Introduction

Kansas Oasis Education Coordinator (OEC)

Presenter Bio

- New Risk Manager with Kansas Department of Health and Environment (KDHE).
- In this role, she manages all aspects of the Risk Management Program as part of her duties.
- Began in healthcare in 1982. Before joining KDHE in 2016, she worked for the last 17 years for a Global Corporation and was a full-time Risk Manager for the last 5 years.
- Leda’s varied background in Healthcare Risk Management provides the perfect foundation for supporting your Risk Management efforts.
- She is passionate about the management of risk, and how it contributes to improving outcomes for patients and the institutions and professionals that serve them.

Nelleda L. Faria, RN, BSN, MBA, PMP, CPHRM
Health Facility Surveyor- Risk Manager/OASIS Education Coordinator
KDHE/BCHS/Health Facilities Program
1000 SW Jackson St., Suite 330
Topeka, KS. 66612-1365
Ph: 785-296-4714
Fax: 785-559-4250
Nelleda.faria@ks.gov
Objectives

At the end of the session the participant will be able to:

• State the purpose of the OASIS program
• Discuss the OASIS conventions
• Discuss the requirements related to the initial comprehensive assessment
• State the meaning of key definitions used in OASIS
• Identify the location of resources and FAQs to aid in OASIS problem solving
• Identify strategies to problem solve in areas CMS has identified field issues
• State the changes related to the implementation of ICD-10
• Discuss quality measures and STAR rating reports.
Housekeeping Tasks

- Agenda- Time for Breaks and Lunch?
- Location of restrooms?
- Handouts?
- iclickers – What are these? How do I use them?
- Is your phone or electronic device on silent/airplane mode?
- Track questions and submit them in writing if they haven’t been covered. Provide contact information. FAQ document will be drafted.
Training Agenda

9:00  **Introductions**
- Overview of OASIS and C2 Implementation
- Oasis Answers HD Termination and CMS Fatal Error Listing for 2017
- Conventions

10:30  **Break– 15 minutes**

10:45  **Morning Domains**
- Living Arrangements/Sensory Status
- Respiratory/Cardiac Status
- Elimination Status
- Neuro/Emotional/Behavioral Status

12:00  **LUNCH On Your Own – 1 hour**

1:00  **Afternoon Domains**
- ADLs/IADLs
- Medications/Care Management
- Wounds – Clinical Assessment
- Integumentary Items

2:45  **Break– 15 minutes**

3:00  **Quality Measures (OBQI, OBQM, PBQI)/Home Health Compare/Star Ratings**

3:50  **Wrap Up/ Resource Discussion and Question Submissions**
Clicker Demo

What is your professional background?
Select the corresponding letter for the correct answer:
• A. Registered Nurse
• B. Physical Therapist
• C. Occupational Therapist
• D. Speech Therapist or Pathologist
• E. Social Worker, Dietitian, Pharmacist, or Other
Updates due to ICD-10

• Item Set Changes
  • OASIS-C1_ICD10 – M0090 (Date Assessment Completed 10/01/2015 or greater) – will generate a end date.
    ▪ New Items – for ICD-10 implementation
      • M1011 – replaces M1010
      • M1017 – replaces M1016
      • M1021 – replaces M1020
      • M1023 – replaces M1022
      • M1025 – replaces M1024

• Announced July, 2015—

• Proposed OASIS data set changes for CY 2017 include the addition of items allowing risk adjustment of the pressure ulcer measure (including reporting of height and weight to allow calculation of BMI, and reporting of PVD, PAD and DM as active diagnoses.) Additionally, changes to existing OASIS items M1308 – Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable, and M1309 Worsening in Pressure Ulcer Status since SOC/ROC are being proposed.
Changes for 10/1/15

• End date of 09/30/2015 implemented for OASIS C1 ICD 9 Assessments
  ▪ New Items – for ICD-10 implementation
    • M1011 – replaces M1010
    • M1017 – replaces M1016
    • M1021 – replaces M1020
    • M1023 – replaces M1022
    • M1025 – replaces M1024
  • And in 2017  Anticipate new items
    ▪ Functional
    ▪ Falls
What is OASIS??

• Acronym for Outcome and Assessment Information Set
• Standardized data collection instrument
• 100+ items-questions collected at various time points
• Compares patient outcomes at two points in time
• Utilized to calculate payment for Medicare Prospective Payment System
• Required as a Medicare Condition of Participation
## Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Tracking</td>
<td>Elimination Status</td>
</tr>
<tr>
<td>Clinical Record Items</td>
<td>Neuro/Emotional/Behavioral Status</td>
</tr>
<tr>
<td>Patient History &amp; Diagnosis</td>
<td>ADLs/IADLs</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td>Medications</td>
</tr>
<tr>
<td>Sensory Status</td>
<td>Care Management</td>
</tr>
<tr>
<td>Integumentary Status</td>
<td>Therapy Need &amp; Plan of Care</td>
</tr>
<tr>
<td>Respiratory Status</td>
<td>Emergent Care</td>
</tr>
<tr>
<td>Cardiac Status</td>
<td>Discharge</td>
</tr>
</tbody>
</table>
Data Collection Time Points

Not all items are completed at every assessment time point.

<table>
<thead>
<tr>
<th>Time Points</th>
<th>Home Visit</th>
<th>Completion Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start of Care (SOC)</td>
<td>Yes</td>
<td>Within 5 days &gt; SOC date</td>
</tr>
<tr>
<td>Resumption of Care (ROC) &gt; Inpt. stay</td>
<td>Yes</td>
<td>Within 48 hours of inpt. Discharge</td>
</tr>
<tr>
<td>Recertification within the last 5 days of each 60-day certification period</td>
<td>Yes</td>
<td>During the last 5 days of each 60-day certification period</td>
</tr>
<tr>
<td>Other Follow-up</td>
<td>Yes</td>
<td>Within 48 hours of significant change in condition</td>
</tr>
<tr>
<td>Discharge from homecare</td>
<td>Yes</td>
<td>Within 48 hours of becoming aware of need to discharge</td>
</tr>
<tr>
<td>Transfer to Inpt. Facility/Death @ home</td>
<td>No</td>
<td>Within 48 hours of knowledge of transfer or death</td>
</tr>
</tbody>
</table>
# Who Completes Assessment??

<table>
<thead>
<tr>
<th><strong>Who Can Complete</strong></th>
<th><strong>Who Cannot Complete</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>Physical Therapy Assistant</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Occupational Therapy Assistant</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>Master of Social Work</td>
</tr>
<tr>
<td>Speech Language Therapist</td>
<td>Home Health Aide</td>
</tr>
</tbody>
</table>
Start of Care Comprehensive Assessment

In cases involving nursing:

• A RN must complete the comprehensive assessment at the start of care.
• Any discipline qualified to perform assessments may complete subsequent assessments.
  o RN
  o PT
  o SLP
  o OT

For therapy only cases:

• It is acceptable for a PT or SLP to conduct and compete assessment at Start of Care.
• An OT may only complete the assessment if OT established program eligibility.
Top 10 Fatal Error List

10. Invalid format-# where letter should be and vice versa. (.03%)
9. Invalid record, invalid HHA ID (.05%)
8. Inconsistent M1020.M1022 values, ICD and severity ratings are inconsistent (.06%)
7. Inconsistent dates i.e. DOB > start of care (.07%)
6. Incorrect format SSN, not enough digits (.08%)
5. Incorrect format, Medicare # (.26%)
4. Inconsistent M0150 Values 1,2,3,4 must be checked (.29%)
3. No match found, trying to do a correction for an assessment not found in the system (.31%)
2. Invalid value i.e. Items to be selected are 1,2,3,4 and you pick 7 (.46%)
1. Duplicate assessment. Hit send twice. (2.92%)

Happens about 600,000 times a year.
The Conventions

#1—Time Period Under Construction

• Report what is true on the day of the assessment, unless a different time period is indicated in the item.

• The “day of assessment” is defined as the 24 hours immediately preceding the home visit and the time spent during the home visit. Roughly 26 hours...
The Conventions

#2—The Care Episode

• AKA the Quality Episode
• Begins with the Start of Care or Resumption of Care assessment
• Ends with a Transfer or Discharge Assessment
The Conventions

#3—When Ability or Status Varies

Report what is true greater than 50% of the time, unless the item specifies differently.

Consider the medication or equipment for which the most assistance is needed.
Case Scenario

You are admitting Mr. Jefferson to home care during a visit that began at 10:00am. He reported to you that he was allowed to remove his bilateral eye patches when he woke up that am. Prior to this he was unable to locate the long handled tool that enabled him to reach and cleanse his rectal area. His wife had to lay out his supplies and utensil within his reach for him the two days prior to this am. Since this morning, he has been independent with all aspects of toileting hygiene.
Case Scenario

Ms. Baker can take all oral medications as ordered except she forgets to take the new daily blood pressure medication and must be reminded. How would you score M2020?

<table>
<thead>
<tr>
<th>(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. <strong>Excludes injectable and IV medications.</strong> (NOTE: This refers to ability, not compliance or willingness.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>NA</td>
</tr>
</tbody>
</table>
The Conventions

#4—Minimize NA and Unknown Responses

I Don't Know.
# The Conventions

## #5—Don’t make references to prior assessments

<table>
<thead>
<tr>
<th>Items Documenting Current Status</th>
<th>Process Items documenting Prior Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent observation of patient condition and ability at time of</td>
<td>Acceptable to review time period “at the time of or since the time of the most recent SOC, ROC F/U</td>
</tr>
<tr>
<td>the assessment</td>
<td>OASIS assessment”</td>
</tr>
<tr>
<td>No referring to prior assessments</td>
<td>Clinical record</td>
</tr>
</tbody>
</table>
The Conventions

#6—Use multiple strategies to complete items.
Combine strategies and recognize opportunities to gather data from multiple sources.

• Patient observation
• Interview with caregivers or physicians
• Physical assessment
The Conventions

#7—The meaning of “assistance.”

• Refers to assistance form another person(s)
• It is not limited to physical contact—including verbal cues, stand-by assistance and supervision.
The Conventions

#8—Be Accurate and Comprehensive

• Accuracy should be based on CMS guidance
• Follow skip patterns, as indicated.

#9—Understand definitions in OASIS

Certain words have specific definitions such as “surgical wound.” “wounds resulting from a surgical procedure except ostomies, cataract surgeries of the eye, surgery to mucosal membranes, or a gynecological surgical procedure that has a vaginal approach.”
The Conventions

#11—Stay Current
OASIS-C Guidance Manual

CMS Questions and Answers (Q & As)
https://www.qtso.com/hhadownload.html

CMS Quarterly Q & As
http://www/oasisanswers.com
The Conventions

#12—One Clinician Rule (Strict)

- Only one clinician takes responsibility for accurately completing a comprehensive assessment unless otherwise indicated.
- Can’t change an assessment—reassess, if necessary.
- Exception: Therapy re: # of visits and drug regimen review can utilize collaborative effort, if useful.
The Conventions

#12—One Calendar Day

• Example: (M2002) Was a physician or the physician-designee contacted within one calendar day to resolve clinical significant medication issues, including reconciliation?

• “One calendar day” means until the end of the next calendar day.
The Conventions

#14—”Specifically” and “For Example”

“Specifically” means only the circumstances listed
Patient requires a urinary catheter (specifically, external, indwelling, intermittent, or suprapubic.)

“For Example” means the clinician may consider other relevant circumstances or attributes.

M2430  Reason for hospitalization
Response 3-  Respiratory infection (for example pneumonia, bronchitis)
ADL/IADL Conventions

#1—Report Ability, Not Performance

• Report the patient's ability, not their actual performance or willingness to perform a task.

Ability = What one can do
Performance - What one does do
#2—Safe Ability
The level of ability refers to the patient's ability to safely complete specified activities.
Observe the patient performing tasks to assess safety.

Able to do unsafely= Unable to do.
#3—Consider only included tasks

Understand which tasks are included and excluded.

Pay attention to task, behaviors, and symptoms specifically included in each item.

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving, or make up, teeth or denture care, fingernail care)
ADL/IADL Conventions

#4—When ability varies between tasks

• Report what is true in the majority of the included tasks
• Give more weight to tasks that are preformed more frequently.

(M1800) Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

- 0 – Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 – Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 – Someone must assist the patient to groom self.
- 3 – Patient depends entirely upon someone else for grooming needs.
Mrs. Spencer

On the day of assessment, you observe Ms. Spencer is able to obtain her grooming supplies and independently wash her face and hands, brush her teeth, and comb her hair at least daily. However, she needs assistance with applying make up, which she wears occasionally, and with fingernail care (once per week.)

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

A-- □ 0 – Able to groom self unaided, with or without the use of assistive devices or adapted methods.
B-- □ 1 – Grooming utensils must be placed within reach before able to complete grooming activities.
C-- □ 2 – Someone must assist the patient to groom self.
D-- □ 3 – Patient depends entirely upon someone else for grooming needs.
ADL/IADL Conventions

#5—Medical Restrictions

- Consider medical restrictions when selecting the best response to functional items such as ambulation and transferring.

Physician orders bedrest or specific non-weight bearing status.
Living Arrangements

In the care providers professional judgement determine:

- Whether the patient is living alone, with others or in a congregate setting
- The availability of caregivers to provide in-person assistance. (does not include home health caregivers...)
- When? SOC, ROC
Living Arrangements

- Living alone-Home, apartment, in own room at a boarding house, lives alone with paid help, normally lives alone but temporarily has a caregiver staying in the home, lives alone but has a lifeline to call for help.

- Lives with others, spouse, family, significant other, normally lives with others but is occasionally alone when they travel out of town or at work

- If the patient recently changed their living arrangement due to their condition-- report the usual living arrangement, unless the new arrangement is expected to be permanent.
Availability of Assistance

• Around the clock means 24-hours a day
• Regular daytime-daytime hours every day with infrequent exceptions
• Regular nighttime-nighttime hours every day with infrequent exceptions
• Occasional/short term assistance means someone is available to provide in-person assistance only a few hours a day or on an irregular basis or may only be able to help occasionally.
• No assistance available means no one provides any assistance.
Availability of Assistance

• The caregiver need not live in the home but assistance via telephone is not a consideration.
• Documents time available not quality of the assistance. Adequacy of caregiver assistance is considered in M2100.
• If someone lives in the home but is completely unable to or unwilling to provide assistance do not count them as a caregiver.
M1100-Priscilla

Priscilla lives alone in her own apartment. Since her hospital discharge, her two daughters alternate staying with her during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care.

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient lives alone</td>
<td>Around the clock: 01, Regular daytime: 02, Regular nighttime: 03, Occasional/short-term assistance: 04, No assistance available: 05</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>Around the clock: 06, Regular daytime: 07, Regular nighttime: 08, Occasional/short-term assistance: 09, No assistance available: 10</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td>Around the clock: 11, Regular daytime: 12, Regular nighttime: 13, Occasional/short-term assistance: 14, No assistance available: 15</td>
</tr>
</tbody>
</table>

A= 01, Priscilla is considered to be living alone even if her daughters are staying with her temporarily. Daughters are providing around the clock care, even if they leave the house briefly.

B=03, Priscilla is considered to be living alone since her daughters are only there temporarily. Since they sometimes leave in the daytime they provide regular nighttime assistance.

C=04. Priscilla is considered to be living alone since her daughters are only there temporarily. Since they sometimes leave to run errands they are considered to be providing occasional/short term assistance.

D= 07, Priscilla is living with others since they are living there during the assessment period. The daughters provide regular daytime assistance since they sleep at night.
M1100-Miguel

- Miguel lives alone in his home but his son and daughter-in-law live across the street. They bring Miguel dinner every night and are available around the clock by telephone.

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<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>□ 01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>□ 06</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation</td>
<td>□ 11</td>
</tr>
</tbody>
</table>

A= 01, Miguel lives alone and has around the clock assistance since family is available by telephone and can get to him so quickly.

B= 03, Miguel lives alone but his family is available every night to offer in-person assistance.

C= 06, Miguel lives with others since his family is living on the same street. He has around the clock assistance since they are available by telephone and can get to him so quickly.

D= 08, Miguel lives with others who are available every night to offer in-person assistance.
M1100-Binh

- Binh lives with his daughter who works during the day but is home every evening and sleeps there every night. A paid aide comes in 3 days a week to assist with ADLs. His daughter has back problems that prevent her from lifting patient, but she assists the patient with dressing every morning and takes him to doctor’s appointments.

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<tbody>
<tr>
<td>Around the clock</td>
<td>Regular daytime</td>
</tr>
<tr>
<td>Regular nighttime</td>
<td>Occasional / short-term assistance</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>□ 01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
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</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td>□ 11</td>
</tr>
</tbody>
</table>

A=04  Binh lives alone and the daughters assistance is considered “occasional” since there is much she cannot help with.
B= 05, Binh lives alone but a paid aide is not counted as “assistance” and the daughter is limited in her abilities.
C= 06, Binh lives with another person and between the paid aide and the daughter they can be consider “around the clock” assistance.
D=, 08  Binh lives with others who are available at night. Even though his daughter can’t meet all of his needs, she is available at night.
E=, 09, Binh lives with others and the paid aide won’t be there forever so the assistance should be considered short term.
Break Time
Respiratory M1400

- If the patient wears O2 continuously, assess SOB while on O2.
- If the patient wears O2 intermittently, assess SOB without O2.

**M1400**  When is the patient dyspneic or noticeably *Short of Breath*?

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)
Respiratory M1410

• (M1410) Respiratory Treatments utilized at home: (Mark all that apply.)
  • 1 - Oxygen (intermittent or continuous)
  • 2 - Ventilator (continually or at night)
  • 3 - Continuous / Bi-level positive airway pressure
  • 4 - None of the above

• Mr. Hunter’s daughter reports that he wears his oxygen only while the home health nurse is in the home. The rest of the time he goes without it because “I never needed it anyhow.”
Neuro/Emotional/Behavioral
OASIS Item:  M1700

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
Neuro/Behavioral/Emotional

Identifies current (at the time of the assessment and preceding 24-hours) level of cognitive function, including:

• Alertness
• Orientation
• Comprehension
• Concentration
• Immediate memory for simple commands
Neuro/Behavioral/Emotional

• Nonresponsive means that the patient is unable to respond or the patient responds in a way that you cannot make a clinical judgement about the patient level of orientation.

• Behaviors can be observed by the clinician or reported by the patient, family or others.
Willful choice vs. impaired decision-making

- It is not the intent in this section to report non-compliance or risky choices made by cognitively intact patients.
- The assessing clinician will have to determine if the patient has a disorder that is causing noncompliance or are they making a choice not to comply competently with physician's order cognizant that there are implications of the choice.
Willingness and adherence are not the focus in this section. It simply addresses the patient’s ability to safely perform grooming. This ability can be temporarily or permanently limited due to:
• Physical impairments i.e. limited range of motion, impaired balance
• Emotional/Cognitive/Behavioral i.e. memory problems, fear. Impaired judgement
• Sensory impairment i.e. impaired vision or pain
• Environmental barriers i.e. accessing grooming aids, no functional bathtub or shower
Grooming Variability

- If ability varies over time, choose the response that describes the patient’s ability more than 50% of the time.
- Grooming includes several activities. Patient ability to do more frequently performed activities but unable to do less frequently performed activities should be considered as having more ability in grooming.
Prosthetic, Orthotics and Support Devices

- Prosthetic, orthotic, or other support devices applied to the upper or lower body should be considered as body dressing items.
Bathing

M1830

• Identifies the patient’s ability to bathe the entire body and the assistance that may be required to safety bathe, including transferring in and out of the tub/shower.

• The intent is to identify ability, not necessarily the actual performance.
Bathing

• If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe due to combined medical restrictions and environmental barriers.

• If the patient does not have a tub or shower or it is unusable, the patient should be considered as unable to bathe in the tub or shower.
Toileting

• Consideration of toileting capability excludes consideration of ability to manage personal hygiene or their clothing. (M1845)

• If the patient can get to the toilet in the daytime but uses the commode or urinal at night for convenience, select Response 0

• If the patient requires standby assistance, verbal cueing or reminders, Select Response 1

• If the patient can get to the toilet but requires assistance to get on and off the toilet, Select Response 1

• A patient who is unable to get to the toilet or commode, but is able to place/remove the bedpan or urinal independently, Select Response 1.

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

0 - Able to get to and from the toilet and transfer independently with or without a device.

1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

4 - Is totally dependent in toileting.
Transferring

• Ability not performance

• If there is no chair or the patient doesn’t routinely transfer from the bed in to a chair in the bedroom, report ability to move from supine position in bed to a sitting position at the side of the bed and then ability to stand and then sit on whatever surface is applicable in the patient's environment.

• Assistance = anything, any amount
Feeding or Eating

• Identifies the ability to feed self, including the process of eating, chewing, and swallowing food. The intent is to identify the ability, not performance.

• This excludes the evaluation of the preparation of food items, and transporting the meal to the table. Responses would be based on the amount of assistance needed once food is placed in front of them.

• Assistance includes verbal cueing, reminders, supervision, and hands-on assistance.
More definitions

• “Needed some help” means that the patient contributed effort but required help from another person to accomplish the activity safely.
• Ambulation refers to walking with or without an assistive device.
• Transfer refers specifically to the tub, shower, commode, and bed to chair transfers.
• Household tasks refer specifically to light meal preparation, laundry, shopping and phone use.
Medications

• If portions of the drug regimen review are completed by staff other than the clinician responsible for completing the SOC/ROC, information about the drug regimen review findings must be communicated to the clinician responsible for the assessment so that the appropriate response for M2000 can be selected.
Definitions

- **Adverse drug reactions (ADR)** - a form of adverse consequences such as a secondary effect that is usually undesirable and different from the therapeutic effect of the medication or any response to a med that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

- **Side effect** is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

- **High risk medications** are those identified by quality organizations (ISMP, TJC) as having considerable potential for causing significant patient harm when they are used erroneously.

- **Effective safe medication management** includes knowledge of effectiveness, potential side effects, drug reactions and when to contact their care provider.
Medications

• Clinically significant problems are those that in the care provider’s judgement pose and actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors or non-adherence to prescribed medication regimen.

• If a medication problem is identified and resolved by agency staff by the time the assessment is completed, the problem does not need to be reported as a clinically significant problem.
Medications

• Drug education should address all medications the patient is taking—including prescribed and OTC—by any route.
• Anything a pharmacist does—does not count as “assistance.”
• Again, evaluate ability not performance or willingness.
Break Time!
Pressure Ulcers, Stasis Ulcers, Surgical Wounds and Lesions
<table>
<thead>
<tr>
<th>questions</th>
<th>#</th>
<th>category</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1300 – M1324</td>
<td>11</td>
<td>pressure ulcers</td>
</tr>
<tr>
<td>M1330 – M1334</td>
<td>3</td>
<td>stasis ulcers</td>
</tr>
<tr>
<td>M1340 – M1342</td>
<td>3</td>
<td>surgical wounds</td>
</tr>
<tr>
<td>M1350</td>
<td>1</td>
<td>other wounds</td>
</tr>
</tbody>
</table>
Wound Assessment

Source: Case Mix Report OASIS OBQM 2009, 2002
Definitions

Pressure Ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. (NPUAP)

Suspected deep tissue injury a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Tissue may be painful and firm, mushy, boggy warmer, or cooler than adjacent tissue.

Epithelialization regeneration of the epidermis across a wound surface.
Healing

Based on research and the opinion of National Pressure Ulcer Advisory Panel (NPUAP):

• Stage I and II pressure ulcers can heal through epithelization.

• State III and IV pressure ulcer heal through a process of contraction, granulation, and epithelialization. *They can never be considered “fully healed.”* They can be considered closed when the wound surface is covered with new epithelial tissue.
Most Problematic

• The “most problematic” pressure ulcer may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure.

• If the patient has only one pressure ulcer—it is the most problematic.
Unstageable Wounds

• Those that are known or suspected but unobservable due to dressings or devices that cannot be removed to assess the skin underneath.

• Suspected ulcers that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures.

• Suspected deep tissue injury
Pressure Ulcer or Surgical Wound??

- A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and should not be reported as a pressure ulcer.
- A pressure ulcer treated with a skin graft is still a pressure ulcer and should not be considered a surgical wound.
- A pressure ulcer that has been surgically debrided is still a pressure ulcer.
Stasis Ulcers

- Identifies patients with ulcers caused by inadequate venous circulation in the area affected—most often lower legs. Stasis ulcers do not include arterial lesions or arterial ulcers.
- Once epithelialized, it is considered healed and should not be reported.

Venous
- Shallow
- Superficial
- Irregular shape
- Small to large
- Pain related to edema, phlebitis or infection
- Usually appear on the lower leg and ankle
- Frequent contact dermatitis

Arterial
- Full thickness wound
- Punched out appearance
- Pain often occurs at night
- Pain relieved by lowering leg below heart
- Often on lateral foot
- Wound has bright red granulation tissue
Surgical Wounds

**(M1340)** Does this patient have a **Surgical Wound**?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No [At SOC/ROC, go to M1350 ; At FU/DC, go to M1400 ]</td>
</tr>
<tr>
<td>1</td>
<td>Yes, patient has at least one observable surgical wound</td>
</tr>
<tr>
<td>2</td>
<td>Surgical wound known but not observable due to non-removable dressing/device [At SOC/ROC, go to M1350 ; At FU/DC, go to M1400]</td>
</tr>
</tbody>
</table>

Identifies the presence of a wound resulting from a surgical procedure. A wound is considered unobservable if it is covered by a dressing or device which is not to be removed *per physician order*. 
Roy

Roy has a surgical site closed with staples and/or chemical bonding. Is this considered a surgical wound for OASIS purposes?

A. Yes
B. No
C. It depends on the location and size of the wound.
Stacy

• Stacy has a bowel ostomy that is closing on its own. Is this considered a surgical wound for OASIS purposes?

  A. Yes
  B. No
  C. It depends on how long she has had the ostomy.
Genevieve and Tashi

Genevieve has an orthopedic pin. Tashi has a central line. Are these considered surgical wounds for OASIS purposes?

A. Yes, both are considered surgical wounds.
B. No, neither are surgical wounds for OASIS purposes.
C. Genevieve’s is but Tashi’s is not.
D. Tashi’s is but Genevieve’s is not.
Oscar

Oscar had cataract surgery. Is cataract surgery and surgery to the mucous membranes or GYN surgeries via a vaginal approach considered surgical wounds according to OASIS?

• A. Yes
• B. No
• C. From this list, only surgery to the mucous membranes is considered to be a surgical wound when it comes to OASIS.
Taylor

• Taylor has a PICC line. Is a PICC line considered a surgical wound for OASIS purposes?
  • A. Yes
  • B. No
Roderick

- Roderick has a bowel ostomy. Is this considered a surgical wound for OASIS purposes?
  - A. Yes
  - B. No, it never is considered a surgical wound.
  - C. No, unless a “take-down” procedure has been performed and then it is considered a surgical wound for OASIS purposes.
Christian was playing outside and fell into a glass storm window his dad had removed while cleaning windows. He received a severe foot laceration that required the surgeon to do a traumatic laceration repair. Is this considered a surgical wound for OASIS purposes?

A. Yes
B. No
C. It is not a surgical wound if it was sutured. It is a surgical wound if it required surgical repair.
Peggy

Peggy went home from the hospital with a drain to a wound on her hip. Is this considered a surgical wound for OASIS purposes?

A. Yes
B. No
June had a biopsy for an area suspicious for skin cancer. Is this considered a surgical wound for OASIS purposes?

A. Yes, all biopsies for skin cancer are considered a surgical wound for OASIS purposes.

B. No

C. It depends on the technique used to obtain the biopsy specimen.
Spencer had a chest tube site following an accident with his four-wheeler. Is this considered a surgical wound for OASIS purposes?

A. Yes
B. No
C. Only if there is still a tube or drain at the chest tube site.
Skin Lesions, Open Wounds

(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, **that is receiving intervention** by the home health agency?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>-</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Identifies the presence or absence of a skin lesion or open wound **not already addressed** in previous items that are receiving clinical assessment or intervention from the agency.

“Yes” should be selected for burns, diabetic ulcers, abscesses, edema, wounds caused by trauma, PICC and peripheral IV lines, non-bowel ostomies and etc.—if the patient is receiving clinical interventions and it is included in the plan of care.
Skin Lesions, Open Wounds

• Lesions—an area of pathologically altered tissue. All alterations in skin integrity are considered to be lesions.

• There are many types of skin lesions.

• Certain open wounds are not included
  • Bowel ostomies (they are reported in M1630)
  • Wounds resulting from cataract surgery, mucosal membrane surgeries or GYN surgeries by a vaginal approach.
  • Tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by HHA is part of the plan of care.
Break Time
Scenarios
Start of Care Date

For the purpose of answering M0030, Start of Care Date, the assessing clinician must respond with the date the:

a. Initial assessment is completed.
b. Patient signed the consent to treat form.
c. First billable service is delivered.
d. The comprehensive assessment is completed.
Medicare Number

Which of the following statements is TRUE regarding the response for the Medicare number?

a. Only enter the Medicare number if Medicare is the primary payer for the payment episode.

b. If the patient is a member of a Medicare HMO, enter the HMO identification number.

c. If the Medicare number is not known, enter the SSN.

d. Enter the number identified as “claim number on the patient’s Medicare card.

M0063
(M0063) Medicare Number:

______________________

NA – No Medicare

(including suffix)
Mr. Smith was admitted to home care on 5/15 following discharge from Rehab on 5/14 for aftercare of a healing traumatic fracture of his left hip. He has a longstanding diagnosis of dementia and chronic venous insufficiency. The dementia cause the patient to become confused and combative for several days requiring sedation after surgery. He continued to wear his compression stockings after discharge—which is his regular habit. What would be the correct response to Inpatient Diagnosis?

a. Hip fracture
b. Dementia
c. Hip fracture, dementia and chronic venous insufficiency
d. Hip fracture and dementia
Sensory Status

Mr. Fisk

(M1200) Vision (with corrective lenses if the patient usually wears them):
0 - Normal vision: sees adequately in most situations; can see medication
   labels, newsprint.
1 - Partially impaired: cannot see medication labels or newsprint, but can
   see obstacles in path, and the surrounding layout; can count fingers at
   arm’s length.
2 - Severely impaired: cannot locate objects without hearing or touching
   them or patient nonresponsive.

Mr. Fisk greets you at the door and escorts you to the kitchen table. He
steps around a cat sleeping on the rug in the hallway. You ask him to sign the
consent form and he asks you to put your finger near the line so he can “find
it.” After he signs the form his wife hands him a magnifying glass which he
holds about 3 inches from the page and states, “That is much better, let’s
continue.” He is able to sign the remaining forms without difficulty. The
correct response is:

a. 0
b. 1
c. 2
d. Unknown
Ms. Bookman had a Stage II pressure ulcer on her left elbow at SOC, a reported Stage IV pressure ulcer covered with a non-removable dressing on her left buttock. At DC, the Stage IV on the buttock could be observed and a small amount of muscle was visible, the left elbow ulcer was now a Stage IV with bone visible and there was a new Stage II on her left ear. The assessing clinician would complete the Worsening in Pressure Ulcer Status (M1309) as follows:

a. \( a-1, b=1, c=0, d=0 \)
b. \( a=1, b=0, c=1, d=0 \)
c. \( a=1, b=0, c=0, d=1 \)
d. \( A=1, b=0, 2, d=0 \)
Mr. Hunter is suppose to wear his oxygen continuously but refuses to wear it except at night. “The blasted tubing is all over the house. It’s going to make my wife fall and break open her head. I don’t need it anyhow.”

a. The RN assesses for activities that cause Mr. Hunter to become short of breath during the time spent during that home visit only.

b. The RN observes and interviews Mr. Hunter to determine what activities cause shortness of breath when he is not wearing oxygen on the day of the assessment.

c. The RN observes Mr. Hunter while wearing oxygen and interviews him to determine if shortness of breath has occurred while wearing oxygen in the 24 hours preceding the in-home visit.

d. The RN observes Mr. Hunter with and without the oxygen and identifies the activities that cause him to become short of breath.
Myrtle is not safe ambulating with an assistive device, even with supervision of another person at all times. She does not have a wheelchair in the home. What is the appropriate response on M1860?

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- **0** - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- **1** - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- **2** - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- **3** - Able to walk only with the supervision or assistance of another person at all times.
- **4** - Chairfast, unable to ambulate but is able to wheel self independently.
- **5** - Chairfast, unable to ambulate and is unable to wheel self.
- **6** - Bedfast, unable to ambulate or be up in a chair.
Edna

- Edna complains that for over a month, she’s been exhausted all the time, to the point of forgetting to take her medications and eat her prescribed diet. Her weight has been stable at 110 pounds for years but she has lost 5 pounds in the last 3 months. On the day of assessment, she was taking 7 medications. Her caregiver reported the patient has required 4 trips to the hospital’s ER over the last 5 months. Based on this information, how should (M1033) Risk for Hospitalization be answered?

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
3. Multiple hospitalizations (2 or more) in the past 6 months
4. Multiple emergency department visits (2 or more) in the past 6 months
5. Decline in mental, emotional, or behavioral status in the past 3 months
6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
7. Currently taking 5 or more medications
8. Currently reports exhaustion
9. Other risk(s) not listed in 1 - 8
10. None of the above
Break Time
Navigating the CASPER Reporting Application

Home Health Agency (HHA) providers access the CASPER Reporting application via their CMS OASIS System Welcome page by selecting the CASPER Reporting link.
Navigating the CASPER Reporting Application

Login

- Selecting the Online Reports link from the preceding website connects you to the CASPER Login page.
- Enter your login information in the appropriate fields and select the Login button.
- The CASPER Topics (Home) page displays.

The CASPER Topics/Home page includes a list of related topic links in the left navigation pane. Refer to the CASPER Topics section of this guide for more information.
Navigating the CASPER Reporting Application

To begin using the CASPER Reporting application, select one of the buttons on the CASPER toolbar across the top of the CASPER Topics page or a descriptive link in the Home Page pane.

If you select the Reports button [Alt + r] from the toolbar or the Reports link from the Home Page pane, you proceed to the CASPER Reports page where you may request reports. If you select the Folders button [Alt + s] or the Folders link, you proceed to the CASPER Folders page where you may view previously requested report output.
# Overview of OASIS-Derived Reports

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Purpose</strong></td>
<td>Outcome-Based Quality Monitoring (OBQM)</td>
<td>Outcome-Based Quality Improvement (OBQI)</td>
<td>Process-Based Quality Improvement (PBQI)</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Agency-determined; 1st recommended to be annual report; subsequently no more frequently than quarterly.</td>
<td>Agency-determined; suggested annually to allow care process change to have an impact on outcomes.</td>
<td>Agency-determined; suggested quarterly to monitor trends in use of best practices.</td>
</tr>
<tr>
<td><strong>Method of Obtaining</strong></td>
<td>Downloaded from state OASIS server</td>
<td>Downloaded from state OASIS server</td>
<td>Downloaded from state OASIS server</td>
</tr>
<tr>
<td><strong>Accompanying Report(s)</strong></td>
<td>Agency Patient-Related Characteristic Report--for same cases and time period as the Potentially Avoidable Event Report</td>
<td>Agency Patient-Related Characteristic Report--for same cases and time period as the Outcome Report; Patient Talley Report</td>
<td>Patient Tally Report</td>
</tr>
<tr>
<td><strong>Outcomes to Investigate</strong></td>
<td>Adverse event outcomes</td>
<td>1-3 target outcomes for each annual report</td>
<td>1-2 target process measures and those related to target outcomes</td>
</tr>
<tr>
<td><strong>Selecting Outcomes for Review</strong></td>
<td>Prioritize (a) those with most clinical relevance to the agency, (b) those with highest incidence compared to reference group should be investigated first.</td>
<td>Follow criteria for selecting target outcomes.</td>
<td>Select process quality measures that are required under agency policy, related to target outcomes, or relevant to agency goals.</td>
</tr>
<tr>
<td><strong>Time Interval to Review Care Provided</strong></td>
<td>Investigation of the 13 adverse event outcomes can proceed in a phased manner and over several months</td>
<td>Process of care investigation completed within one month of obtaining Outcome Report</td>
<td>Process of care investigation completed within one month of obtaining Outcome Report</td>
</tr>
<tr>
<td><strong>Result of Care Review</strong></td>
<td>Improvement plan if areas for improvement are discovered; sharing of appropriate care examples with staff.</td>
<td>Plan of action developed and implemented to spread best practices cross the agency</td>
<td>Plan of action developed and implemented those of best practices across the agency</td>
</tr>
<tr>
<td><strong>Instructional Material</strong></td>
<td>Available from OASIS web site</td>
<td>Available from OASIS web site</td>
<td>Available from OASIS web site</td>
</tr>
<tr>
<td><strong>Goal of Monitoring</strong></td>
<td>To reduce incidence of adverse events, recognizing they may never get to zero.</td>
<td>To improve those target outcomes selected for remediation (improvement) or to maintain excellent care.</td>
<td>Increase use of evidence-based best practices in care delivery.</td>
</tr>
</tbody>
</table>
Goals vs. Outcomes

• OBQI is premised on a clear and practical definition of outcomes as changes in patient health status between two or more time points.

• Goals are what clinicians establish (with the patient) with the hope and intention to bring the patient to a certain point in terms of health status. Goals or expected outcomes are typically highly individualized or uniquely tailored to a specific patient's plan of care, as they should be.

• According to that definition, patient goals or expected outcomes are not outcomes in OBQI.
Outcome Rates

Outcome rates =

% of patient episodes achieving a specific outcome during episode

All eligible patient episodes
Improvement & Stabilization

• The end-result outcomes are of two types: improvement outcome measures and stabilization outcome measures. It is important to understand the definitions of each type of measure.

• If the patient is less disabled or less dependent at discharge than at start (or resumption) of care, then the patient has improved.

• A patient stabilizes in a specific outcome when the scale value for the health attribute under consideration shows non-worsening in patient condition when the two time points are compared.
All Patients’ Risk Adjusted Outcome Report
# Bathing Example

## Improvement in Bathing

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Percentage of home health episodes of care during which the patient got better at bathing self.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Number of episodes during which the value recorded on the discharge assessment indicates less impairment in bathing at discharge than at start or resumption of care.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of episodes ending with a discharge during the reporting period, minus excluded episodes.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Episodes for which patient, at start or resumption of care, was able to bath self independently, episodes that end with inpatient facility transfer or death or patient is nonresponsive.</td>
</tr>
<tr>
<td>OASIS-C Items Used</td>
<td>(M1830) Bathing (M1700) Cognitive Functioning</td>
</tr>
</tbody>
</table>
## Bathing Example

<table>
<thead>
<tr>
<th>OASIS ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(M1830) Bathing:</strong> Current ability to wash entire body safely. <strong>Excludes grooming (washing face, washing hands, and shampooing hair).</strong></td>
</tr>
<tr>
<td>0 - Able to bathe self in <strong>shower or tub</strong> independently, including getting in and out of tub/shower.</td>
</tr>
<tr>
<td>1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.</td>
</tr>
<tr>
<td>2 - Able to bathe in shower or tub with the intermittent assistance of another person:</td>
</tr>
<tr>
<td>(a) for intermittent supervision or encouragement or reminders, <strong>OR</strong></td>
</tr>
<tr>
<td>(b) to get in and out of the shower or tub, <strong>OR</strong></td>
</tr>
<tr>
<td>(c) for washing difficult to reach areas.</td>
</tr>
<tr>
<td>3 - Able to participate in bathing self in shower or tub, <strong>but requires presence of another person throughout the bath</strong> for assistance or supervision.</td>
</tr>
<tr>
<td>4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.</td>
</tr>
<tr>
<td>5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.</td>
</tr>
<tr>
<td>6 - Unable to participate effectively in bathing and is bathed totally by another person.</td>
</tr>
</tbody>
</table>
Example

**IMPROVEMENT!**
as long as the score selected at DC is numerically less than the score selected at SOC/ROC

**NO IMPROVEMENT!**
If the score selected at DC is numerically higher than the score selected at SOC/ROC

OASIS ITEM

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

- 0. **Unable to bathe self in shower or tub independently, including getting in and out of tub/shower.**
- 1. With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2. **Unable to bathe in shower or tub with the intermittent assistance of another person:**
  - (a) for intermittent supervision or encouragement or reminders, **OR**
  - (b) to get in and out of the shower or tub, **OR**
  - (c) for washing difficult to reach areas
- 3. **Unable to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.**
- 4. **Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode:**
- 5. **Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.**
- 6. **Unable to participate effectively in bathing and is bathed totally by another person.**
## Potentially Avoidable Events

<table>
<thead>
<tr>
<th>Potentially Avoidable Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergent Care</strong></td>
</tr>
<tr>
<td>Emergent Care for Injury Caused by Fall</td>
</tr>
<tr>
<td>Emergent Care for Wound Infections, Deteriorating Wound Status</td>
</tr>
<tr>
<td>Emergent Care for Improper Medication Administration, Medication Side Effects</td>
</tr>
<tr>
<td>Emergent Care for Hypo/Hyperglycemia</td>
</tr>
<tr>
<td><strong>Change in Health Status</strong></td>
</tr>
<tr>
<td>Development of Urinary Tract Infection</td>
</tr>
<tr>
<td>Increase in Number of Pressure Ulcers</td>
</tr>
<tr>
<td>Substantial Decline in 3 or More Activities of Daily Living</td>
</tr>
<tr>
<td>Substantial Decline in Management of Oral Medications</td>
</tr>
<tr>
<td><strong>Discharge</strong></td>
</tr>
<tr>
<td>Discharged to the Community Needing Wound Care or Medication Assistance</td>
</tr>
<tr>
<td>Discharged to the Community Needing Toileting Assistance</td>
</tr>
<tr>
<td>Discharged to the Community with Behavioral Problems</td>
</tr>
<tr>
<td>Discharged to the Community with an Unhealed Stage II Pressure Ulcer</td>
</tr>
</tbody>
</table>
FIGURE 3.1: Sample (Graphical) Potentially Avoidable Event Report.

Agency Name: FAIRCARE HOME HEALTH SERVICES
Agency ID: HHA01
Location: ANYTOWN, USA
CCN: 009001 Branch: All
Medicaid Number: 969988001
Date Report Printed: 03/21/2012

Potentially Avoidable Event Report

<table>
<thead>
<tr>
<th>Elig. Cases</th>
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<th>Current</th>
<th>Adjusted Prior</th>
<th>National Reference</th>
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<td>Emergent Care for Wound Infections, Deteriorating Wound Status</td>
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Number of Cases in Reference Sample: 2325615
## Process Measure Domains

<table>
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<tr>
<th>Domain</th>
<th>Measure Title</th>
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<tr>
<td><strong>Timely Care (1)</strong></td>
<td>Timely Initiation of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
<td><strong>Care Coordination (1)</strong></td>
<td>Physician Notification Guidelines Established</td>
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<tr>
<td><strong>Assessment (4)</strong></td>
<td>Depression Assessment Conducted&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
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<td>Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
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<td>Pain Assessment Conducted&lt;sup&gt;HHC&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Pressure Ulcer Risk Assessment Conducted&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
<td><strong>Care Planning (6)</strong></td>
<td>Depression Interventions in Plan of Care</td>
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<tr>
<td></td>
<td>Diabetic Foot Care and Patient Education in Plan of Care</td>
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<tr>
<td></td>
<td>Pain Interventions in Plan of Care</td>
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<tr>
<td></td>
<td>Falls Prevention Steps in Plan of Care</td>
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<td></td>
<td>Pressure Ulcer Prevention in Plan of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care</td>
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<tr>
<td><strong>Care Plan Implementation (5)</strong></td>
<td>Depression Interventions Implemented during All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<td>Diabetic Foot Care and Patient/Caregiver Education Implemented During All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<td>Heart Failure Symptoms Addressed During All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<td>Pain Interventions Implemented During All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<td>Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented</td>
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<td><strong>Education (2)</strong></td>
<td>Drug Education on High Risk Medications Provided to Patient/Caregiver at Start of Episode</td>
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<td>Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Prevention (10)</strong></td>
<td>Influenza Immunization Received for Current Flu Season&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<tr>
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<td>Influenza Immunization Offered and Refused for Current Flu Season</td>
</tr>
<tr>
<td></td>
<td>Influenza Immunization Contraindicated</td>
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<tr>
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<td>Pneumococcal Polysaccharide Vaccine Ever Received&lt;sup&gt;HHC&lt;/sup&gt;</td>
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<td>Pneumococcal Polysaccharide Vaccine Offered and Refused</td>
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<td></td>
<td>Pneumococcal Polysaccharide Vaccine Contraindicated</td>
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<td></td>
<td>Potential Medication Issues Identified and Timely Physician Contact at Start of Episode</td>
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<tr>
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<td>Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care</td>
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<tr>
<td></td>
<td>Falls Prevention Steps Implemented for All Episodes of Care</td>
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<td></td>
<td>Pressure Ulcer Prevention Implemented During All Episodes of Care&lt;sup&gt;HHC&lt;/sup&gt;</td>
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</tbody>
</table>

<sup>HHC</sup> Publicly reported on Home Health Compare
The Quality Improvement Process

OBQI
The Outcome-based Quality Improvement Process

1. Collect & transmit OASIS data
2. Measure patient outcomes
3. Interpret outcome reports
4. Specify target outcome(s)
5. Investigate care processes
6. Identify problems/strengths and best practices
7. Develop action plan
8. Implement action plan
9. Monitor action plan
Star Ratings

9 Quality measures used to provide a single Star Rating to represent how one HHA compares with the rest of the HHAs

• Improvement in Bathing
• Improvement in Ambulation
• Improvement in Transferring
• Improvement in Dyspnea
• Improvement in Pain interfering w/function
• Acute Care Hospitalization
• Timeliness of Care
• Drug Education on All Meds
• Influenza Immunization
## Star Rating Scorecard

### HHC Star Rating Scorecard

<table>
<thead>
<tr>
<th>Measure Score Cut Points by Initial Decile Rating</th>
<th>Initial Decile Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely initiation of care</td>
<td>1</td>
</tr>
<tr>
<td>Drug education on all medications</td>
<td>2</td>
</tr>
<tr>
<td>Received flu shot for current season</td>
<td>3</td>
</tr>
<tr>
<td>Improved walking or moving around</td>
<td>4</td>
</tr>
<tr>
<td>Improved getting in and out of bed</td>
<td>5</td>
</tr>
<tr>
<td>Improved bathing</td>
<td>6</td>
</tr>
<tr>
<td>Had less pain moving around</td>
<td>7</td>
</tr>
<tr>
<td>Breathing improved</td>
<td>8</td>
</tr>
<tr>
<td>Admitted to hospital</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
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<tr>
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<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Your HHA Score</th>
<th>94.6</th>
<th>95.6</th>
<th>75.6</th>
<th>57.6</th>
<th>51.8</th>
<th>63.5</th>
<th>70.1</th>
<th>57.9</th>
<th>17.3</th>
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<tbody>
<tr>
<td>Your Initial Decile Rating</td>
<td>3.5</td>
<td>2.5</td>
<td>3.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.5</td>
<td>3.5</td>
<td>2.0</td>
<td>1.5</td>
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<tr>
<td>Your Number of Cases (N)</td>
<td>4,919</td>
<td>4,860</td>
<td>2,966</td>
<td>3,397</td>
<td>3,246</td>
<td>3,420</td>
<td>2,309</td>
<td>2,883</td>
<td>1,881</td>
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<tr>
<td>National (All HHA) Median</td>
<td>93.1</td>
<td>96.3</td>
<td>75.5</td>
<td>60.7</td>
<td>56.2</td>
<td>66.4</td>
<td>67.6</td>
<td>64.8</td>
<td>15.9</td>
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<tr>
<td>Your Statistical Test Probability Value (p-value)</td>
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<td>0.264</td>
<td>0.397</td>
<td>0.080</td>
<td>0.000</td>
<td>0.000</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Your HHA Adjusted Rating</td>
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<td>2.5</td>
<td>2.0</td>
<td>2.5</td>
<td>3.0</td>
<td>2.0</td>
<td>1.5</td>
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</table>

| Your Average Adjusted Rating | 2.5 |
| Your Average Adjusted Rating Rounded | 2.5 |

### Your Overall Star Rating (1.0 to 5.0) | ★★★ (3.0 stars)
Details

• HHC Star Ratings are updated quarterly

• To receive an HHC Star Rating, agencies must have sufficient quality episodes for at least 5 of the 9 measures in the calculation.

• Currently, HHAs must have at least 20 complete quality episodes for data on a measure to be reported on HHC.

• HHAs that are new (< 6 months old) will also not have star ratings displayed.
Star Rating Report (Not enough data)

<table>
<thead>
<tr>
<th>Initial Decile Rating</th>
<th>Timely Initiation of Care</th>
<th>Drug Education on All Medications</th>
<th>Received Flu Shot for Current Season</th>
<th>Improved Walking or Moving Around</th>
<th>Improved Getting in and out of Bed</th>
<th>Improved Bathing</th>
<th>Had Less Pain Moving Around</th>
<th>Breathing Improved</th>
<th>Admitted to Hospital</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>0.0-79.6</td>
<td>0.0-79.7</td>
<td>0.0-44.0</td>
<td>0.0-43.3</td>
<td>0.0-34.9</td>
<td>0.0-45.7</td>
<td>0.0-43.7</td>
<td>0.0-33.0</td>
<td>20.1-100.0</td>
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<td>3</td>
<td>79.7-85.4</td>
<td>79.8-87.7</td>
<td>44.1-58.1</td>
<td>43.4-50.0</td>
<td>35.0-42.8</td>
<td>45.8-54.5</td>
<td>43.8-53.7</td>
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<td>4</td>
<td>85.5-88.8</td>
<td>87.8-91.6</td>
<td>58.2-86.1</td>
<td>50.1-54.6</td>
<td>42.9-48.1</td>
<td>54.6-59.5</td>
<td>53.8-59.2</td>
<td>46.2-54.3</td>
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<td>5</td>
<td>88.9-91.0</td>
<td>91.7-94.0</td>
<td>66.2-71.3</td>
<td>54.7-57.8</td>
<td>48.2-52.3</td>
<td>59.6-63.2</td>
<td>59.3-63.0</td>
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<td>94.1-95.7</td>
<td>71.4-75.4</td>
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<td>52.4-55.4</td>
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<td>60.0-64.1</td>
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<td>75.5-79.0</td>
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<td>61.7-65.2</td>
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<td>71.2-75.0</td>
<td>11.9-13.3</td>
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<td>86.6-92.2</td>
<td>68.8-74.0</td>
<td>65.3-70.9</td>
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<td>78.8-86.7</td>
<td>75.1-80.3</td>
<td>10.0-11.8</td>
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<td>92.3-100.0</td>
<td>74.1-100.0</td>
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<td>80.8-100.0</td>
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<td>80.4-100.0</td>
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<td>75.4</td>
<td>60.4</td>
<td>55.5</td>
<td>66.3</td>
<td>66.5</td>
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<td>Your Average Adjusted Rating Rounded</td>
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<td>21</td>
<td>Your Overall Star Rating (1.0 to 5.0)</td>
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<td>Data Not Available</td>
<td>Data Not Available</td>
<td>Data Not Available</td>
<td>Data Not Available</td>
<td>Data Not Available</td>
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</tr>
</tbody>
</table>
Resources

• Further reading and FAQs:
  

• Questions or comments about HHC star ratings – send email to: HHC_Star_Ratings_Helpdesk@cms.hhs.gov

• Home Health Compare:
  
  [http://www.medicare.gov/homehealthcompare](http://www.medicare.gov/homehealthcompare)
Resources

• PBQI Manual

• OBQI Manual

• OBQM Manual

• User friendly, concise tables with a complete description of OASIS-based quality measures for home health agencies

• Technical documentation of process quality
TECHNICAL DOCUMENTATION OF Outcome, Process Measures, Potentially Avoidable Events


Risk Adjustment Technical Documentation


Casper Reporting System

Wrap Up

- Turn in iClickers
- Evaluations
- Certificates
- Drive Carefully
Thank you!

• Nelleda L. Faria, RN, BSN, MBA, PMP, CPHRM
• Health Facility Surveyor- Risk Manager/ OASIS Education Coordinator
• KDHE/BCHS/Health Facilities Program
• 1000 SW Jackson St., Suite 330
• Topeka, KS. 66612-1365
• Ph: 785-296-4714
• Fax: 785-559-4250
• Nelleda.faria@ks.gov