Good afternoon everyone. My name is Olivia Henze and I will be moderating today's webinar. Thank you for joining us today. Today's webinar is called HHC-Making Your CASPER Data Work For You Part II: A Data Driven Approach To Improving Your Outcomes. I will review some housekeeping items. This call will be recorded for training purposes. I will provide you with details on accessing the recording at the end of this webinar. The phone lines will be on mute for the duration of this presentation and we will take questions at the end and I will provide instructions on how to on mute your line or you can pose a question in the chat box. At this time I will introduce today's speaker Ann Olson. Unfortunately Kathryn Roby was not able to present today. However you are in very capable hands with Ann. She is a health expert with the New England QIN-QIO. Her experience includes serving as a CEO of Interim Healthcare of Hartford a full-service healthcare agency where she lead consistent quality and financial outcomes and diversification through expansion to include a licensed home hospice division and a registered personal care and support division. Please welcome her.

Hi. Good afternoon everyone. I hope you are all doing well and enjoying a sunny day wherever this call finds you. It is so nice. We were having way too much rain last week. I don't know how you all feel but it has been a welcome change having some sunshine. So we are thrilled to be here today to talk about some important information about how to access your CASPER data. Just to give you a brief overview again of who we are. As Olivia mentioned, I am with Qualidigm. I am a vice president here, representing the New England quality innovation network the QIN-QIO. As you know or might not know, CMS had modified their QIO program and there used to be 53 contracts throughout the country. They did consolidate that down to 14 quality improvement networks or QIO contracts. So Qualidigm and HealthCentric advisors is the QIN-QIO for the six New England states. As you can see in the slide this is located in Rhode Island focuses on Massachusetts main in Rhode Island and Qualidigm which is where I work, we are focused on the Connecticut area and we also oversee New Hampshire and Vermont.

So we want to invite you all to visit our New England website that you see on the screen. There is a great amount of information there that you can access. And we really welcome you to view that. As I mentioned, working in the six New England states with HealthCentric we are providing and does a tremendous amount of education and we encourage you to visit the website.
You can see here, if you do sign on and go to the website, you can click on providers and that will bring you to a multitude of resources and information that can be helpful for you on a daily basis.

So today's agenda, we are looking to refresh your knowledge of the CASPER system. We actually had kind of a record registration for this program today. I believe I am speaking for all of you in that all home health agencies are feeling the pressure's to really be monitoring and improving their quality measures. We are all very focused on star ratings and implications of that. This is for us as providers. It is something that is really going to make a difference in terms of our market share and our sustainability and our ability to really compete in this ever-changing industry that we are in. So we are really excited to review the CASPER system for you, not only for the star ratings, but also thinking about value-based purchasing, which as you know, was released in January of this year and is impacting nine states. But it is something that will be coming to all of us and knowing where your quality stands and working on that to improve it will really position you for home health value-based purchasing in the future.

We are also going to be describing how the data is developed, reported, and used. We will be looking at some of the critical reports and CASPER. This overview will be just kind of an overview. Obviously. You will need to go play within the system that hopefully we can highlight those critical areas that will help you on a day-to-day basis to focus on improving some of your scores. We also want to talk about setting some goals for targeted outcomes. Obviously, that is where the rubber hits the road. We need to really look at what are we week in and what are our areas that we can improve. We want to set those goals and target them for improvement. We will also talk about some of the reports you can use to create PDF say plans and we will be reviewing that process. The bottom line is the CASPER reports as I mentioned can really help you to position yourself for success in this ever-changing market that we are in.

So where does the data come from? As you know, the home health care is really delayed in terms of the reporting of the outcomes. We all wish that it was a more up-to-date report, but it is not. As you know what is on home healthcare right now is really looking at October 2014 through September 2015. And when you're looking at the re-hospitalization data, which are different dates, that is July 1 through July 30 of 2015. So it is really hard to be looking at improving your scores when you are working on old information. So the important piece about CASPER, what to understand here, is the data is something is as real-time is available through the OASIS data that you submit through CMS. Obviously if you have OASIS scrubbers, you can be using that data as well. But this is a list adjusted information that is based
on completed episodes that you submit with your OASIS. A completed episode, as you know, is a start of care to transfer or discharge or a resumption of care to transfer or discharge. The outcome measures, I am sure this is a review for you. That really is looking at what was the end result of your episode and then the process measures mean what was your process and how did you work so hard to arrive at that end results?

So looking at the CASPER access, and I am sure you are all probably thinking, oh my gosh, this is what I need to know, right? Many of us have with the busyness of our days and agency demands, you don't get the CASPER site frequently and night and then when you do get there, you are confused as to how to access it and what do you do first and second. Obviously, this is really critical to maintaining your knowledge about your agency and hopefully, when we review the steps, it can help you to understand how to access the data and then what to do from there. So when you do log on to the national system, you will need your user id. That is your provider number and your password. If you don't know what your password is, you can click. You can see if you are unable to login, just click on the link there and that will prompt you to get the information you need to be able to login. We have heard of many agencies that possibly your quality person left and they left with your password. It happens. Don't feel like you can't submit that you don't know what your password is. You have more company in that category then I am sure people would like to admit. So it's important that you figure out your login and get your password and be able to get onto the system so you can get access to this great information.

So this next slide is really just showing you once you are able to login. And the red arrow is pointing to the CASPER reporting link, which is where you would be clicking so that you can get to all of the reports that we will be talking about.

Once you are here you get to this little more colorful slide. It has a lot of information. But as you can see, on the top right it's giving you several opportunities to access information. The one that you want to click on is the reports tab. It is in the middle of those tabs at the top.

Once you click on that, he will go into see this section here that says report categories. When you click on that, you will see the drop-down. You can see home health agency provider, OASIS OBQI and OBQM. And the survey report, which most agencies use their Vendor to access that information. And then the OASIS quality improvement report. The one you will want to click on is the OASIS quality improvement report or quality improvement tab.
So once you do that you will see access to a number of reports. We wanted to just highlight this is really a slide that you want to keep close to your computer. These are the ones you want to click on. There are a lot more reports that are available in the drop-down, which can get confusing. So you really want to just keep this is your go to list. This will really give you the information that you need to really drill down and understand what is going on for your agencies.

So the five essential reports, you can read them but I will go through them quickly. Number one, the agency patient related characteristic report, and that really provides a thumbnail sketch of your agency population, so just kind of giving you an overview of what your population looks at. Number two is the risk adjusted outcome report. That really compares your outcomes, and again that is the end result of the care provided. But it also accounts for the differences between your population and the expectations for patients who are like yours. And we will be talking about risk adjustments and some case mix considerations. That is where this report will take that information into consideration so that it is risk-adjusted. The third reports, all patients process quality measures report, this is the same process as your number two, but, again, it's looking at your process. How did you get to your outcomes? The fourth report is the home health agency trend analysis report, and this is a great report and we will show you a screenshot of that as we go forward. It's really important because it compares specifically the selected outcomes, month over month, to track the impact of your process improvement plan. So, again, this is more of current data that you can get on home healthcare and as we know, when you are working so hard to improve your outcomes, you need to see improvement. It's important for you as managers and it's also important for your staff to share this information so they can see how you are improving and how their hard work in the changes that you are making are really making a difference in your outcomes. This is a great way to show that. And to really celebrate your successes as you go forward. And the last report, number five, is the agency patient related characteristics case mix analysis summary report. This really allows you to identify a specific population that you want to focus your efforts on for your targeted outcome improvement. And we will be talking about some examples of that later. But as you know, it's important to be able to drill down to some specific patient populations that you want to focus on. And the last report that is up on the top right is a desired report. If they risk-adjusted potentially avoidable event. That is something that we all track from an agency standpoint. This is looking at your potentially avoidable events and this is a great report, not an essential report, but one that can help outline that for you as well.

So looking at improving your outcomes with a PDSA approach. It is really important that we look at all of the different variables that will help you to improve your outcomes. Again, this is the OBQI copy in the outcomes -based quality improvements
effort. Your PBQI is your process-based quality improvement, and the OBQM which is your outcomes-based quality management initiative. When you look at the circle and all of the intersecting circles, it's important to know that all of your efforts really do interact and intermingle with each other. It is not going to be just one particular effort that will make the difference. It is a combination of looking at your OASIS and collecting the data accurately in making sure your oasis OASIS efficiency is where it needs to be. If looking at the outcomes in interpreting the reports that we will be talking about and then targeting a specific outcome and investigating what processes possibly were not supporting the outcomes that you are trying to achieve. What is working and what are your strengths and problems and what are the best practices that are helping? And then looking at an action plan based on all of those pieces to develop the plan and implement it and monitor it and start the whole process again to say, okay, what worked and what didn't and then move on to your next initiative.

So where do you began? I know that it seems overwhelming at times. Home health has been bombarded with so many changes and challenges. Again, I need to stress to you that using your CASPER data really will help you improve your star ratings and position yourself for value-based purchasing. It is time well spent, and I congratulate all of you for being here on the call today to really try to understand how you can do this and what data can you access and what do you need from CASPER We will be talking about the case mix, which is a critical piece to the risk adjustment as you know. And I am sure there are many different agencies on the call with many different populations from an aging population to high cardiac or behavioral health and that is a tremendous challenge. So really looking at how those might be impacting your outcomes and your hospitalization rates, etc. We will be looking, as I said, at the process outcome reports and really trying to look at some targeted outcomes from these reports that can help.

So the next slide really looks at some of the data reports that are available. This is the first report that we talked about, the agency patient related characteristic report. I am sure many of you have seen this. This is something that again is a critical piece to drilling down your data, and this is the way it will display, so you are seeing what your current mean is. And the reference mean is what is the reference to compare your self to as a benchmark. How are you performing as compared to all of the cases in the reference sample? So in this example up on the top right you are seeing the current period, and then you are seeing the number of cases for your agency and then the number of cases that have been submitted through the system through all of the Medicare and certified agencies. That is how they are coming up with that reference mean. It's obviously a huge number so we are very valid and significant as far as the reference sample that you can compare your performance. The next report is looking at all patients process quality measures.
We talked about the process measures. That is looking at how you got there. These are more geared towards timely initiation of care. That is obviously a process. How are you doing as compared to the reference sample? Again, in this example, you are seeing the white is the current performance for your agency, and that is displaying I believe at 99%. I am squinting a little bit. And then your prior performance, which was 99%, and then the reference is 92%. So you are actually above what the national references. This is an area, again, I am a firm believer in congratulating staff on their efforts. You don't always or only want to relay the bad news. These outcomes are things you want to tell people great job and look at how we are measuring as compared to the rest of the country. Looking at care coordination. Again, these are critical pieces to the care and services that you provide. This is the process of ascents - assessment and depression being a critical area and it goes on from there, as you can see. But these are really important high-level categories that you can look at, and again share with your staff and look at as we move forward with the PDSA plan as you might improve them.

The next report is looking at your risk-adjusted outcome report. And again this is the outcomes versus the process. So this is what did you do actually. So we are looking at the improvement. These are again the same breakdown then when you're looking at the reporting and the bar graph there. So for the first one, for example, improvement in grooming. Unfortunately this agency is scoring under what the national benchmark is. So this may be an area of focus. Improvement in toilet transferring, when you move down a little further on this report. This is that 64%. But it did show that even though your current is at 64, your prior was 67. So it is moving in the wrong direction. Again, there are many trends that you can take from these paragraphs that can show you how you are doing and are you improving or are you slipping a little bit. As we all know, sometimes you put a great plan in place and things get better and then unfortunately our attention to that might slack off a bit and the outcome will reflect that. So again this kind of report is really important that you are consistently and frequently looking at so you can see how you are doing and how your improvement plans are working and if there are any improvements, congratulate your staff. And if there are any sliding office or going down that you want to consider putting another plan in place to impact that.

So how do you establish a plan? What additional data do you need from CASPER? I mentioned when we were looking at the different reports, or the different reports available, that there is a home health agency trend analysis report. And again this is looking at what you're trending is as compared to your rates and the risk-adjusted rate, so that is comparing you to agencies like your agency, which is really helpful to do,
and it's important to keep that in mind. Also, it is looking at running your or analyzing your characteristics of these negative outcomes.

So looking at who, meaning which cases in which patients and I said each one of you could mention maybe two or three or five patients that you know of that are causing your hospitalization rates to be higher than you want to be. Or some other patient challenges that you just know that that patients that you that had for a significant amount of time is causing you to have some negative outcomes. But there are reports available in CASPER, specifically this tally report that we will be talking about, that gives you the ability to drill down the information to particular patients and say, okay, so if I scored low on one of those outcomes or process measures that we talked about, who are the patients that are driving those numbers? Where is that coming from? It is probably the two or three or five patients that you know about, but I would dare say that there are some patients that you don't know about, and that is what this report will help you to do. So looking at the next trend analysis report, this does give you a nice overview of where your agency is as compared to your actual rates. So this is your actual OBQI report and then your list adjusted rate, which is available on home healthcare. It's really comparing those two reports, and you can see how that range is. It is very close to where the actual is. But it is what is publicly reported on home healthcare and it's important for you to see that these are very much in sync with each other and is their opportunity to impact those. You can also see further down on the breakdowns, it goes through month over month. So in this example, we are seeing February 2020 month over month. So in this example, we are seeing February 2015 through January 2016. Again, this is much more current data than is available on home healthcare so this is something that you really want to be taking a look at and how your agency is rating in terms of your risk-adjusted score. This is how you are scoring as compared to the national references, and you can see the different percentiles broken down there as well.

This other report, this is just a more detailed emergency department with hospitalization report. It is the agency patient related characteristics analysis summary report, and again it is drilling down further in terms of one specific area that you can see the emergent care, no emergent care and the difference between the two.

This is illustrating the tally reports that I mentioned to you, so if we look through the report from the top down, you can see the agency name and where you are located in the provider number. But then looking at the reporting period, and was very important is to notice the legend which is on the left-hand side there, the third-down. It's telling you how to interpret this patient findings. So you have X, meaning that their outcome is achieved and zero meaning that they did not achieve the outcome and U meaning the outcome did not relate or was not applicable to that patient. Again, you don't have
to be a rocket scientist to know that you want to be zeroing in on the zeros. Those are
the patients that, for example, you see that your improvement in toilet transferring is
lower than what you would like, and you are thinking you really want to focus on that.

You might want to look at Douglas do right. Look at Douglas’ record. And really see
what was it that was happening with them and was there something that we could
have done in particular with him that would have improved his outcome. And then
taking that to the next step is there something from a process standpoint that can be
applied to patients across your agency that could impact that score. So that is really
just one example of how to drill that down. So looking at what is the plan and how are
we going to do this. As I mentioned, you really want to drill down to the per patient.
That is really where you are going to see exactly what is happening and what can you
do to impact that. So the chart auditing is something that we all need to do,
unfortunately. I know in this day and age of electronic medical records and all of the
things that are automated in our world we would love to be able to push a button and
have it already for us. Unfortunately, we are not there yet. So we still need to go back
to the chart and drill down and say, okay, what is going on with this particular case
and how can we learn from that. The example that we are using here today is looking
at your acute care hospitalizations. When you ran those reports you found that your
hospitalization rate was higher than you wanted it to be. You want to look at which
patients did get readmitted. So you'll run that tally report and drill down. Look at was
it a preventable hospitalization. If it was, what targeted plan could you create that
could help to address that.

Also, if you are looking at an area for medication compliance. Is this something that
you can impact. If there is a reasonable goal or is there just able is a. What is more
appropriate? And if you could have improved compliance, what could you have done
to do that. So the PDSA and I am sure that most of you are familiar with that, but I
will just identify what that acronym stands for. So the P stands for plan, and that really
includes collecting and analyzing data so that you can determine the trends and that
really is all of the reports that we have just been talking about. The letter D stands for
do and that really speaks for itself. What changes can you implement? This can be
OASIS training or some patient experience initiatives to improve your survey scores,
but it is really what are you going to do about the data that you found and the analysis
and the trends that you found. Once you start a plan, and you start doing something
about what you have identified, you need to study the impact of those changes. Again,
that is what the CASPER reports will enable you to do. So put your plan in place and
implement it and then go back to those reports and see, are you making a difference.
Is it helping you and is it improving the outcomes and the process outcomes that you
are trying to achieve? The last letter, K, is to act. That is to revise the plan or keep it
going because you are seeing the improvement that you want to achieve.
Looking at the D for do, and we are just offering suggestions on things that you can do to implement your plan. Again, you have ran your reports and you have identified your trends and you have seen what you want to improve on, so what can you do about it? There are a few examples listed here. This is by no means an all-inclusive list. Obviously staff education and engagement is a key piece. Why is it important to your agency? We talk about motivational interviewing all the time in patient care. I think we need to really challenge ourselves to say what will motivate our staff to engage in these plans. Why does it matter to the agency and why will it matter to our staff and help to make it pertinent for them in their term so they can really just embrace what you are presenting and understand why you are proposing it. Really give them the information that they need to be able to implement the strategies that you have identified.

Looking at the patient education and engagement materials, the BPIPs, that are available at HH QIP. This is a tremendous resource to you and I hope that all of you are accessing the data and the resources that are available on HHQI. The BPIPs do have the call the nurse first program. This is a great initiative and strategy to impact your hospitalization rate. This is again so your patient calls the nurse before they get in the car and go to the emergency room. Or the personal emergency plan. These are just two examples of the BPIPs that are available on HHQI. I would really encourage you to go to that site if you are not registered and register and access that information. Another key area for implementing the plan, is getting our doctors to cooperate and assist us in our goals. So much of hospitalization depends on the physicians that you are working with. The position that might the on call when you reach out to them because their patient gets into trouble. So looking at whether you can have some what if plans with the doctor. So really trying to brainstorm and put some plans in place. Again, looking at that acute-care hospitalization example, that might prevent the patient from going to the emergency room. Obviously if they need to go, that is fine, but what can we do with the doctors to try to identify some parameters, whether it might be blood pressure or maybe additional Lasix for someone. I'm sure you have many examples of where you have enlisted the doctors to help you to impact your hospitalization rate, and we need to try to just continue to expand the data to drive that home. We also list at identifying what data are you going to collect his implement the plan. Again, the reports that are available on CASPER are much more current than what is available in home health compare. We encourage you to also look at some specific items that you can access, possibly through your EM are or through your OASIS scrubber that can help you to get even more current data that will show you how to study the impact and study that and the impact of your changes and how often are you going to do that. Put a plan in place for that. Again, look at whether you need to act to revise the plan.
So we talked about, as I mentioned, studying your progress and seeing how you are doing in this initiative. Tracking the rates, as I mentioned, and using your scrubber. We have identified the letter M items here that you can use to track your hospitalization please. You also can do the CASPER home health trend analysis that I referenced. You can also do the agency patient related characteristics case mix analysis summary report. That's a mouthful of a report. You can look at that as well. You need to identify again, make a plan of what this study will look like for you. How often are you going to be doing it. Again, it is so important to communicate your progress to your staff. The worst thing any of us can do is to put a plan in place and then not circle back with the staff as to how they are doing. It will just die on the vine. You have to keep it alive and you need to study it and communicate with your staff as to how it is going.

So once you have done that, what is the data telling you and how is your staff appearing? Are they motivated? I talked about that motivational interviewing piece. Possibly have your staff on a task force with you. When I worked in the agency I was that, we brought field clinicians and as part of our performance improvement plan. They were the ones who really knew what was happening in the field, and always asked the clinician, your most problem clinician, to be part of your task force. You can guarantee that those are the ones who will be talking to all of the other staff and they will talk it up. They will be your greatest advocates if you can get them on board. You will be safe and ready to fly. Again, if you can include them, the more you can include them, the better. Part of this revision is obviously what are some of the obstacles. And this is something, unfortunately, we are all too familiar with. You can put great ideas and plans, but there may be obstacles or one particular physician who is not going to be collaborative. Well, we just need to identify that and move on. So just be aware of what your obstacles are. And then how can you reduce any of those obstacles so that you can improve the outcome?

So hopefully, I have given you a lot to think about. As I mentioned, we are here and all of the home health leaders are here to answer your questions and be available for you, but we would love to address any of the questions that have been sent over. I will let Olivia read those for all of you now.

Thank you. If you would like to ask a question, you can press pound and the number six on your phone to unmute your phone or you can pose a question in the chat box but make sure you send it to all participants.

Just so everyone knows, the link for the handouts for this presentation will be available on our website. The link is there, and we will be sending out thank you e-
mails with the link again as well. It looks like we have a question from Alan. Please explain risk adjustment and which report we should use.

We would need a full other session to talk about risk adjustment. That's a really tough area to give a high level highlight on. But risk adjustment really is looking at the difference of your patient population and trying to say, is your case mix younger and healthier or is your case mix a more old or frail population. So it will really be comparing you to your peers. For example, if your case mix was a younger and healthier population, and looking at that same example, the acute-care hospitalization that we talked about, if your population is younger and healthier, your acute-care hospitalization rate should be lower than an agency whose case mix was a more old or frail. That makes sense, right? So the risk adjustment is exactly that. It is adjusting your outcome based on the complexity of your patient population. The more complex your patience are or the higher your case mix, the adjustment will be in your favor. So if your actual acute-care hospitalization rates were the same, if you have a young population, but your ACH rates were the same, your risk adjustments would raise your outcomes for to reflect that younger and healthier case mix. So it is really giving a consideration for the patients that you serve. The reports that are available for that are actually in the names of the report. So it does specifically say risk-adjusted. So you can see. I am looking for the list. The risk-adjusted outcome and the risk-adjusted process report are the ones that you want to be looking at that is taking that into consideration. I hope that answered that.

A question from Bonnie. What is the reference group that was discussed in the first report described?

So the first report that we described, I am circling back here, I believe you are talking about the agency patient related characteristics report. That was the title of the slide, it was data. I think I've mentioned the reference sample. It was 631-6068. So a large reference sample. That was the reference group. That's all agencies that report OASIS and how your demographic and how your payment scores and episodes and inpatient discharge medical regimen, how all of those compare to that huge reference group of all oasis submissions.

Thank you. Again, if anyone has any questions, they can post it in the chat box or they can press the pound and the number six to take the mute off their line. We will give it a couple more minutes.

Can you tell me what the time period is that you measure hospitalizations or re-hospitalizations for emergency room visits?
What the timeframe?

When you are taking your job to consider whether a patient has been submitted to the hospital or admitted to the hospital percent to the area, how much time are you looking at? Are you looking only through the time we are caring for the patient or do you do it say anytime after the patient is discharged?

I guess there is a couple of answers to that. It's a great question. When you're looking at the reports that are available on CASPER, you will be able to click on a specific period. So the current period that will be looking at it's really an established timeframe, so it's not something you can specify. It really is what has been loaded and is available to you. When you're looking at drilling down on your like PDSA plan, I would recommend as real-time as possible. So if you do have a patient who gets readmitted, we had as I mentioned a readmission task force and we would gather on a weekly basis to look at those cases. So it was very real-time so you could actually implement some lessons learned on that particular patient. As we know, a patient who goes back to the hospital is more at risk to go back again. You want to kind of do both levels of that, looking at the CASPER. That will give you more of the high-level. But also do a real-time in terms of your active clients who do get readmitted. Does that make sense?

Yes. I guess if I could go further because we discharged patient and that patient is subsequently admitted or visits the hospital for any length of time, and we still penalized are once we discharge a patient, are they no longer looking at statistics for re-hospitalization or EER visits?

Great question. Actually, they are not looking at that for home health as it. Although all indications are they will. That is not a measure for us as of yet. As you know, with payments and shared savings plans, they are actually the health system or the ACO or some of the level III plans, for nursing homes, that are going to be penalized for readmissions from when they discharge someone, if it's within that 30 or 60 or 90 day period, they can get penalized. We don't get penalized currently. The one penalty that could occur is that your referral sources. So the hospital or the nursing home, if they see that you have a lot of the patients that they refer to you end up going back to the hospital and they are getting penalized, I would dare say that the referral part pattern to you might end up getting impacted. That would be kind of the indirect penalty, obviously, so it is something that we need to be aware of as well.

Thank you.

Hello. I feel like I'm on a talk show.
I know you mentioned three re-hospitalizations. What are the criteria on the area you are looking at? Could you understand?

So what criteria are we looking at for re-hospitalization?

Know you said one of the areas that you are looking at his re-hospitalization. What are all the things that we have to make sure or look at apart from re-hospitalization? What other areas are they looking at?

Great question. What I would do is I would actually look at your star ratings. So go on to home health compare and look at what your star ratings are and tried to see how you are scoring in the star ratings. If you are low in some of the areas, whether it's ambulation or some of those other key areas, you would want to look at those with your CASPER report so it will be more current data on the same measures. And then you really want to look at trying to impact does. As I mentioned before, the star ratings, I don't know if you all realize, but all of the star rating indicators are in the value-based purchasing measures. The only one that isn't is the timely initiation of care. So all of the star rating indicators are part of value-based purchasing. So if it were me and I was still running an agency, that is where I would start. And then going to your reports to get more current information in terms of those indicators and then trying to put a PDSA plan in place for the ones you are scoring below that are feeding the stars and making you maybe three stars instead of four or four points 545. Does that make sense?

Yes it does. All right.

Great.

Thank you.

You are welcome.

Anyone have any other questions? While we are waiting, I think she wants to talk about the slide that we have currently up right now.

I want to emphasize we are here to help you. This is really important to your success in your sustainability. You need to really make this part of your normal practice. Again, we are here to support you. So you can see the six New England states listed here and the home health leads. You have experts in each of your states who are
Hello. I have a question on the risk adjustment because I am so confused on it. Is that based on each individual patient or is it based on your population of the total agencies? For instance we have several younger patients that are having joint replacements that may be in the 50 or 60, relatively in good health except for good use of the joint. We have several patients that are chronically ill as well as advanced management patients. So they have just gone, not just one individual patient with adjustment looking at the whole patient population.

It's a great question so the risk adjustment is based on the population. But it's a based on the Case mix of your individual patients. So, as you know, your case mix really drives your score and drives your reimbursement. That is particular to that patient and that OASIS assessment. For all of your patients kind of drills or equals your patient population case mix. That is what is taken into consideration for the risk adjustment.

Okay. Thank you.

Does that make sense?

Yes it does.

Thank you you're welcome.

I know Olivia has put up our next webinar, which Kathy Roby is doing through the HHQI CardioLAN. You can see the link there. We invite you to join that. We hope you will join, and Kathy will be happy to share her words of wisdom at that time.

Thank you. I want to thank you all for a great discussion and thanks Anne for filling in for Kathy. The evaluation will automatically pop up on your computer when you close out of the webinar. If you can fill that out, we would appreciate that. If you don't have time to fill that out right now, you will receive an email tomorrow morning with the link for the evaluation as well as the link to the event page on our website. The PowerPoint will be posted on our website. We had a make a few adjustments to it, but it will be posted today and within the next few business days a recording and a transcript will also be added. Be on the lookout for e-mails about a next webinar. The New England home health will be taking a break for the month of June. Thank you for attending. And thank you again to Anne.

Goodbye. [Event concluded]