OASIS, OUTCOMES & YOUR AGENCY'S STAR RATINGS

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OBJECTIVES

• Review CASPER Reports so that participants can understand the outcomes being measured and how to analyze.
• Understand the relation to the 5 Star Ratings
• Understand Home Health Compare
• Understand how to select the outcome measures to focus on
• What to do with the selected outcomes
• How to develop indicators and monitor ongoing to improve selected outcomes

CASPER
Outcome Based Quality Improvement Reports
OASIS LEADS TO THE OUTCOME REPORTS: SO WHAT ARE THEY?

- CASPER is the computer system that compiles the OASIS data of every certified home health agency at 2 time points—ex SOC to DC, or ROC to DC and gives the outcome reports:
  - Agency Patient Related Characteristics
  - Risk Adjusted Outcome Report
  - Potentially Avoidable Events
  - Process Based Quality Improvement

- 3 Bar is most meaningful—your current %, your prior period % and national current %
- Asterisks mean it is statistically significant data

AGENCY PATIENT RELATED CHARACTERISTICS REPORT

- A Lot of great information on your agency, including:
  - Demographics,
  - Payment sources,
  - Therapy days,
  - Length of stay
  - Diagnoses,
  - Results of many M items
- Many of this report’s items contribute to your risk adjustment (like a golf handicap)
- Useful information regarding differences in your agency to others

RISK ADJUSTED OUTCOME REPORT

- Outcomes compared on a 3 bar report give information on the percentage of patients you have improved in various M items, current, prior and nation.
- ADLs, IADLs, Ambulation
- Clinical - Medications, Dyspnea, Pain, UTIs
- Confusion, Anxiety
- Emergency Department and Re-hospitalizations
POTENTIALLY AVOIDABLE EVENTS – PAE

Adverse events:
- Important to audit the pt’s record to try to prevent this from occurring in the future
- Emergent care for: fall, wound infections or deteriorating wound status, improper medication administration or medication side effects and hypohyperglycemia
- Development of UTI, increase in number of pressure ulcers, decline in management of oral medications
- Decline of 3 or more ADLs
- Discharge to community needing wound care, med assistance, toileting assistance, behavior problems or unhealed stage 2 pressure ulcer

PBQI- PROCESS BASED QUALITY IMPROVEMENT

Process Measures - Standards for Best Practices
- Timely initiation of care, physician notification
- Risk assessments – falls, pressure ulcer, depression and pain
- Interventions on the plan of care for depression, Diabetic foot care & pf education, fall prevention, pain, & pressure ulcer prevention
- Implementation of these interventions in the documentation
- Heart failure symptoms addressed
- Influenza and Pneumococcal vaccines
- Medication issues identified and timely physician contact

CASPER REPORTS

- Need to assign someone to look in system monthly to see if reports have been updated
- When updated, do an analysis of the data, focusing on the statistically significant areas
- Write an action plan for needed areas
- Incorporate into your QI plan- have a QI indicator for formal monitoring
- Shared with all staff! That is how you get improvement!
- Plan the episode of care for the patient in order to focus on improving outcomes as a team!
- All of this information comes from what YOU PUT IN OASIS!!
HOME HEALTH COMPARE

- Some of the outcomes from CASPER reports are on this public website.
- Variances to CASPER – agency compared to state and nation and can be compared to other agencies
- Purpose for the public to choose quality HHA’s
  - www.medicare.gov/homehealthcompare/search.aspx
- Can use this information for Marketing your agency when your outcomes are better for patients than other agencies

Home Health Compare
Reports the quality of care provided by Medicare Certified Home Health Providers.

- Provides Information Regarding:
  - Quality of Patient Care
  - Quality Measures
  - Patient Survey Results
  - Patient Survey Star Ratings

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>ABC HAA</th>
<th>XYZ HAA</th>
<th>TEXAS AVERAGE</th>
<th>NATIONAL AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often patients get better at walking or moving around</td>
<td>88%</td>
<td>70%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>How often patients get better at getting in and out of bed</td>
<td>80%</td>
<td>70%</td>
<td>80%</td>
<td>75%</td>
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<tr>
<td>How often the home health team treated their patients’ pain</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often patients got better at bathing</td>
<td>85%</td>
<td>80%</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>How often the home health team checked patients for pain</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>How often patients had less pain when moving around</td>
<td>88%</td>
<td>70%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>How often the home health team treated heart failure (weakening of the heart) patients’ symptoms</td>
<td>100%</td>
<td>Not Available</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often patients’ breathing improved</td>
<td>70%</td>
<td>50%</td>
<td>55%</td>
<td>65%</td>
</tr>
<tr>
<td>How often patients’ wounds improved or healed after an operation</td>
<td>99%</td>
<td>Not Available</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>How often the home health team checked patients for the risk of developing pressure sores (bed sores)</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care</td>
<td>81%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)</td>
<td>81%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital</td>
<td>17%</td>
<td>9%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>How often home health patients had to be admitted to the hospital</td>
<td>16%</td>
<td>14%</td>
<td>15%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Quality of Patient Care

QUALITY OF PATIENT CARE STAR RATINGS
TEXT FROM MEDICARE.GOV WEBSITE
HTTPS://WWW.MEDICARE.GOV/HOMEHEALTHCOMPARE/ABOUT/PATIENT-CARE-STAR-RATINGS.HTML

• Home Health Compare uses a quality of patient care star rating to show consumers how the performance of a home health agency compares to other agencies.
• Agencies get more stars when they follow recommended care practices for more patients, and when more of their patients show improvement.
• The quality of patient care star rating summarizes each agency’s performance on average across 9 of the quality measures reported on Home Health Compare.
• These measures were selected to give a general overview of agency performance on measures that apply to the most people.
• A 4- or 5-star rating means that the agency performed better than other agencies on the measured care practices and outcomes. A 1- or 2-star rating means that the agency’s average performance on the 9 measured care practices and outcomes was below the average of other agencies. Across the country, most agencies fall “in the middle” with 3 or 3½ stars.
• Since the star rating calculation ranks all agencies from lowest to highest, some agencies will be ranked below others even though they’re providing good quality care.

QUALITY MEASURES DIVIDED INTO CATEGORIES, WHICH INCLUDE:

- Managing Daily Activities
- Managing & Treating Pain
- Treating Wounds and Preventing Pressure Wounds
- Preventing Harm
- Preventing Unplanned Hospitalization
QUALITY MEASURES

• The INTENT that CMS provides in the OASIS guidance manual is critical to scoring the OASIS assessment correctly.
• Many agencies with low Star Ratings find that OASIS training is the KEY to increasing outcomes because clinicians do not know and/or follow the intent!
• Another main weakness is that all clinicians do not perform the comprehensive OASIS assessment in the same manner.
• Therefore, one clinician at SOC may have different scores that the next clinician that performs the Discharge OASIS— this will skew your outcomes and will lead to a false Star Rating.

QUALITY MEASURES

• Managing Daily Activities

M1830- BATHING (5)- CURRENT ABILITY TO WASH ENTIRE BODY SAFELY
If afraid of falling and is unwilling to try or have assistance then would pick response 4 or 5 (unable)

Bathing related tasks, ex gathering supplies, preparing bath water, shampooing hair, drying off are not considered

M1840- Toilet Transferring (5)
• Current ability to get to & from toilet or bedside commode Safely AND transfer on/off

Observe pt during transfer on and off toilet
• If pt has pain, difficulty with balance, strength, etc., determine level of assistance needed for pt to be Safe
**M1850- TRANSFERRING:**
*Current ability to move safely from bed to chair, or ability to turn & position self in bed if pt is bedfast.*

Verbal cueing, environmental set up &/or hands on assistance. For minimal assistance the person assisting the pt must contribute less than 25% of the total effort.

**M1860- AMBULATION/LOCOMOTION:**
*Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.*

WATCH THE PATIENT WALK!!!

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**QUALITY MEASURE**

Managing Pain & Treating Symptoms

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**M1240- PAIN ASSESSMENT**
**M1242 ($) - FREQUENCY OF PAIN INTERFERING WITH PTS ACTIVITY OR MOVEMENT**

- To improve Pain in your patients, the entire interdisciplinary team caring for the patient must be working together!
- Choose this as a team outcome at start of care, have all members focus on this on visits, document, and report to all team members.
- This WILL increase your Pain Outcomes! And have a happier patient, therefore CAHPS will be higher as well!!!
PAIN ASSESSMENT

• All team members must be thorough in the pain assessment!
  • Does the pt take their pain meds? What is the pain then? Etc.
  • If pain is not relieved by meds, contact MD
• Severe Pain:
  • Severe pain is defined according to the scoring system for the tool being used. CMS does not endorse a specific tool.
  • Agency must inform staff what rating on scale is Severe! Be consistent!
  • 7 is what most use for severe pain.

M1242 ($) - FREQUENCY OF PAIN INTERFERING WITH PTS ACTIVITY OR MOVEMENT

• Intent indicates that Interference in activities does not just include ADL’s, eg sleeping, watching tv, recreational activities
• Look at the frequency with which pain interferes with pt’s activities, with treatments,
• Pain interferes with activity when pain results in
  • activity being performed less often than otherwise desired,
  • required the pt to have additional assistance in performing the activity,
  • or causes the activity to take longer to complete.

M1400 - WHEN IS THE PT DYSPNEIC OR NOTICEABLY SHORT OF BREATH?

• Timing – 24 hours preceding assessment and during the assessment
  • Use clinical judgment to determine the level of effort required to complete a task.
  • Particularly distinguishing between minimal and moderate for eating, talking, etc.
  • consider the effort required.
  • If pt is on O2, if continuous assess pt while using O2, if O2 is intermittent, assess pt without O2
  • TUG can be used to assess walking 20 feet or more
  • Also use ADLs to assess dyspnea
  • If pt is only SOB when supine, pick response 4-6 or rest
  • If pt modifies environment and is not dyspneic because of this for more than 24 hour period, pick 0
M1501- (FORMERLY M1500) SYMPTOMS IN HEART FAILURE PATIENTS

If pt has been diagnosed with HF, did pt exhibit symptoms indicated by clinical heart failure guidelines (incl dyspnea, orthopnea, edema or weight gain), at the time of or any time since the previous OASIS assessment.

LOOK BACK!
Be sure your agency has a process for how clinicians are to look back through the episode to identify if pt has had symptoms. Ex in physician orders, communication/coordinating of care notes, etc.

M1511- (FORMERLY M1510) If HF, what action(s) have been taken to respond? (mark all that apply)

Examples:

1- No action taken - ex: pt had hf s/s, goes to ER, is admitted, but never called HHA. Therefore on tx you must say No Action Taken
2- Same day symptoms were identified, MD notified and responds
3- Pt has s/s of hf that need immediate attention in ER and is advised to do so by HHA
4- Physician ordered parameters such as reminding pt to take additional dose of diuretics when telehealth shows increase in wt of 3 pounds in 2 days
5- Pt education communicated to pt/cg - handing documents only do not count
6- Change in cp orders - change in visit frequency, ex increasing to 3 x per week due to increased s/s

QUALITY MEASURE

Treating Wounds and Preventing Pressure Ulcers
KEEPING UP WITH CHANGES!

- Ensure that there are staff assigned to keep up with changing guidelines.
- Check WOCN and NPUAP as CMS typically will follow their updates.
- With ICD-10 coding changes, further knowledge needed to accurately code and assess wounds.
- Ensure your clinicians have training on necessary documentation required for wounds and all other systems under ICD-10.

M1313- (FORMERLY M1309) WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC

- Collecting info at Discharge which was previously collected in M1308 Column 2 on worsening pressure ulcer status
- Makes it the same as for Nursing Homes (MDS) and acute care (CARE) tools
- Includes pressure ulcers that at DC are Unstageable due to slough/eschar
- Documents the number that are NEW or have Worsened (increase in numerical stage) since the most Recent SOC or ROC
- Compare current stage to the stage of that ulcer

M1320- PRESSURE ULCER HEALING STATUS

- Visualization of wound bed is necessary to identify the healing status of the ulcer
  - When the wound bed is covered with eschar/slough or non-removable dressing, wound status can be determined and N/A is to be selected
  - DTPI are included here.
  - Most problematic may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc.
  - WOCN guidance is followed to determine the most problematic observable pressure ulcer
  - Because Stage II ulcers and DTPI do not granulate & newly epithelialized Stage II ulcers are not counted, the only appropriate response for a Stage II ulcer is 3- Not Healing
M1322- CURRENT NUMBER OF STAGE 1 PRESSURE ULCERS

- Be sure when non-blanchable redness in a localized area is present to document a stage 1.
- Caution to ascertain if the redness is a previous stage 3 or 4!
- Look at historical medical records, ask physicians and family.
- There are NRS points so be sure to document supplies used for stage 1 ulcers.
- Often see documentation of redness by aide but no documentation by RN of a stage 1 pressure ulcer. Ensure aide is reporting to RN and it’s followed up!

Stasis Ulcers

- Use WOCN oasis c2 guidelines to determine stasis ulcers healing status.
- When a stasis ulcer is completely epithelialized it is healed and is no longer a stasis ulcer.
- Fully granulating:
  - Wound bed filled with granulation tissue to the level of the surrounding skin; no dead space; no necrotic tissue (such as slough); no signs of infection; wound edges are open.
- Early/partial granulation:
  - ≥25% of wound bed is covered with granulation tissue; <25% wound bed covered with avascular tissue; no signs of infection; wound edges open.
- Not Healing:
  - Wound with ≥25% avascular tissue OR signs of infection OR clean but non-granulating wound bed OR persistent failure to improve despite appropriate comprehensive wound management.

Surgical Wounds

M1340- DOES PATIENT HAVE A SURGICAL WOUND?
M1342- STATUS OF MOST PROBLEMATIC SURGICAL WOUND THAT IS OBSERVABLE

- CMS Follow WOCN guidelines when assessing status of a surgical wound:
  - Surgical wounds healing by primary intention do not granulate.
  - A surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is a surgical wound until re-epithelialization has been present for approximately 30 days, unless it develops or present signs of infection.
  - After 30 days, it is generally described as a scar and is no longer reportable as a surgical wound.
A surgical wound that has dehisced or has incision separation is considered to be healing by secondary intention.

- If the presence of staples does not mean surgical wound is not healing.
- Do not consider openings in the skin adjacent to the incision line, closed by staples or suture removal, as part of the surgical wound. This would instead go into M1350—skin lesion/open wound.

- Steri strips are skin closures and not a dressing or device.

A dehisced wound or one healing by secondary intention no longer has vascular tissue and is classed 2—subject to m1340 surgical wound.

- An implanted vascular device is an observable surgical wound whether or not it is being accessed.
- New epithelialized is appropriate response when insertion site has healed.

- Pressure Ulcers with Skin Grafts
- Pressure Ulcers with Muscle Flaps
- Implanted infusion devices
- Implanted pumps
- Cardiac Cath by Cutdown
- Cardiac Cath by needle puncture
- I&D with drain (even if drain pulled)
- I&D without a drain
- Wound with drain even after pulled
- Repair of an internal trauma
- Repair of traumatic laceration
- Thoracotomy or any wound ending in -otomy
- Take down of ostomy
- Ostomy allowed to close on its own

- Pacemaker (until epithelialized for 3-30 days)
- Pacemaker once epithelialized (3-30 days)
- VP shunt
- Grafted Site
- Suture site for Grafts
- Suture site for Grafts
- Arthroscopy
- Posterolateral Approach
- Posterior Excision of Nipple
- Excision

- Pap smear
- Cervical or Endometrial Biopsy
- Biopsy of uterus
- Biopsy of cervix
- Biopsy of vagina
- Ovum捡查
- Histological Analysis
- Biopsy of skin
- Histological Analysis
- Biopsy of liver
- Histological Analysis
- Biopsy of pancreas
- Histological Analysis
- Biopsy of spleen
- Histological Analysis
- Biopsy of bone
- Histological Analysis
- Biopsy of muscle
- Histological Analysis
M1342 SURGICAL WOUND –IMPLANTED VENOUS DEVICE:

- When first implanted, the incision is the surgical wound. The assessing clinician will follow the 12/09 WOCN guidance to determine the healing status of the incision.
- Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of “Newly epithelialized” for as long as it is present in the patient’s body, unless it later develops complications.
- This guidance clarifies and supersedes CMS OASIS Q&A Category 4b, Q105.3.

M1350- SKIN LESION OR OPEN WOUND
WHAT GOES INTO M1350?

- Burns
- PICC lines & peripheral IV sites
- Diabetic & arterial ulcers
- Ostomies (excluding bowel) if care is provided (i.e., gastrostomy, thoracotomy, cystostomy)
- Cellulitis & abscess
- Wounds due to trauma
- Edema, rashes, peristomal breakdown, etc.

WHAT DOESN'T GO INTO M1350- SKIN LESION OR OPEN WOUND

- Bowel ostomies
- Tattoos, piercing, other skin alterations
- Muscular surface ulcers
- Surgery for cataracts
- GYN procedures via vaginal
QUALITY MEASURE

Preventing Harm

Timely Initiation of Care
% of episodes that occur within 2 days of the referral date, or the inpatient discharge date, whichever is later.
OASIS items include:

- M0102: Date of Physician-Ordered SOC
- M0104: Date of Referral
- M0030: Start of Care Date
- M0032: Resumption of Care Date
- M0100: Reason for Assessment
- M1000: Inpatient Facility Discharge Date
- M1005: Inpatient Discharge Date

Tend to see better compliance at SOC, but ROC is an issue if resumption visit doesn’t occur within 2 days.
This is because there isn’t a “physician-ordered” ROC date option.
It’s important to do ROC within 2 days!

How can we improve...
M1730- DEPRESSION SCREENING
SOC M2250 D depression were interventions included on plan of care
DC M3401 c. (formerly M3400) were the depression interventions provided
during episode of care

M1730 Ch.3 Guidance –
What’s changed?
Response-Specific Instructions

- Depression testing, symptoms, and/or
  interventions may be determined by the clinician or
  reported by the patient and/or caregivers.

- Select Response 1 if the PHQ-9 is completed,
  and score the appropriate responses in item 4.

- Emphasis not to ask for depression not
  interventions or outcome. If the patient
  scores three points or more on the PHQ-9,
  then further depression screening is indicated.

- Allow all appropriate broad scope defined.

M1041- INFLUENZA VACCINE
Does this episode of care (SOC/ROC to transfer/dc) include
any dates on or between October 1 and March 31?

- Identifies whether the pt was receiving services from the HHA during the
time period for which influenza vaccine data are collected.
- (Oct 1-March 31)
- SOC: Immunizations received in last 12 months, suggest to include in
OASIS review to ensure answered correctly.
- DC: M1046 Did the patient receive the influenza vaccine for this year’s flu
  season? Suggest including this question in DC review process.
- High error rates at the beginning and the end of the flu season.

M1051- PNEUMOCOCCAL VACCINE

- Has the pt ever received pneumococcal vaccination (for ex, pneumovax)?
- Yes or No
- Simplified item to report if ever has received
- Eliminated “during episode of care” and “from your agency”
  - Suggest including these items in OASIS review process
- SOC: Immunizations received in last 12 months.
- DC: M1051: Has the patient ever received the pneumococcal vaccination?
  - DC: M1056: Reason Pneumococcal Vaccine not received.
M1056- REASON PNEUMOCOCCAL VACCINE NOT RECEIVED

- Simplified item to report reason pt never received – explains why
- CDC recommendations removed
- Still agency responsibility to make current guidelines available to clinicians

1. Offered and declined
2. Assessed and determined to have medical contraindication(s)
3. Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
4. None of the above

SOC & ROC: M2250 b. Diabetic Foot Care included in the plan of care.

DC: M2401 a. (formerly M2400 a) Diabetic foot care included monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care.

- Not only do staff need to instruct on Diabetic foot care, but they need to document status of the feet.
- If SN opens and PT does the remainder of case, they must also assess and document.

M1910: Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?

SOC: M2250 c. Fall prevention interventions

DC: M2401 b. (formerly M2400 b) Fall prevention interventions performed during episode of care

- If patient is homebound and does not show risk for falls, this should cue further investigation. It is possible, but infrequent.
- If not using MAHC-10, then SN must perform TUG with the fall risk on SOC. Cannot use the TUG done by therapist for determining fall risk.
MEDICATION EDUCATION & IMPROVEMENT IN MEDICATION ADMINISTRATION

OASIS ITEMS INCLUDED
• SOC M2010: Patient/Caregiver High-Risk Drug Education
• SOC M2020 & M2030: Management of Oral and Injectable Drugs
• DC M2005 (formerly M2004): Medication Intervention
• DC M2016 (formerly M2015): Patient/Caregiver Drug Education Intervention
• DC M2020 & M2030: Management of Oral & Injectable Medications

2001 (FORMERLY M2000) - DRUG REGIMEN REVIEW
THIS IS A COP AND IS NOT NEW!

- Does a complete drug regimen review indicate potential clinically significant med issues, etc. drug reactions, ineffective drug therapy side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?
  0- Not assessed/reviewed
  1- No problems found during review
  2- Problems found during review
  NA- Pt is not taking any medications

2001 (FORMERLY M2000) - DRUG REGIMEN REVIEW
THE PROBLEMS IN 1 AND 2 INCLUDE:

- Adverse reactions to meds (eg, rash)
- Ineffective drug therapy (eg, analgesics that do not reduce pain)
- Side effects (eg, fever or nausea from an antimicrobial)
- Drug interactions (eg, sertraline drug drug level and drug disease interactions)
- Duplicate therapy (eg, generic name and brand name drugs that are both prescribed)
- Omissions (missing drugs from an ordered regimen)
- Dosage errors (eg, too high or too low)
- Noncompliance (regardless of whether the noncompliance is purposeful or accidental)
- Impairment or decline in a pts mental or physical condition or functional or psychosocial status
### 2001 (FORMERLY M2000) - DRUG REGIMEN REVIEW
SELECT RESPONSE 2: PROBLEMS FOUND - WHEN:

- Pt's list of meds from the in-pat facility do NOT match the meds the pt shows the clinician at the SOC/ROC assessment visit.
- Assessment showed that depres of pt taking drugs for are NOT adequately controlled.
- Pt seems confused about when/how to take meds indicating a high risk for med errors.

### (M2003) MEDICATION FOLLOW-UP: DID THE AGENCY CONTACT A PHYSICIAN (OR PHYSICIAN-DESIGNEE) BY MIDNIGHT OF THE NEXT CALENDAR DAY AND COMPLETE PRESCRIBED/RECOMMENDED ACTIONS IN RESPONSE TO THE IDENTIFIED POTENTIAL CLINICALLY SIGNIFICANT MEDICATION ISSUES?

### (M2005) MEDICATION INTERVENTION: DID THE AGENCY CONTACT AND COMPLETE PHYSICIAN (OR PHYSICIAN-DESIGNEE) PRESCRIBED/RECOMMENDED ACTIONS BY MIDNIGHT OF THE NEXT CALENDAR DAY EACH TIME POTENTIAL CLINICALLY SIGNIFICANT MEDICATION ISSUES WERE IDENTIFIED SINCE THE SOC/ROC?

### M2016 (FORMERLY M2015)- PT/CG DRUG EDUCATION INTERVENTION- A COP!

- At the time of, or at any time since the previous OASIS assessment, was the pt/cg instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
Pt's current ability to prepare & take all oral meds reliably & safely, including administration of the correct dosage at the appropriate times/interval. Excludes injectable & IV meds.

• No change to question or intent, however there is addition to the guidance:
  • Includes assessment of the patient's ability to obtain the med from where it is routinely stored.
  • The ability to read the label (or otherwise identify the med correctly, for ex: a pt that is unable to read and/or write may place a special mark or character on the label to distinguish between meds).
  • Open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.

### M2020 - MANAGEMENT OF ORAL MEDICATIONS:

**Pt's current ability to prepare & take all oral meds reliably & safely, including administration of the correct dosage at the appropriate times/interval. Excludes injectable & IV meds.**

- No change to question or intent, however there is addition to the guidance:
  - Includes assessment of the patient’s ability to obtain the med from where it is routinely stored.
  - The ability to read the label (or otherwise identify the med correctly, for ex: a pt that is unable to read and/or write may place a special mark or character on the label to distinguish between meds).
  - Open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.

### HOW CAN WE IMPROVE MEDICATIONS?

- Suggest staff request patients gather all drugs, Prescription and OTC, at SOC. This allows assessment of physical ability and safety to go to meds.
- Assess if patient knows what the drugs are for and what to report.
- Ensure all high-risk meds are noted at SOC/ROC visits. Document these drugs by name in clinical note.
- If med box present check that planner is accurately filled for times meds are due.
- Always compare to discharge med list and call on any medication issues at SOC. This includes duplicating drugs and medication interactions.
- How every discipline (PN, PT, OT) ask if any med changes at each visit and document if any changes.
- If medication education is documented as needed, requested by physician, or reflected in M2102 c. (checked 3 for medication education needed), then ensure ability to take meds on M2020 & M2030 show the need for education.
- Remind staff of the timeline to consider when answering the questions.

### PREVENTING UNPLANNED HOSPITAL CARE

OASIS items included:

- Transfer M0100 - Transferred to an inpatient facility
- Transfer M2301 (formerly M2300) - Emergency care: At the time of, or any time since the previous OASIS assessment, has the patient utilized a hospital emergency department (includes holding/observation status)
- Transfer M2410 - To which inpatient facility has the patient been admitted.
- DC M2301 (formerly M2300) - Emergency Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)
- DC M2410 - To which inpatient facility has the patient been admitted.
Preventing Unplanned Hospital Care

- Frontloading visits
- Case Conferences
- Physician Notification – early and timely!
- Communication with patient between visits
- Proper Utilization of Services
- In-depth Medication Reconciliation
- Know your patient’s health history and level of compliance
- Continuity of Care
- QM Indicator

As we can see...

It is critical to ensure staff understand how to answer the OASIS correctly.

This includes knowing the Conventions and Timepoints.

OASIS CONVENTIONS (RULES)

- Time Periods must know what it is for each M item.  
  - Report what is true on day of assessment unless a different time period has been indicated in the item or guidance.  
  - Day of assessment is defined as 24 hrs immediately preceding the visit.  
- A Care episode or quality episode must have beginning (SOC, ROC assessment) & a conclusion (Tx or DC) to be considered a complete care episode.
OASIS CONVENTIONS (RULES)

- If Pt's ability or status varies on day of assessment, report Pt's 'usual status' or what is true > than 50% of the assessment time frame, unless the item specified differently.
- Minimize use of NA and Unknown responses.
- Response to Pt current status should be independent observation of the Pt's condition & ability at time of assessment without referring back to prior assessments.
- Several process items require documentation of prior care, at the time of or since the time of the most recent assessment. Instructions in guidance and M items.

- Combine observation, interview, & other relevant strategies to complete OASIS data items as needed (for ex, dc summary from hosp), however when assessing physiologic or functional health status, direct observation is the preferred strategy.
- OASIS items refer to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact & includes both verbal cues & supervision.

OASIS CONVENTIONS (RULES)

- Complete OASIS items accurately & comprehensively
- Understand definitions of words in OASIS
- Stay current with evolving CMS OASIS guidance updates. CMS may post updates up to twice per year, in June & Dec
- Only one clinician may take responsibility for accurately completing a comprehensive assistance, except for selected items when collaboration is appropriate, noted in item specific guidance.

OASIS CONVENTIONS (RULES)
OASIS CONVENTIONS
(RULES)

• When OASIS item includes language specifying “One Calendar Day” (for ex, read fu M2003(formerly M2002), this means until the end of the next calendar day. When says “Same Day” (ex, M1511 (formerly M1510) Heart Failure fu), this means by the End of Today.
• Conventions specific to ADL/IADL items
• Follow rules in Item specific guidance (chapter 3 of OASIS Manual)

M0100-OASIS TIMEPOINTS

• SOC- initial assessment
• ROC- within 48 hours of pts return home from inpt facility admission of 24 hours or more for reasons other than diagnostic test
• Refr- not less frequently than last 5 days of every 60 day episode beginning with SOC date
• Day 56-60 of each cert period
• Other Follow Up- Major decline or improvement in health status
• Transfer to Inpt facility- Not discharged
• Transfer to Inpt facility- Discharged
• Death at Home
• Discharge

Patient Survey Results
BEST TO GO STRAIGHT TO THE SOURCE!
HTTPS://WWW.MEDICARE.GOV/HOMEHEALTHCOMPARE/ABOUT/SURVEY-
RESULTS/HOMEHEALTHCOMPARE/ABOUT/SURVEY-RESULTS.HTML

INFORMATION ON BULLETS BELOW TAKEN DIRECTLY FROM THE WEBSITE:

• It collects patients (or their family or friend’s) feedback about topics for which the patient is the best source of information.
• This is the first national standard for collecting information on patient experiences that would enable valid comparisons among all home health agencies.
• HHCAHPS has a core set of questions.
• Agencies can add their own customized questions to the survey to support internal customer service and quality-related activities.

See the website above for sample of questions!

HOW TO IMPROVE PATIENT SURVEY RESULTS:

• Make sure staff know what is on the survey.
• Make sure patients & caregivers know that the survey may come. Request that they fill them out honestly and return promptly.
• Share survey results with staff and QAPI as soon as possible.
• Focus on areas needing improvement, but also focus on areas of improvement!
• Include areas that need improvement on Focus & Clinical Record Reviews

PATIENT SURVEY STAR RATINGS
PATIENT SURVEY STAR RATINGS

HTTPS://WWW.MEDICARE.GOV/HOMEHEALTHCOMPARE/ABOUT/PATIENTSURVEYSTAR-RATINGS.HTML

• As stated on Medicare.gov: "HHCAHPS (Home Health Consumer Assessment of Healthcare Providers & Systems) star ratings help you quickly and easily assess the patient experience of care information provided on Home Health Compare. You can use these ratings to more easily compare home health agencies using a 5-star scale, with more stars indicating better quality care."

• Results based on patient experience and care provided, not on OASIS answers. These results are listed for all to see!

• New software is available, and being utilized by facilities, to show Star Ratings to the patient/caregiver at the time of choosing an agency!

• Marketers are using these ratings to gain business and patients!

• Very important include these results when determining areas to focus on.

• To learn more about the HHCAHPS Survey, please visit https://homehealthcahps.org.

SO, NOW THE QUESTION IS....

How Do We Choose What Areas To Focus On To Improve Our Outcomes?

It's EASY! Right?

• Review:
  - Casper Reports
  - Outcomes From OASIS
  - Potentially Avoidable Events
  - Patient Survey Responses/Comments
  - Patient Complaint Logs
  - Infection Logs
  - Home Health Compare - Outcomes & Pt Survey
  - 5 Star Ratings
5 STAR MEASURES

Outcome Measures
- Bathing
- Dysphagia
- Ambulation
- Bed transferring
- Pain

Process Measures
- Timely initiation of care
- Drug education all meds all episodes
- Influenza received for current flu season

Utilization outcomes:
- ACH claims based

OUTCOMES FROM OASIS

- Grooming
  - Dysphagia
  - Bathing
  - Bed transferring
  - Toilet transferring
  - Easing
  - Speech & Language
  - Improvement in Management in oral meds
  - Urinary Incontinence
  - Confusion Frequency
  - UTI
- Bowel incontinence
- Ambulation
- Status of Surgical/Wounds
- Behavior problem freq
- Pain interfering with activity
- Upper body dressing
- Lower body dressing
- Light meal
- Phone Use
- Anxiety Level

OUTCOMES FROM OASIS

- Stabilization in:
  - Grooming
  - Bathing
  - Bed transferring
  - Light Meal Prep
  - Phone Use
  - Mgmt. oral meds
  - Speech & language
  - Cognitive functioning
  - Anxiety level
  - Toilet transferring
  - Toilet hygiene
  - Discharged to community
  - Acute care hospitalization (ACH)
  - Emergency (ED) use with hospitalization

Claims based:
- ACH 1st 60 days HH
- Rehosp 1st 30 days HH
- ED w/o hosp. 1st 60 days HH
- ED use w/o hosp. 1st 30 days HH
POTENTIALLY AVOIDABLE EVENTS - PAE

- Emergent care for:
  - Fall
  - Wound infections, deteriorating wound status
  - Improper med admin, med side effects
  - Hyper/hypoglycemia
- Development of UTI
- Increase in # pressure ulcers

- Discharge to community needing:
  - Wound care
  - Med assistance
  - Substantial decline in:
    - 11 or > ADL
    - Mgmt. oral meds

Look At The Following:

- Statistically Significant outcomes to focus on
- Items that are below National/State Averages
- Clinical, multidisciplinary, each discipline significant
- Develop an indicator to incorporate in QAPI to assist in identifying if there is an OASIS understanding deficit, or if an actual care issue.

WHEN CHOOSING INDICATORS TO DEVELOP:

- Task force of stakeholders to brainstorm areas to improve care to increase outcomes.
- Target high volume/ high risk/ problem prone areas
- Develop Audit Tools for each and include in QAPI program
- Continue OASIS Education on specific M items identified in knowledge deficit.
- Educate task force on clinical record reviews to read assessments associated with M items to improve
<table>
<thead>
<tr>
<th>Wound Audit Tool</th>
<th>Review Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt Name:</td>
<td>SOC/Recert Date:</td>
</tr>
<tr>
<td>Type of Wound:</td>
<td>PU</td>
</tr>
<tr>
<td>Number of Wounds:</td>
<td></td>
</tr>
</tbody>
</table>

Criteria: Y N NA Comments

- Wound Care Orders specific and appropriate by physician
- Nsg visits document wound care to physician orders
- Nsg documents complete wound assessment
- Weekly Wound Measurements
- Nsg notifies physician for changes in wound
- Nsg documents education to pt and caregiver
- Nsg documents return demonstration by pt or caregiver
- Total Compliance %

Action Plan:
The QI coordinator or designee will audit 25% or 10 records of patients with falls per quarter to criteria with expected threshold 90%.
Falls will be <10% of patient population.

- Was fall assessment complete on SOC?
- Was fall assessment completed on ROC and Recert?
- Were interventions documented if risk was medium or high?
- Were interventions appropriate for the patient?
- Was there documentation of patient/caregiver education?
- Was the physician notified of the fall?
- Emergent care for fall? If yes, was there anything the Agency could have done to prevent the fall?

CONCLUSION
- Don’t allow yourself to be caught up in all of the New Regulations and Terms because:
  - Most all comes down to how you perform the Comprehensive OASIS Assessment, how the OASIS is scored, and what your patients think and report about you!
  - There are the SAME items we have been doing for decades!
  - CASPER and Home Health Compare reports have been here since 2003!
  - So take a deep breath and work on what you can!
  - Have a great QAPI program to focus and formalize your efforts... and
  - Educate and involve your clinicians!
  - You will find that your Outcomes and Star Rating will improve by keeping it simple!!!!!!!!
THANK YOU

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