Basic Training: Home Health Edition

OASIS and Outcomes

April 2, 2013

Presented by:
Rhonda Will, RN, BS, COS-C, BCHH-C,
Assistant Director of the Competency Institute,
Fazzi Associates, Inc.

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Instructions and Handouts for:
Basic Training: Home Health Edition
OASIS and Outcomes
April 2, 2013 1:00pm - 2:15pm EST

It is very important that you have these materials printed and ready to use prior to the start of the training.

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2. When prompted, enter Conference ID Passcode: 291-509-770
3. You can also participate using your microphone and speakers. To do so select “Mic & Speakers” in the control panel. Please ensure your speaker volume is turned on.
4. To view the presentation online, you must click on the link sent to you from GoToWebinar.

* Note: Please do not forward your own webinar login information as each one is email specific. Once you are logged in to the webinar anyone else that tries to use your information will not be allowed in.
Objective for this session

1. Identify the process, components and outcomes of OASIS data collection.

Presenter Bio

Rhonda Will, RN, BS, COS-C, HCS-D is the Assistant Director of the OASIS Competency Institute for Fazzi Associates, Inc. She is responsible for developing and overseeing Fazzi’s OASIS competency products and services focused on the comprehensive OASIS assessment. She has thirty-eight years of experience as a registered nurse and has extensive experience in staff development and training. Her areas of expertise include care planning, care management, patient outcomes, process measures and basic ICD-9-CM coding. Rhonda has acted as the Co-Director of the National OASIS Integrity Project 2004, clinical director of the National OASIS-C Best Practices Project 2009, and a facilitator at the Delta National Excellence in Therapy Forum September 2010.

Directions on how to Receive Contact Hours

This continuing nursing education activity was approved for 1.25 Contact Hours.

Fazzi Associates is an approved provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

1. Each participant must complete an electronic evaluation in order to receive contact hours.

2. Click on the following link in order to access the online evaluation form:
   https://www.research.net/s/FXNSKCC
ORIENTATION SERIES

OASIS & OUTCOMES

Rhonda Will, RN, BS, COS-C, BCHH-C
Assistant Director of the Competency Institute
Fazzi Associates, Inc.

PRESENTED BY:

Rhonda Marie Will, RN, BS, COS-C, BCHH-C
Assistant Director OASIS Competency Institute
Fazzi Associates, Inc.

DISCLOSURES

Successful Completion of Education Activity
• Listen to entire program
• Complete evaluation

Disclosures
• No conflict of interest for presenters & planners
• No commercial company support
• No noncommercial company support
• No endorsement of any products, services, or company
Objective: Identify the process, components and outcomes of OASIS data collection.

HISTORY
Outcome ASessment Information Set

- Research and demonstration program—20+ years
- CMS with additional funding from Robert Wood Johnson Foundation and the New York State Department of Health
- 1999 Data collection began
  - Group of standard performance data elements
  - Comparative measurement of patient outcomes at two points in time
  - Agencies to assess and improve quality of care provided to the patient
- 2003 Home Health Compare

2010 OASIS-C
- Address issues of provider community
- Measure rates for use of specific evidence based care processes
  - Promote use of best practice
- Align measures with other instruments being developed to measure care across post acute care settings
  - Endorsement of measures by the National Quality Forum
- OASIS Alert! Prepare for October 2014 OASIS-C1 with ICD-10 implementation.
**HOME HEALTH CARE**

**Assessment With OASIS**

**Plan of Care**

**Care Coordination**

**Home Environment**

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**INITIAL ASSESSMENT VISIT COP 484.55**

- Conducted by RN at SOC when nursing and therapy services ordered; therapist when therapy only.
- Within 48 hrs. of referral, return home by patient or Doctor ordered Start of Care (SOC).
- Determine immediate care and support needs; if Medicare, to determine eligibility including homebound status.
- Separate purpose but often combined with the SOC visit/assessment.

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**COMPREHENSIVE ASSESSMENT COP 484.55**

- Patient specific.
- Reflects current health status.
- Includes information that may be used to demonstrate patient progress towards desired outcomes.
- Identifies continuing need for home care and
- Meet medical, nursing, rehabilitative, social and discharge planning needs.
- For Medicare: Verifies eligibility for home health benefit including homebound status.
<table>
<thead>
<tr>
<th><strong>COMPREHENSIVE ASSESSMENT COP 484.55</strong></th>
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<tbody>
<tr>
<td>• Required for all patients serviced by a Medicare certified Home Health Agency.</td>
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<tr>
<td><strong>In addition</strong></td>
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<tr>
<td>• Incorporates Outcome and Assessment Information Set (OASIS) items for:</td>
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<tr>
<td>– All skilled Medicare and Medicaid fee for service patients</td>
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<td>– All skilled Medicare and Medicaid managed care patients</td>
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<td>– Except patients:</td>
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<tr>
<td>• under the age of 18</td>
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<td>• receiving maternity services</td>
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<td>• receiving only chore or housekeeping services</td>
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<tr>
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<tr>
<td>• Completed by the RN at SOC or</td>
</tr>
<tr>
<td>– Physical Therapist, SLP if skilled nursing not ordered by the physician and</td>
</tr>
<tr>
<td>• Allowed by State Regulations/State Practice Act</td>
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<tr>
<td>– Occupational Therapy may conduct if meets other Non Medicare/Medicaid payer requirements.</td>
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<td>• Any discipline may do subsequent comprehensive assessments.</td>
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<tr>
<th><strong>COMPREHENSIVE ASSESSMENT COP 484.55</strong></th>
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<tr>
<td>• Includes drug regimen review to identify:</td>
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<tr>
<td>– Any potential adverse effects and drug reactions</td>
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<td>– Ineffective drug therapy</td>
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<td>– Significant side effects</td>
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<tr>
<td>– Significant drug interactions</td>
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<tr>
<td>– Duplicate drug therapy</td>
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<tr>
<td>– Noncompliance with drug therapy</td>
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COMPREHENSIVE ASSESSMENT

• Updated (including OASIS data) as frequently as the patient’s condition warrants due to a major decline or improvement in patient health status.

• Not less frequently than:
  – The last 5 days of every 60 day episode
  – Beneficiary elected transfer
  – Significant change in condition
  – Discharge and return to the same HHA during the 60 day period
  – Within 48 hours of the patient return home from a hospital admission of 24 hrs. or more for any reason other than diagnostic tests
  – Discharge

ASSESSMENT DOMAINS

• Patient history
• Physiologic
• Functional
• Psychosocial
  – Cognitive, behavioral, emotional
  – Living arrangements
  – Supportive assistance
• Medications
• Environment and equipment management
• Emergent care and hospitalizations
• Discipline specific items

OASIS DATA ITEMS

• 114 data items
• Different items collected at various time points
• 25 items specific to payment
  – Episode and non routine supplies
• 61 items specific to calculate quality measures
• 78 items relate to patient outcomes through risk factor adjustment
OASIS TIME POINTS

Data Items Collected at Specified Time Points
- Start of Care (SOC)
- Recertification (Recert)
- Transfer to Inpatient Facility (TRN, TIF)
- Significant Change in Condition (SCIC)
- Resumption of Care (ROC)
- Discharge (D/C)

DATA COLLECTION STRATEGIES

- Direct observation
- Interview of patient and caregivers
- Review clinical data from physician and previous providers
- Review of care notes

THE OASIS WALK®

Watch
Assess
Listen
Know
ABILITY: THE OASIS WALK® IN PACES

Physical condition
Activities permitted
Cognitive condition, mental and emotional status
Environment and availability of Equipment
Sensory condition

The level of ability at which a functional activity is performed safely on the day of assessment is a clinical judgment.

IMPACT OF OASIS DATA

OASIS

Plan of Care
Payment
Quality and Value
Care Coordination

Shaping the Future

VALUE BASED PURCHASING

• Quality management
• Improve patient care practices
• Transparency via Home Health Compare
• Patient impressions of home health care
• Used in survey and certification process
OBQI AND OBQM

• OBQI Outcome Reports
  – 37 risk adjusted outcome measures
  – End result and utilization measures

• Agency Patient-Related Characteristics Report
  – Patient attributes or circumstances at SOC/ROC likely to impact health status
  – Discharge info such as LOS, ACH and ER visits

• Patient Tally Report
  – Descriptive information for individual cases used to select cases for review

OBQI AND OBQM

• Potentially Avoidable Events (PAE) Report
  – Incident rates for 12 infrequently occurring untoward events
  – Reflect a serious health problem or health status that could have been potentially avoided
    • Unmet needs?
    • Inadequate provision of care?

• Process Based Quality Improvement
  – 47 measures that report specific processes/practices that promote good patient outcomes

QUALITY EPISODES

<table>
<thead>
<tr>
<th>OASIS-C Quality Episodes</th>
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<tbody>
<tr>
<td>SOC/ROC</td>
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<tr>
<td>SOC</td>
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Report what happened at the time of or during the quality episode of care
**HEALTH STATUS CHANGES**

- Improvement
- Stabilization
- Decline

**END RESULT: IMPROVEMENT IN FUNCTION**

- Grooming
- Dressing: Upper and Lower Body
- Bathing
- Toilet Transferring
- Toileting Hygiene
- Bed Transferring
- Ambulation-Locomotion
- Eating
- Light Meal Preparation
- Phone Use
- Management of Oral Medications

**END RESULT: IMPROVEMENT IN HEALTH**

- Dyspnea
- Pain Interfering with Activity
- Speech and Language
- Status of Surgical Wound
- UTI
- Urinary Incontinence
- Bowel Incontinence
- Frequency of Confusion
- Anxiety Level
- Frequency of Behavior Problems
END RESULT: STABILIZATION IN FUNCTION

- Grooming
- Bathing
- Toilet Transferring
- Toileting Hygiene
- Bed Transferring
- Light Meal Preparation
- Phone Use
- Management of Oral Medications

END RESULT: STABILIZATION IN HEALTH

- Speech and Language
- Cognitive Functioning
- Anxiety Level

UTILIZATION OUTCOMES

- Received Emergency Care
- Acute Care Hospitalization
- Discharged to the Community
**RISK ADJUSTMENT**

- Allows for a fair comparison
- Risk factors come from OASIS
  - Health status characteristics and other attributes from SOC
- Outcome measures and potentially avoidable events are risk adjusted
- Process measures are not risk adjusted

**RISK FACTORS**

320 Risk Factors
- Range 4-118 per outcome measure
  - 118 - Improvement in lower body dressing
  - 110 - Improvement in light meal prep
  - 99 - Acute care hospitalization
  - 83 - Emergency room with hospitalization
  - 4 - Increase in # pressure ulcers when unstageable or Stage II present at SOC/ROC

**POTENTIALLY AVOIDABLE EVENTS**

- Emergent care for:
  - Injury caused by fall
  - Wound infections, deteriorating wound status
  - Improper medication administration, medication side effects
  - Hypo/hyperglycemia
- Development of UTI
- Increase in the number of pressure ulcers
### POTENTIALLY AVOIDABLE EVENTS

- Substantial decline in:
  - 3 or more activities of daily living
  - Management of oral medications

- Discharged to the community:
  - Needing wound care or medication assistance
  - Needing toileting assistance
  - With behavioral problems
  - With an unhealed stage II pressure ulcer

### PROCESS MEASURES

- **Timely care**
- **Care Coordination**
- **Assessment**
  - Depression
  - Multifactor Falls Risk
  - Pain
  - Pressure ulcer risk

- **Care Planning in the POC**
  - Depression interventions
  - Diabetic Foot Care and Patient education
  - Falls prevention
  - Pain interventions
  - Pressure ulcer prevention
  - Pressure ulcer treatment

- **Care Plan Implementation**
  - Short term, long term and all episodes
  - Depression interventions
  - Diabetic Foot care and Patient/Caregiver education
  - Heart failure symptoms addressed
  - Pain interventions
  - Treatment of pressure ulcers based on moist wound healing principles
**PROCESS MEASURES**

**Education**
- High Risk medications
  - at start of episode
- Drug education on all medications to patient/caregiver
  - Short term, long term, and all episodes

**PROCESS MEASURES**

**Prevention**
- Falls prevention steps implemented
  - Short term long term and all episodes
- Influenza Immunization received for current flu season
  - Offered and refused
  - Contraindicated
- Pneumococcal Polysaccharide vaccine ever received
  - Offered and refused
  - Contraindicated

**PROCESS MEASURES**

- Prevention
  - Potential Medication issues identified and timely physician contact at start of episode
    - During short term, long term and all episodes
  - Pressure Ulcer prevention implemented
    - Short term, long term and all episodes
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HHCAHPS®)

Patient experience of home health care
- 34 items, adjusted for populations
- Care of Patients
- Communication between providers and patients
- Specific Care Issues
- Rating of the home health care 0-10
- Would you recommend this home health agency?

HOME HEALTH COMPARE

<table>
<thead>
<tr>
<th>Outcome of Care Measure</th>
<th>Process of Care Measure</th>
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<tr>
<th>Your Agency</th>
<th>State</th>
<th>National Average</th>
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Managing Daily Activities
- Improvement in ambulation
- Improvement in bed transfer
- Improvement in bathing

Managing Pain and Treating Symptoms
- Pain assessment conducted
- Pain interventions implemented
- Improvement in pain interference with activity
- Heart failure symptoms addressed
- Improvement in dizziness

Preventing Harm
- Timely initiation of care
- Drug education on all medications provided to patient/caregiver
- Multifactor fall risk assessment conducted
- Depression assessment conducted
- Pressure ulcer prevention implemented per protocol
- Pneumococcal polysaccharide vaccine ever received
- Diabetic foot care and education implemented
- Improvement in management of oral medications
- Depression assessment conducted
- Pressure ulcer prevention included in the plan of care
- Pressure ulcer risk assessment completed
- Improvement in status of surgical wound

Treating Wounds and Preventing Pressure Sores
- Pressure ulcer prevention implemented
- Pressure ulcer prevention included in the plan of care
- Pressure ulcer risk assessment completed

Preventing Unplanned Hospital Care
HHCAHPS Results

<table>
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<tr>
<th>HHCAHPS Measures</th>
<th>Year Agency</th>
<th>State</th>
<th>National Average</th>
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<tbody>
<tr>
<td>Care of patients</td>
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<td>Communications between providers and patients</td>
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<tr>
<td>Specific care issues</td>
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<tr>
<td>Overall rating of care given by HHA care providers</td>
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<tr>
<td>Patient willingness to recommend HHA to family and friends</td>
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PONDER THESE

- Is your quality data intentional or accidental?
  - Based on accurate OASIS data or a hurried assessment?
  - Based on care interventions?
  - Grounded in interdisciplinary communication and coordination?
- How does clinical practice include outcome and overall quality management?

RESOURCES

- Home Health Agency Conditions of Participation (COP)

- Home Health Compare: About the Data
  http://www.medicare.gov/homehealthcompare/(X(1)Si(rgyoztigprfS553nsf5n4))/Search.aspx

- Home Health Quality Initiative

- Home Health Care CAHPS Survey
  https://homehealthcahps.org/