Connect 4!
CoPs, OASIS, Coding, Quality Care

HCAC Annual Conference 2019

Learning Outcomes

• Understand regulatory requirements of the CoPs, IMPACT Act and Quality Reporting Program.
• Describe strategies to compensate for deleted OASIS items in the comprehensive assessment.
• Develop a plan of care to address identified needs and achieve patient and agency goals.
• Utilize care coordination, collaboration and best practices to improve IMPACT Act quality measures.
Regulatory Requirements

Conditions of Participation, IMPACT Act, Home Health QRP

Comprehensive Assessment

• Identify patient’s continuing need for home care and eligibility for the home health benefit
• Identify patient’s medical, nursing, rehabilitative, social and discharge planning needs
• Measure patient’s progress toward outcomes and goals of the plan of care
• OASIS data must accurately reflect patient’s status at the time the information is collected
• Agency accepts patients with a reasonable expectation that needs can be met safely and effectively in the patient’s residence
Requirement for Hospitalization Risk Assessment and POC actions

• HHA must include an assessment of the patient’s level of risk for Emergency Department visits and hospital re-admission
  • Must be patient’s specific risk factors
  • No specific tool or process defined for use
• Plan of Care must include all necessary interventions to address and mitigate the underlying risk factors identified on assessment

Care Planning

• Agency develops an individualized POC to address ALL needs identified by the patient assessment
• Plan of Care must specify the care to meet patient’s specific needs - include all necessary interventions to address and mitigate the underlying risk factors for hospitalization or ED use, as identified on assessment
• POC must include patient-specific measurable outcomes
• Patient has the right to participate in choosing goals and outcomes for care
Patient Participation

• HHA must involve the patient, representative, and caregivers in coordinating care activities
  • Agency’s responsibility to support and foster collaboration and communication among disciplines caring for patient
  • HHA must ensure patient and caregiver receive ongoing training and education from the HHA on the care and services they are expected to implement...including education about post-discharge care duties and appropriate follow up with the patient’s PCP

Patient Participation

• HHA must notify patient, their representative, caregivers and physician when POC is updated
  • Due to a significant change in patient’s health status
  • Related to plans for patient’s discharge

• A patient’s legal representative, such as a guardian, has been legally designated or appointed to make health-care decisions on the patient’s behalf. Evidence that there is a legal representative may include guardianship, a power of attorney for health care decision-making, or a designated health care agent. A patient-selected representative participates at the request of a patient in decisions related to the patient’s care or well-being but is not legally designated or appointed to do so. The patient determines the role of the patient-selected representative.
Requirement for Written POC to Patient

- Agency gives patient and representative a written copy of the POC (components under 484.60(e))
  - Medication name, dose, frequency, instructions
  - Disciplines and visit schedule (frequency)
  - Treatments to be administered by agency, including therapy
  - Any other pertinent instructions related to care/treatment (i.e. goals for home care)
  - Name and contact information of the HHA clinical manager

Coordination of Care

- HHA must integrate services, whether provided directly or under arrangement, to assure:
  - Identification of patient needs and factors that could affect patient’s safety and treatment effectiveness
  - Involvement of the patient, representative (if any), and caregivers in the coordination of care activities
  - The coordination of care provided by all disciplines
  - Facilitate communication between HHA, physicians and other providers during HH services and after discharge
  - Each patient and caregiver receives any training necessary for a timely discharge from the HHA
  - Integration of orders, keep all physicians involved in the POC informed relevant to their participation in care of the patient
Content of the Plan of Care

• All pertinent diagnoses (all known diagnoses)
• Patient’s mental, psychosocial and cognitive status
• Types of services, supplies and equipment required
• Frequency and duration of visits by each discipline
• Prognosis and Rehab potential
• Functional limitations and Activities permitted
• Nutritional requirements
• All medications and treatments
• Safety measures to protect against injury

Content of the Plan of Care (con’t)

• Description of patient’s risk for emergency dept. visits and hospital admission, and all necessary interventions to address the underlying risk factors
• Patient and caregiver education and training to facilitate timely discharge
• Patient-specific interventions and education, measurable outcomes and goals identified by the agency and the patient
• Information related to any advanced directives
• Additional items the HHA or physician choose to add: social/other barriers to good outcomes
• Coordination with community resources
New Quality Measures

New standardized items support measurement domains mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), including new quality measures:

• New standardized items J1800, J1900 - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF # 0674)

• New standardized items GG0130, GG0170a-b, d-s - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

• Modification to OASIS item M1311 to support a new standardized pressure ulcer measure to replace the current standardized pressure ulcer measure. The new measure is Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Falls Quality Measure

• Reports the percentage of quality episodes in which the patient experiences one or more falls with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness or subdural hematoma)

• Adopted for calendar year 2020 HH Quality Reporting Program, data for measure calculation submitted via OASIS Jan-Dec 2019
  • J1800 gateway item, J1900C data item for measure

• This measure is not risk-adjusted
Falls Quality Measure

**Numerator** = number of quality episodes in which J1900C is response 1 or 2

**Denominator** = All quality episodes *except*:

- Occurrence of falls was not assessed (J1800 is dash “—”)
- Or
- Assessment indicates fall occurred AND the number of falls with major injury was not assessed (J1900C is dash “—”)

Functional Quality Measure

- “Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function”
- Reports the percent of episodes with a SOC/ROC and a DC functional assessment and a treatment goal that addresses function; the treatment goal proves that a care plan with a goal has been established for the patient, and documentation of a goal for one functional item reflects the care plan addresses function.
- Not risk-adjusted
Functional Quality Measure

**Numerator** = number of quality episodes with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal at SOC/ROC, and valid numeric score or reason not attempted score for each of the functional assessment items on the DC assessment.

**Denominator** = All quality episodes (no measure – specific exclusions, all OASIS patients)

NOTE: for HH episodes ending in a qualifying admission to an inpatient facility (Transfer) or Death at Home, the discharge functional status data would not be required for the episode to be included in the numerator (just need a valid numeric score or reason not attempted code for SOC/ROC and a valid numeric score for at least one self-care or mobility goal on the SOC/ROC assessment).

Items Included in Quality Measure

**Self-Care Items**
- Eating GG0130A
- Oral hygiene GG0130B
- Toileting hygiene GG0130C

**Mobility Items**
- Sit to lying GG0170B
- Lying to sitting GG0170C
- Sit to stand GG0170D
- Chair/bed-to-chair transfer GG0170E
- Toilet transfer GG0170F

For patients who are walking:
- Walk 50 ft GG0170J
- Walk 150 ft GG0170K

For patients who use a wheelchair:
- Wheel 50 ft with 2 turns GG0170R
- Wheel 150 ft GG0170S
Revised Quality Measure

- M1311 will be used to calculate the revised Quality Measure for pressure ulcers: Percentage of Patients with Change in Skin Integrity, aligning with the IMPACT Act measure Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Reports the percentage of quality episodes with reports of Stage 2-4 pressure ulcers or unstageable pressure injuries/ulcers due to eschar/slough, non-removable dressing/device or deep tissue injury, that were not present or were at a lesser stage on admission
- OASIS Discharge information will be compared back to the SOC/ROC information

Pressure Ulcer Quality Measure

**Numerator** = number of quality episodes in which assessment at DC indicates one or more new or worsened Stage 2-4 or unstageable pressure ulcer/injuries compared to SOC/ROC assessment

**Denominator** = All quality episodes except:
- End in Death at Home or Transfer to Inpatient Facility
- No assessment completed at BOTH SOC/ROC and DC
- DC assessment does not have usable response for M1311a-f
DRR Quality Measure

• “Drug Regimen Review Conducted with Follow-up for Identified Issues”
• Reports the percentage of patient care episodes in which a DRR was conducted at SOC/ROC, and timely follow up with a physician occurred each time potential and actual clinically significant med issues were identified throughout that care episode
• Process measure: not risk adjusted

DRR Quality Measure

**Numerator** = number of episodes in the denominator where the medical record contains documentation of DRR conducted at SOC/ROC with all potential clinically significant med issues identified during the course of care and followed up with a physician or physician designee

**Denominator** = All complete quality episodes (with a discharge, transfer or death at home assessment during the reporting period)
Items Included in Quality Measure

• M2001 Drug Regimen Review
• M2003 Medication Follow-up
• M2005 Medication Intervention
• If a dash “—” is entered for any of these three items:
  • The quality episode will not be included in numerator
  • The quality episode will be included in denominator

Quality Resources

• Home Health Quality Reporting Program website
  • Spotlight and Announcements
  • Home Health Quality measures, Star Measures
  • OASIS data sets and Guidance Manuals
  • HH Quality Reporting Training
• Home Health Quality Help Desk email:
  homehealthqualityquestions@cms.hhs.gov
Quality of Patient Care STAR Rating Measures

Outcome Measures
- Improvement in Ambulation
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Pain Interfering with Activity
- Improvement in Shortness of Breath
- Improvement in Management of Oral Medications

Process Measures
- Timely Initiation of Care
- Drug Education on all Medications Provided to Patient/Caregiver
- Influenza Immunization Received for Current Flu Season

Utilization Measure
- Acute Care Hospitalization (Claims-based)

Assessment and Care Planning
Assessment starts with Intake Process

- Accurate intake data collection
  - Who takes referral?
  - What information is obtained?
  - Identify primary language, arrange interpreter if needed
  - Specific physician ordered date for SOC?
- Availability of intake data to clinicians at SOC
- How are referral orders/info transferred to the assessment and/or the POC?
  - Collaboration with agency staff, others
  - Correction of any errors on intake information, verify with physician if needed

Comprehensive Assessment

- Identify patient’s eligibility for the home health benefit and continuing need for home care services
- Identify patient’s medical, nursing, rehabilitative, social and discharge planning needs
- Physical assessment, focus on pertinent diagnoses
- Perform Drug Regimen Review
  - Determine patient’s goals, agency goals and set measurable outcomes for home care
    - Gather info on prior level of function
  - Collect OASIS data to accurately reflect patient’s status at the time of assessment, document supporting info
Don’t overlook

• Hospitalization and ED risk assessment
  • Prior hospital admission, hx recurrent problems, any diagnoses with higher incidence of ACH, cognitive status, pain control, chronic wound, fall risk and hx falls, >5 meds or any high-risk meds, support system

• Emergency preparedness plan
  • Hazard assessment for patient’s home/environment: fire, power outage, winter storm, tornado, other?
  • Best refuge area in home, evacuation plan, assist needed to leave, alternate relocation address/phone

• Advance directives
  • Assess if patient has advance directive, living will, DPOA for healthcare decisions. If not, provide info

Assessment of education needs

• Knowledge of disease processes and management
  • Patient
  • Family and caregivers

• Cognitive status, ability to learn
  • Is patient the primary learner? Secondary learner?

• Patient activation and engagement

• Support system, family/caregiver involvement, available resources for care

• Discharge plan for patient, with family input
Assessment: OASIS Key Points for Care Planning

• Primary, Other Secondary Diagnoses – M1021, M1023
• Therapies – M1030
• Additional diagnoses – M1028
• Risk of Hospitalization – M1033
• Height and weight – M1060
• Patient Living Situation – M1100
• Vision/hearing/speech, ability to communicate – M1200
• Pain, functional impact – M1242
• Integumentary Status – M1306-M1342
• Shortness of breath – M1400

Assessment: OASIS Key Points (con’t)

• Presence of UTI – M1600
• Urinary and bowel incontinence – M1610-M1620
• Presence of bowel ostomy – M1630
• Cognition, confusion, anxiety, depression, psych and behavioral symptoms – M1700-M1745
• ADL ability/performance – M1800-M1860
• IADL ability/performance (eating) – M1870
• Fall risk – M1910
• Drug regimen review, issues – M2001, M2003
• Medication administration – M2020-M2030
• Types and sources of assistance – M2102f
• Therapy Need – M2200
• Self Care and Mobility – GG0130, GG0170
Assessment: Other Key Points

- Other Pertinent Diagnoses (up to 25 total)
- Vaccination status
- Trauma wounds, diabetic ulcers, etc.
- Risk factors for falls, pressure ulcers
- Next physician appointment or follow-up needs
- Current family/caregiver/community resources, unmet needs in specific areas

*This is where the patient is today – where does the patient want to be?*

Identify Needs → Set Goals

- Patient’s goal(s) for home care
- Agency goals for treatment
- Measurable outcomes to achieve
- Physician input related to goals
- Are goals reasonable and able to be achieved by patient, family, and caregiver(s)?
Goal Setting List – side 1

My goals for home care services:
1. ________________________________________________           Date________
2. ________________________________________________           Date________
3. ________________________________________________           Date________
4. ________________________________________________           Date________
5. ________________________________________________           Date________

Family’s goals for home care services:
1. ________________________________________________           Date________
2. ________________________________________________           Date________
3. ________________________________________________           Date________
4. ________________________________________________           Date________
5. ________________________________________________           Date________

Available for download at www.selmanholman.com

Goal Setting List – page 2

_______________________ Home Care Agency is your partner in health care:

1. We will explain the care and services you will get from the agency, and discuss any changes in treatment with you.
2. We will discuss a home safety plan.
3. We will discuss all prescription and over the counter medicines you take.
4. If you have new medicines, we will explain the purpose of the medicine, how to take it, and possible side effects to report to the agency.
5. We will discuss how to manage your pain so you are comfortable.

additional agency goals and outcomes:
6. ______________________________________________________________
7. ______________________________________________________________
8. ______________________________________________________________
9. ______________________________________________________________
10. ______________________________________________________________
Align Goals, Prep for Care Planning

- Reconcile goals of patient, family, caregiver
- Set expectations for home health services
- May need to break down into steps – short term and long term goals
- Collaborate with other disciplines ordered
- Are there additional needs that require approval by physician?
- Identify common readmission drivers

Disciplines, frequencies, durations

- Appropriate skilled reason for all disciplines
- Timeliness of evaluations
- Utilization of therapy services
- Utilization of home health aide services
- Frequency considerations
  - Dangers of “1wk9”
  - Scheduling of LPN, PTA and COTA visits, oversight by RN, PT, OT
- Benefits of MSW utilization
- Indications for reduced frequency or discharge of a discipline – value of the “return demo”
Skilled Care Interventions

- Observation and assessment
- Management and evaluation of the care plan
- Skilled teaching
- Medication administration/treatment
- Catheter care
- Wound care
- Psychiatric treatment
- Skilled therapy services

Goals for Skilled Care

Set appropriate goals

- Goals should be objective and measureable
- Goals should be reasonable for condition
- Goals should be functional and meaningful
- Goals should be patient-based and specific
- Goals should be evaluated for progress and continued appropriateness at every visit
Goals for Home Care

- Improve disease management
- Prevent disease progression
- Relieve symptoms, stabilize condition
- Improve exercise/activity tolerance, functional ability
- Improve health status, reduce risk factors
- Prevent and treat complications/exacerbations
- Reduce mortality, hospitalizations
- Prevent/minimize side effects of treatment
- Prepare patient/family for discharge success, establish emergency plan

Development of the Plan of Care

- List confirmed diagnoses
- Identify needs, consider goals
  - Diagnoses, problems, ED/ACH risks, EPP, resources
- Determine interventions
  - Utilize disciplines effectively
  - Address any refusal of care/disciplines
- Plan visit frequency
  - Front-loading for nursing, therapy
- Time frame for home care interventions
- Communicate with certifying physician
- Documentation of admission case conference
Measurable Outcomes

- Should be jointly established by the patient, agency disciplines, and physician(s)
- Should address goals pertinent to the Plan of Care, including:
  - Discipline-specific goals
  - Patient safety goals
  - Patient self-management goals
  - Goals to avoid unnecessary emergent care visits and hospital admissions

Care Planning is Critical!

*If you don’t know where you’re going, you’ll end up someplace else!*

- What is patient’s baseline at SOC?
  - Prior level of function vs current baseline at SOC
- What are the goals for home care services?
- What interventions will help achieve those goals?
- Is the patient/caregiver engaged and willing to participate in the interventions?
- Evaluate progress every visit, revise the plan as needed
Improving Quality Measures
Care Coordination, Collaboration and Best Practices

Expansion of the One Clinician Rule

• CMS is promoting a team approach to data collection, as present in other PAC settings

• Comprehensive assessment includes OASIS items and is part of legal HHA clinical record. While only the assessing clinician is responsible for accurately completing and signing comprehensive assessment, s/he may collaborate to collect data for all OASIS items, as agency policy allows. (per CoPs)

• Signature is attestation that to the best of his/her knowledge, the document reflects the patient status as assessed, and supported as documented.
Expansion of the One Clinician Rule

- Collaboration may consider information from others such as patient, caregivers, physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection. (per OASIS guidance effective 1/1/18)
- Collaboration must occur within the appropriate assessment timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.
- M0090 = last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including OASIS items. Must be within allowed assessment time frame.

Details Re: Collaboration

- Other Agency Staff: LPN/LVN, PTA, COTA, MSW, HHA
- All must function within the scope of their practice and state licensure.
- Direct contact or other means: In-person, healthcare monitoring devices, video streaming, review of photograph, phone call, etc.
- Clinical/patient assessment: Base responses on assessment by agency staff, and not directly on documentation from other care settings.
- OASIS Quarterly Q&A April 2018
Collaboration Considerations

Need a way to identify what was actually collected by the clinician through assessment, and what was gathered from others via collaboration

• Who did you collaborate with?
• What information was shared?
• When did you discuss this information?
• How is this additional information going to be used to answer OASIS items?
• How is this collaboration going to be documented in the medical record?

Care Coordination

• Patient has the right to accept or refuse disciplines / treatment
• Each discipline should document discussion of their interventions and goals with patient and caregivers
• Document communication between disciplines, patient/caregiver, physicians at key time points
• Validate decisions to recertify or discharge patient
Examples of Coordination of Care

• Managing the scheduling of patients, taking into consideration the type of services that are being provided on a given day. For example, a patient may become fatigued after a HH aide visit assisting with a bath, thus making a physical therapy session scheduled for directly after the HH aide visit less effective.

• Managing pain during physical therapy or physical care (i.e. dressing changes or wound care) in order to minimize patient discomfort while maximizing the effectiveness of the therapy session.

• Working with the patient to recommend and make safety modifications in the home.

• Assuring that staff who provide care are communicating any patient concerns and patient progress toward the goals identified in the plan of care with others involved in the patient’s care.

Implementation of POC at Visits

• Plan each visit, be flexible to patient’s needs
  • Clinical Pathways, teaching checklists, protocols

• Follow visit routine, assessment, follow POC, check meds

• Address the primary diagnosis every visit; other diagnoses at least once during episode (more if problems); be specific on teaching topics, infection control/prevention

• Evaluate progress toward goals at each visit
  • Teach, assess recall, have patient “teach back”

• Revise POC as needed, deal with problems, supervise prn
  • Interventions and goals, keep family involved, update DC plan

• Ongoing progress toward discharge, link to resources

• Communication between disciplines, with patient
Interventions

• Ongoing assessment each visit
• Ordered intervention tasks
  • Interventions for specific ACH risk factors
• Education and training, contracts if indicated
• Initiate community support services early in care
• Measure progress toward goals *each visit - by every discipline!*
• Update and revise POC, including goals and interventions as needed

Medication Interventions

• Review medication list in home every visit
• Evaluate compliance with med regimen
• Assess med knowledge, educate as needed
• Assess for s/sx adverse effects or interactions
• Documentation to easily locate for follow up
Educational Interventions

• Education based on knowledge deficits identified by assessment, pt/cg goal setting
• Primary and secondary learners
• Identification of needed topics
• When is “re-teaching” a valid skill?
• When is it time to stop teaching?
• Appropriate teaching materials, resources
  • HHQI – free tools, updated, variety of topics
• Documentation of teaching

Coordination to Prevent Falls

• Accurate, consistent, timely assessment of fall risk
  • Who is falling? When? Why? Therapy eval needed?
• Communication between staff and pt/cg re: fall risk and prevention measures, address meds, device use
• Multifactorial interventions that address identified risks
• Education targeted to identified risks, evaluate pt/cg compliance with instructions
• Exercise program: balance, LE strengthening, gait and transfer training, stair training, coordination, cognitive training
Coordination to Prevent/Heal Pressure Ulcers

- Accurate, timely risk assessment for pressure ulcers
- Education to reduce identified risk factors
- Interventions by all disciplines to reduce risk and promote healing
  - Skin/wound care, address incontinence
  - Nutrition and hydration
  - Positioning, transfers, mobility
- Ongoing assessment of skin integrity

Coordination to Reduce ACH

- Assessment
  - Risk Assessment for ED or hospitalization
- Problem identification
- Goal setting
- Interventions
- Evaluation of progress
- Discharge planning
Discharge Planning

- Assessment:
  - Prior level of function
  - Prognosis, expectations for recovery
  - Barriers to progress, strengths, support system
- Start the discussion w/ pt and family at SOC visit
- Include all disciplines in DC planning
- Initiate any follow-up care early in episode, evaluate effectiveness, revise, adapt if needed
- Re-evaluate DC plan at each case conference
- Recert or discharge?

Interdisciplinary Coordination

- Opportunity to support medical necessity, homebound status and skilled need for medically necessary homecare
- Information from all disciplines should agree
- Avoid contradictions between disciplines
- Follow up on problems identified
- Provide supporting education and assessment of effectiveness of interventions
Care Coordination Tools

- Assessment and Screening tools
- Patient/family/caregiver engagement, use of contracts to encourage self-management, pre-visit notes for physician office visits, DC checklist
- Team-based care, health/disease management programs, protocols
- Care coordination infrastructure: methods to communicate, document coordination
- Transitional care processes
- Evaluation of quality measures, process measures

What questions do you have?

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SAVE THE DATE

INSIGHT 2019
A SELMAN-HOLMAN HOME HEALTH SUMMIT
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