Home Health Within-Stay Potentially Preventable Hospitalization (PPH)

Why is the Centers for Medicare and Medicaid Services (CMS) Measure Important?

Proper management of care by home health agencies (HHA), along with clear instructions and referrals at home care discharge, could potentially prevent patient hospital visits. The goal is to identify opportunities for enhancing patient care to reduce hospitalizations and observation stays throughout home health visits.

PPH Measure Description[1]

Medicare claims are used to determine the percentage of home health patients with at least one potentially preventable hospitalization or observation stay under a list of diagnoses that CMS deems "potentially preventable."

- Incorporates entire patient stay; not limited to the 60 days following the start of care

Exclusions: Patients with planned admissions, patients who have had multiple HHAs during the period and patients who have had limited visits by the HHA under LUPA.

Some Common Home Health Diagnosis Groups in the Measure	
Adult asthma / COPD	Septicemia
Congestive heart failure	Dehydration/Electrolyte issues
Diabetes complications	Skin infections
Hypo/Hypertension	Aspiration pneumonitis
Influenza	Arrythmia
Bacterial pneumonia	Intestinal impaction
UTI/Kidney infection	Pressure ulcers

Strategies to Enhance PPH Measure Outcomes

- **Analyze Trends**: Assess your agency's historical data to identify the top reasons for hospitalizations and be familiar with when patients tend to be hospitalized.
  - By pinpointing patterns, interventions can be tailored to address specific risk factors.
- **Quality Assurance and Performance Improvement (QAPI)**: Gather and analyze your agency's data using the QAPI process. Develop a performance improvement plan based on insights from your data.
  - This proactive approach helps prevent unnecessary hospitalizations and improves patient outcomes.
- **Recognize Changes in Health Conditions**: Talk with staff about spotting and promptly reporting patient changes that are critical to ensuring the patient's well-being and safety.
  - Early detection helps facilitate timely intervention and treatment, mitigate deterioration and prevent potentially serious complications that can lead to hospitalization.
- **Education and Discharge Planning**: Ensure that patients receive clear discipline-of-care discharge instructions and referrals. Educate patients and caregivers about managing their health conditions at home.
  - Effective discharge planning can reduce the likelihood of hospitalizations or observation stays.
- **Monitor Real-Time Rehospitalizations**: Track the number of real-time rehospitalizations and observation stays through health-information services and technology, if available.
  - Regular monitoring allows for prompt intervention to address any issues that may lead to hospitalization.
- **Collaborate and Communicate with Hospitals**: Strengthen relationships by sharing relevant patient information, care plans and medication details during transitions.
  - Coordinated care transitions can help prevent hospital readmissions.

[1] Specifications for the Home Health Within-Stay Potentially Preventable Hospitalization Measure for the Home Health Quality Reporting Program, CMS

Helpful Resources

- Call Us First Toolkit for Home Health Organizations*: Interventions to help decrease hospital readmissions and emergency department (ED) use.
    - Features diagnosis-specific (stop-light) action plans to help patients manage their health conditions (page 9), and many other tools.
- **Timeliness of Care Toolkit**: Helps reduce delays in the start of home health services following a hospital discharge or any time a patient is referred for home health care.
    - Home Care Intake Scripting Tool: Helps staff explain the benefits of receiving home health care visits and how it can help patients improve their health at home.
    - Timeliness of Care Instructional video: Demonstrates how to track home care acceptance rates using a Tracking Tool with an example and Instructional PPT Handouts.
- Social Drivers of Health (SDOH) Z Code Documentation Guide
    - Highlights z codes that capture SDOH for systemic data collection.
    - Social Drivers of Health - ICD-10-CM: Z Diagnosis Codes and Documentation Video
- Patient Change in Condition Poster, Superior Health Quality Alliance (Superior Health), to share with staff.
- Recognizing Resident Change in Condition: YouTube recording 3:31 min (for leaders/managers).
- Recognizing Resident Change in Condition: PDF File – includes links (for leaders/managers).
- Superior Health Change in Conditions Front Line Forces Module web course (for Front Line Staff).
    - Front Line Forces Main page: Short on-demand learning modules and other resources for front line and direct care staff working in long-term care and other health care settings.
- Home Health Quality Reporting Program, CMS
- Home Health Quality Reporting Program Help Desks, CMS: Contact information to ask questions, troubleshoot problems and request guidance and support.
    - Guide to Home Health Help Desks, CMS: Provides an explanation of which number to call.

* Developed by Superior Health in 2023 in collaboration with HHAs in Minnesota, Michigan and Wisconsin.

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