

OASIS-C Best Practices Adventures from a Year in the Jungle

Missouri Alliance for Home Care Annual Conference

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Objectives



- **Identify critical OASIS-C trends that challenged providers in 2010;**
- **Detail operational and clinical issues, including assessment and documentation practices, that effect agency priorities;**
- **Reference source documents to clarify Medicare Guidance on assessment items that impact clinical and operational issues;**
- **Discuss “lessons learned” from providers across the country to support agency OASIS-C Best Practices in a PPS Era.**

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Another Adventurous Year

G Code Updates

Face to Face

PPS Updates

Visit Efficiencies



C Clarifications



Enhanced Audits



Therapy Requirements

What Next?

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HCR (ACA) Paves the Way

- **Consumer is King**
- **Medicare Pilots Detailed**
 - ACO's
 - Bundling
 - Medical Homes
- **Medicare Value Based Purchasing**
- **Physician Engagement & Accountability**
- **Focus on Chronic Care Management**
- **CMS Center for Innovation**
- **Enhanced Fraud and Abuse Initiatives**
 - ZPICS; Integrity Audits; MAC's; Heat Teams; RACS



Health care

Is there a cure?

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How Does Your New Report Card Look?

2010: Home Care Compare Updates

Quality Measures	Missouri	National	Top 25%
Timely Care*	88%	87%	93%
Immunizations	66%	71 %	77%
Pain Assessment*	98%	97%	99%
Risk Assessment & Plan of Care for Pressure Ulcers*	97% 91%	95% 90%	99% 98%
Diabetic Foot Care*	86%	84%	90%
Heart Failure Follow Up*	98%	97%	99%
Depression Screen *	88%	92%	97%
Falls Risk Assessment*	97%	94%	98%
Medication Education – All Meds	86%	84%	92%

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Agency Report Cards from OASIS-C

- **Medicare publishes Agency Process Report Cards on Home Care Compare**
- **How Do Your Reports Look?**
- **CMS: Dark on Agency Data**
 - **Black Out Period**
 - Process Outcomes Now on Web Site
 - Quality Outcome Dark until 6/11
 - **Dark Period**
 - Home Care Lights the Way
- **Outside Vendors Provide Data**
 - Whose Your Vendor?
- **What's It All Mean for You?**



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Reportable Data Updates: 1/4/11

Dates	OASIS-C Data on Casper	Risk Adjusted Outcomes	Pot. Avoidable Events	Process Outcomes	Home Care Compare
March, 2011	1/10-12/10	12 mo B Data	12 mo B	12 mo C Data	9 mo C <u>Process</u>
April, 2011	2/10-1/11	12 mo B Data	12 mo B	12 mo C	12 mo C <u>Process</u>
June, 2011	4/10-3/11	12 mo C Data	12 mo C	12 mo C Data	
July, 2011	5/10-4/11	12 mo C Data	12 mo C	12 mo C Data	4/10-3/11 <u>All Outcomes</u>
August, 2011	6/10-5/11	12 mo C Data	12 mo C	12 mo C Data	
Sept, 2011	7/10-6/11	12 mo C Data	12 mo C	12 mo C Data	
October, 2011	8/10-7/11	12 mo C Data	12 mo C	12 mo C Data	7/10-6/11 <u>All Outcomes</u>
Nov, 2011	9/10-8/11	12 mo C Data	12 mo C	12 mo C Data	
Dec, 2011	10/10-9/11	12 mo C Data	12 mo C	12 mo C Data	

How About Your Other Quality Outcomes?

2010 Benchmark Data: 2010

Quality Measures	Your Agency	National	Top 25%
Ambulation*		58%	72%
Bed Transferring*		55%	75%
Pain Interfering with Activity		66%	70%
Improvement in Bathing*		67%	74%
Management of Oral Medications*		51%	59%
Improvement in Dyspnea		65%	68%
Improvement in Healing Status Surgical Wound*		85%	88%
Acute Care Hospitalization**		27%	21%
Emergent Care w/o Hospitalization*		4%	2%

* Outcomes for P4P

Coming to You by CASPER: 6/11

OASIS-C & HH-CAHPS

- **OASIS-C Data Risk Adjusts HH-CAHPS Results**
 - Diagnoses
 - Functionals
 - Living Circumstances
 - Age
 - Other
- **OASIS-C Correlates with HH-CAHPS**
 - Pain
 - Medication Items
 - Safety
- **How Are Your HH-CAHPS Results?**

HH-CAHPS & OASIS-C

- **What Do Your Patients Think of You?**
- **Overall Rating of Care = % (9 or 10)**
 - National = 86% Missouri = 88%
- **Would Definitely Recommend this Agency = %**
 - National = 83% Missouri = 88%
- **Care of Patients = %**
 - National = 89% Missouri = 89%
- **Specific Care Issues = %**
 - National = 83% Missouri = 83%
- **Communication with Patients = %**
 - National = 84% Missouri = 84%

HH-CAHPS & C: There's More

- **Providers Excel at**
 - Treating Gently and with Courtesy & Respect (↑90%)
- **Provider HH-CAHPS Opportunities**
 - Keep you Informed of Arrival Times (↓83%)
- **Specific Care Issues (↓86%)**
 - *Talk about how to set up home to be safe (80%)*
 - *Talk about purpose of taking medications (83%)*
 - *Talk about side effects of medications (70%)*
- **Communication Issues = (↓88%)**
 - *How long to get help or advice: Same Day = ↓78%*

OASIS-C Cross Correlates with HH-CAHPS

Exceptional Providers

- **Will Thrive in Health Care Reform**
- **Provide Customized, Individualized Care**
 - Admission Dates and Times on Request
 - Visit Times on Request
 - Scheduling Changes as Requested
 - Immediate Response to Questions or Needs
 - Addresses All Questions & Needs Prioritized by Patient/Family
 - Anticipate and Provide Education to Decrease
- **Exceed Client Expectations**
 - Professional, Responsive, Respectful, Exceptional Services

Your Data Profile Considerations

- Patient-Related Characteristics Report: 2010

- Inpatient Discharges
- Risk Adjusters
- Care Management
- Sensory
- ADLS
- Therapy Visits
- Diagnoses
- LOS

**Check Agency Profile Report
Review with Clinical Staff**

- Emergent Care & Hospitalizations

- What Inconsistencies are Significant Here?

Data Drives Practice Changes

- Audit Review Process

- Real Time Visit & Outcome Data
- Make Visit Decisions Based on Data

- Clinician Feedback

- Plan of Care; Visit Schedule; Goals; Issues
- What Do You Need To Know to Manage a Patient?

- Field Supervisions with IRR

- Clinician Skill Set: Orientation & Supervisions
 - Care Management versus Case Management
- Continuity of Care (Vacations; Staffing; Missed Visits)

- What Do You Need To Drive Change?

- Agency Specific Outcome Goals

Does Your Agency?

- **Review OASIS-C Quick Time?**
 - Split Screen/Dual Screen Review/Automated Programs
 - Case Conferences/Team Conferences
- **Provide Written Scorecard Feedback to Staff?**
 - Team & Staff Scorecards (See Samples)
- **Benchmark OASIS-C Edits?**
 - Agency Goals for Accuracy
- **Incentivize OASIS-C Accuracy?**
- **Perform & Monitor Transfer/Discharge Reviews**
 - Look Back Compare Tool/Screen
- **Culture of Accountability for OASIS-C Accuracy**

What Are Your Agency's Risks with C?

- **Not Accurately Representing Patient Complexity on Risk Adjustment Items and Plan of Care Items**
- **Inconsistent Use of Risk Assessments**
 - Risk assessments (Falls; Integument)
- **Inconsistent documentation between nursing and therapies**
- **Inconsistencies between the POC Synopsis (M2250) and the Look Back Item (M2400)**
 - Falls; Diabetic Foot Care; Depression; Pain
- **General clinical documentation that does not support OASIS Scores or Therapy Services**



Poor Quality = Payment Denial

Other C Related Updates

- **State Surveyor Manual (SOM) Updated**
 - http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_11.pdf
 - Effective May 1, 2011
 - **Surveyor Worksheets are Posted**
- **Appendix B: Part 1**
 - Revised Standard Protocols directly related to patient care processes
 - Expanded Pre-Survey Document Review
- **Appendix B: Part 2**
 - OASIS Submission: Timely Recertifications
 - Therapy Requirements

Pre-Survey SOM Updates

- **Surveyor Worksheets**
 - Potentially Avoidable Events (PAE)
 - OBQI Outcome Reports
 - Patient/Agency Characteristics Report
 - Submission Statistics by Agency Report
 - Error Summary Report by HHA
- **Tier 1 PAE**
 - Emergent Care for injury caused by fall at home or
 - Emergent care for wound infections, deteriorating wound status
 - Select patient records & home visits based on PAE identified on report

More on Pre-Survey Report Review

- **Tier 2 PAE**
 - Select closed patient records based on current agency incidence rate of equal to or greater than twice the national reference rate
- **OBQI Outcome Report**
 - Review Most Recent Risk Adjusted Outcome Report
 - Select two (2) for focus during on site survey
 - At least thirty reported cases
 - Large and unfavorable difference (10%) between the agency and the national reference rates
 - Statistical significance equal to or less than 0.10 as depicted by 1 or 2 asterisks (*)

More on Pre-Survey Report Review

- **Patient/Agency Characteristic Report**
 - Same timeframe as OBQI report
 - Focus on acute conditions and home care diagnoses that are statistically significant and are equal to or greater than 15 % higher than reference mean
 - Choose three conditions or diagnoses that meet the criteria
 - Select one or two records of patients with diagnoses that meets the criteria review
- **Submission Statistics**
 - Investigate compliance with OASIS submission
 - Submitting data less often than monthly
 - Has greater than 20 % of records rejected

More on Pre-Survey Report Review

- **Error Summary Report by HHA**
 - Inconsistent MO090: Identify percent of recertifications done on 60 day cycle
 - Investigate if error rate over 20%
 - Data Sequence Error Rate
 - Investigate if error rate over 10%
 - Investigate compliance with OASIS Reporting Requirements
- **Survey Integrates OASIS-C Data**
 - High Risk Data Focuses On Site Surveys
 - Access and review your data on a regular basis
 - Review your data in Performance/Quality Processes
 - Focus Education on Problematic C Data

Your OASIS-C Data

- **Drives Performance Improvement Processes**
 - Competitive Initiatives Require High Quality Data
 - Identify Agency Priorities & Goals
 - Consider Integration with Performance Standards
 - Integrate with Agency Scorecard
- **Focuses Education Initiatives**
 - Enhance C items that indicate inconsistencies
- **Ensures Reference Baseline Data**
 - Compare multi site programs with one another
 - Compare to national reference data
- **Refines Audit Priorities: Priorities; Case Conferences**

Timeliness of Care: 88%

Missouri= 88%

- **Condition of Participation (Interpretive G 484.55)**
 - The initial assessment visit must be held within 48 hours of referral, OR within 48 hours of the patient's return home, OR on the physician-ordered start of care date.
 - In the absence of a physician-specified start of care date, the initial assessment visit is conducted within 48 hours of the referral. If the physician specified a start of care date, this supersedes the 48 hours time frame. Check the intake or clinical record for documentation of a specified start of care date.
 - *How Do You Ensure Your assessment visit within 48 hours of referral?*

Score Outcome

- **Manual Defines**
 - M0030 Start of Care Date with
 - M0102; M0104; **M1005 (Facility D/C Date)**
- **Auditors will also review**
 - Intake & referral data (Dates)
 - Dates on referral data & faxes
- **Ensure your processes that update referral data and dates**
 - Revised date of referral (notes)
 - Delays in return home (notes)
 - Uncorrected revised dates in automated systems
 - **Reasons for Delays**

Timeliness of Care: CoP

- **M0102 Date of Physician-ordered SOC/ROC:** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

___/___/___ (Go to MO 110, if date entered)

month/ day/ year

NA – No specific SOC date ordered by physician

- **Identifies date home care services are ordered to begin, if the date was specified by the physician**
- If ordered SOC is delayed (extended hospitalization), then date specified on the **updated/revised order**
- **Mark N/A if the initial orders did not specify a SOC date**
- **If physician agrees with revised SOC date, complete M0104**

Timeliness of Care

- **MO104 Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

___/___/___

month/ day/ year

- Specifies the **referral date** which is the **most recent date** that verbal, written, or electronic authorization to begin home care was received by the home health agency
- If the start of care date is delayed, then list the **updated/revised** referral information for home care services to begin
- This does **NOT** refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission
- **Ensure automated date is accurate on admission (corrected as indicated)**

What About Risk Adjustment?

- A complex mathematical methodology that allows comparisons between home health agencies with different patient populations
 - Levels the playing field for providers with higher risk or more frail patients
- A prediction model to factor in patient characteristics that may effect a certain outcome
- Variables from specific OASIS-C items are factored to account for patient differences
 - Patient characteristics (clinical & non clinical)
 - Treatment status
 - Other health variables & events

Risk Adjustment Impact

- Risk adjustment rates are better than actual rates
- Comparison of risk adjusted rates are more accurate
- Actual rates do NOT take into consideration patient characteristics (case mix)
- Outcome Example:
- Agency actual Improvement in Oral Meds = 61%
- *Agency predicted (risk adjusted) rate = 68%*
- Another Example: HH-CAHPS
- Agency Specific Care Issues = 83%
- *Agency predicted (risk adjusted) = 87%*

Overall Status: A Risk Adjuster

- **M1034 Overall Status: Which description best fits the patient's overall status? (Check one)**

0 – The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age)

1 – The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

2 – The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.

3 - The patient has serious progressive conditions that could lead to death within a year.

UK – The patient's situation is unknown or unclear

Check Your Case Mix Profile

M1034: Overall Status

- New Assessment Item consistent with CARE Tool
- **Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment**
- Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy
- A "Do Not Resuscitate" order does **not** need to be in place for Responses 2 & 3
 - Fragile health with **ongoing** high risk of serious complications and death
 - Considerations: Oncology; advanced pulmonary and cardiac; multiple hospitalizations; treatment changes
 - Serious **progressive** conditions that could lead to death within a year
 - Considerations: Oncology; advanced pulmonary and cardiac patients; progressive neurological patients including ALS, MS, Parkinson's, Alzheimer's, Dementia

Some Examples: How Would You Score?

■ Overall Status (M1034)

- 79 year old female admitted post pacemaker; Atrial Fib; CHF; HTN; Depression; History of Falls
Overall Status =
- 68 year old female with wound dehiscence post hysterectomy; cellulitis; HTN; COPD; CAD; morbid obesity
Overall Status =
- Young male with sepsis; MRSA; Spina Bifida; RLE amputation; Stage 4 pressure ulcer; suprapubic catheter; colostomy
Overall Status =

M1036: Risk Factors

- M1036 Risk Factors: either present or past, likely to affect current health status and/or outcome: (Mark all that apply)
 - 1 – Smoking
 - 2 – Obesity
 - 3 – Alcohol dependency
 - 4 – Drug dependency
 - 5 – None of the above
 - UK – Unknown
- Timeframe revised for assessment purposes
- Utilize professional judgment
- Specific definitions not provided by CMS
- Consider BMI guidelines for determination of obesity



Check Your Case Mix Profile

Risk for Hospitalization

- **M1032 Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply)
 - 1 – Recent decline in mental, emotional, or behavioral status
 - 2 – Multiple hospitalizations (2 or more) in the past 12 months
 - 3 – History of falls (2 or more falls-or any fall with an injury – in the past year)
 - 4 - Taking five or more medications
 - 5 – Frailty indicators, e.g. weight loss, self reported exhaustion
 - 6 – Other
 - 7 – None of the above

Check Your Case Mix Profile

Sample System “Other” Risk Scale

- **Prior hospitalization:** in last 6 months
- **Problem medications:** anticoagulants, insulin, aspirin & clopidogrel, digoxin, narcotics
- **Polypharmacy:** ≥ 5 routine medications
- **Principal diagnosis:** cancer, stroke, diabetes, COPD, heart failure
- **Punk (depression):** screen positive or diagnosis
- **Poor health literacy:** unable to do Teach Back
- **Patient support:** absence of caregiver to assist with discharge & home care
- **Palliative care:** advanced or progressive illness

Comparison of OASIS-C and 8 Ps

<i>8P Screening Tool</i>	<i>OASIS-C M1032 Risk for Hospitalization</i>
<i>Problem Medications: Anticoagulants, insulin, aspirin & clopidrogel dual therapy, digoxin, narcotics</i>	<i>6 (Other)</i>
<i>Psychosocial: (depression)</i>	<i>1</i>
<i>Principal diagnosis: Cancer, stroke, DM, COPD, heart failure</i>	<i>6 (Other)</i>
<i>Polypharmacy: (greater than or equal to 5 or more medications)</i>	<i>4</i>
<i>Poor health literacy (inability to do teach back</i>	<i>6 (Other)</i>
<i>Patient support (absence of caregiver to assist with discharge and home care)</i>	<i>6 (Other)</i>
<i>Prior hospitalization (non-elective; in last 6 months)</i>	<i>2</i>
<i>Palliative Care</i>	<i>6 (Other)</i>

Current Diagnoses Items

- **M1020/1022/1024 Diagnoses, Symptom Control and Payment Diagnoses**
- *The diagnoses are to be listed in the order that best reflects the seriousness of each condition and support the disciplines and services provided*
- **Symptom Control replaces Severity Index (0-4)**
- **The sequencing of the symptom control ratings may not match the sequencing of the diagnosis**
- **Do not assign symptom control ratings for V & E codes**
- **1020 Primary Diagnosis**
- **1022 Other Diagnoses**
- **1024 Payment Diagnoses (OPTIONAL)**

Surveyors SOM Addresses Dx

- **Review the Plan of Care for the primary diagnosis**
 - Do the POC Goals reflect patient complexity?
 - Does the initial assessment reflect assessment of primary diagnosis elements?
- **Review patient's co-morbidities**
 - Is there evidence that inter-related factors are addressed in managing the patient's care?
 - Ex: Addressing nutrition and skin care in a wound care patient who has diabetes?
- **Does the clinical record show consistency in assessment of patient's status and progress over many visits?**

Symptom Control Ratings More Risk Adjusters

Replaces Severity Index

- 4- Symptoms poorly controlled; history of re-hospitalizations 4
- 3- Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring 3
- 2- Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring 2
- 1- Symptoms well controlled with current therapy 1
- 0- Asymptomatic, no treatment needed at this time 0

Score These Scenarios

- Patient released post hospitalization for TKR. Long term use of anti-hypertensives. How do we score symptom rating for HTN? ____
- Diabetic patient on insulin coverage at mealtimes. Score symptom rating for DM. ____
- Patient has multiple cardiac dx. Hospitalized times two for CHF past 8 months. Score CHF symptom rating. ____
- Patient is being treated for hypothyroidism. Post hospitalization for fall and OA pain. Score symptom rating for hypothyroidism. ____

New Procedure Items on OASIS-C

- M1012 List each Inpatient Procedure and associated ICD-9-CM procedure code relevant to the plan of care.

<u>Inpatient Procedure</u>	<u>ICD-9-CM Code</u>
a. _____	_ _ _ . _ _
b. _____	_ _ _ . _ _
c. _____	_ _ _ . _ _
d. _____	_ _ _ . _ _

■ NA – Not applicable

■ UK - Unknown

M1012 Item Guidance

- Identifies medical and surgical procedures that are relevant to the Plan of Care. Patient **MUST** have been in an inpatient setting the past 14 days.
- Include only those procedures that occurred during the inpatient stay that are relevant to the home health plan of care, based on the information available at the start or resumption of care.
- Do not include inpatient procedures that are not relevant to the home health plan of care.
 - Example: diagnostic procedure (CT scan); x-rays; MRI; other
- Data Sources
 - Patient/caregiver interview
 - Physician
 - Referral information (H&P; progress notes; D/C summary)

OASIS Q & A Update: July, 2010

- **Question 2:** If a patient's inpatient diagnosis was a Hemorrhagic Bleed, should the CT Scan of the Brain be considered a procedure relevant to the home health plan of care and be reported in M1012 – Inpatient Procedures?
- **Answer 2:** *A diagnostic procedure that confirmed a diagnosis that is addressed in the home health plan of care is relevant and would be reported in M1012 – Inpatient Procedures. Assessing clinicians need to use their judgment in determining if a procedure is relevant to the home health plan of care.*

OASIS Q & A Update: October, 2010

- **M1012 Inpatient Procedures**
- **Question 3:** What is meant by “medical procedure” in the item intent for M1012? **Would physical therapy and occupational therapy be considered as a “medical procedure” to be listed in this item if the assessing clinician considered it relevant to the POC?**
- **Answer 3:** The term “medical procedure” in M1012 can be defined as any procedure in Volume 3 of the ICD-9-CM coding manual, if it occurred during an inpatient stay with a discharge date within the past 14 days, and is relevant to the home health plan of care. *The intent of this item is to provide a more comprehensive picture of the patient’s condition prior to the initiation of home care. Typically, this would include recent surgical procedures, but any procedure that the clinician identified as significantly impacting the patient’s health status and care needs should be documented, based on the information that is available to the agency at the start (or resumption) of care. In some cases, this could include diagnostic or rehabilitation procedures.*

Common Case Scenarios

- **Mrs. Smith had a radical mastectomy. What procedure codes would be most common with this surgical procedure?**

Mr. Hanson has lung cancer, and was admitted for dehydration and electrolyte imbalance secondary to chemotherapy. What procedure codes would be used in this case?

Common Home Health Codes

■ Cardiac Procedure Codes

□ Check specificity & Code also

- AAA 38.64
- Aortic Valve Replacement 35.22
- CABG 36.1x
- Cardiac catheterizations 36.22
- Angioplasty 36.09
- Endarectomy 38.1
- Pacemaker insertions 37.8x
- Tricuspid valve replacement 35.28

■ What Other Cardiac Procedure Codes are Common in Your Agency?

□ Print a 2010 Procedure Code List for Your Agency

More Common Procedure Codes

■ Orthopedic Codes

□ Check specificity & Check Code also

- Total knee replacement 81.54
- Revision of the knee 81.55
- Total hip replacement 81.51
- Hip revision 81.53
- ORIF 79.35

■ Other Common Home Health Procedure Codes

- Hernia Repair 53.00 – See details
- G-tube 46.32
- J tube 46.38
- Bowel resection 45.7x
- Peg replacement 43.11
- Colostomy closure 46.52

Other Common Procedure Codes

- Venous Catheter-NEC 38.93
- Venous catheter-renal dialysis 38.95
- Ureteral catheter 59.8
 - Removal of Foley Catheter 97.64
- Other Incision w/Drain & Subcutaneous Tissue 86.04
- Non Excisional Wound Debridement Infect/Burn 86.28
- PT 93.39 (PT SNF 93.38)
- OT 93.83
- Other Common Home Health Procedure Codes
 - Lap Choley 51.23
 - Lysis of Peritoneal adhesions 54.59
 - Thoracentesis 34.91
 - Infusion of electrolytes 99.18

Procedures Are Vital

- The OASIS-C uses Procedure Codes for Risk Adjustment of agency quality outcomes
- Procedure Codes reflect patient clinical complexity as well as
- Procedure codes also support assessment and Plan of Care
- Absent or blank Procedures will not support the current home health Plan of Care
- Ensure you obtain all pertinent procedures
- Review OASIS Chapter 3 for details
- Your thoroughness is critical for accuracy



Dx Selection & Sequencing

- **CMS expects HHA's to understand each patient's specific clinical status before selecting and assigning each diagnosis.**
 - Each patient's overall medical condition and care needs must be comprehensively assessed BEFORE the HHA identifies and assigns each diagnosis for which the patient is receiving home care.
 - See Appendix D
- **Primary Diagnosis (M1020)- the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.**

Secondary Diagnoses



- **Secondary Diagnoses M1022**

“All conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care.”
- **In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.**

More on Secondary Codes

Coding Clinic Guidance

- **Certain co-morbidities MUST always be coded because they impact care in the home, *even if the agency is not actively addressing these conditions***

Diabetes

COPD

HTN

CAD

PVD

Blindness

Status amputation

History of malignant neoplasm when care is directed at a current neoplasm

**May or may not
be in top 6**

Chronic diseases:

Parkinson's

Alzheimer's

MS

Dementia

CHF

Another Common Case Scenario

- **Patient admitted to home health post joint replacement. Meds include Inhalers; Prednisone; Prilosec; Warfarin; Lasix; Oxycodone.**

- **M1020/M1022**

~~A/C Jt Replacement~~

~~Abnormal Gait~~

~~Osteoarthritis~~

~~Anticoagulant therapy~~

~~Drug Monitoring~~

~~Joint Replaced~~

- **M1020/1022/1024**

A/C Joint Replacement

Abnormal Gait

Osteoarthritis

COPD

GERD

Drug monitoring

Anticoagulant therapy

Joint Replaced

Point Increase
C1 to C2 = \$380.41

How About This Case?

What's the Point Difference Here?

- Patient admitted post hospitalization for diverticulitis, pain, and weakness. Rehab only for balance, gait, fall preventions, muscle strengthening . **Clinical note and meds indicate HTN.**

- ~~M1020/M1022~~

~~Admission for Therapy
Diverticulitis
Muscle weakness
Arthritis
Pain~~

- M1020/1022/1024

Admission for Therapy
Diverticulitis
Muscle weakness
Arthritis
Pain

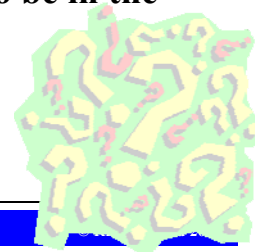
Point Increase
C1 to C2 = \$380.41

HTN

So What Does CMS Want?

- Do a comprehensive, holistic assessment on your SOC/ROCs/Recerts
- Critically assess the symptoms and sequencing of each patient's diagnoses
- What diagnoses MOST impact your Plan of Care?
- What diagnoses are NOT pertinent to be in the TOP 6 items (M1020/1022)?

Be a Detective
Clinician Process



OASIS-C Medication Risks

- **Medication Reconciliation Processes**
 - Clear agency protocol
 - Documentation for no return communication (M2002)
 - Follow up processes for patient safety (Agency instructions)
 - Therapy only processes: Documentation & report
- **High Risk Drug Items**
 - Can agency staff identify high risk drug categories?
 - Ensure agency education is specific & standardized
 - Admission packet education tools for high risk drugs
- **Does documentation indicate communication with physician to clarify discrepancies?**
 - Specific medication discrepancies (dosage; frequency, etc.)

Patient/Caregiver Drug Education

May be collaborative item

- **M2010 Patient/Caregiver High Risk Drug Education**: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics and anticoagulants) and how and when to report problems that may occur?
 - 0 - No
 - 1 - Yes
 - NA – Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

OASIS-C Medication Considerations

- **Establish your agency medication benchmarks**
 - Education of High Risk Medications
 - Is 95% a reasonable benchmark here?
 - Can staff readily identify this agency goal?
- **Do you have a clear agency protocols for all medication items?**
- **Does agency documentation clearly indicate clarification of medication issues?**
 - 31% of clinical records did **NOT** identify the specific medication(s) with potential clinically significant issues
 - 39% of clinical records did **NOT** clearly identify the medication that was high risk

More on Drug Education - All

- **M2015 Patient/Caregiver Drug Education Intervention:** Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?
 - 0 – No
 - 1 – Yes
 - 2 – NA Patient not taking any drugs

Address ALL meds: Prescribed and OTC's
If agency selects "0", document rationale in the clinical record for not providing this education

Missouri = 86%

January 2011 Q & A

- **Q: M2015:** A patient is seen in an assisted living facility (ALF) by the physical therapist. The patient is unable to manage their medications independently. Facility staff provides medication management and have been instructed by facility supervisors on side effects, etc. In this situation, should we consider the ALF staff to be caregivers who are instructed by "other health care providers?"
- **Answer 18:** *You may answer "1-Yes" to M2015 in this specific situation, if there was documentation in the medical record that the ALF staff, who are the patient's caregivers, had been instructed by on-site health care providers and it was demonstrated to the assessing clinician that they knew how to monitor the effectiveness of all drug therapy (prescribed, as well as all over-the-counter medications), drug reactions, and side effects, and how and when to report problems that may occur.*

Management of Oral Meds

- **M2020 Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications, (NOTE: This refers to ability, not compliance or willingness.)
 - 0 – Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
 - 1 – Able to take medication(s) at the correct times if
 - a. Individual dosages are prepared in advance by another persons OR
 - b. Another person develops a drug diary or chart
 - 2 – Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
 - 3 – Unable to take medication unless administered by another person
 - **NA – No oral medications prescribed**

Missouri = 42%

January 2011 Q & A

- **Q19:** In reference to M2020 if the patient does not have her prescribed medications in the home because she cannot afford them and she does not plan on getting them, what is the most common appropriate response for M2020?
- **A19:** *When completing M2020 you are reporting the patient's ability to take all oral medications reliably and safely at all times on the day of the assessment. If the patient did not take her medications on the day of the assessment because they were not present in the home, you cannot make assumptions about a patient's ability to take medications she doesn't have. If the medications were not in the home, you would not be able to determine if she could take each medication at the correct time and dose. The patient's status would be reported as "3-Unable to take medications unless administered by another person."*

M1340: Surgical Wound

- **M1340: Does this patient have a Surgical Wound?**
 - 0 – No
 - 1 – Yes, patient has at least one (observable) surgical wound
 - 2 – Surgical wound known but not observable due to non-removable dressing
- **Presence of a wound resulting from surgery**
 - Debridement is **NOT** a surgical wound
 - Muscle flap, skin advancement or rotational flap is a surgical wound
 - Ostomies are **excluded** from this item (unless "take-down")
- **If complete epithelialization present for over 30 days, then the surgical wound is no longer included in this item**

What's A Surgical Wound?

- Most surgical incisions
- Orthopedic pin sites
- Wounds with drains
- Central line sites
- Mediport sites
- Implanted infusion devices
- Venous access devices
- Peritoneal dialysis catheters
- Muscle flaps
- I&D if excision occurs
- Shave, punch or excisional biopsy sites
- Skin graft donor sites
- Thoracentesis sites
- Arthrocentesis sites (if performed via arthroscopy)
- Paracentesis site (if drain placed)
- Wound creased for ostomy reversal or take down
- Trauma with surgical repair

What's Not A Surgical Wound?

- Ostomies (all openings ending in "ostomy")
- Ostomy closing on itself
- Surgical line thru a fresh ostomy
- Debridement
- Simple I&D
- Cardiac catheterization via needle puncture (even if stents are placed)
- Cataract surgery
- GYN surgery by vaginal approach
- PICCS (even if insertion requires Fluoroscopy)
- Defibrillators (after original incision has healed)
- Arthrocentesis/thoracentesis/paracentesis sites utilized for simple aspiration of fluid
- Peripheral IV's sutured in place
- Pressure ulcers sutured in place
- Traumatic lacerations
- Skin graft recipient site

M1342: Status of Surgical Wound

- **M1342: Status of Most Problematic (Observable) Surgical Wound**
 - 0 – Newly epithelialized
 - 1 – Fully granulating
 - 2 – Early/partial granulation
 - 3 – Not healing
- **Identifies the degree of healing in the most problematic, observable surgical wound**
- **Score “0” for implanted venous access devices and infusion devices when the insertion site is healed**
 - Epithelialization is regeneration of the epidermis across a wound surface (resurfacing)

Case Mix Item

April 2010 Q & A

- **Q: In reference to M1342, Status of Most Problematic (Observable) Surgical Wound, for surgical incisions healing by primary intention is it true that the only correct responses are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue?**
- **A: Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly Epithelialized or 3-Not Healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.**

Surgical Wound Healing



Some Case Scenarios

- **Joint replacement with steri strips. Serous drainage still evident. Scored Newly epithelialized. How would you score this item?**
- **Surgical wound with staples intact. Incision reddened. Scored Newly Epithelialized. How would you score this item?**
- **When we review surgical wounds – what are we looking for?**
 - Narrative notes
 - Drainage; swelling; redness; signs and symptoms of infection; scabs; other

Quick Check: Wounds



- A surgical wound is no longer considered a surgical wound when
 - We no longer apply dressings
 - 30 days or more of complete epithelialization
 - 4-6 weeks post op
- If a surgical wound is scabbed we score healing status as “newly epithelialized”
 - True
 - False
- Surgical wounds healing by primary intention can only be scored non healing or newly epithelialized.
 - True or False

Falls Risk Assessment

SNL 100% Really?

- **M1910** Has the patient had a multifactor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
 - 0 – No multi factor falls risk assessment conducted
 - 1 – Yes, and it does not indicate a risk for falls
 - 2 – Yes, and it indicates a risk for falls



What Test Do You Use for Chairbound & Bedbound Patient's?

Detail Test & Score on OASIS-C

OASIS-C Review: M1910

- **1. For M1910 the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment, like the TUG or Functional Reach Assessment, combined with one other factor, (e.g. fall history, polypharmacy, impaired vision, incontinence, etc.) to meet the requirements of the multifactor, standardized validated fall risk assessment. It is the agency's responsibility to determine if your tool includes these elements.**
- **Source: OASIS Q & A: Question 15 (1/2010)**

Functional Reach Test

- **Functional Reach Test (Use for Non-Ambulatory or Unsafe Walker)**
 - Starting position: Feet flat on floor, arm outstretched at shoulder height with hand in closed fist
 - Using a measuring tool: measure distance from beginning position of MCP joint to end position of MCP joint
 - Instruct patient to reach forward as far as possible without losing balance or moving feet
 - Reaching \leq 6 inches indicates high risk for falls
 - Reaching 6-10 inches indicates moderate risk for falls
 - Criteria to stop is lifting feet or falling forward
 - Guard closely due to patient tendency to fall forward
- (Duncan et al.1990; Franchignomi et al. 1998; Light et al. 1995; Thomas & Lane 2005)

Care Management

- **M2100 Types and Sources of Assistance:**
Determine the level of *caregiver ability* and *willingness* to provide assistance for the following activities, if assistance is needed. (Check only one box in each row).

- ADL assistance
- IADL assistance
- Medication
- Medical procedures/treatments
- Supervision and safety
- Advocacy or facilitation

**Why Is This Item
on Discharge?**

Consider: Medical Necessity

Care Management Clarifications

- **Identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient.** Note that this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items
- **If more than one response in each row, select the response with greatest need**
- Caregiver(s) **not likely** to provide indicates an **unwillingness** to provide assistance, or that the caregiver(s) is/are physically and/or cognitively **unable** to provide needed care.
- **Unclear** indicates the caregiver(s) may express a willingness to provide care, but their ability to do so is in question or there is **reluctance on the part of the caregiver(s)** that raises questions as to whether the caregiver will provide needed assistance

More M2100 Clarifications

- **Row c Medication Administration**

- Prescribed & OTC's

- **Row d Medical Procedures/treatments**

- ROM
- TEDS
- Postural drainage
- Wound treatments including (wound vac dressing, foam and drape)
- Orthotics; Braces; Slings



- **Row e Management of Equipment (safely)**

- Oxygen
- IV/Infusion
- CPM
- Wheelchair; Hoyer Lift
- **Wound vac: emptying VAC canister; disconnection/reconnection**

Plan of Care Synopsis

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient has no pressure ulcers with need for moist wound healing

Bottom Line on M2250

- **POC Pressure Ulcer Prevention = 98%**
- Agency can score **NA** if an informal **OR** a formal tool has been used for:
 - Pain (M1240)
 - Depression (M1730)
 - Risk for Pressure ulcers (M1300)
 - Fall Risk (M1910)
- **M2250 is based on the presence of interventions in the Plan of Care (485; orders)**
 - **Pressure Ulcer Prevention**; Fall Prevention Interventions; Assess pain & Teach Pain Management

April, 2010 Q & A

- **Q: How does the clinician answer M2250 if the patient does not have pain on the Start of Care OASIS (paraphrased: Question 8).**
- **A: When answering M2250, Plan of Care Synopsis, Row e, the assessing clinician is reporting whether the physician ordered plan of care included interventions to monitor and mitigate pain, any pain, not just severe pain. “NA” is an option if the comprehensive assessment, and not necessarily the formal assessment, revealed the patient had no pain. “Yes” or “No” can be selected for M2250 based solely on the physician ordered Plan of Care to monitor and mitigate pain, regardless of whether or not the patient was assessed for pain.**
- **Source: *OASIS Q & A: Question 8 (4/2010)***

July, 2010 OASIS-C Q & A

- **Q: If we are using standardized agency parameters, do they have to be listed specifically in the Plan of Care or can the order read “Notify MD of VS as per agency’s patient clinical parameter guidelines?”**
- **A: The specific parameters must be included. The physician has to be aware of what he/she is agreeing to and cannot possibly be aware of every home health agencies standardized parameters.**
- **Source: OASIS Q & A: Question 22 (7/2010)**

Intervention Items: “Look Back”

(M2400) Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers <u>OR</u> patient has no pressure ulcers with need for moist wound healing

What Process Items Come from M2400?

■ Diabetic Foot Care = 86%

- Check POC; orders
- How about visit notes
- Document return demonstrations
- Continue to perform foot & skin



■ Pain Intervention = 95%

- Check POC; orders
- How about visit notes
- Do orders & visit notes indicate monitoring AND mitigating pain?

■ Pressure Ulcer Treatment Based on Moist Wound Healing (Check orders; visit notes; other)

Easy Money for CMS

CAUTION

■ Compliance Issues

- Orders; RAPS's & Final Claims
 - F2E; Physician signatures & dates; Therapy Reassessments & Supervisions
- CoP's
 - Timeliness; DRR; Physician orders; OASIS

■ Survey Issues

- Care Planning; Coordination; Communication
 - Addresses every identified risk or potential risk
- Look Back Documentation
 - Have you implemented the POC?

■ Audit Issues

- OASIS-C supports medical necessity & services
- OASIS-C supports therapy utilization
- Consistent clinical documentation

• Quality & Reimbursement Issues: More To Come

Leadership Priorities

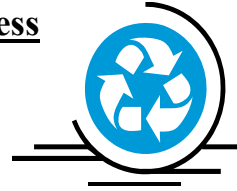
- **Regulatory**
 - Compliance processes
 - 485's; F2E; Physician signature & dates
 - Verbal orders; physician communication; therapy documentation
- **Operational**
 - Outcomes Data; Process Best Practices; HH-CAHPS
 - Efficiencies: Clinical & Operational
 - Episode Management; Visit Utilization
 - Expansion: Medicare PPS
- **Strategic = Survival in Health Care Reform**
 - Marketing; Outreach; Innovation; Partnerships
 - Be At the Table on Pilot Programs

Data Drives Change

- **Ongoing Benchmark Data & Goals for all staff**
 - Case Mix Index (Monthly): Team/Agency/Clinician
 - Quality Outcomes & Process Outcomes Reports
 - Episode Management Data
 - Visits per episode
 - Outcomes per diagnoses categories
 - Costs per categories/episodes
- **Utilizes multiple data indicators for agency evaluation and process revisions**
 - Goal setting
 - Recruitment & retention
 - Resources for Outcome Enhancement
 - **Monitoring & Evaluation Processes**

C Lessons Learned

- **Clinical Practice is an Iterative Process**
- **Reinforce**
 - OASIS Champions/Specialists
 - Case/Team Conferences
- **Apply**
 - Current Case Scenarios
- **Refine Practices**
 - Quarterly Updates
 - From the Field Updates/Successes
- **Preceptors/Team Access**
 - Celebrate; Reward



OASIS Tips
OASIS Newsletters
OASIS Boards
OASIS Cards
OASIS Fairs

Resource Web Site

- CMS OASIS Web Page (Errata 12/10)
 - www.cms.hhs.gov/oasis
- CDC
 - www.cdc.gov
- CMS Medicare Learning Network (MLN) Website
 - www.cms.hhs.gov/MLNGeninfo/
- Office of Inspector General (OIG)
 - www.oig.hhs.gov
- American Physical Therapy Association
 - www.apta.org
- American Occupational Therapy Association
 - www.aota.org



Two Year Transition from OASIS-B1 to OASIS-C: Reportable data on CASPER and Home Health Compare: Revised 01-04-2011

Reported in Calendar Month	OASIS-B1 Data Reported on CASPER	OASIS-C Data Received	OASIS-C Data Reported on CASPER	HOME HEALTH OBQI CASPER Reports					Home Health Compare	
				All Patients' Risk Adjusted Outcome	Potentially Avoidable Event	Agency Patient-Related Characteristics	Tally (Various) ³	All Patients' Process Quality Measure	Outcome Measures ⁴	Process Quality Measures ⁵
Jan-10	Nov08 - Oct09	N/A	N/A	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	N/A	12 mo "B1" data (Oct08 - Sep09)	N/A
Feb-10	Dec08 - Nov09	Jan10	N/A	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	N/A		
Mar-10	Jan09 - Dec09	Jan10 - Feb10	N/A	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	12 mo "B1" data	N/A		
Apr-10	N/A	Jan10 - Mar10	N/A	Static ¹	Static ¹	Static ¹	Static ¹	N/A	12 mo "B1" data (Jan09 - Dec09)	N/A
May-10	N/A	Jan10 - Apr10	N/A	Static	Static	Static	Static	N/A		
Jun-10	N/A	Jan10 - May10	N/A	Static	Static	Static	Static	N/A		
Jul-10	N/A	Jan10 - Jun10	N/A	Static	Static	Static	Static	N/A	Display data not updated	N/A
Aug-10	N/A	Jan10 - Jul10	N/A	Static	Static	Static	Static	N/A		
Sep-10	N/A	Jan10 - Aug10	Jan10 - Jun10	Static	Static	6 mo "C" data	6 mo "C" data	6 mo "C" data		
Oct-10	N/A	Jan10 - Sep10	Jan10 - Jul10	Static	Static	7 mo "C" data	7 mo "C" data	7 mo "C" data	Display data not updated	6 mo "C" data (Jan10 - Jun10)
Nov-10	N/A	Jan10 - Oct10	Jan10 - Aug10	Static	Static	8 mo "C" data	8 mo "C" data	8 mo "C" data		
Dec-10	N/A	Jan10 - Nov10	Jan10 - Sep10	Static	Static	9 mo "C" data	9 mo "C" data	9 mo "C" data		
Jan-11	N/A	Jan10 - Dec10	Jan10 - Oct10	Static	Static	10 mo "C" data	10 mo "C" data	10 mo "C" data	Display data not updated	9 mo "C" data (Jan10 - Sep10)
Feb-11	N/A	Jan10 - Jan11	Jan10 - Nov10	Static	Static	11 mo "C" data	11 mo "C" data	11 mo "C" data		
Mar-11	N/A	Jan10 - Feb11	Jan10 - Dec10	Static	Static	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Apr-11	N/A	Jan10 - Mar11	Feb10 - Jan11	Static	Static	12 mo "C" data	12 mo "C" data	12 mo "C" data	Display data not updated	12 mo "C" data (Jan10 - Dec10)
May-11	N/A	Jan10 - Apr11	Mar10 - Feb11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Jun-11	N/A	Jan10 - May11	Apr10 - Mar11	Preview Report of HHC "12 mo 'C' data" provided ²	Preview Report of 12 mo "C" data provided ²	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Jul-11	N/A	Jan10 - Jun11	May10 - Apr11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data (Apr10 - Mar11)	12 mo "C" data (Apr10 - Mar11)
Aug-11	N/A	Jan10 - Jul11	Jun10 - May11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Sep-11	N/A	Jan10 - Aug11	Jul10 - Jun11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Oct-11	N/A	Jan10 - Sep11	Aug10 - Jul11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data (Jul10 - Jun11)	12 mo "C" data (Jul10 - Jun11)
Nov-11	N/A	Jan10 - Oct11	Sep10 - Aug11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data		
Dec-11	N/A	Jan10 - Nov11	Oct10 - Sep11	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data	12 mo "C" data		

¹ The CASPER Reports values will remain unchanged from April 2010 values.

² A Preview All Patients' Risk Adjusted Outcome and Potentially Avoidable Event Reports would be made available to HHAs during this month using the new "OASIS-C only" measures and prediction models. The HHC Preview OBQI Report would cover the time period Jan10 - Dec10.

³ The Agency Patient-Related Characteristics Tally Report begins September 2010. The Agency Patient-Related Characteristics (Outcome) Tally Report begins June 2011. The Potentially Avoidable Event Report: Patient Listing begins June 2011.

⁴ Home Health Compare contains a subset of All Patients' Risk Adjusted Outcome and Potentially Avoidable Event measures.

⁵ Home Health Compare contains a subset of the All Patients' Process Quality measures.

CARE MANAGEMENT

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Medical procedures/ treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SAMPLE NURSING DASHBOARD

Month: January, 2011

Requested Period: January, 2011

YTD Period: 1/1/11 to 1/31/11

MEASURE	CURRENT	YTD	2010	2011 Goal
START of CARE Case Mix	1.26	1.26	1.22	1.3
FINAL CLAIM Case Mix	1.13	1.13	1.16	1.28
# Visits Per Episode	18.2	18.2	18.42	17.00
Margin Per Episode	(12.6%)	(12.6%)	(7.3%)	10%
% Hospitalization	25%	25%	24%	20%
% LUPAs	13.9%	13.9%	14.7%	12.0%
Variance Per Protocols:				
➤ OASIS Score Edits				
➤ Timely Recertifications				
➤ Timely Documentation				

SAMPLE THERAPY DASHBOARD

Month: February, 2011

Requested Period: February, 2011

YTD Period: 1/1/11 to 2/28/11

MEASURE	CURRENT	YTD	2010	2011 Goal/Margin
Evaluations Done in 48 hours	72% 73/101	72% 73/101	65%	80% (8%)
Evaluations Done in 72 Hours	80% 81/101	80% 81/101	80%	85% (5%)
START OF CARE (SOC) Case Mix				
# Visits Per Episode	6.24	6.24	6.42	
# Visits per First Week	1.7	1.7	1.5	2.5
% LUPAs	9.3%	9%	9.7%	9%
Variance Per Protocols:				
➤ Functional Score Edits				
➤ Objective Goals: 485				95%
➤ Timely Reassessments				100%