PROVIDERINSIGHTS

Home Health Hospitalization Measures Compared

CMS Claims Based Measures *(Traditional Medicare Patients Included)*

This tool provides the distinctions between CMS claims-based measures, involving hospitalizations, at a glance!

Measure	Timeframe	Definition/Goal	Helpful Hints for Home Health Professionals	Impacts
60-Day Acute Care	First 60 days of care	Measures the percentage of patients who are hospitalized for an acute event within 60 days after SOC. The goal is to minimize hospital readmissions.	• Coordinate with primary care providers to monitor patient status. • Engage in regular follow-up care to prevent readmission. Ensure clear discharge instructions and post-discharge support.	Publicly reported on Care Compare. Retired from Star and HHVBP
Potentially Preventable Hospitalization (PPH)	The entire stay. Counts one time, even if multiple hospitalizations	Measures the percentage of hospitalizations that could have been avoided through improved care and management of health conditions. Focuses on preventable hospitalizations.	• Identify high-risk patients early and implement preventive strategies. • Educate patients and caregivers on early warning signs and when to seek care. • Conduct regular assessments of patients' conditions.	Impacts five star and HHVBP beginning in 2025
DTC-PAC (Discharge to Community Post-Acute Care)	31 days after discharge	Measures the percentage of patients discharged who remain in the community without hospitalization for 31 days.	• Implement touchpoints during the first month after discharge. • Ensure continuity of care by coordinating with community services. • Promote patient independence and safe home environments.	HHVBP beginning in 2025

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Helpful Hints For Home Health Teams That Impact ALL Claims Based Measures:

Communication:	Ensure clear communication between the home health team, primary care physicians, and family members.
Patient Education:	Educate patients and caregivers about managing symptoms, when to seek care, and self-care strategies to prevent readmission.
Timely Follow-Up:	Schedule follow-up visits as needed to monitor the patient's condition and address any potential issues early. May include “front-loading” visits.
Comprehensive Care Plan:	Develop individualized care plans that include prevention strategies for avoidable hospitalizations and support for safe community reintegration.
Discharge Planning:	Ensure timely patient-empowering discharge planning is provided. Implement “touch points” with high-risk patients for 31 days after discharge.

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