

FREE WEBINAR | HOME HEALTH

Unlocking Home Health Success

Analytics and KPIs for Financial
and Clinical Excellence

TUE, OCT 29 | 12 PM CT



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YOUR SPEAKERS



Lisa Selman-Holman

VP of Education & Quality
McBee, part of Netsmart



Michelle Horner

Manager - Clinical Consulting & Education
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Agenda

- Identify key KPIs and analytics that drive successful revenue and outcomes in home health.
- Understand the impact of recent HHVBP, star ratings, and PDGM changes on agency performance.
- Learn strategies for leveraging data to improve agency operations, patient care, and compliance with new regulations.

Key Performance Indicators

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Key Performance Metrics

Common KPIs used in Home Health

Financial:

- Periods per Episode (PPE)
- Recertification Rate
- LUPA rate
- Functional Impairment Level
- Visits per Episode
- Visits per Period
- Comorbid Adjustment breakdown
- Clinical Grouper Breakdown

Clinical Outcome Improvement:

- Care Compare Star ratings

Patient Satisfaction:

- HHCAHPS

Value Based Purchasing:

- Acute Care Hospitalization (ACH/ED Use)
- Potentially Preventable Hospitalization (PPH)
- Discharge to Community – Post-Acute Care
- Discharge Function Score
- TNC Self-care and Mobility

Data Analysis

2025 Data

Periods per Episode	1.21
Revenue per Period	\$1,865
Revenue per Episode	\$2,262
Visits per Period	11.96
Visits per Episode	14.50
Percent Early Periods	72.39%
Average Early Case Mix	1.09
Average Case Mix	1.04
LUPA Rate	3.93%
Percent Outliers	0.00%
Percent Functional Low	42.53%
Percent Functional Medium	35.63%
Percent Functional High	21.84%
Average Wage Index	0.89
Recert Rate	4.61%
Total Revenue 2025	\$1,519,964

2025 Star Rating Data

Periods per Episode	1.70
Revenue per Period	\$1,904
Revenue per Episode	\$3,234
Visits per Period	7.71
Visits per Episode	13.10
Percent Early Periods	29.65%
Average Early Case Mix	1.27
Average Case Mix	0.99
LUPA Rate	6.87%
Percent Outliers	3.52%
Percent Functional Low	22.54%
Percent Functional Medium	31.26%
Percent Functional High	46.19%
Average Wage Index	0.98
Recert Rate	31.34%
Total Revenue 2025	\$7,016,636,234

Coding Metrics

Percent of Periods by
Clinical Grouping
Provider

MMTA Cardiac	17.78%
MMTA Endocrine	6.88%
MMTA GIGU	4.97%
MMTA infectious	4.68%
MMTA Other	3.70%
MMTA Respiratory	7.28%
MMTA Surgical	3.47%
MS Rehab	21.40%
Complex	2.74%
Behavioral	2.18%
Neuro	10.98%
Wound	13.93%

Percent of Periods by
Clinical Grouping
State

MMTA Cardiac	25.03%
MMTA Endocrine	10.16%
MMTA GIGU	4.51%
MMTA infectious	4.13%
MMTA Other	3.88%
MMTA Respiratory	6.71%
MMTA Surgical	2.03%
MS Rehab	17.75%
Complex	1.57%
Behavioral	2.59%
Neuro	11.44%
Wound	10.19%

Percent of Periods
by Co-Morbidity
Provider

None	44.03%
Low	52.27%
High	3.69%

Percent of Periods
by Co-Morbidity
National

None	30.73%
Low	52.57%
High	16.70%

Average # of
Therapy Visits by
Functional Level
Provider

Low	4.58
Medium	5.87
High	4.39

Average # of
Therapy Visits by
Functional Level
National

Low	3.19
Medium	3.94
High	4.48

Average # of
Therapy Visits by
Functional Level
State

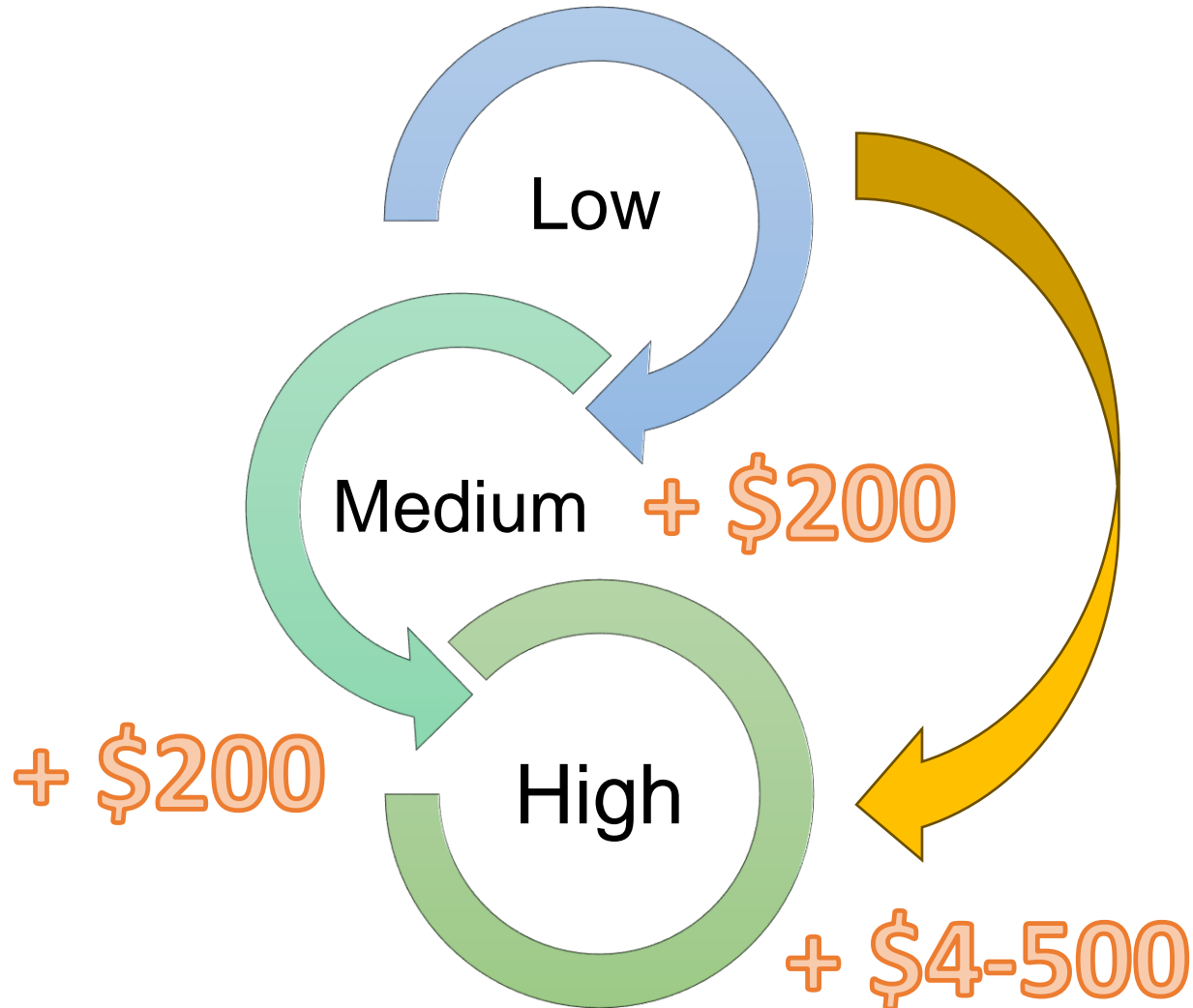
Low	3.53
Medium	4.81
High	5.18

Changes in Quality Measures

Proposed OASIS Points Table CY2025

OASIS Item	OASIS Answer	CY2023	CY2024	CY2025
M1800	0 or 1	0	0	0
	2 or 3	3	3	3
M1810	0 or 1	0	0	0
	2 or 3	5	5	5
M1820	0 or 1	0	0	0
	2	4	3	3
	3	12	11	11
M1830	0 or 1	0	0	0
	2	2	0	3
	3 or 4	10	7	10
	5 or 6	17	14	18
M1840	0 or 1	0	0	0
	2, 3 or 4	6	6	5
M1850	0	0	0	0
	1	3	3	1
	2,3,4 or 5	6	6	4
M1860	0 or 1	0	0	0
	2	6	6	6
	3	5	4	2
	4,5, or 6	20	20	18
M1033	4 or more items checked	10	11	12

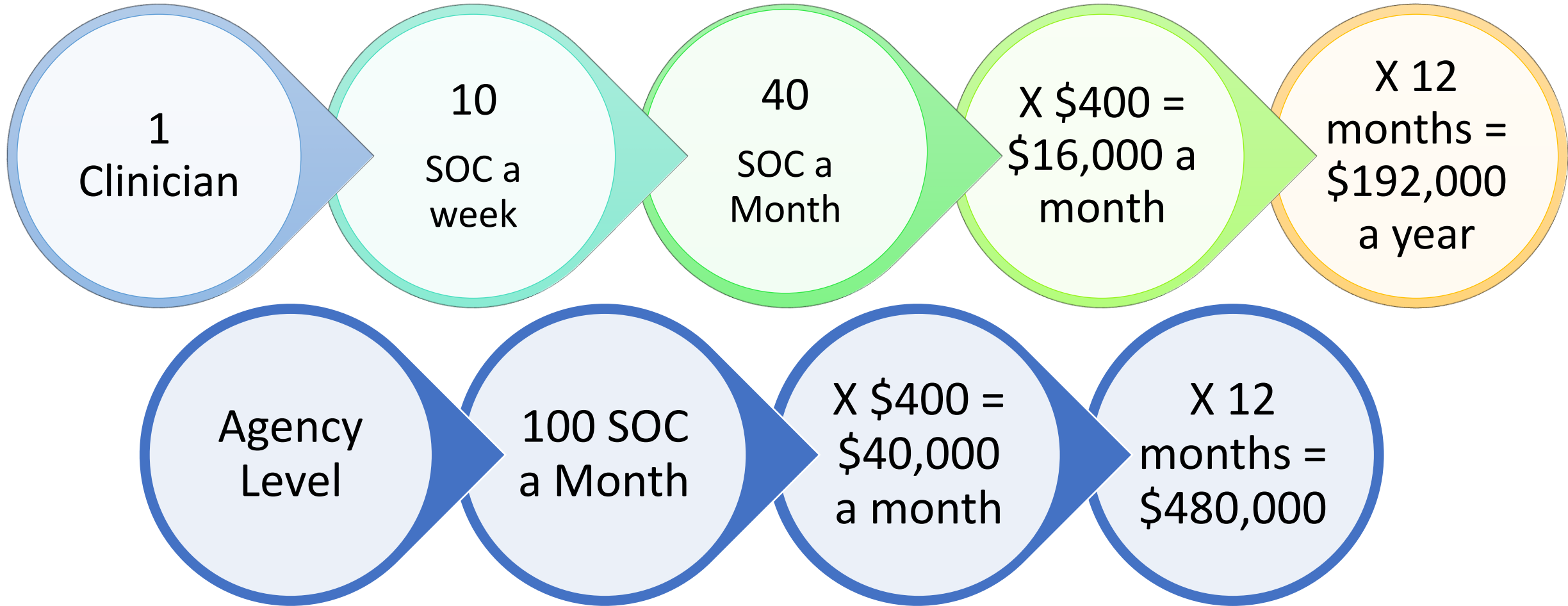
Functional Score Percentages



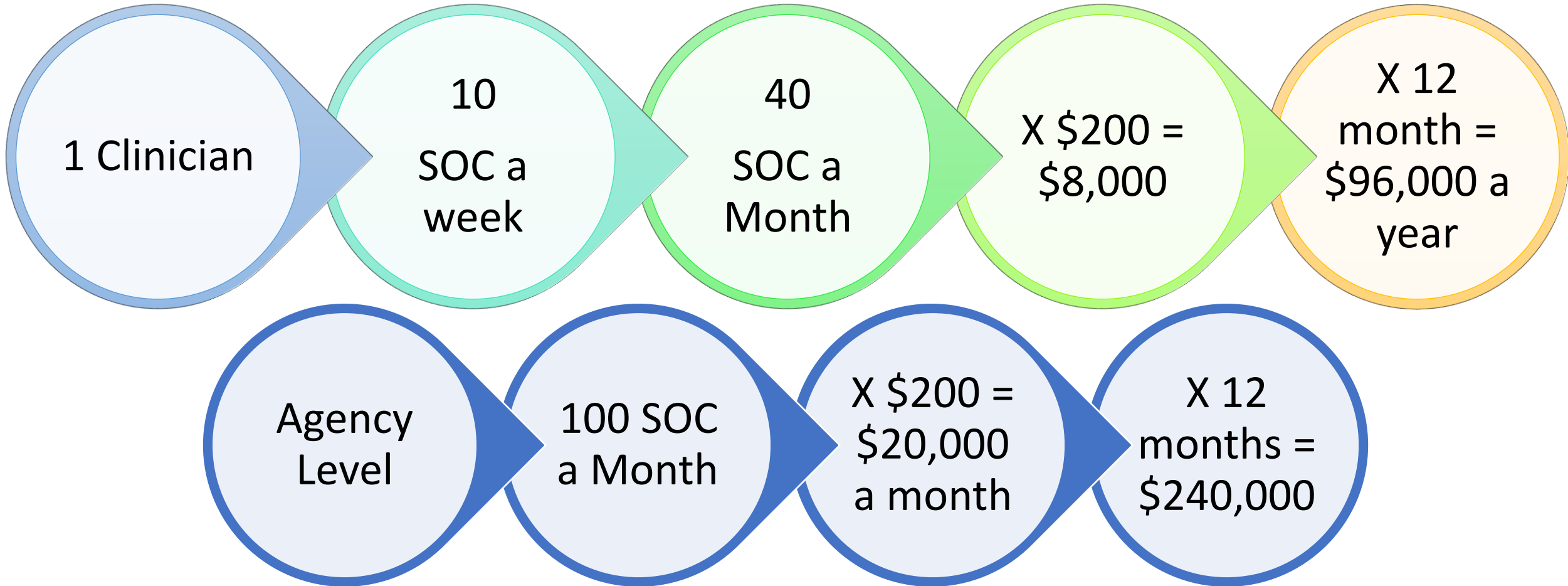
2025 Star Rating Data

Periods per Episode	1.67
Revenue per Period	\$1,937
Revenue per Episode	\$3,225
Visits per Period	7.84
Visits per Episode	13.06
Percent Early Periods	32.59%
Average Early Case Mix	1.26
Average Case Mix	0.99
LUPA Rate	7.25%
Percent Outliers	3.72%
Percent Functional Low	25.02%
Percent Functional Medium	32.22%
Percent Functional High	42.76%
Average Wage Index	0.99
Recert Rate	28.00%
Total Revenue 2025	\$2,979,070,403

Impact of Inaccurate OASIS Scoring (\$400)



Impact of Inaccurate OASIS Scoring (\$200)



IPR/APR

Performance Summary for TNC Change Measures [b]

Your HHA's count of eligible quality episodes [c]	102					
OASIS Item [d]	Changes in OASIS Item Responses between SOC/ROC and EOC as a Percent of Eligible Quality Episodes [e]					
	YOUR HHA			AVERAGE FOR YOUR HHA'S COHORT [f]		
	% No Change	% Positive Change	% Negative Change	% No Change	% Positive Change	% Negative Change
Total Normalized Composite (TNC) Change in Mobility						
M1840 Toilet Transferring (0-4)	16%	81%	3%	28%	71%	1%
M1850 Transferring (0-5)	15%	82%	3%	21%	78%	1%
M1860 Ambulation/Locomotion (0-6)	14%	81%	5%	19%	79%	1%
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)	8%	92%	0%	19%	80%	1%
M1810 Current Ability to Dress Upper Body (0-3)	7%	93%	0%	18%	81%	1%
M1820 Current Ability to Dress Lower Body (0-3)	8%	92%	0%	19%	80%	1%
M1830 Bathing (0-6)	11%	89%	0%	16%	83%	1%
M1845 Toileting Hygiene (0-3)	9%	91%	0%	20%	79%	1%
M1870 Feeding or Eating (0-5)	31%	68%	1%	44%	54%	2%

IPR/APR

Performance Summary for TNC Change Measures [b]

Your HHA's count of eligible quality episodes [c]	446					
OASIS Item [d]	Changes in OASIS Item Responses between SOC/ROC and EOC as a Percent of Eligible Quality Episodes [e]					
	YOUR HHA			AVERAGE FOR YOUR HHA'S COHORT [f]		
	% No Change	% Positive Change	% Negative Change	% No Change	% Positive Change	% Negative Change
Total Normalized Composite (TNC) Change in Mobility						
M1840 Toilet Transferring (0-4)	42%	56%	2%	28%	71%	1%
M1850 Transferring (0-5)	56%	43%	1%	21%	78%	1%
M1860 Ambulation/Locomotion (0-6)	34%	66%	1%	19%	79%	1%
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)	24%	75%	1%	19%	80%	1%
M1810 Ability to Dress Upper Body (0-3)	26%	73%	1%	18%	81%	1%
M1820 Ability to Dress Lower Body (0-3)	25%	74%	1%	19%	80%	1%
M1830 Bathing (0-6)	32%	67%	1%	16%	83%	1%
M1845 Toileting Hygiene (0-3)	23%	75%	1%	20%	79%	1%
M1870 Feeding or Eating (0-5)	53%	46%	1%	44%	54%	2%



Meet with us!



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CHANGES in HH VBP Quality Measures

Current Measure Category	Measures Removed	Replacement Measure Category	Replacement Measures 2025
OASIS-based	TNC Change in Self-Care	OASIS-based	Discharge Function Score (DC Function)
	TNC Change in Mobility		
OASIS-based	Discharged to Community	Claims-based	Discharge to Community – Post Acute Care (DTC-PAC)
Claims-based	Acute Care Hospitalization (ACH)	Claims-based	Home Health Within-Stay Potentially Preventable Hospitalization (PPH)
	Emergency Department Use without Hospitalization (ED Use)		

7 Measures of Quality for Star Ratings

Timely Initiation of Care (process measure)

Improvement in Ambulation (outcome measure)

Improvement in Bed Transferring (outcome measure)

Improvement in Bathing (outcome measure)

Improvement in Shortness of Breath (outcome measure)

Improvement in Management of Oral Medications (outcome measure)

~~Acute Care Hospitalization (outcome measure)~~

Potentially preventable hospitalization (outcome measure)

Home Health Within-Stay Potentially Preventable Hospitalization

Removal of ACH and ED use measures

Measure Title	Care Compare	NQF Status	Risk Adjusted	Measure Description	Numerator	Denominator	Measure-specific Exclusions
Home Health Within-Stay Potentially Preventable Hospitalization	October 2023 or as soon as technically feasible	Not Endorsed	Yes	Home health agency-level rate of risk-adjusted potentially preventable hospitalization (PPH) or potentially preventable observation stays (PPOBS) that occur within a home health stay for all eligible stays.	<p>The risk-adjusted prediction of the number of HH stays with at least one potentially preventable hospitalization (i.e., in an ACH/LTCH) or observation stay.</p> <p>For PPH, an HH stay is a sequence of HH payment episodes separated by two or fewer days. A separation between HH payment episodes greater than two days results in separate HH stays.</p>	The risk-adjusted expected number of hospitalizations or observation stays. This estimate includes risk adjustment for patient characteristics with the HHA effect removed. The "expected" number of hospitalizations or observation stays is the projected number of risk-adjusted hospitalizations or observation stays if the same patients were treated at the average HHA appropriate to the measure. Numerator over denominator times the national observed PPH rate equals the reported risk-standardized rate.	<p>1) Stays where the patients are less than 18 years old.</p> <p>2) Stays where the patients were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the HH admission date through the end of the home health stay.</p> <p>3) Stays that begin with a Low Utilization Payment Adjustment (LUPA) claim.</p> <p>4) Stays where the patient receives service from multiple agencies during the home health stay.</p> <p>5) Stays where the information required for risk adjustment is missing.</p> <p>If one of the four conditions occur, the stays will be excluded:</p> <ul style="list-style-type: none"> • Missing beneficiary's birth date information. • Beneficiary has gender other than male or female. • Missing payment authorization code information. • Beneficiary has Medicare Status Code other than the following: <ul style="list-style-type: none"> o Aged without ESRD o Aged with ESRD o Disabled without ESRD o Disabled with ESRD o ESRD only

Risk Factor 1: Demographics

Demographic Covariates

Age and Sex: Age-sex interaction covariates allow the model to account for the differing effects of age on the outcomes for each sex. Age is subdivided into 12 bins for each sex: ages 18-34, 35-44, 45-54, five-year age bins from 55 to 94, and one bin for ages over 95.

- The reference group is Male 65-69.

Enrollment Status: Original reason for Medicare entitlement:

- Age (reference)
- Disability
- ESRD

Functional Impairment Levels: Based on PDGM calculated functional impairment score/level.

- Medium (reference)
- Low
- High

Risk Factor 2: Care Received during the Prior Proximal Hospitalization

Covariates account for immediate prior care setting, principal dx and procedures

Length of Prior Proximal Hospitalization:

- 0-7 days (reference)
- ≥ 8 days

Clinical Classification Software (CCS) during Prior Proximal Hospitalization:

- Relies on CCS diagnosis and procedure groups to adjust for beneficiary health status during a prior proximal hospitalization, if a prior proximal hospitalization occurred.
- CCS diagnosis groups are defined using principal diagnosis codes from the prior proximal hospitalization.
- CCS procedure groups are defined using procedure codes recorded during the prior proximal hospitalization.

CCS Diagnosis Groups
No CCS Diagnosis due to No Prior Proximal Hospitalization (Reference)
Septicemia (except in labor) (CCS Diagnosis 2)
Mycoses (CCS Diagnosis 4)
Other and unspecified benign neoplasm (CCS Diagnosis 47)

CCS Procedure Groups
Incision and excision of CNS (CCS Procedural 1)
Insertion; replacement; or removal of extracranial ventricular shunt (CCS Procedural 2)
Laminectomy; excision intervertebral disc (CCS Procedural 3)

Risk Factor 3: Other Care Received within One Year of Stay

Covariates account for Prior Care Number of Stays and Comorbidities (HCC)

Covariate	Time Frame
Number of Prior Acute Discharges	In the past year, excluding those within 30 days prior to SOC/ROC
0 Prior Acute Discharges (Reference)	
1 Prior Acute Discharge	
2 Prior Acute Discharge	
3 Prior Acute Discharge	
4 Prior Acute Discharge	
5+ Prior Acute Discharges	

Risk Factor 3: Other Care Received within One Year of Stay

Covariate	Time Frame
Number of Outpatient Emergency Department Visits	Within 1 year of HH Stay
0 Outpatient ED Visits (Reference)	
≥ 1 Outpatient ED Visit	
Number of Skilled Nursing Facility (SNF) Visits	
0 SNF Visits (Reference)	
≥ 1 SNF Visits	
Number of Inpatient Rehabilitation Facility (IRF) Visits	
0 IRF Visits (Reference)	
≥ 1 IRF Visits	
Number of Long-term Care Hospital (LTCH) Visits	
0 LTCH Visits (Reference)	
≥ 1 LTCH Visits	

Risk Factor 3: Other Care Received within One Year of Stay

Covariates account for Prior Care Number of Stays and Comorbidities (HCC)

- **Hierarchical Condition Categories (HCC)**
Comorbidities: account for beneficiary health status *within one year of the HH stay*, using the HCC framework.
- HCC comorbidities are defined using **secondary diagnoses from the prior proximal hospitalization** (if a prior proximal hospitalization occurred) and all other diagnoses recorded in the inpatient, outpatient, and carrier settings during **the year prior to the home health stay**.

HCC Comorbidity
HCC8: Metastatic Cancer and Acute Leukemia
HCC9: Lung and Other Severe Cancers
HCC10: Lymphoma and Other Cancers
HCC18: Diabetes with Chronic Complications
HCC19: Diabetes without Complication
HCC21: Protein-Calorie Malnutrition
HCC28: Cirrhosis of Liver

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

Category & Source	Claims-based QM – from Medicare fee-for-service (FFS) Claims
Measure Description	<p>This measure assesses successful discharge to the community from an HHA, with successful discharge to the community including no unplanned hospitalizations and no death in the 31 days following discharge.</p>
Measure Calculation	<p>Numerator: The risk-adjusted estimate of the number of patients who are discharged to the community, do not have an unplanned admission to an acute care hospital (ACH) or long-term care hospital (LTCH) in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window.</p> <p>Denominator: The risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient characteristics with the HHA effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average HHA appropriate to the measure for home health stays that begin during the two (2) year observation window.</p> <p>Risk-Standardized Rate: Numerator over denominator times the national observed DTC-PAC rate.</p> <p>Measure-specific Exclusions: Home health stays discharged: to psychiatric hospital, against medical advice, to disaster alternative care sites or federal hospitals, court/law enforcement, or hospice; enrolled in hospice in the post-discharge observation window; not continuously enrolled in Medicare Parts A and B or enrolled in Part C; a short-term acute care stay or psychiatric stay for non-surgical treatment of cancer in the 30 days prior to PAC admission; discharge to another home health agency; or baseline nursing facility residents who return to nursing home as place of residence.</p>

DTC-PAC Calculation

Numerator

- The risk-adjusted **prediction** of the number of HH stays resulting in a discharge to the community (Patient Discharge Status codes equal to 01 or 81), without an unplanned admission to an ACH/LTCH or death in the 31-day post-discharge observation window.
- This estimate starts with the **observed discharges** to community, and is risk adjusted for patient characteristics and a statistical estimate of the HHA effect beyond case mix.

Denominator

- The risk-adjusted **expected** number of discharges to community. This estimate includes risk adjustment for patient characteristics with the HHA effect removed.
- The “expected” number of discharges to community is the projected number of risk-adjusted discharges to community if the same patients were treated at the average HHA appropriate to the measure. During the 2-year observation window.

DTC-PAC Reported Rate

$$\frac{\text{Numerator}}{\text{Denominator}} \times \text{National Observed DTC-PAC Rate} = \text{Risk-Standardized Rate}$$

Care Compare simplifies it

Discharge to community

Numerator

- Number of home health stays for patients who have a Medicare fee-for-service claim with patient discharge status codes 01 and 81, don't have an unplanned admission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window.

Denominator

- Number of home health stays that begin during the 2-year observation period.

How to improve? Set the patient up for success

- PPE
- Recert rate
- Medication Management
- Dyspnea
- Functional Improvement
- SDoH
- REAL Discharge Planning
 - Do not discharge until goals met
 - Discharge OASIS assessment



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Periods Per Episode—What's the Impact?

2024 Data

36.9 days

Periods per Episode	1.26
Revenue per Period 2024	\$2,264
Revenue per Episode 2024	\$2,850
Visits per Period	10.36
Visits per Episode	13.04
Average Early Case Mix	1.25
Average Case Mix	1.17
% Early Periods	64.03%
LUPA Rate 2024	8.53%
Recert Rate	8.81%

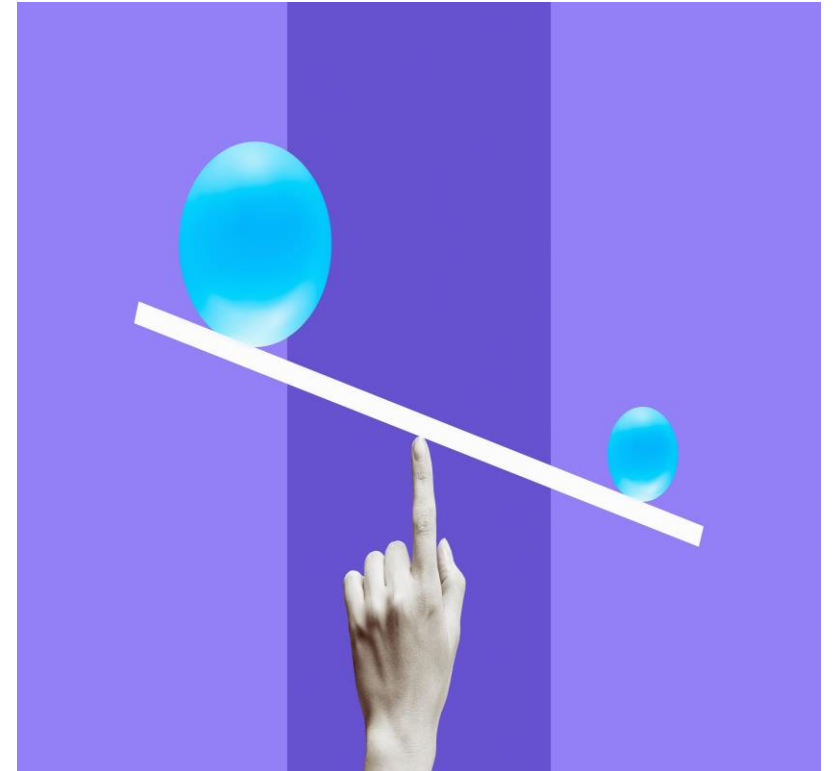
2024 National Data

51 days

Periods per Episode	1.70
Revenue per Period 2024	\$1,947
Revenue per Episode 2024	\$3,308
Visits per Period	8.07
Visits per Episode	13.71
Median Early Case Mix	1.25
Median Case Mix	0.97
% Early Periods	31.04%
LUPA Rate 2024	6.96%
Recert Rate	36.54%

Recertification or Discharge??

- ⦿ National average is 30.69%
- ⦿ Average for 4 star and higher agencies is 31.21%
- ⦿ Eligible for care?
 - Skilled care
 - Physician or NPP orders
 - Met all goals?
 - Patient set up for success
- ⦿ Plans for Discharge—follow through with patient's personal goals
 - Dangers of the Desk DC or NBDC
- ⦿ Treat OASIS as a part of the patient's ongoing health care instead of something we have to do for Medicare



Role of Follow-Up Phone Calls

- Use follow-up phone calls to supplement visits before discharge
 - Include medications, pain and safety on all the calls
- Include follow-up calls in your documentation
- Include follow-up calls on your claim with appropriate G code (no payment)
- Continue follow-up phone calls after discharge (no bill)
 - Once per week for 30 days (include it in your discharge teaching)
 - Medications, safety and pain
 - Any changes?
- Your goals are to:
 - 1) Anticipate any changes warranting additional care
 - New referral
 - Keep them out of the ACH/LTCH
 - 2) Top of mind if they receive their patient satisfaction survey



DC Function Measure: OASIS Items

Item	Item Description
GG0130A	Eating
GG0130B	Oral Hygiene
GG0130C	Toileting Hygiene
GG0170A	Roll Left and Right
GG0170C	Lying to Sitting on Side
GG0170D	Sit to Stand
GG0170E	Chair/Bed-to-Chair Transfer
GG0170F	Toilet Transfer
GG0170I	Walk 10 Feet
GG0170J	Walk 50 Feet with 2 Turns
GG0170R	Wheel 50 Feet with 2 Turns

- 10 GG items used to score 10-60
- The observed discharge function score is the sum of individual function items at discharge if scored with a 1-6.
- If an ANA score is used, the imputation occurs
- Different locomotion items are used if the patient uses a wheelchair than for the remaining patients.

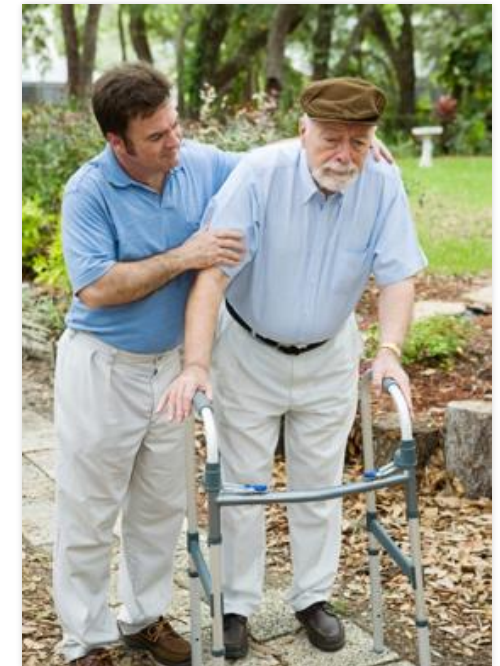


Knee Surgery – Both start as a 29 – What is the expectation?



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Item	Item Description	
GG0130A	Eating	6
GG0130B	Oral Hygiene	6
GG0130C	Toileting Hygiene	3
GG0170A	Roll Left and Right	2
GG0170C	Lying to Sitting on Side	2
GG0170D	Sit to Stand	2
GG0170E	Chair/Bed-to-Chair Transfer	2
GG0170F	Toilet Transfer	2
GG0170I	Walk 10 Feet	2
GG0170J	Walk 50 Feet with 2 Turns	2
GG0170R	Wheel 50 Feet with 2 Turns	



Covariate Groups Used to Risk-Adjust DC Function Score

Age Category	Admission Source
Admission Function Score	Body Mass Index
Prior surgery	Risk for Hospitalization
Prior Function/Device Use	Confusion
Pressure Ulcers	Vision
Cognitive Function	Medication Management Needs
Incontinence	Supervision and Safety Sources of Assistance
Availability of Assistance and Living Arrangement	HCC Comorbidities

iQIES Preview of HHA Quality Measure Scores to be posted on Care Compare

End Result Outcome Measures (REPORTING PERIOD: 04/01/2023 - 03/31/2024)

Measure Name	Number of HHA Episodes Included in the Numerator	Number of HHA Episodes Included in the Denominator	Agency Average % ⁽²⁾	State Average % ⁽³⁾	National Average %
Improvement in Bathing	34	81	73.03	86.66	89.28
Improvement in Bed Transfer	13	50	48.97	86.51	88.39
Improvement in Ambulation/Locomotion	25	70	67.98	84.97	87.50
Discharge Function Score	63	69	91.30	70.58	67.15
Improvement in Management of Oral Medications	57	92	82.03	81.21	85.98
Improvement in Dyspnea	36	66	76.91	88.32	89.70
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	0	115	0.00	0.38	0.25
Percent of Patients Experiencing One or More Falls with Major Injury	4	216	1.85	1.57	0.95

iQIES Preview of HHA Quality Measure Scores to be posted on Care Compare

Claims Based Outcomes Post-Discharge ^[1]

Discharge To Community - Post Acute Care (PAC) Home Health Quality Reporting Program

(REPORTING PERIOD: 01/01/2022 - 12/31/2023)

Number of Discharges to Community	Number of Eligible Stays	Observed Discharge to Community Rate	Risk-Standardized Discharge to Community Rate**	National Observed Rate	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Performed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
998	1,185	84.22%	89.48% (87.61%, 91.43%)	76.06%	Better Than National Rate	3,545	2,988	1,802	1,744

Claims Based Outcome Within-Stay ^[1]

Home Health Within-Stay Potentially Preventable Hospitalization Measure

(REPORTING PERIOD: 01/01/2023 - 12/31/2023)

Number of Within Stay Hospitalizations	Number of Eligible Stays	Observed Within Stay Hospitalization Rate	Risk-Standardized Within Stay Hospitalization Rate***	National Observed Rate	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Performed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
28	640	4.38%	5.63% (4.17%, 7.47%)	9.90%	Better Than National Rate	751	5,792	818	2,113

Data Analysis

Track Your Metrics

- ① Identify your agency's key performance metrics
- ① Implement systems for collecting, tracking, trending and analyzing data related to your agency's key performance metrics.
- ① Collect the data and monitor trends over time to identify areas for improvement, through use of:
 - Electronic health records (EHRs)
 - Quality improvement software; OR
 - Other data management tools, such as Analytics Vendor(s)
- ① Identify metrics that are demonstrating downward trends
- ① Look for patterns, root causes, and opportunities for intervention
- ① Ask for Expert Help!



Meet with us!



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QUESTIONS



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