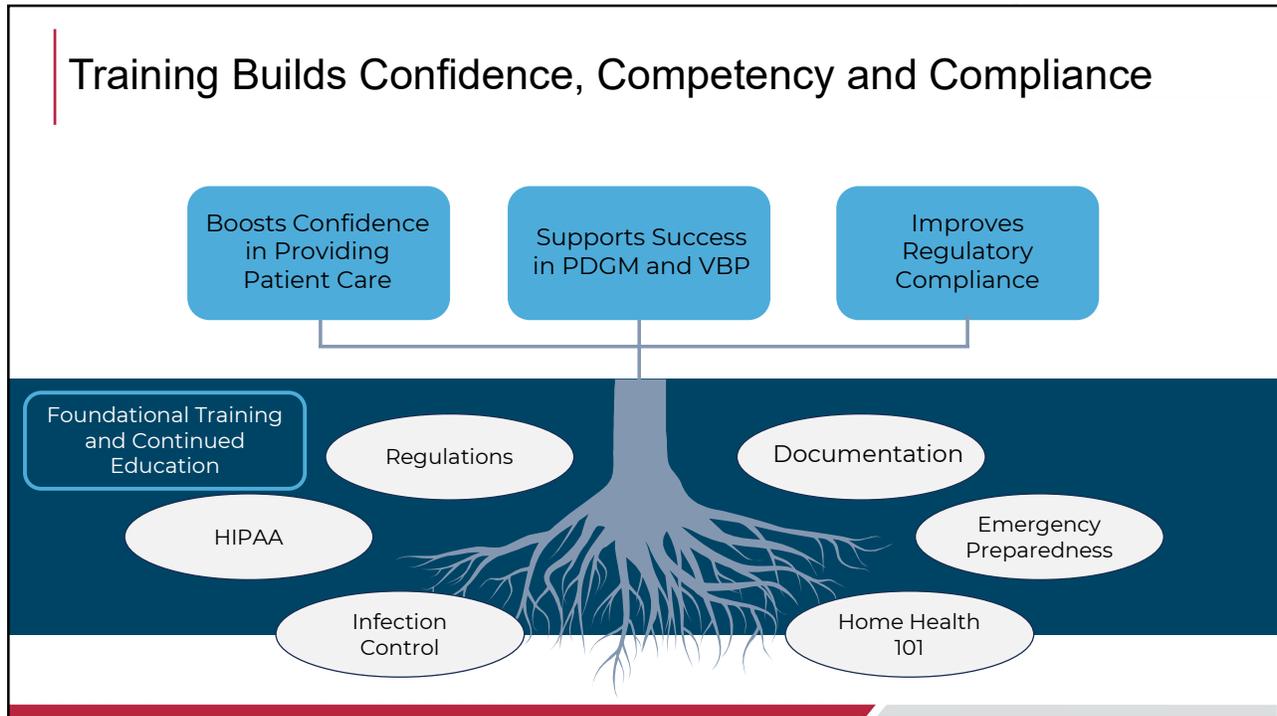


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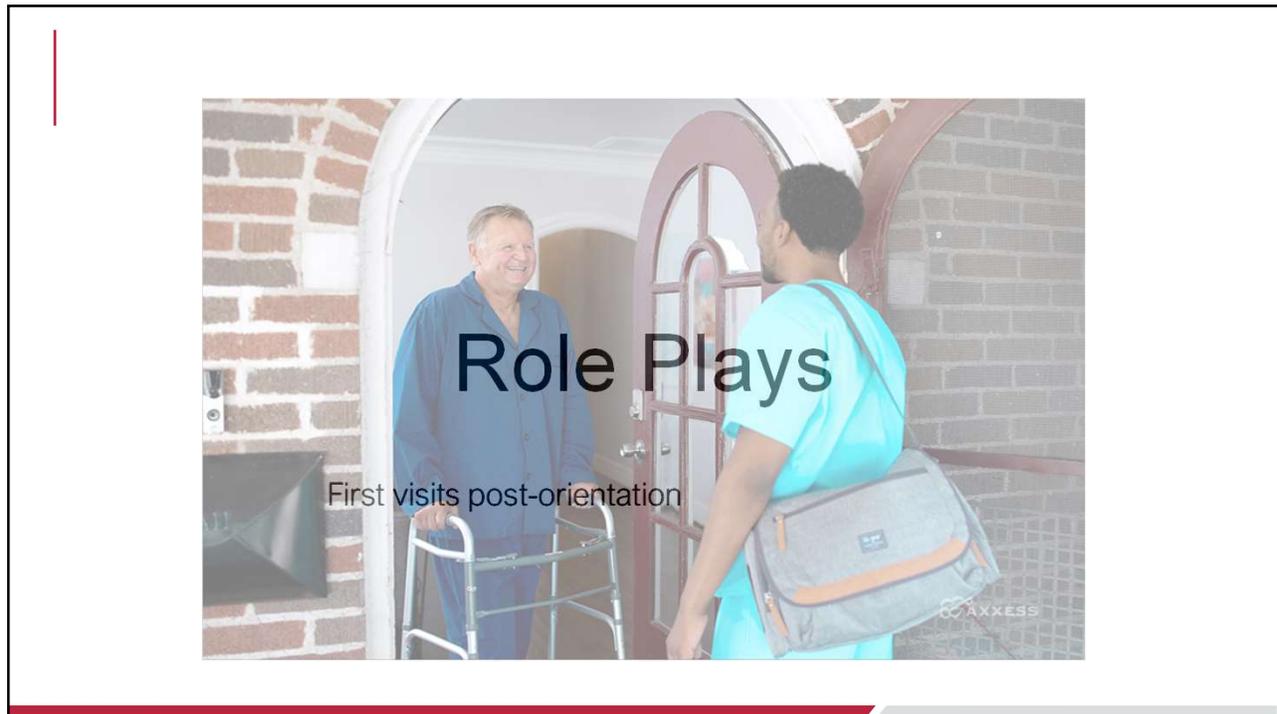
## Mentorship Bridges the Gap



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## Discussion Questions

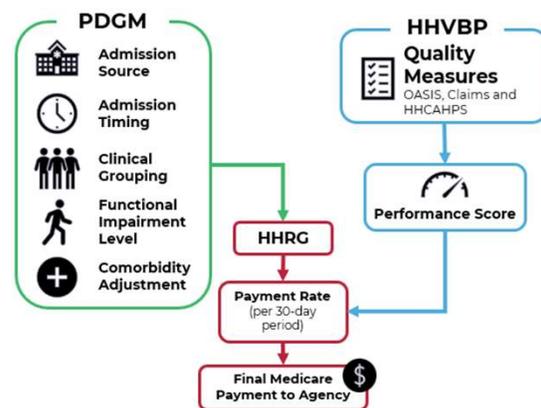
- What did the clinician miss?
- What did the clinician do well?
- Compare both clinicians. What are the key differences you noticed?
- What elements of orientation, mentorship and training could help improve both nurses experience?



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## Bonus Question

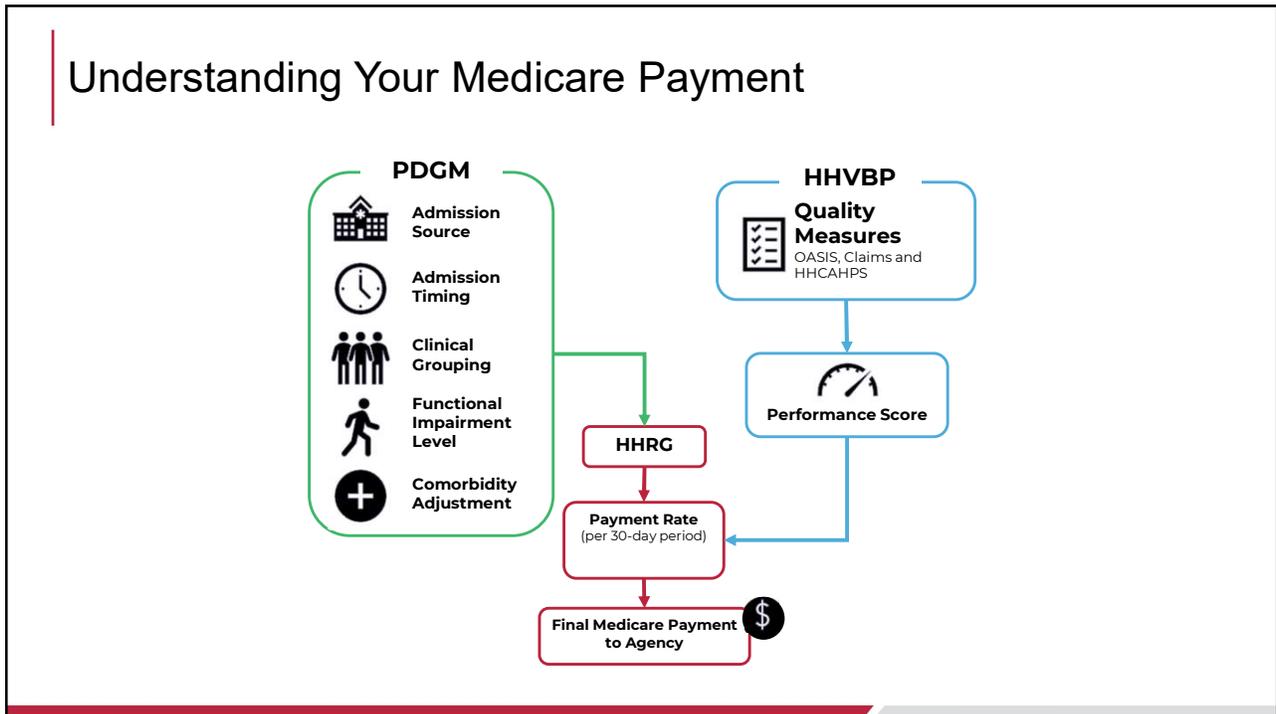
- Of the aspects of care that either clinicians missed, could this impact patient outcomes, PDGM and VBP?



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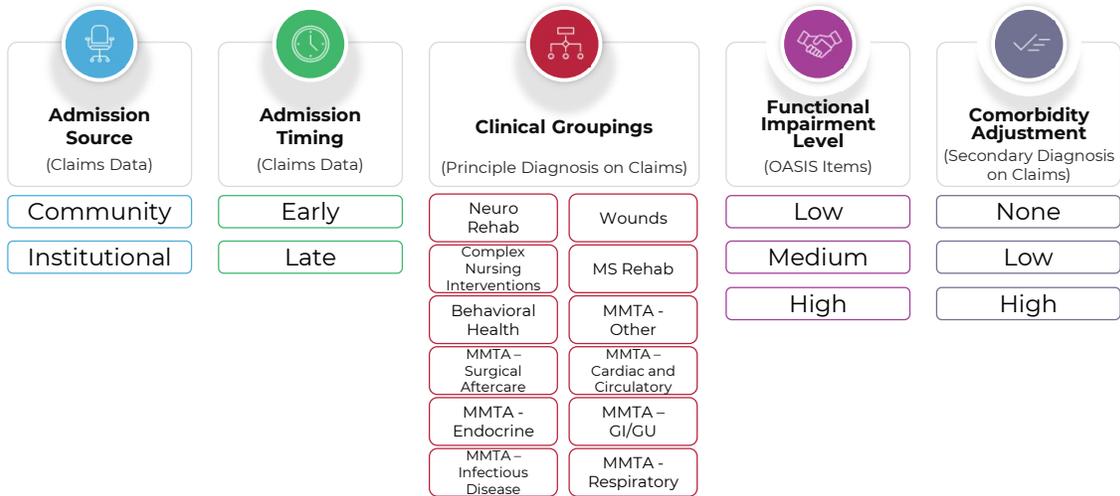


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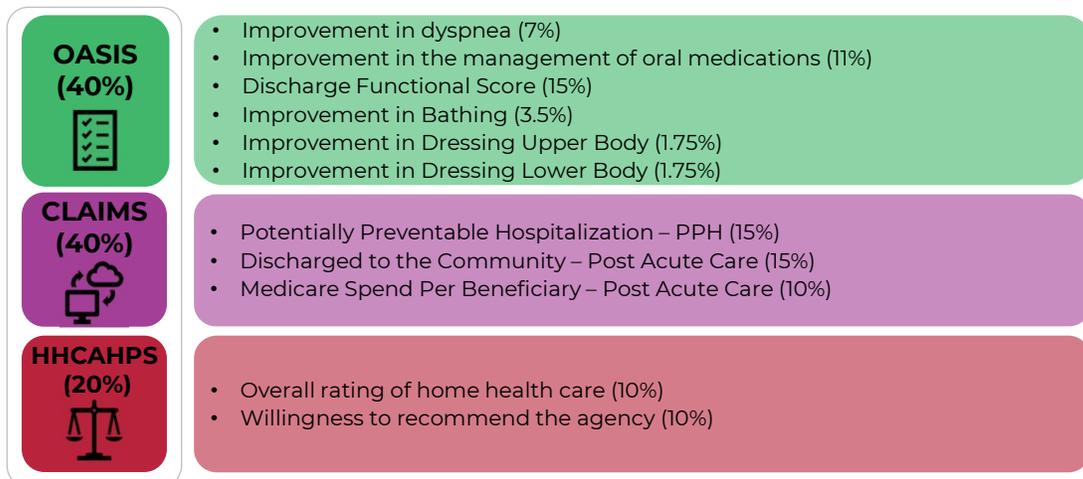
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## Components of PDGM



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## Components of VBP



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## OASIS Items

**OASIS  
(40%)**

Improvement in dyspnea (7%)  
 • M1400

Improvement in management of oral medications (11%)  
 • M2020

Improvement in Bathing (3.5%)  
 • M1830

Improvement in Dressing Upper Body (1.75%)  
 • M1810

Improvement in Dressing Lower Body (1.75%)  
 • M1820

Discharge Functional Score (15%)

**GG0170 Section - Mobility:**

- GG0170A – Rolling left and right
- GG0170C – Lying to sitting
- GG0170D – Sit to stand
- GG0170E – Bed-to-chair transfer
- GG0170F – Toilet transfer
- GG0170I – Walk 10 feet
- GG0170J – Walk 50 feet with 2 turns
- GG0170 – Wheel 50 feet with 2 turns

**GG0130 Section - Self Care:**

- GG0130A – Eating
- GG0130B – Oral hygiene
- GG0130C – Toilet hygiene

**Average Function Scores**

At Admission	Predicted	At Discharge
36.3	54.0	53.5

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## Claim-Based Measures

**CLAIMS  
(40%)**

Potentially Preventable Hospitalization – PPH (15%)

Discharge to the Community – Post Acute Care (15%)

Utilize claim-based data to identify hospitalizations that fall under specific **Ambulatory Care Sensitive Conditions** (e.g., CHF, Diabetes, COPD, UTI and Pneumonia)

% of patients **discharged** from a PAC setting who return to the community **without readmission or death within 30 days** (higher percentage is better)

Both measures are **risk-adjusted**, so agencies are not penalized for treating a higher-risk population.

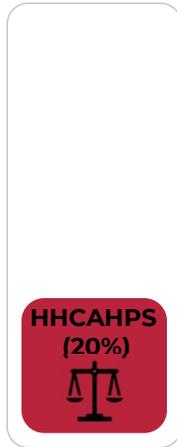
Medicare Spend Per Beneficiary – MSPB (10%)

Measures the average Medicare spending per beneficiary during the episode of care, including:

- The HH episode itself
- Related Services before and after the episode (e.g., hospitalizations, physician visits, skilled nursing)

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## HHCAHPS Questions



### Overall rating of home health care – Q20 (10%)

- Rate your care from this agency's home health providers from 0-10.
- Only scores of **9** and **10** are considered positive

### Willingness to recommend the agency – Q25 (10%)

- Would you recommend this agency to your family or friends if they needed home health care?
- Only **Definitely Yes** is considered a positive score

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## Opportunities for Success in VBP

### Achievement Points

Agency score during the performance year on each measure **compared to their cohort**

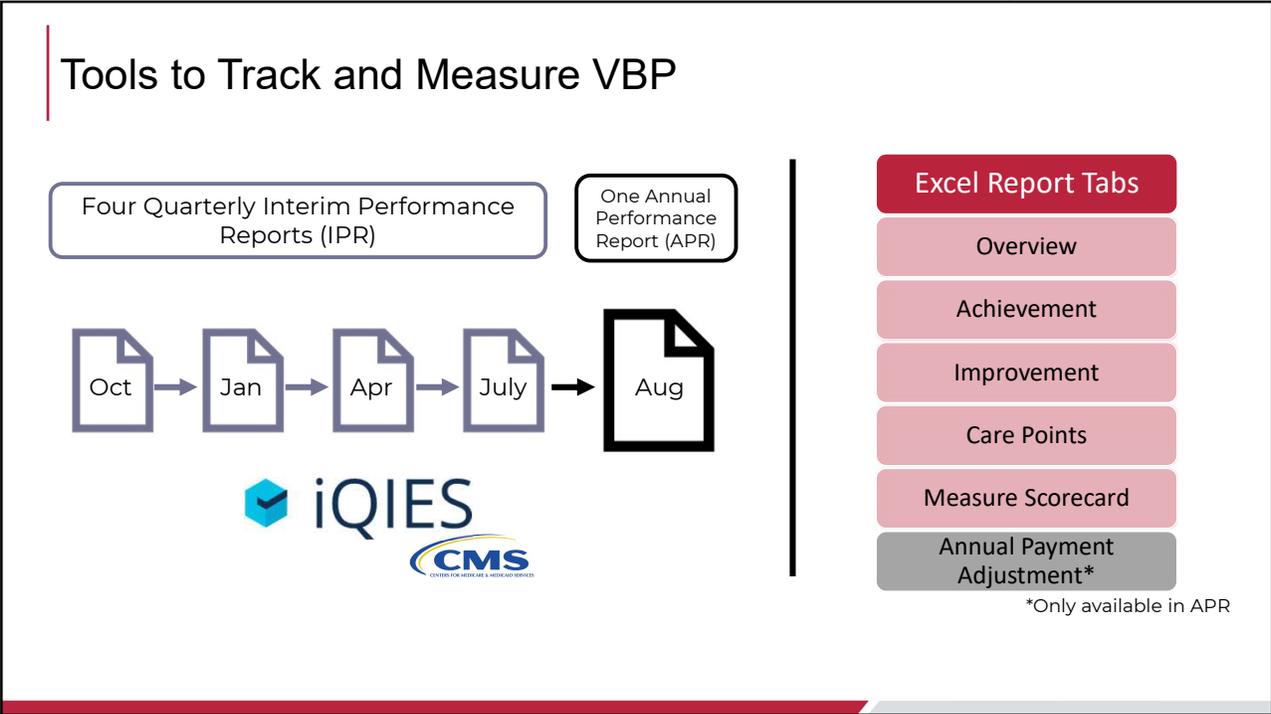
### Improvement Points

Agency score during the performance year on each measure **compared to the agency score during the baseline year**

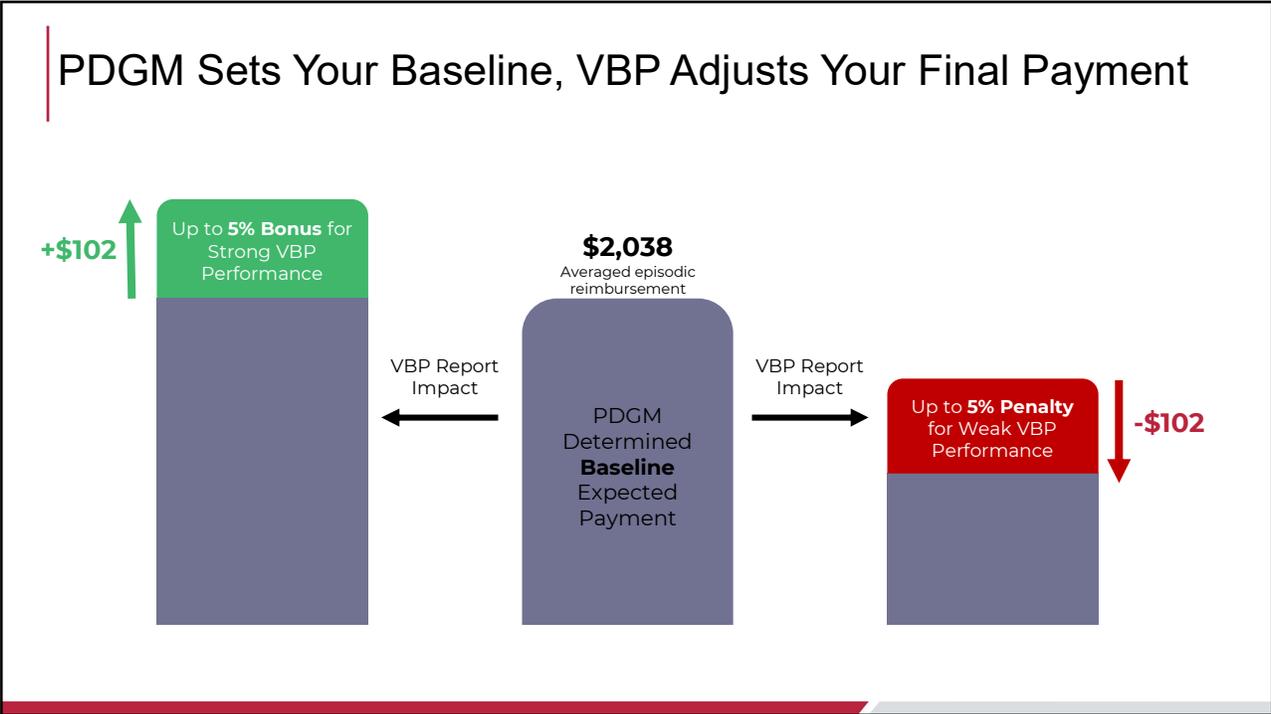
After comparing Achievement Points and Improvement Points, only the **HIGHER** point value is kept.



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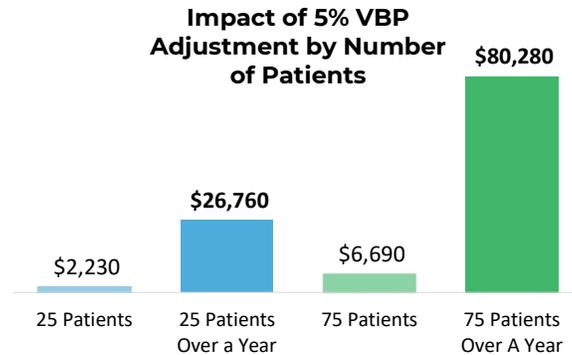


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## Take Control of Your Reimbursement



Would you want this number to be **additional reimbursement** or a **reduction in reimbursement**?

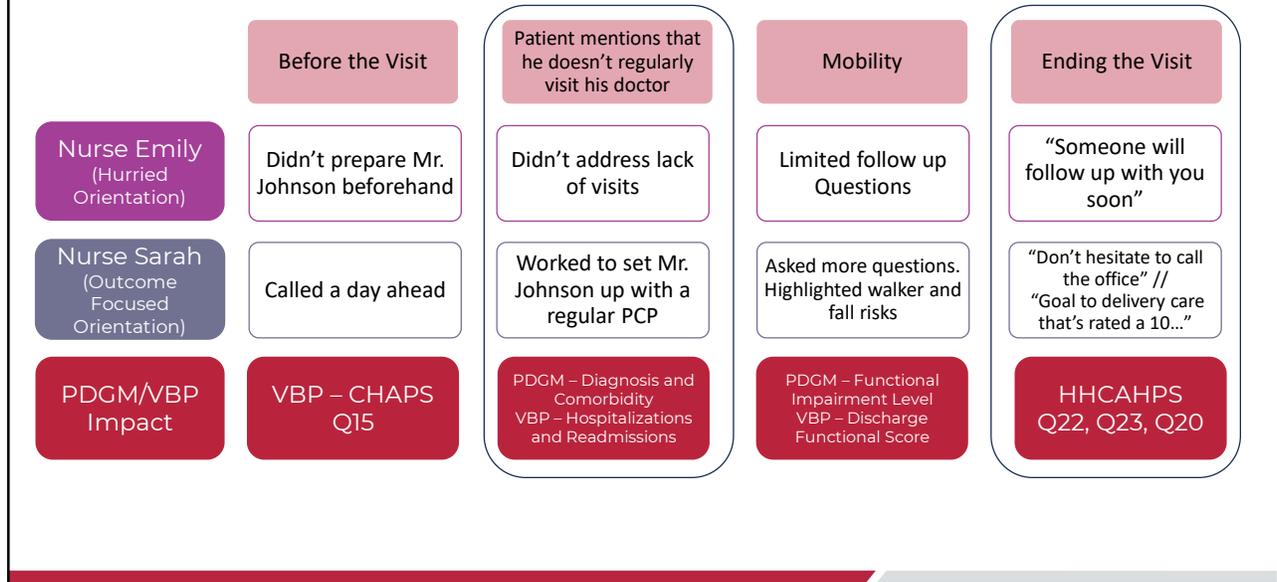
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Let's Revisit the Impact of Mr. Johnson visit with Nurse Emily and Nurse Sarah

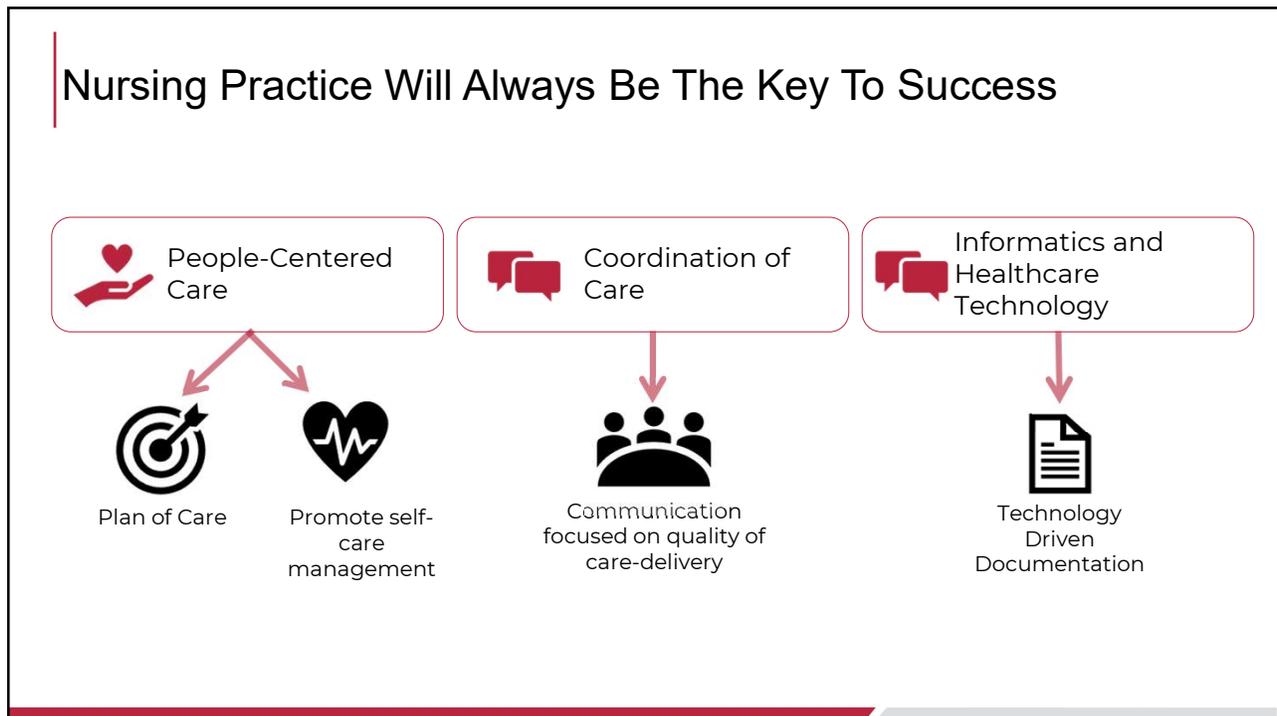
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## Small Changes, Major Impacts



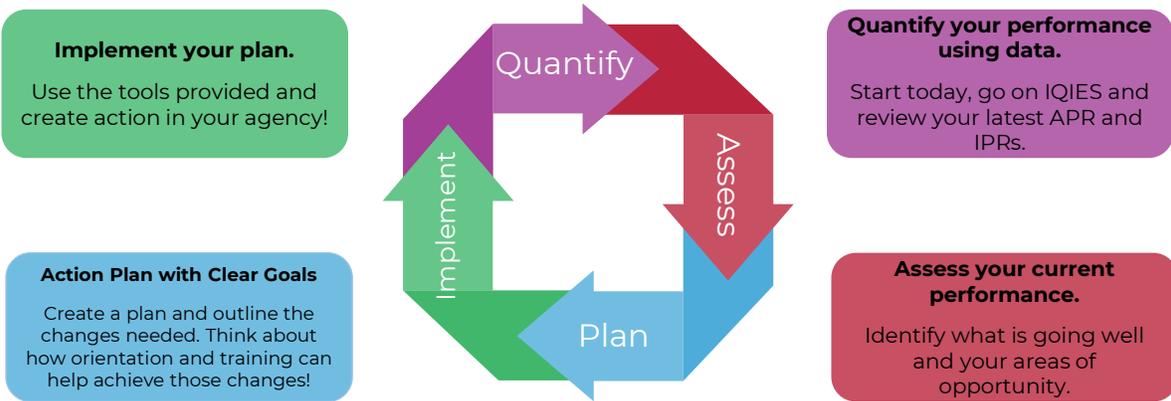
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## Nursing Practice Will Always Be The Key To Success



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## QAPI is Driven by Intentional and Meaningful Im



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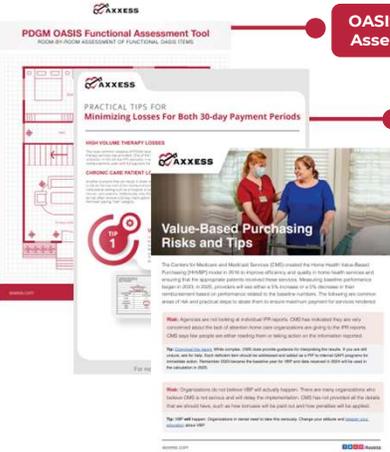
## Tools for Change



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# Work Smarter By Leveraging Great Tools!





**OASIS Functional Assessment Tool**

**Minimizing Losses for Payment Periods**

**VBP Risks and Tips**

**And Many More Tools Available on Axxess.com**

Click on the red boxes to directly access tools available online.



**HHCAPHS Scripting**

**Home Safety Assessment Tool**

**HHCAPHS Letter to Patient**

**What To Do If You Fall**

**Tuck In Call Fall Prevention**

**Tools Only Specially Shared Today!**

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# HHCAPHS Scripting

## Overview

Understand **each question** asked. What **purpose** of each question is? Learn a **seed statement/question** to use during your visit. Apply **recommended frequency**.

## HHCAPHS Questions

Question	Training	Frequency
<p><i>According to our records, you received care from the home health agency, ABC Home Health Agency, Inc. Is that right? As you answer the questions in this survey, think only about your experience with this agency.</i></p>	<p><b>Purpose:</b> This first question is to ensure that responses relate to the agency care and not the hospital or skilled nursing experience.</p> <p><b>Seed Statement/Key Words:</b> "Hello, I'm (name), your (nurse/therapist/social worker) from "ABC home care agency." "I'm giving you a folder of information about your care team from "ABC home care agency." "Good afternoon. This is (name), call from your "ABC home care agency."</p>	<p><b>By every staff member caring for the patient at every visit or phone call</b></p>

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**Discharge Letter to Patient Template**

Dear [Insert Patient and Care Giver Name],

Thank you for choosing [Insert Agency Name] to meet your in home skilled nursing and therapy needs. Our goal is to exceed your expectations for care and customer service. If at any time you can't rate my professional and support staff a 10 on a scale of 1-10, where 10 is the best possible score and 1 is the worst possible score, PLEASE call me. I have the most dedicated and professional staff in the business however at times we make mistakes. Please allow us the opportunity to correct this.

You may receive a survey after you are discharge from our care. It is very important to me and the agency that you complete and return this survey. By participating in the survey you help improve the care we provide and the outcomes our patients obtained. The survey is required to be mailed in a plain white envelope so it is easy to be over looked. Please be on the lookout and if any of may staff do an exceptional job, feel free to mention them by name.

Again, thank you for your trusting us as your health care provider. I hope we earn your referral to friends and family that may need home health services. If I can assist you in any way please free feel to call me at [Insert Best Contact Number].

\_\_\_\_\_  
[Insert Administrator Name]  
Administrator [Insert Agency Name]

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**Safety Assessment Tool**

When performing the Home Safety Assessment, consider the following safety issues. Report safety issues to the family or caregiver. Make recommendations for change.

Client:

1. Check shoes- should be secure, properly fitting and have non-skid soles
2. Avoid shoes with extra thick soles
3. Recommend lace up instead of slip-ons, and keep laces tied (If trouble tying laces recommend footwear with fabric fasteners
4. Check for dizziness, encourage slow sit – stand, dangle at bedside prior to getting up (bed or chair)

Entrway

1. Steps and walkways that are in poor condition and have crumbling edges which may cause a fall
2. The "peephole" in the front door is too high so the client has difficulty seeing who is at the front door.
3. Inadequate lighting-the outdoor lighting should illuminate the front steps and backyard.

Living Areas:

1. Narrow doorways that are not wide enough to pass through with a wheelchair or a walker
2. Cluttered walkways.
3. Smoke detectors that do not work.
4. Overloaded electrical outlets or frayed electrical cords.
5. Long oxygen tubing that sits on top of the carpet or flooring surface which may pose a fall risk.
6. Casters or wheels on the furniture legs.
7. Throw rugs that are not tacked into place.
8. Telephone that is not easily accessible from all rooms (consider an emergency alert necklace).
9. Poor lighting
10. Windows that are difficult to close or won't open.
11. Rodent or bug infestation.
12. Consider glow in the dark or illuminated switches
13. Handrails on both sides of steps/stairway
14. Assistive devices properly maintained and always within easy reach
15. Emergency numbers within easy reach

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### Rising from a Fall

- **Panic is often the first reaction.**
- How you react after a fall can cause more injuries than the fall itself.
- If you try to get up too quickly or in the wrong position you may make an injury worse.
- Remember to **take several deep breaths...**
- Determine if you are hurt.
- **If you believe you are injured, do not attempt to get up. Instead, call 911 or get help from a family member.**
- If you feel strong enough to get up, follow these steps provided by the American Academy of Orthopedic Surgeons

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### TUCK IN CALL Fall Prevention

Process: All patients at risk for fall will receive at least one call per week to check their status and determine if additional interventions are needed to help prevent falls. Calls can be performed at any time, but Tuck-In-Calls are highly encouraged to occur on Friday to tuck in patients for the weekend.

**Legend**

Tuck-In-Calls	Performed on a Friday for any high-risk patient for fall. Onsite check in visit may be performed
Wellbeing Call	Call is performed at anytime and is generally for those patients that have new needs such as recent hospitalization or change in condition.
Monday Wake Up Call	For any patient that called the ON CALL service over the weekend or reported a change of condition or at the request of the resident.
Scheduled	Telehealth visit or designed to complement disease management.

Patient Name: \_\_\_\_\_ Certification Period: \_\_\_\_\_ - \_\_\_\_\_

Type of Call:  Tuck-In-Call  Wellbeing  Monday Wake-Up  Scheduled

Resident Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

	YES	NO
Is there any change in the patients health?		
Any increase in pain? Location: _____ Intensity 0 to 10 scale: _____		
Have you experienced any falls or injuries since the last call?		
Have you taken your medications today?		
Any changes in medications since the last visit? (List the changes below.) _____ _____		
Do you understand how to take your medications? If not name of home health agency if applicable		
Does the patient /caregiver know how to access the On-Call phone number?		
Are you drinking adequate liquids to include water?		
Do you have any new symptoms such as dizziness, shortness of breath, or chest pain?		
Findings/Required Action:		

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**Questions?**



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## References

Anything underlined are clickable links

1. [Medicare Benefit Policy Manual – Chapter 7: Home Health Services](#)  
Covers definitions of homebound, skilled services, intermittent care, documentation requirements, face-to-face encounter, and what must be in the plan of care .
2. [42 CFR §484 – Home Health Services Regulations](#)  
These federal regulations detail documentation procedures like Notice of Admission (NOA) timing, RAP filing, and provider responsibilities .
3. Medicare Administrative Contractor (MAC) Guidance  
Go to your MAC (NGS, CGS, Palmetto, Novitas, etc.) Website, and search for for “Home Health Documentation” or “Home Health Clinical FAQs” to find updated guidelines tailored to coverage and claims.
4. [Medicare Benefit Summary Handbooks](#)  
e.g., “Medicare & Home Health Care” (Publication 10969) that provide clear, patient-friendly definitions of “intermittent,” visit limits, and certification .
5. [CMS Preparing for HHVBP CY 2025](#)  
Provides breakdown of VBP Measures in 2025 and how measures have changes since inception.
6. [CMS HHVBP APR Example Report CY 2024](#)  
Measures have changed between 2024 and 2025, but format of tabs remain the same

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## Standard HH1-1A



 The Home Health Agency (HHA) is in compliance with federal, state and local laws. 484.100 (G848), 484.100(b) (G860).

The Home Health Agency (HHA) and its personnel must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides for licensing of HHAs, the HHA must be licensed.

The HHA, its branches, and all persons furnishing services to patients must be licensed, certified, or registered, as applicable, in accordance with the state licensing authority as meeting those requirements.

The HHA has a physical location and all required license(s) and or permit(s) are current and posted in a prominent location accessible to public view in all locations/branches and/or in accordance with appropriate regulations or law.

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## Standard HH1-1A Cont.



The HHA is an established entity with legal authority to operate and has the appropriate Articles of Incorporation or other documentation of legal authority. Legal authority is granted to one individual, members of a limited liability corporation, a board of directors, or a board of health (usually referred to as the governing body), and as allowed in state statutes for the appropriate type and structure of the organization. The entity, individual or HHA has a copy of the appropriate documentation or authorization(s) to conduct business.

**Evidence:** Copy of all current applicable licenses/permits for each location and copy of Articles of Incorporation/Bylaws and all applicable amendments

**Evidence:** Observation

**Evidence:** Personnel Files

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**Thank you**

[tross@axxess.com](mailto:tross@axxess.com)

[mcarr@axxess.com](mailto:mcarr@axxess.com)



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