

# Medication Management: The Single Most Important IADL

*Presented for*



*Missouri Alliance for*  
**HOME CARE**

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*Presented by*

**Karen Vance, OTR**  
Supervising **Consultant**

**BKD**<sup>LLP</sup>  
**CPAs & Advisors**

BKD Health Care Group

[kvance@bkd.com](mailto:kvance@bkd.com)

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## Goal: Remain *Safely* at Home

- Home Health has been challenged to reduce the acute care hospitalization rate
- A top reason for hospitalizations has been attributed to ineffective medication management
- Another top reason is falls
- Two key risk factors for falls are polypharmacy and ineffective medication management
- Medication management is a critical ADL

## Home Health and Medications

- Drug Regimen Review is included in the Conditions of Participation (CoP) 484.55
- Medications as a topic earned a separate section in OASIS C
  - ❖ Reflecting the CoP regulation
  - ❖ Increasing the accountability and importance of addressing medications on the part of home health agencies

## 42 CFR 484.55(c)

- *Drug regimen review*: a review of all medications the patient is currently using in order to identify:
  - ❖ any potential adverse effects and drug reactions, including...
  - ❖ ineffective drug therapy,
  - ❖ significant side effects,
  - ❖ significant drug interactions,
  - ❖ duplicate drug therapy,
  - ❖ and noncompliance with drug therapy

## Potential Adverse Effects and Drug Reactions

- Does the patient report or exhibit signs of any adverse drug reactions? Examples:
  - ❖ Intolerance
  - ❖ Toxicity
  - ❖ Bizarre (or idiosyncratic) effects
  - ❖ Allergy

## Ineffective Drug Therapy

- Does the patient report symptoms or exhibit signs that medication is ineffective?
  - ❖ Taking meds for pain, but experiences pain, including breakthrough pain or pain that interferes with activity.
  - ❖ Taking oral diabetic drugs and managing activity/diet but blood glucose is elevated or depressed.
  - ❖ Taking antihypertensives but blood pressure remains elevated.

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## Significant Side Effects

- Does the patient report symptoms or exhibit signs of significant side effects?  
Examples, Patient is:
  - ❖ Lethargic
  - ❖ Dizzy
  - ❖ Orthostatic
  - ❖ Hypomanic or manic
  - ❖ Bleeding or bruising excessively when taking a given medication as ordered.

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## Significant Drug Interactions

- Does pharmacy software or other review of medications indicate that the patient has *prescribed or is taking* a combination of medications which interact significantly?
- Does pharmacy software or review combined with patient report or clinician observation indicate a significant drug-diet or drug-disease interaction?

## Duplicate Drug Therapy

- Are there redundant prescriptions?
  - ❖ Patient taking the same medication from two different bottles?
  - ❖ Two different providers are prescribing the same or similar medication(s)?
  - ❖ Patient is taking two different dosages/strengths of the same medication?
  - ❖ Patient is taking a generic and also taking the corresponding branded medication?
- Does pharmacy software or other review indicate that the patient is taking medications that are redundant or duplicative?

## To This Point . . .

- All of the aspects of the drug regimen review pertain to the medications
- The patient's report (symptoms, side effects) provides information about appropriateness of the medications and dosages
- Nothing thus far addresses the patient's medication *management*
- The last aspect, *compliance*, addresses the patient's *behavior* in regard to the medication regimen, or *medication management*

## Noncompliance with Drug Therapy

- Does the patient report *not* taking ordered medications or dosing that differs from orders?
- Does the patient express opinions or beliefs about medication which indicate that the patient is not taking medication, taking more or less than ordered *or* not taking it consistently?
- Does the patient express concerns about taking medication (concerns or fears of side effects)?
- Does the patient identify barriers to obtaining medication (finances, transportation) that result in taking fewer doses or fewer medications or having gaps between refills?

OASIS ITEM
<p><b>(M2000) Drug Regimen Review:</b> Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?</p> <p><input type="checkbox"/> 0 - Not assessed/reviewed [ <i>Go to M2010</i> ]</p> <p><input type="checkbox"/> 1 - No problems found during review [ <i>Go to M2010</i> ]</p> <p><input type="checkbox"/> 2 - Problems found during review</p> <p><input type="checkbox"/> NA - Patient is not taking any medications [ <i>Go to M2040</i> ]</p>
ITEM INTENT
<p>Identifies if a review of the patient's medications indicated the presence of potential clinically significant problems. This item captures information for calculation of a process measure to identify best practices related to medications.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of Care</p> <p>Resumption of Care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>Includes all medications, prescribed and over the counter, administered by any route (e.g. oral, topical, inhalant, pump, injection).</li> <li>If portions of the drug regimen review (e.g., identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2000 may be selected. Collaboration in which the assessing clinician evaluates patient status (e.g., presence of potential ineffective drug therapy or patient noncompliance), and another clinician (in the office) assists with review of the medication list (e.g. for possible duplicate drug therapy or omissions) does not violate the requirement that the comprehensive patient assessment is the responsibility of and must be ultimately completed by one clinician. Agency policy and practice will determine this process and how it is documented. The M0090 date – the date the assessment is completed – would be the date the two clinicians collaborated and the assessment was completed.</li> <li>The definition of a problem for responses 1 and 2 includes the following:  <p>Potential clinically significant medication issues which include adverse reactions to medications (e.g., rash), ineffective drug therapy (e.g., analgesic that does not reduce pain), side effects (e.g. potential bleeding from an anticoagulant), drug interactions (e.g., serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (e.g. generic name and brand name drugs that are equivalent both prescribed), omissions (missing drugs from an ordered regimen), dosage errors (e.g., either too high or too low), noncompliance (e.g., regardless of whether the noncompliance is purposeful or accidental) or impairment or decline in an individual's mental or physical condition or functional or psychosocial status.</p> <p><b>Note:</b> Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.</p> </li> </ul>

**Guidance for this item updated 12/2010**

OASIS ITEM
<p><b>(M2020) Management of Oral Medications:</b> <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <b>Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</li> <li><input type="checkbox"/> 1 - Able to take medication(s) at the correct times if: <ul style="list-style-type: none"> <li>(a) individual dosages are prepared in advance by another person; <u>OR</u></li> <li>(b) another person develops a drug diary or chart.</li> </ul> </li> <li><input type="checkbox"/> 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times</li> <li><input type="checkbox"/> 3 - <u>Unable</u> to take medication unless administered by another person.</li> <li><input type="checkbox"/> NA - No oral medications prescribed.</li> </ul>
ITEM INTENT
<p>This item is intended to identify the patient's ability to take <b>all</b> oral (p.o.) medications reliably and safely at <b>all</b> times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:</p> <ul style="list-style-type: none"> <li>- physical impairments (e.g., limited manual dexterity)</li> <li>- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)</li> <li>- sensory impairments, (e.g., impaired vision, pain)</li> <li>- environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)</li> </ul>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care Resumption of care Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> <li>• Includes all prescribed and OTC (over-the-counter) medications that the patient is currently taking and are included on the plan of care.</li> <li>• Exclude topical, injectable, and IV medications.</li> <li>• Only medications whose route of administration is p.o. should be considered for this item. Medications given per gastrostomy (or other) tube are <u>not</u> administered p.o., but are administered "per tube."</li> <li>• If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0.</li> <li>• Select Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (e.g., set up a "planner device") <b>and/or</b> if another person must develop a drug diary or chart which the patient relies on to take medications appropriately.</li> </ul>

**Guidance for this item updated 12/2010**



## Therapy Only Admissions

- Medication reconciliation/drug regimen review software assisted or manually by agency office
- Agency policy must set up communication
  - ❖ Timely transfer of admission information *from* therapist to the office for review
  - ❖ Physician contact re significant findings completed and tracked by office?
  - ❖ Results of communication back *to* therapist for documentation on OASIS
- Agency practice to develop parameters for when and what findings warrant a nursing referral

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## Understand the Distinction . . .

- Input from the National Quality Forum (NQF) and industry research suggests *drug regimen review* and *medication reconciliation* increases the accuracy of medication administration and agency processes.
- Agency policy determines this process.

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## How and whether a patient adheres to medication regimen . . .

- Is dependent on all staff:
  - ❖ Accurately assessing the patient's current performance, capacities and preferences,
  - ❖ Exercising effective clinical reasoning,
  - ❖ Implementing patient-centered strategies to optimize capacities.

## Three Separate but Related Issues

- Is the **medication regimen** appropriate and effective for the patient?
- Is the *patient capable of implementing* the medication regimen?
- Is the **patient (or caregiver)** managing medications effectively?

## Adherence $\neq$ Performance

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## Medication Management as ADL

- Medication routines are a **Self Care Activity** focusing on looking after and maintaining one's own health (World Health Organization, 2001).
- Medication management is an Instrumental ADL. IADLs are more complex than basic self-care skills.
- We are missing the chance to optimize outcomes if we don't focus on medication management as an activity!

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# Medication Management Care Planning Tool

**Purpose: To improve assessment of patient’s medication management performance and assist selecting strategies to support improved medication management**

Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
<ul style="list-style-type: none"> <li>Fills only some prescriptions</li> <li>Takes only some medications</li> <li>“I don’t want to be on a lot of medications.”</li> <li>“I don’t think it’s good for me to take medications.”</li> <li>Someone I know took pills like those and got worse so I don’t want to take them.”</li> </ul>	<ul style="list-style-type: none"> <li>Fearful or anxious about addiction or dependence OR</li> <li>Fearful of undesired effects of medications</li> </ul>	<ul style="list-style-type: none"> <li>Allow/encourage patient to express, elaborate on concerns</li> <li><i>Fear or anxiety is a legitimate emotional inability to take some or all meds</i></li> </ul>	<ul style="list-style-type: none"> <li>RN referral to address fears, provide education on purpose, effects, and side effects of medication(s)</li> <li>SW referral for brief counseling related to fears/anxiety</li> <li>Rule out financial barriers</li> </ul>
<ul style="list-style-type: none"> <li>“I have trouble reading all that stuff on the bottles.”</li> <li>Resists requests to read information on medication labels or other medication information</li> </ul>	<ul style="list-style-type: none"> <li>Limited literacy</li> </ul>	<ul style="list-style-type: none"> <li>Ask if patient learns better by hearing, seeing demo or reading</li> <li>Assess reading ability to determine literacy (how does patient manage other print information?)</li> </ul>	<ul style="list-style-type: none"> <li>OT referral to address alternate means of information acquisition</li> <li>Try visual model of meds/dosages (i.e. picture of meds for times and dosage)</li> <li>Try audio recordings of med instructions</li> <li>If instruction too complicated for model or audio recording, enlist caregiver to supervise complex dosing</li> </ul>
<ul style="list-style-type: none"> <li>“I have trouble reading the labels.”</li> <li>“I can’t tell which pill is which, they look alike.”</li> <li>Unable to:                             <ul style="list-style-type: none"> <li>read information on container OR</li> <li>read other instructional material OR</li> <li>discern shapes/shadings or discriminate between pills</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Visual impairment</li> </ul>	<ul style="list-style-type: none"> <li>Does patient have/use corrective lenses?</li> <li>Does patient have/use magnification beyond corrective lenses?</li> </ul>	<ul style="list-style-type: none"> <li>Consult pharmacy re: system to color code or apply large print or high contrast label to containers</li> <li>OT referral for low vision compensation strategies</li> <li>Large print/high contrast model (example) for dosing or filling mediplanner</li> </ul>

# Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> <li>• “I have trouble swallowing pills, especially those big ones.”</li> <li>• Patient coughs or gags when attempting to take pills</li> <li>• Patient is on a modified diet for dysphagia</li> </ul>	<ul style="list-style-type: none"> <li>• Dysphagia or uses technique that risks aspiration</li> </ul>	<ul style="list-style-type: none"> <li>• Is patient on dysphagia diet?</li> <li>• Observe patient’s technique to administer/swallow pills and if coughing or gag occurs</li> </ul>	<ul style="list-style-type: none"> <li>• OT or SLP consult for swallowing eval and dysphagia intervention</li> <li>• Consult with pharmacist to determine if:                             <ul style="list-style-type: none"> <li>○ Meds can be crushed, or cut</li> <li>○ Meds can be administered in semisolids (pudding/applesauce)</li> <li>○ Med is available in a different form i.e. liquid</li> <li>○ Med is available in a smaller size?</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>• Patient leaves pill containers open or leaves pills out of containers</li> <li>• Patient doesn’t take meds if containers are securely capped</li> <li>• Patient can’t open caps or close securely, or spills contents when trying to open container</li> <li>• “I can’t get the bottles open”</li> </ul>	<ul style="list-style-type: none"> <li>• Fine motor skills (grasp, dexterity) impairment and/or joint pain</li> </ul>	<ul style="list-style-type: none"> <li>• Observe performance</li> </ul>	<ul style="list-style-type: none"> <li>• OT referral to analyze and simplify task</li> <li>• Consult with patient, family and pharmacist re: appropriateness of non-child proof containers</li> <li>• Explore other dispensing containers (eg. punch packs)</li> <li>• Consider having pharmacist or caregiver set up mediplanner with easy-open compartments</li> </ul>

# Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> <li>• “I remember my medications in the morning but I forget about those new ones I’m supposed to take later in the day.”</li> <li>• “Sometimes I remember to take my pills and sometimes I don’t.”</li> <li>• “Some days I get up early and other days I stay in bed all day.”</li> <li>• Patient has few routines or daily routine varies on different days of the week</li> <li>• New meds or new dosing times have been added to existing medication schedule</li> <li>• Patient is missing new dosing times but seldom misses long established dosing times</li> </ul>	<ul style="list-style-type: none"> <li>• May be a cognitive/memory impairment but also:</li> <li>• Lack of established routine limits ability to routinize medications OR</li> <li>• Patient has established routine on some days (and takes meds) but not on other days OR</li> <li>• Additional dosing times are not yet routinized</li> </ul>	<ul style="list-style-type: none"> <li>• Assess for presence and consistency of routine and if there are alternate routines (eg dialysis or attending day program)</li> <li>• What are the routines associated with dosing times that patient seldom misses</li> <li>• What interrupts successful routines</li> </ul>	<ul style="list-style-type: none"> <li>• Rule out cognitive (memory) impairment: does the patient have problems remembering other daily tasks?</li> <li>• OT referral to assess for presence and stability of routines and to incorporate new dosing times into established routines</li> <li>• Consult with prescriber re: options for reducing number of dosing times or synchronizing dosing times with most stable and consistent daily routines</li> <li>• Consider portable (1 day) mediplanner to take along on days when routine is different or locate second mediplanner in location where patient will be at later dosing time</li> </ul>
	<ul style="list-style-type: none"> <li>• “I just can’t remember to take my medications.”</li> <li>• “I can’t keep track of whether I took my medications or not.”</li> <li>• Pill count shows many doses missed or fewer doses left than refill date indicates</li> <li>• Patient exhibits memory deficits in other activities</li> </ul>	<ul style="list-style-type: none"> <li>• Memory disorder (temporary or permanent)</li> </ul>	<ul style="list-style-type: none"> <li>• Rule out reversible causes of memory problems (UTI, medication interactions, overdosing, use of OTC meds affecting cognitive status)</li> <li>• Assess for depression</li> <li>• Assess for cognitive impairment</li> </ul>	<ul style="list-style-type: none"> <li>• Consult with physician/prescriber re:               <ul style="list-style-type: none"> <li>○ UTI</li> <li>○ Interactions</li> <li>○ Beers list meds</li> </ul> </li> <li>• OT or SLP referral for cognitive assessment</li> <li>• OT or SLP referral for alternative storage/dispensing devices</li> <li>• Consider use of pre-filled mediplanner to provide visual reminder</li> <li>• Work with caregivers on strategies to involve patient in medication administration but reduce risk of over or underdosing</li> </ul>

# Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> <li>• “My (daughter/friend/spouse, etc) gives me my medicine when I need it. I don’t even think about it.”</li> <li>• “My (daughter/spouse/family) doesn’t want me to take my medicine without help.</li> <li>• Caregivers express anxiety or resistance to having self-administer medications</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of knowledge about medications</li> <li>• Risk of over or undermedicating if knowledgeable caregiver is not present</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge of purpose/dosing of each medication</li> <li>• Alternatives patient or caregivers have established in case caregiver is not present</li> <li>• Observe patient demonstrating physical task of dispensing and administering medication</li> </ul>	<ul style="list-style-type: none"> <li>• Work with patient and caregiver to engage patient in all aspects of administration that s/he is capable of performing</li> <li>• Work with patient and caregivers on strategies to ensure that patient can safely and accurately administer PRN medications</li> </ul>
	<ul style="list-style-type: none"> <li>• “It’s too much trouble to go to the (bathroom/kitchen/etc) to get my medicines.”</li> <li>• “I can only go up and down the stairs once a day so I can’t get back there to take my medicine.”</li> <li>• “We have to keep my pills where the children can’t get them, but then it’s hard for me to reach.”</li> <li>• Patient is unable to access or has difficulty accessing where medications are stored</li> </ul>	<ul style="list-style-type: none"> <li>• Medications are inaccessible</li> </ul>	<ul style="list-style-type: none"> <li>• Ask patient to retrieve medications (instead of having them out prior to your visit)</li> <li>• Observe retrieval and patient’s endurance, mobility, balance, reach to successfully retrieve meds</li> </ul>	<ul style="list-style-type: none"> <li>• Work with patient and caregivers on options to store medications where they are accessible to patient at all dosing times but not accessible to children, pets or adults with cognitive impairment</li> <li>• OT or PT referral to improve activity tolerance and/or mobility</li> <li>• OT referral to develop environmental adaptations to optimize medication accessibility</li> </ul>



## All skilled clinicians should be able to:

- Conduct a drug regimen review
- Assess the patient's ability to self-administer medications
- Assess the patient's current medication management
- Identify needs and make appropriate referrals to other team members to address medication-management related needs
- Collaborate with the care team to optimize patients (and/or caregivers) medication management

## Equip Therapists

- Consult guidance and standards published by the therapy professional organizations
- Consult the state practice acts and regulations of each discipline
- Provide training and precepting as needed to optimize therapists' competencies
- Consult guidance in the *Caring* article:  
OASIS, Scope of Practice and the Therapies  
*Caring*, November 2010, pp. 28-33



## Team-Based Care

- Collaborate to optimize patients' (and/or caregivers') medication management capacities
- Coordinate interventions to achieve medication-related outcomes
- Communicate re: interventions and physician-interaction so that transfer and discharge OASIS data is accurate

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## Key points:

- Drug regimen review and assessment of medication management are required, but these two tasks are not enough . . .
- Addressing medication management as an IADL is important *not only* for medication-related outcomes, *but also* impacts other outcomes reported on Home Health Compare and OBQI report
- Use existing resources: *OASIS Guidance Manual*, HHQI Medication Management BPIP, *Caring* article and therapy association guidance
- Optimizing medication management is *everyone's* responsibility--coordinated team-based care is the key

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# OASIS, Scope of Practice, and the Therapies

By Janet Brown, Rebecca Skrine,  
Cindy Krafft, Tonya Miller,  
Karen Vance, and Carol Siebert





Revisions to the Outcome and Assessment Information Set (OASIS) came from many years of data analysis, input from experts such as the National Quality Forum (NQF) and other industry experts, and requests made by home health providers all over the nation.

However, the revisions have sparked renewal of old OASIS controversy in the therapy community, and in some cases this has led to debate between therapists and agency management as to whether collecting some data elements is within the scope of practice of a therapy discipline or disciplines. This debate can be distilled to the difference between professional responsibility and professional competency.

Agencies facing this debate may adopt very different approaches in determining who completes the comprehensive assessment, who collects OASIS data, and how training is provided. At the heart of the controversy lies the need for a clear understanding of what OASIS is and is not, what each professional's individual scope of practice and training needs are, and how agencies and therapists can communicate better with each other to achieve the goal of accurate and efficient OASIS data collection.

### OASIS-C and the Conditions of Participation

OASIS is a discipline-neutral data collection tool mandated by the Conditions of Participation (CoPs) to be integrated into a comprehensive assessment. The CoPs mandate that comprehensive assessments be completed by skilled professionals at pre-determined time points. Long before the Code of Federal Regulations published OASIS requirements in Section 484.55 of the Medicare Home Health Conditions of Participation, CMS commissioned the Center for Health Policy Research at the University of Colorado to create a system for measuring home health quality. The OASIS data set was developed to provide key information about patient status, what the patient "looks like."

### Guidance from CMS is as follows:

*OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines (Chapter 1-8).*

*As with OASIS-B1, OASIS-C is not intended to represent a comprehensive assessment in and of itself. Each agency is expected to incorporate the OASIS items into its own comprehensive assessment documentation and follow its own assessment policies and procedures. (Chapter 1-9).*

The CoPs and the discipline-neutrality of the OASIS data set have not changed. The core of the comprehensive assessment, including OASIS data items, concerns the patient, not the discipline conducting the assessment.

Skilled professionals have a responsibility to conduct a comprehensive assessment and to be competent in completing all aspects of the comprehensive assessment, including aspects that are discipline-neutral and aspects that are specific to their own discipline. It is the agency's responsibility to provide adequate training to assure competency in collecting the data.

Another standard in the home health CoPs that has not changed is the drug regimen review (§484.55 (c)). Though this standard has not changed, accountability for completing a drug regimen review was amplified with its inclusion as a process measure in OASIS-C. This issue is at the heart of the therapy controversy and addresses the distinction between professional responsibility, competency, and scope of practice.

### Scope of Practice and Training

Occupational therapy, physical therapy, and speech-language pathology address a large spectrum of disorders and interventions that vary across the life span and continue to develop new areas of specialization and practice. No clinician, regardless of years of experience, can claim to be competent in every aspect of therapy practice within his or her professional scope of practice. For example, a speech-language pathologist who has years of experience working with swallowing disorders in geriatric patients is not competent to treat infants with swallowing problems without additional training.

It is critical that home health agencies be knowledgeable of state practice act or licensure law for each of the three therapies. Because these acts and laws are written very broadly, OASIS may not be specifically mentioned. Therapists can still learn to complete the OASIS tool unless the state licensing or certifying body specifically excludes it. In addition, home health agencies must be knowledgeable about the difference between a therapy discipline's professional scope of practice and individual competence. Once it has been de-



termined that there is no state practice prohibition, agencies should provide training necessary for development of desired skills such as conducting OASIS assessments that are within the therapist's scope of professional practice .

Administering OASIS and scoring it appropriately is a learned skill. Therefore, training in completion of OASIS must be tailored to the individual therapist. For example, some areas such as observing skin integrity may be unfamiliar to practitioners like speech-language pathologists. Agencies have the responsibility to provide training and support that allow the therapist to confidently and accurately score the items in OASIS.

Competency is achieved at different rates by different people. One therapist may be a quick study and the next may be apprehensive or inexperienced and require much more assistance. A "one size fits all" approach — particularly one that provides only a minimum level of training — may result in avoidance of completing the OASIS, conflict over perceived scope of practice issues, inaccurate or inconsistent scoring, and ultimately, staff retention problems or OASIS compliance problems. Competence must be assessed in "real life" and include observation, not just through verbal or written means.

### Who Gets How Much Training?

All agency staff benefit from knowing what the OASIS items are and how they are used. Different levels of training may benefit staff depending on their roles and the likelihood of them needing and retaining competencies to administer OASIS. Agencies should consider quality as well as cost and time efficiencies when deciding the appropriate level of training for their employees and contract staff about OASIS.

For example, even though occupational therapists are prohibited from admitting Medicare patients, they may admit patients and conduct start-of-care OASIS assessments when Medicare is not the payer. Thus it might be prudent to prepare occupational therapists to collect OASIS data at all time points. On the other hand, training contract staff to complete OASIS compounds the challenges previously discussed. Managers may find that therapists who provide occasional services to a home health agency may not be available for enough training to become competent, or may lack sufficient opportunities to administer OASIS to retain competency from their training.

Keep in mind that OASIS is not a part of the admission process only. Because therapists may well be collecting data at recertification or resumption of care, transfer, and discharge, it is critical that they be trained to complete OASIS

### Speech-Language Pathology and OASIS

The American Speech-Language-Hearing Association (ASHA), the national credentialing and professional association for speech-language pathologists, does not have an official policy about speech-language pathologists administering OASIS. However, several ASHA policy documents provide guidance that can help clarify discussions about completing OASIS. With regards to the issue of individual competence vs. professional scope of practice (see above), ASHA's Code of Ethics, Principle I, Rule A states, "Individuals shall provide all services competently." Rule B states, "Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided." Principle II, Rule B states, "Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience" (ASHA, 2010).

The implication of these statements is that individuals who are certified or licensed to practice are still ethically constrained not to provide services for which they are not personally trained and competent. Thus, until the speech-language pathologist (SLP) has received sufficient training to demonstrate the required competencies in an area (including administration and scoring of OASIS), that therapist may not ethically participate in that area of practice.

ASHA also developed a position statement on multi-skilled personnel to address the role of the speech-language pathologist in performing patient care activities that are not exclusive to a single discipline. It states, "Cross-training of basic patient care skills, professional nonclinical skills, and/or administrative skills is a reasonable option that clinical practitioners at all levels of practice may need to consider depending on the service delivery setting, geographic location, patient/client population, and clinical work force resources." An example cited within the glossary of the document is that "home care patients' compliance with prescribed medications can be verified by clinicians already coming to the home on a regular basis" (ASHA, 1996).

Thus, ASHA's existing documents provide guidance to SLPs who are concerned that administering OASIS may be out of their scope of practice regardless of training. The successful implementation of this guidance relies on open communication between managers and SLPs to ensure that training is provided to allow the SLP to demonstrate competence in their individual scope of practice and to feel assured of ongoing agency support as needed.



### Occupational Therapy Standards, Competencies, and Medication Routines

An occupational therapist working in a Medicare-certified home health setting is responsible for delivering appropriate services as well as understanding and complying with the regulatory and payer requirements of the setting, such as OASIS data collection. Occupational therapy professional standards published by the American Occupational Therapy Association (AOTA) address this responsibility explicitly.

#### Standards of Practice

“Standard I. Professional Standing and Responsibility: An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines and state, federal, and other regulatory and payer requirements relevant to practice and service delivery.”

“Standard II. Screening, Evaluation, and Re-evaluation: An occupational therapist initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data in accordance with federal and state law, other regulatory and payer requirements, and AOTA documents.” (AOTA, 2010)

#### Standards for Continuing Competence

“Occupational therapy personnel are expected to work within their areas of competence and to pursue opportunities to update, increase, and expand their competence.” (AOTA, 2010)

Given these standards, occupational therapists have a

responsibility to perform assessments required by federal regulations. In addition, the therapist should appraise his/ or her assessment competencies. A therapist may identify the need to acquire additional competencies in order to perform a comprehensive assessment accurately. Similarly, an occupational therapist may need to acquire additional competencies in order to accurately assess or effectively provide interventions within the domain of occupational therapy and appropriate to the needs of the home health population. One such example is the completion of the required drug regimen review and addressing medication routines as an important daily activity. According to AOTA's *Occupational Therapy Practice Framework* (2008), medication routines are an instrumental activity of daily living, or IADL, within the domain of occupational therapy. Medication routines include both administering and managing one's medications. In order to complete the drug regimen review accurately, an occupational therapist must analyze the patient's performance (e.g., does the client report symptoms or exhibit signs that medication is ineffective or producing side effects?), collaborate with other clinicians, or use pharmaceutical software to address the required elements of the review. In order to accurately assess the patient's ability to manage medication routines, the occupational therapist must identify the patient's existing routines, analyze the activity demands associated with administering and managing medications, and assess the patient's skills in relation to the activity demands. From this evaluation process, the therapist then selects appropriate intervention approaches (e.g., remediation, establishment, compensation, adaptation) to best support the patient's performance of medication routines. In many cases, this intervention is coordinated with nursing intervention focused on medication teaching.

accurately. Lack of knowledge at these time points can have a negative impact on outcome measures as well as the collection of process measure information.

#### Accuracy and Outcomes

The role of therapists in OASIS extends beyond the moments in which they directly complete the tool. Episodes where the therapist never touches the OASIS form still require a degree of attention to the information being collected as well as a focus on both outcome and process measures. Documentation of these efforts should be seen in the content of the evaluation visit as well as throughout the course of care.

#### Tips for Greater OASIS Consistency:

- Assess competence and provide education to any clinician that completes OASIS at any time point. This would include:
  - Physical therapists;
  - Occupational therapists; and
  - Speech language pathologists.
- Ensure therapist access to admission documentation. In accordance with OASIS guidance, the agency has five days to gather assessment information to complete OASIS at the start of care. Input and feedback from team members is an integral part of accurate data collection.



- Create a process for communication. Never assume that clinicians are talking to each other about OASIS. Establishing a process for constructive dialogue about this information is much more effective than encouragement alone.
- Assess therapy evaluations for consistency. Examine the responses in relation to OASIS data collected to see if the answers are supported. Key areas extend beyond the functional items and include:
  - Dyspnea;
  - Interfering pain;
  - Incontinence;
  - Cognitive status; and
  - Vision.

### Physical Therapy and OASIS

There are various resources that a physical therapist can utilize when determining whether a specific assessment or intervention is within the scope of a physical therapist. The American Physical Therapy Association (APTA), the national professional association for physical therapists, offers several. First is APTA's *Guide to Physical Therapy Practice, 2nd Edition*. This guide is a resource outlining the entire scope of practice for physical therapists and physical therapist's assistants.

Regarding specific areas of OASIS-C data collection, APTA has addressed the role of physical therapists in a document entitled, "RE: Title of Information Collection - Medicare and Medicaid Programs OASIS Collection Requirements as Part of the COPs for HHAs and Supporting Regulations in 42 CFR." This document was submitted to CMS on Jan. 13, 2009 and is available on the website for APTA's home health section at [www.homehealthsection.org/associations/9809/files/APTA.HHS.PPSCComments.pdf.pdf](http://www.homehealthsection.org/associations/9809/files/APTA.HHS.PPSCComments.pdf.pdf).

Finally, a resource that all agencies should utilize when determining scope of practice for a physical therapist is the individual state practice act. Your state practice act can be found by visiting the state licensing board website. A complete list of state licensing boards can be found on the Federation of State Boards of Physical Therapy's website, [www.fsbpt.org](http://www.fsbpt.org). By utilizing resources from APTA and their state practice act, agencies can make an informed decision about specific practice policies for the organization.

### Tips for Improved Outcomes of Care:

- Involve all disciplines in outcomes. There is no "discipline assignment" when looking at outcomes. Not every patient gets therapy and not every patient gets nursing, but every patient has OASIS outcome information collected. Therapy can help reduce rehospitalizations and improve medication management. Nursing can be a critical element to improvements in ambulation and bathing.
- Get the team involved when OASIS identifies a problem but not "why." It is up to the team to determine why the patient has issues in a particular area, since each patient is unique. Based on those findings, the care plan should reflect intentional efforts to address those identified areas of concern. For example, impaired cognitive or communication status may be behind a patient's difficulty in complying with safety precautions or an exercise program.

### The Solution: Communication and Training

In summary, the bottom line in talking to therapists on OASIS is threefold:

- Inform yourself about each profession's state practice act;
- Listen to your therapists' self-evaluations of their competency in various aspects of OASIS items — remember that each therapist may be different; and
- Provide appropriate training to ensure that the therapists' and your comfort levels are satisfied, and be sure to have training "refreshers" to maintain that comfort level.

Your demonstrated commitment to training and achieving consistency and quality in OASIS assessments by your therapists will pay dividends in the long term.

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**About the Authors:** *Janet Brown, MA, CCC-SLP is director of health care services for the American Speech-Language Hearing Association.*

*Rebecca Skrine, MA, CCC-SLP is rehabilitation services manager at Baptist Hospital East Home Health Agency in Louisville, KY.*

*Cindy Krafft is president of the American Physical Therapy Association's Home Health Section.*

*Tonya Miller is director of rehab education and program development and regional director for Central Pennsylvania for Celtic Healthcare.*

*Karen Vance, OTR/L is a supervising consultant with BKD, LLP.*

*Carol Siebert, MS, OTR/L, FAOTA is an occupational therapist with Duke Community Health Network in Chapel Hill, NC.*

*All are members of NAHC's Therapy Advisory Committee and represent their respective therapy associations.*



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