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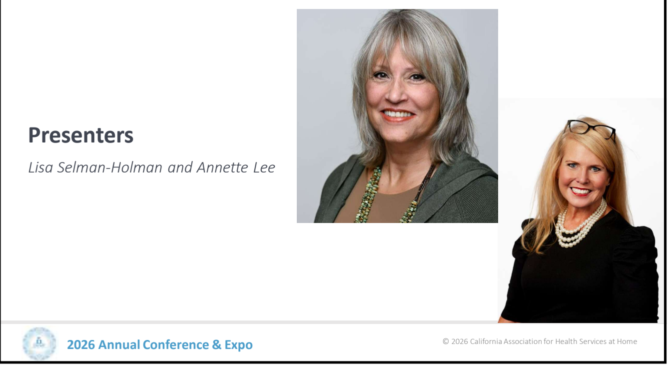

2

No final DC assessment
Bad Habit- No matter what you call it!
DDC, NVDC, BODC

Discharges without a visit to complete the OASIS

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What's the Requirement?

Discharge from agency services requires an *in person visit* to complete the assessment.

A Discharge (DC) OASIS is required within 2 days of discharge.

- Agency policy may dictate the date of discharge, e.g., date of the last visit or, 2 days after last visit in the case of a required notice of discharge to the patient or request for discharge.

In the case of an unplanned discharge, CMS still requires the DC OASIS to be based on an assessment. There is no OASIS guidance allows for a "non-visit" discharge OASIS assessment.

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Benefits of Completing a Compliant DC OASIS

An accurate discharge OASIS assessment and a timely discharge are essential to keeping that patient safe at home.

An effective discharge is even more important with the Discharged to Community—Post Acute Care VBP claims-based outcome (and impacts MSPB, too).

You need a real end timepoint for the outcomes (Improvement in Oral Med Management, Improvement in Dyspnea, DC Function)

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Should We Recertify or Discharge the Patient?

Recert

- Of course I'm going to recert her. Who will take care of her if we don't?
- I think we should recert him because he doesn't want us to go.
- I need to recert, because I get extra money if I don't discharge.
- If I discharge, I have to complete that LONG OASIS.
- She is my favorite patient.

- *Discharge*

- I say we discharge. He keeps refusing all my visits even after we agree on a day & time.
- She keeps hiding her meds and saying that she took them.
- I'm coming to the end of the first 30 days (or 60 days). I have to discharge.
- He lives 27 miles beyond my next farthest-away patient and I'm tired of driving that much.

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From Bad to Worse

The patient refused another visit, so the decision was made to do an NBDC. The PT was the last qualified clinician that saw the patient, but she doesn't do OASIS, so the RN who saw the patient 3 weeks ago will complete the DC OASIS.

No communication with the patient regarding DC plans or arrangements for seeing the physician or getting her meds from the pharmacy

No good way to determine how to answer the GG items or other items at DC.

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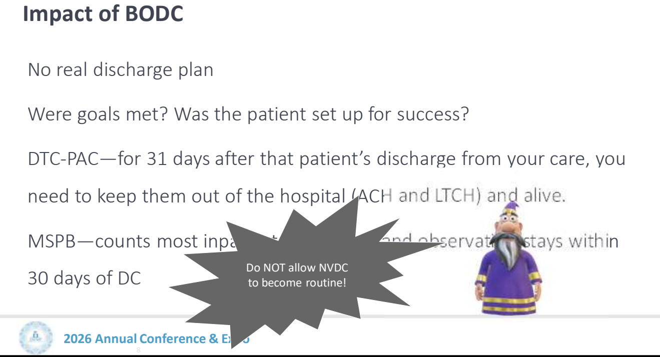

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What to Do

DC planning from the first visit, emphasizing the patient's goal.

Get a *meaningful* "Patient Centered Goal"

Emphasize with the patient ready to be discharged the importance of completing the DC OASIS in person

- It helps to tell the patient that it is a Medicare requirement.

Keep in touch with that patient after discharge.

- Care calls
- Ensure the patient knows how to reach the agency with questions

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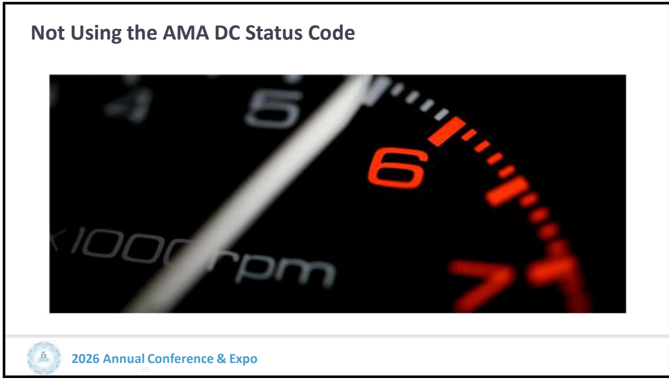
Not Using the AMA DC Status Code



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Here's where DTC is on your VBP reports.

CY 2025 Measure Set: Final Achievement Thresholds and Benchmarks

Measure	Data Period [b]	Achievement Threshold [c]		Benchmark [c]	
		Smaller-volume Cohort	Larger-volume Cohort	Smaller-volume Cohort	Larger-volume Cohort
OASIS-based Measures					
Discharge Function (DC Function)	12-31-2023	51.355	62.350	91.426	83.179
Improvement in Dyspnea	12-31-2023	83.260	89.672	100.000	99.422
Improvement in Management of Oral Medications	12-31-2023	73.666	85.175	99.997	98.746
Claims-based Measures					
Discharge to Community – Post Acute Care (DTC-PAC)	12-31-2023	75.665	85.161	93.536	95.089
Potentially Preventable Hospitalizations (PPH)	12-31-2023	10.066	10.003	7.565	6.302
HHCAHPS Survey-based Measures					
Care of Patients	12-31-2023	-	89.507	-	94.585
Communications Between Providers and Patients	12-31-2023	-	86.821	-	93.192
Specific Care Issues	12-31-2023	-	82.373	-	91.297
Overall Rating of Home Health Care	12-31-2023	-	86.328	-	94.687
Willingness to Recommend the Agency	12-31-2023	-	80.226	-	91.391

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Discharge to Community-PAC

Care Compare simplifies it

- 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.

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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.

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Against Medical Advice Discharges

3. Discharges against medical advice

Rationale: Patients who discharge themselves against medical advice are excluded because their care plan may not have been fully implemented, and the discharge destination may not reflect the agency's discharge recommendation. Additionally, patients discharged against medical advice may potentially be at higher risk of post-discharge admissions or death, depending on their medical condition, or due to potential non-adherence or non-compliance with care recommendations.

Disappears off the face of the Earth

Refused further visits

Discharge because of non-compliance

Document discussion with the provider!!

Patient's right to self-determination or autonomy while attempting to do what you think is best for the patient

Inadequately treated medical problems can result in the need for readmission

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When is 07 appropriate?

The patient voluntarily terminates services before the planned discharge date without clinician agreement.

The patent refuses further skilled care, despite education on risks and benefits.

The patient leaves the home health plan of care abruptly, and the agency has made reasonable efforts to:

- Educate the patient on consequences.
- Offer alternatives or adjustments to care.
- Engage caregivers or family if appropriate.

The provider who ordered home health care should also be consulted.

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When is 07 not appropriate?

The patient is discharged due to completion of care goals or stabilization.

The patient is transferred to another provider or care setting (e.g., SNF, hospice).

The patient is non-compliant but continues to receive care.

The discharge is initiated by the agency due to safety concerns, ineligibility, or lack of skilled need.

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Documentation Tips:

1. Clearly state who initiated the discharge and why.
2. Include date/time of last contact, patient statements, and staff actions.
3. If the patient refuses to sign an AMA form, document the refusal and witness statements.

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Using ANA Codes Inappropriately

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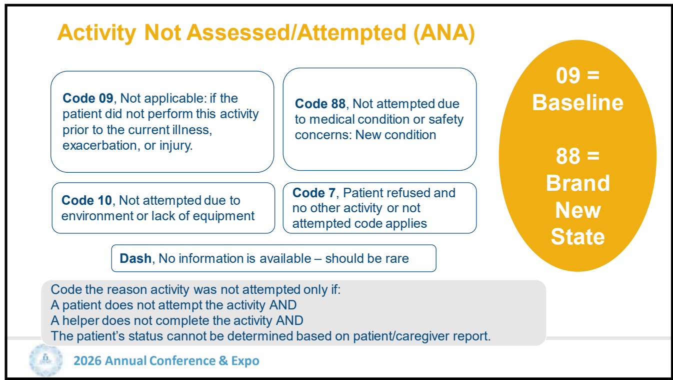

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New 2025 Achievement and Benchmarks

What is your Improvement Threshold? (IPR Tab: CY2025 Baseline)

Measure	Measure Weighting	Large Cohort Statistics				
		25th Percentile	50th Percentile	75th Percentile	90th Percentile	99th Percentile
OASIS-based Measures	**35%**					
Discharge Function (DC Function)	20%	51.180	62.350	70.090	83.179	91.260
Improvement in Dyspnea	6%	81.109	89.672	94.382	99.422	100.00
Improvement in Management of Oral Medications	9%	75.179	85.175	91.280	98.476	100.00
Claims-based Measures	**35%**					
Discharge to Community - Post Acute Care (DTC - PAC)	9%	73.550	80.510	84.980	90.123	92.670
Potentially Preventable Hospitalizations (PPH)	26%	11.720	9.760	8.110	6.081	5.080
HHCAHPS Survey-based Measures	**30%**					
Care of Patients	6%	87.076	89.507	91.524	94.585	96.319
Communication Between Providers and Patients	6%	83.649	86.821	89.355	93.192	95.123
Specific Care Issues	6%	77.812	82.373	86.020	91.297	93.984
Overall Rating of Home Health Care	6%	82.336	86.328	89.659	94.687	97.805
Willingness to Recommend the Agency	6%	74.880	80.226	84.714	91.391	95.268

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Where do you stand?

CY 2025 Measure Set: Performance Summary

Measure	Performance Year Data Period [b]	Your HHA's Performance Year Measure Value	Your HHA's Percentile Ranking Within Your HHA's Cohort [c]	Your HHA's Cohort Statistics [d]			
				25th Percentile	50th Percentile	75th Percentile	99th Percentile
OASIS-based Measures							
Discharge Function (DC Function)	03-31-2025	87.722	≥75	54.157	67.487	76.738	95.290
Claims-based Measures							
Discharge to Community – Post Acute Care (DTC-PAC)	12-31-2024	93.941	≥75	78.080	84.772	89.229	96.798
Potentially Preventable Hospitalizations (PPH)	12-31-2024	5.540	≥75	12.517	10.371	8.642	5.345

CY 2025 Measure Set: Performance Summary

Measure	Performance Year Data Period [b]	Your HHA's Performance Year Measure Value	Your HHA's Percentile Ranking Within Your HHA's Cohort [c]	Your HHA's Cohort Statistics [d]			
				25th Percentile	50th Percentile	75th Percentile	99th Percentile
OASIS-based Measures							
Discharge Function (DC Function)	03-31-2025	56.000	25-49	54.157	67.487	76.738	95.290
Claims-based Measures							
Discharge to Community – Post Acute Care (DTC-PAC)	12-31-2024	63.360	<25	78.080	84.772	89.229	96.798
Potentially Preventable Hospitalizations (PPH)	12-31-2024	24.598	<25	12.517	10.371	8.642	5.345

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Answering the GG Items is a BIG DEAL!

- Activity Not Assessed/Attempted (ANA) responses are IMPUTED to a 01 to 06 response
- Discharge responses are imputed *(what should the score be, based on the other info in the assessment?)* and compared to the agency response
- We do not want CMS guessing for us!

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DCF Coefficients

Covariate	GG0130A1	GG0130B1	GG0130C1	GG0170A1	GG0170C1	GG0170D1	GG0170E1	GG0170F1	Locomotion 1 Walk (GG0170I1)	Locomotion 2 Walk (GG0170J1)	Locomotion 1 Wheel (GG0170R1)
Prior Functioning: Self-Care — Dependent	-0.1549	-0.1695	-0.1569	-0.0648	-0.1969	0.0853	-0.1892	-0.0296	0.3177	0.0982	-0.0477
Prior Functioning: Self-Care — Some Help	-0.0497	-0.0405	-0.0156	0.0452	-0.0165	0.0491	0.0102	0.0723	0.1083	0.0302	0.0208
Prior Functioning: Indoor Ambulation — Dependent	-0.2327	0.1388	-0.0680	-0.1494	-0.0797	-0.2342	-0.1070	-0.1680	-0.7771	-0.3103	-0.0719
Prior Functioning: Indoor Ambulation — Some Help	-0.2010	0.0727	-0.0102	-0.0884	-0.0604	-0.0086	0.0177	-0.0737	-0.1949	-0.1616	-0.0756
Prior Functioning: Stair Negotiation — Dependent	0.1414	-0.0681	-0.0042	0.0697	0.0287	-0.0276	0.0030	0.0368	0.0568	-0.0317	0.1210
Prior Functioning: Stair Negotiation — Some Help	0.0195	-0.0181	-0.0123	0.0112	-0.0137	-0.0129	-0.0275	0.0194	0.0704	-0.0222	0.0042
Stage 2 Pressure Ulcer	0.0446	0.0512	-0.1073	-0.0560	-0.0762	-0.0356	-0.0344	-0.0052	0.0152	0.0045	-0.0609
Stage 3, 4, or Unstageable Pressure Ulcer/Injury	0.0125	0.0128	-0.0971	-0.0726	-0.0656	-0.0684	-0.0174	-0.0094	-0.0193	-0.0049	-0.0153
Cognitive Function: Moderately Impaired	-0.0512	-0.0721	-0.0476	0.0191	-0.0179	0.0160	-0.0059	0.0312	0.0205	-0.0278	-0.1410
Cognitive Function: Severely Impaired	-0.1483	-0.3148	-0.1353	0.0107	-0.0002	0.0733	0.0071	0.0260	0.0665	0.0290	-0.3983
Bladder Incontinence: Incontinent	0.0208	-0.0097	-0.1052	0.0198	-0.0416	-0.0028	-0.0046	-0.0128	0.0131	-0.0295	-0.0762
Bladder Incontinence: Catheter	0.0144	0.0448	-0.2371	0.0045	-0.0487	-0.0213	0.0150	-0.0237	0.0096	-0.0337	0.1624
Bowel Continence: Always Incontinent	-0.0892	0.0079	-0.3712	-0.0371	-0.0844	-0.0358	-0.0243	-0.0639	-0.0083	-0.0058	-0.1581
Bowel Continence: Incontinent Less than Daily	-0.0545	0.0105	-0.1383	0.0072	-0.0454	-0.0013	0.0313	-0.0277	0.0159	-0.0132	-0.0720

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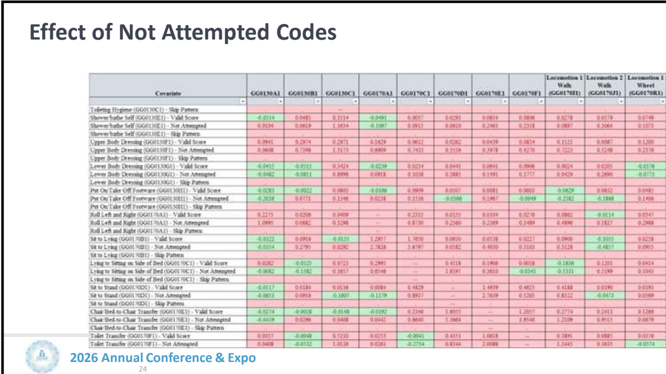
Effect of Not Attempted Codes



Covariate	GG0130A1	GG0130B1	GG0130C1	GG0170A1	GG0170C1	GG0170D1	GG0170E1	GG0170F1	Locomotion 1 Walk (GG0170I1)	Locomotion 2 Walk (GG0170J1)	Locomotion 1 Wheel (GG0170R1)
Toileting Hygiene (GG0130C1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Shower/bathe Self (GG0130E1) - Valid Score	-0.0314	0.0483	0.3534	-0.0491	0.0037	0.0293	0.0854	0.0806	0.0278	0.0579	0.0749
Shower/bathe Self (GG0130E1) - Not Attempted	0.0104	0.0619	1.1654	-0.1097	0.0935	0.0610	0.2483	0.2358	0.0897	0.3064	0.1073
Shower/bathe Self (GG0130E1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Upper Body Dressing (GG0130F1) - Valid Score	0.0941	0.2974	0.2971	0.1629	0.0612	0.0282	0.0439	0.0834	0.1525	0.0087	0.1200
Upper Body Dressing (GG0130F1) - Not Attempted	0.0608	0.7398	1.3173	0.6909	0.7433	0.5558	0.3978	0.4270	0.7223	0.5248	0.2378
Upper Body Dressing (GG0130F1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Lower Body Dressing (GG0130G1) - Valid Score	-0.0455	-0.0515	0.3424	-0.0239	0.0234	0.0441	0.0641	0.0906	0.0024	0.0205	-0.0576
Lower Body Dressing (GG0130G1) - Not Attempted	-0.0482	-0.0811	0.8998	0.0918	0.1038	0.3885	0.1491	0.1777	0.0429	0.2690	-0.0773
Lower Body Dressing (GG0130G1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Put On/Take Off Footwear (GG0130H1) - Valid Score	-0.0283	-0.0022	0.0803	-0.0166	0.0909	0.0107	0.0081	0.0003	-0.0629	0.0832	0.0485
Put On/Take Off Footwear (GG0130H1) - Not Attempted	-0.2038	0.0771	0.1346	0.0238	0.1516	-0.0368	0.1987	-0.0049	-0.2382	-0.3868	0.1406
Put On/Take Off Footwear (GG0130H1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Roll Left and Right (GG0170A1) - Valid Score	0.2275	0.0206	0.0409	–	0.2535	0.0155	0.0104	0.0278	0.0862	-0.0114	0.0347
Roll Left and Right (GG0170A1) - Not Attempted	1.0995	0.0882	0.3298	–	0.8730	0.2580	0.2189	0.3489	0.4896	0.1827	0.2988
Roll Left and Right (GG0170A1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Sit to Lying (GG0170B1) - Valid Score	-0.0322	0.0958	-0.0135	1.2957	1.7850	0.0830	0.0538	0.0227	0.0900	-0.3055	0.0278
Sit to Lying (GG0170B1) - Not Attempted	-0.0354	0.2795	0.0292	2.7828	3.6797	0.0582	0.4030	0.1103	0.3128	-0.4857	0.0955
Sit to Lying (GG0170B1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Lying to Sitting on Side of Bed (GG0170C1) - Valid Score	0.0282	-0.0525	0.0723	0.2995	–	0.4518	0.1968	0.0018	-0.1838	0.1201	0.0414
Lying to Sitting on Side of Bed (GG0170C1) - Not Attempted	-0.0082	-0.1582	0.1857	0.8546	–	1.8197	0.3810	-0.0345	-0.3331	0.5599	0.1043
Lying to Sitting on Side of Bed (GG0170C1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Sit to Stand (GG0170D1) - Valid Score	-0.0117	0.0184	0.0136	0.0084	0.4829	–	1.4939	0.4825	0.4188	0.0190	0.0393
Sit to Stand (GG0170D1) - Not Attempted	-0.0653	0.0958	-0.1807	-0.1179	0.8937	–	2.7639	0.5205	0.8522	-0.0473	0.0569
Sit to Stand (GG0170D1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Chair/Bed-to-Chair Transfer (GG0170E1) - Valid Score	-0.0274	-0.0028	-0.0148	-0.0192	0.2348	1.6055	–	1.2057	0.2774	0.2413	0.1266
Chair/Bed-to-Chair Transfer (GG0170E1) - Not Attempted	-0.0419	0.0296	0.0408	0.0442	0.6640	5.3664	–	3.9548	1.2109	0.9515	0.0679
Chair/Bed-to-Chair Transfer (GG0170E1) - Skip Pattern	–	–	–	–	–	–	–	–	–	–	–
Toilet Transfer (GG0170F1) - Valid Score	0.0357	-0.0048	0.3210	0.0253	-0.0041	0.4351	1.0818	–	0.3891	0.0885	0.0378
Toilet Transfer (GG0170F1) - Not Attempted	0.0408	-0.0132	1.0126	0.0261	-0.2734	0.8344	2.0088	–	1.2445	0.3635	-0.0574

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What should we do? Work our Magic!

- Educate on the GGs immediately.
- Work to improve the patients' functior
- Use 09 and 88 when correct.
- Limit use of 10 and 07.
- Dash is trash.

ABRA CADABRA PATA DE CABRA

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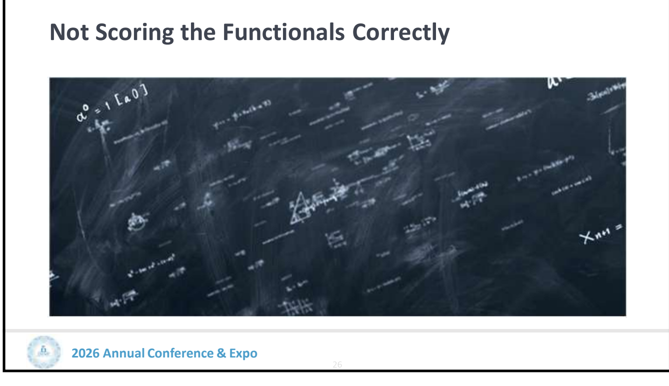

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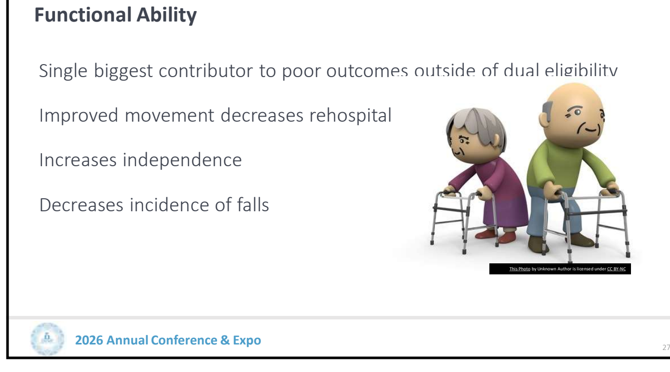

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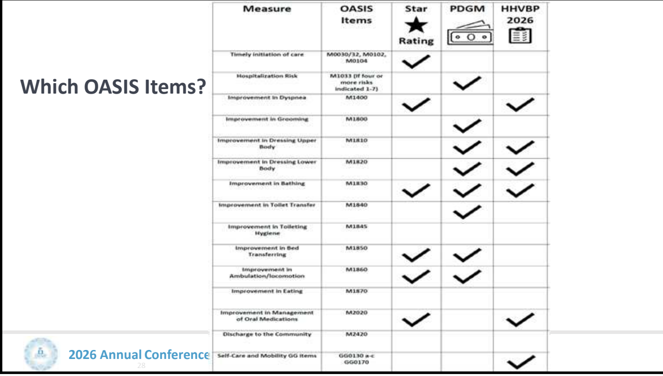

Which OASIS Items?

Measure	OASIS Items	Star Rating	PDGM	HHVBP 2026
Timely initiation of care	M0030/32, M0102, M0104	✓		
Hospitalization Risk	M1033 (If four or more risks indicated 1-7)		✓	
Improvement in Dyspnea	M1400	✓		✓
Improvement in Grooming	M1800		✓	
Improvement in Dressing Upper Body	M1810		✓	✓
Improvement in Dressing Lower Body	M1820		✓	✓
Improvement in Bathing	M1830	✓	✓	✓
Improvement in Toilet Transfer	M1840		✓	
Improvement in Toileting Hygiene	M1845			
Improvement in Bed Transferring	M1850	✓	✓	
Improvement in Ambulation/locomotion	M1860	✓	✓	
Improvement in Eating	M1870			
Improvement in Management of Oral Medications	M2020	✓		✓
Discharge to the Community	M2420			
Self-Care and Mobility GG Items	GG0130 a-c GG0170			✓

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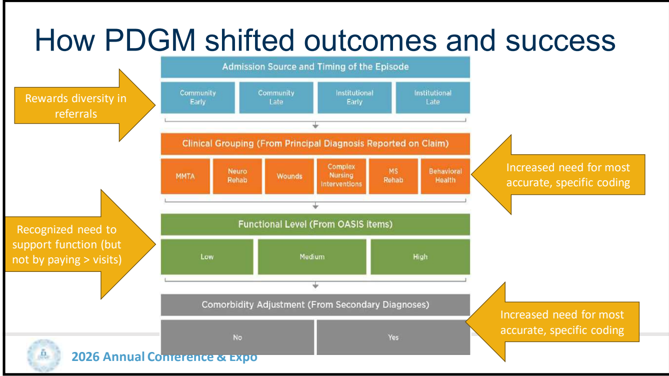

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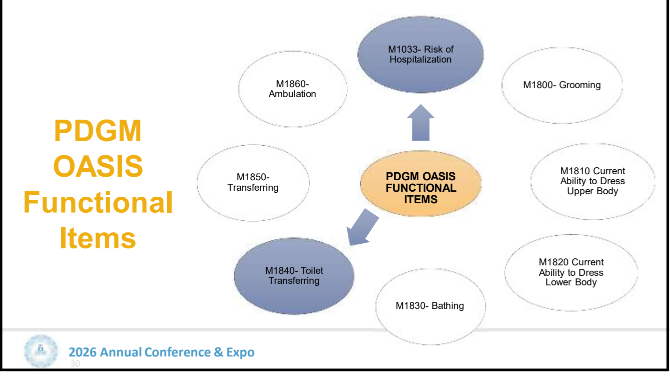

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Functional Adjustment Payment

~$250 increase in average payment from *low* to *medium* adjustment

~$250 increase in average payment from *medium* to *high* adjustment

~$500 increase in average payment from *low* to *high* adjustment

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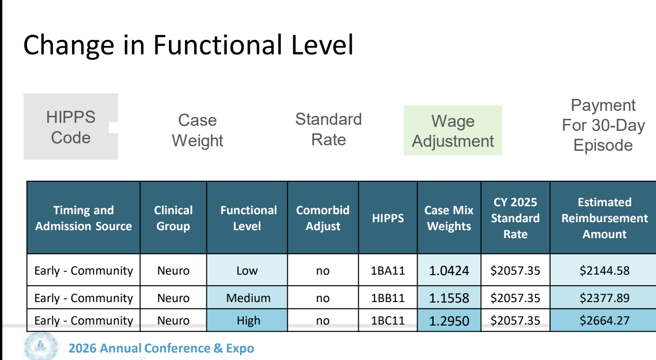

Timing and Admission Source	Clinical Group	Functional Level	Comorbid Adjust	HIPPS	Case Mix Weights	CY 2025 Standard Rate	Estimated Reimbursement Amount
Early - Community	Neuro	Low	no	1BA11	1.0424	$2057.35	$2144.58
Early - Community	Neuro	Medium	no	1BB11	1.1558	$2057.35	$2377.89
Early - Community	Neuro	High	no	1BC11	1.2950	$2057.35	$2664.27

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Payment – Reimbursement Time Points

SOC

Recertification

ROC can provide an update to payment

Other follow-up (SCIC) can provide an update to payment

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Risk Adjustment Models (M1800s)

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

- Medium (reference)
- Low
- High

SOC, ROC, DC

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Key Is Accuracy

Is therapy warranted?

If not therapy, what else can we do?

Can we show real improvement?

- Important during care
- Important after care

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Not Owning Up to Injuries from Falls

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Key Findings by the OIG

Underreporting of Falls

55% of falls with major injury and hospitalization among Medicare home health patients were not reported in OASIS assessments as required.

These assessments are used by CMS to calculate fall rates and inform the public via the Care Compare website.

https://oig.hhs.gov/reports/all/2023/home-health-agencies-failed-to-report-over-half-of-falls-with-major-injury-and-hospitalization-among-their-medicare-patients/

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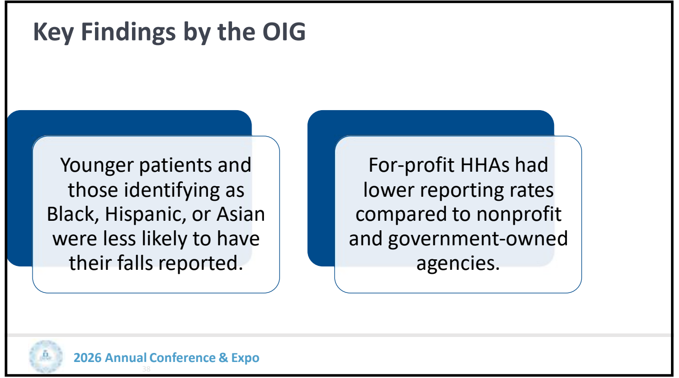
Key Findings by the OIG



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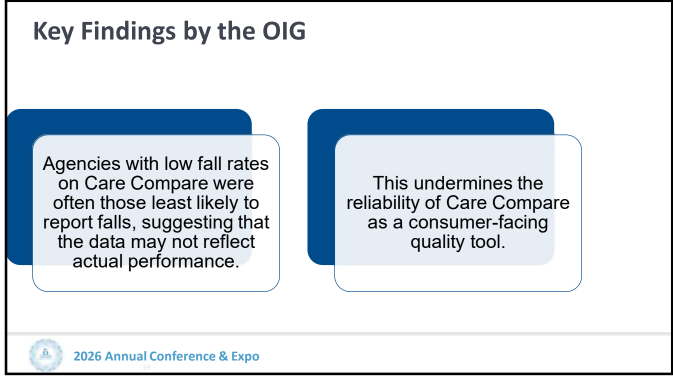
Key Findings by the OIG



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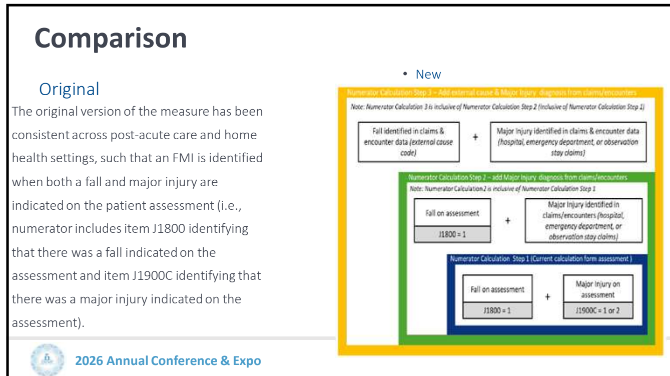

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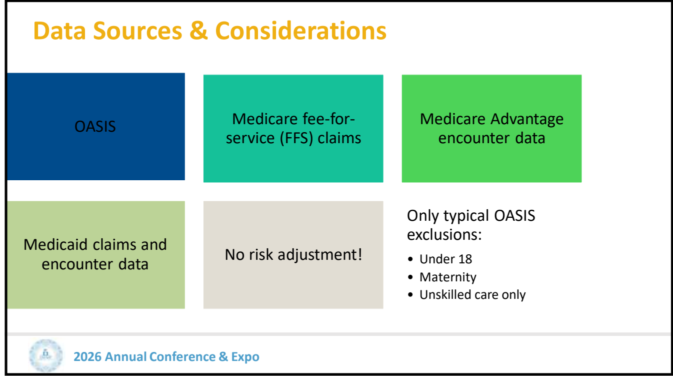

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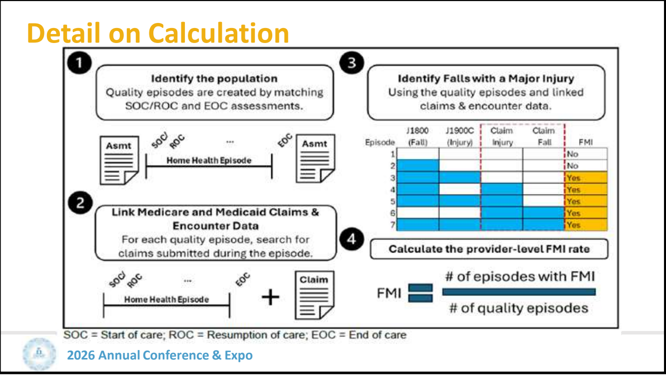

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New Calculation Shows a Different Story

Numeration Calculation Step	Data Source	Mean FMI Rate	Percent Providers with No FMI Events
Numerator Calculation Step 1 (Assessment data only)	Assessment	1.053	28.1%
Numerator Calculation Step 2 (Assessment + Major Injury in Claims)	Assessment, Claims	1.73	17.6%
Numerator Calculation Step 3 (Assessment + fall or Major Injury in Claims)	Assessment, Claims	2.37	14.5%

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Preventing Falls With Major Injury – Clinical Focus Areas

Medication Review: Evaluate medications that impact balance, cognition, sedation, or blood pressure (e.g., antihypertensives, opioids, psychotropics, diuretics).

Orthostatic Hypotension: Routinely assess for orthostatic changes and address symptomatic drops in blood pressure.

Visual Impairment: Identify vision deficits that limit hazard recognition and depth perception, increasing fall risk.

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Preventing Falls with Major Injuries (continued)

Mobility & Strength Deficits: Assess for muscle weakness, gait instability, impaired coordination and limited endurance that compromise safe ambulation.

Risk-Taking & Unsafe Behaviors: Address behaviors such as rushing, improper footwear, refusal or misuse of assistive devices, and nonadherence to safety recommendations.

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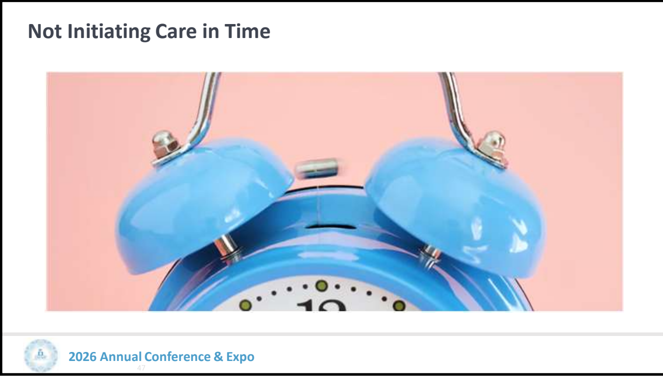

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Timely Initiation of Care

CMS requires that home health care begins within 48 hours of:

- The referral date
- The inpatient discharge date, or
- The physician-ordered start-of-care date, whichever is later.

This is tracked through the Timely Initiation of Care (TIOC) process measure, which affects public reporting and agency performance scores.

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Impact on Care

Patients who wait more than 2 days after hospital discharge for their first home health visit face a 12% higher risk of rehospitalization or emergency department visits.

Delays can lead to:

- Missed medication doses,
- Poor wound care,
- Lack of education on lifestyle changes,
- Increased risk of complications

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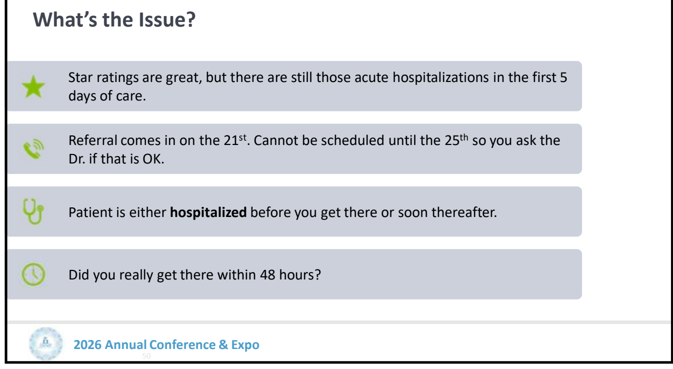
What's the Issue?



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What led to the TIF?

AND - What could have been done to prevent it?

Lack of coordination of Care
Lack of Appropriate Training / Education
Incomplete / Lack of Med Assessment / Education or follow up from Clinician
Lack of Timely Insurance Authorization (Missed Visits)
Not front-loading visits for high-risk patients
Could have done a better Baseline assessment
Missed visits
Lack of timely order from Provider
Failure of Hospital Processes
Missing and/or inappropriate Intervention / Orders

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4 Pillars of Transitional Care – the Stats

Dr. Eric Coleman

Patients are more likely to return to the hospital in days 1-5
Related to medications or diagnosis

Patients are more likely to return to the hospital in days 10-15
Related to SDoH

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4 Pillars of Transitional Care – the Solutions

Engage, Educate, Empower

Medication (Self) Management

Timely initiation of care / specialty follow up

- Front loading
  - 7 Touches in 7 Days
  - Tuck-in Thursdays

Knowledge of red flags that indicate a worsening in condition and how to respond

The Personal Health Record

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Missed Visits

Medically Necessary Care

Homebound

LUPAs

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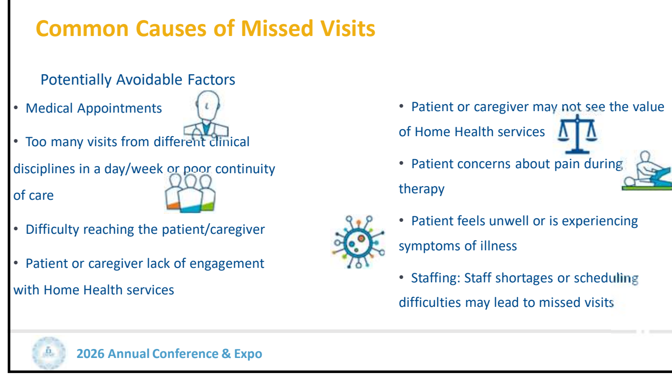

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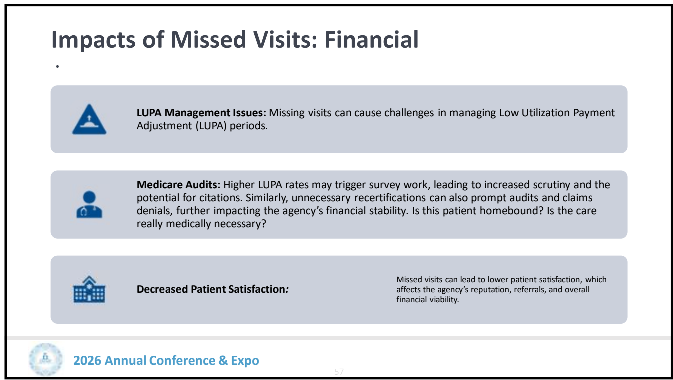

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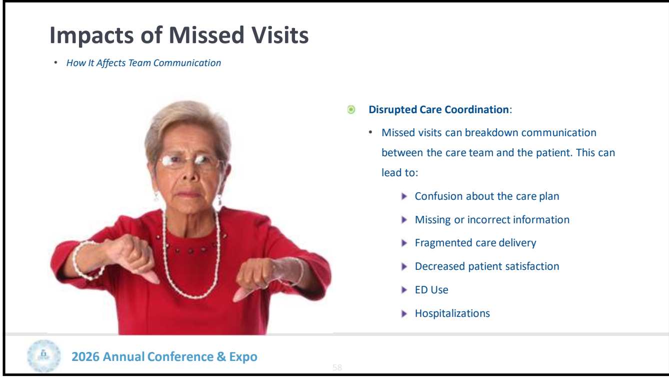

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References

The Geriatric Care Transition

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OIG Report: Under Reporting of Falls with Major Injuries by Home Health Agencies

- https://oig.hhs.gov/reports/all/2023/home-health-agencies-failed-to-report-over-half-of-falls-with-major-injury-and-hospitalization-among-their-medicare-patients/

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Thank You!

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