Clinician Conference

CoPs, Documentation, Star Rating

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Objectives

- State a requirement in the 2018 Conditions of Participation for patient rights, care planning and care coordination
- Describe one strategy to implement care coordination and include patients/families in care planning, goal setting and discharge planning
- Identify three documentation requirements for CMS eligibility and payment
- State a best practice to improve one HH Quality of Care Star rating measure

Conditions of Participation

Patient Rights, Comprehensive Assessment, Care Planning, and Coordination of Care

Patient Rights

- Notice of rights and responsibilities to patient and representative: verbal and written, preferred language in an easily understood way, during initial eval visit, in advance of providing care (patient signature confirms receipt of written copy)
- Copy of OASIS Privacy notice (if OASIS data collected)
- Provide language assistance if needed
- Provide business contact info for administrator
- To be treated with respect, free from injury/abuse
- To make complaints, no reprisal/discrimination

Patient Rights

- Receive information: toll-free home health hotline (phone number, operating hours); list of federal, state and local organizations (name, address, phone) that provide consumer info/services/protection relevant to needs of agency population; agency policies on admission, transfer and discharge.
- Information provided to patients must be in plain language, and in a manner that is both accessible and timely to the individual (considering disability or LEP)

Patient Rights

- Patient and/or their representative has the right to participate in, be informed about, and to consent or refuse care; includes participation in assessment of needs, setting patient goals, and care preferences
- Patient has the right to receive a copy of his individualized HHA plan of care to be kept in his home, including all updated plans of care. HHA must inform patient of any changes in care prior to those changes being made in POC

Exercise of Rights

- In the event a patient is declared incompetent by state Court, the rights of that patient could be exercised by the person appointed by the state Court
- There are many circumstances where patients may be partially or fully unable to participate in their care decisions; agencies must allow patient's to participate to the degree they are able and interested in doing so, and ensure patient choice is respected while patient safety is assured

Comprehensive Assessment

- Identify patient's continuing need for home care and eligibility for the home health benefit
- Identify patient's medical, nursing, rehabilitative, social and discharge planning needs
- Measure patient's progress toward outcomes and goals of the plan of care
- OASIS data must accurately reflect patient's status at the time the information is collected

Individualized Plan of Care

- Agency accepts patients with a reasonable expectation that needs can be met in the patient's residence
- Agency develops an individualized POC to address needs identified by the patient assessment
- Agency gives patient and representative a written copy of the POC (components under 484.60(e)
  - Medication name, dose, frequency, instructions
  - Disciplines and visit schedule (frequency)
  - Treatments to be administered by agency, including therapy
  - Any other pertinent instructions related to care/treatment (i.e. goals for home care)
  - Name and contact information of the HHA clinical manager

Patient Participation

- POC must include patient-specific measurable outcomes
- Patient has the right to participate in choosing goals and outcomes for care
- HHA must involve the patient, representative, and caregivers in planning and coordinating care activities
  - Agency's responsibility to support and foster collaboration and communication among disciplines caring for patient
- HHA must ensure patient and caregiver receive ongoing training and education from the HHA on the care and services they are expected to implement…including education about post-discharge care duties and appropriate follow up with the patient's PCP after discharge from the agency's care

Requirement for Hospitalization Risk Assessment and POC

- HHA must include an assessment of the patient's level of risk for Emergency Department visits and hospital re-admission
  - Must be patient's *specific* risk factors
  - No specific tool or process defined for use – because there is no one-size-fits-all!
- Plan of Care must include all necessary interventions to address and mitigate the underlying risk factors identified on assessment

Required Components of the POC

- *ALL* pertinent diagnoses and conditions
- Mental, psychosocial and cognitive status
- Types of services, supplies, equipment required
- Frequency and duration of visits
- Prognosis, rehab potential
- Functional limitations, activities permitted
- Nutritional requirements
- All medications and treatment
- Safety precautions to prevent injury
- All patient care orders, including verbal orders, must be recorded in the Plan of Care

Required Components of the POC

- *Description of patient's risk for ED visits and hospital readmission and all necessary interventions to address the underlying risk factors*
- *Patient/caregiver education and training to facilitate timely discharge*
- Patient specific measurable outcomes and goals identified by the HHA *and the patient*
- *Information related to any advanced directives*
- *Consider social determinants that may contribute to poor health outcomes*
- *Assess and address factors that may create a barrier to good outcomes*
- *Coordination with community resources*

Coordination of Care

- HHA must integrate services, whether provided directly or under arrangement, to assure:
  - Identification of patient needs and factors that could affect patient's safety and treatment effectiveness
  - Involvement of the patient, representative (if any), and caregivers in the coordination of care activities
  - The coordination of care provided by *all disciplines*
  - Communication with the physician
  - Each patient and caregiver receives any training necessary for a timely discharge from the HHA
  - Integration of orders, keep all physicians involved in the POC informed relevant to their participation in care of the patient

Strategies to Insure Patient Rights: Written Forms

- Patient Rights information
  - All listed rights, availability of language assistance or aids
  - Must have signatures
  - HHA administrator contact info
  - State home health hotline info
  - Alternate languages r/t HHA's patient population
- Notice of OASIS privacy rights
- ABN and NOMNC forms
- Updated list of federal, state and local resources and organizations
- Copy of agency policy and criteria for admission, transfer and discharge

Informed Refusal of Care

- Applies to:
  - Refusal of admission to HHA
  - Refusal of needed/ordered disciplines
  - Refusal of services before goals met
- Two part process:
  - Provide and explain info to patient
  - Obtain patient signature to validate agreement and understanding (best practice)
- "Patients don't know what they don't know"

Informed Refusal of Care

- Provide information on services ordered or recommended by physician
- Educate patient/family on benefits of treatment, risks of not treating
- Provide opportunity for questions and discussion of options
- Review circumstances of refusal of care
- If a patient, patient representative or family member validly refuses treatment, it is not abuse or neglect if HHA does not provide that care
- HHA must inform ordering physician of patient refusal and circumstances

Shared Decision-Making Model

A mutually respectful exchange that recognizes the individuality of the patient, and a process in which responsibility is divided among the patient, physician and agency

Care Planning/Coordination Strategies:

- Assessment of patient status? ACH risk factors?
- Focus of care?
- Other problems to address?
- Goals?
- Disciplines needed? Frequency?
- Interventions? Addressing ACH risk?
- Outcome measures?
- Anticipated final outcome for episode?

Comprehensive Assessment

- Physical assessment, focus on pertinent diagnoses for POC
- Knowledge of disease processes and management
- Cognitive status, ability to learn
- Patient activation and engagement
- Support system, family/caregiver involvement, available resources for care
- Discharge plan for patient, with family input

Assessment: OASIS Key Points for Care Planning

- Primary, Other Secondary Diagnoses – M1021, M1023
- Therapies – M1030
- Risk of Hospitalization – M1033
- Risk factors – M1036
- Patient Living Situation – M1100
- Vision, hearing, speech – M1200-M1230
- Pain, functional impact – M1240, M1242
- Integumentary Status – M1300-M1342

Assessment: OASIS Key Points (con't)

- Shortness of breath – M1400
- Respiratory treatments – M1410
- Presence of UTI – M1600
- Urinary and bowel incontinence – M1610-M1620
- Presence of bowel ostomy – M1630
- Cognition, confusion, anxiety, depression, psych and behavioral symptoms – M1700-M1750
- ADL ability/performance – M1800-M1860

Assessment: OASIS Key Points (con't)

- IADL ability/performance – M1870-1890
- Prior functioning ADL/IADL – M1900
- Fall risk – M1910
- Drug regimen review, issues – M2001
- Medication administration – M2020-M2030
- Prior med management – M2040
- Types and sources of assistance – M2102
- Therapy Need – M2200
- Plan of Care Synopsis – M2250

Identify risks for ACH and ED use

(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

What drives *your agency's* ACH and ED use?

- Review agency patients that had a hospitalization or Emergency Dept. visit –
  - Why did the patient go to ED or hospital?
  - What happened at the last visit before that event?
  - Did you contact the physician? Response?
  - Did you follow up? Coordinate with all staff?
  - Did the pt/cg call the office before going to ED?
  - Compliance with plan of care?
- *How accurate is your assessment tool identifying patients that are REALLY at high risk?*
- *What are your readmission drivers?*

Common re-admission drivers – considerations for care planning

- Diagnoses: HF, COPD, Pneumonia, GI, psych, other?
- Medications in home? Able to administer?
- Timely PCP follow up appointment?
- Patient/family knowledge of s/sx to report?
- Fall risk factors addressed?
- Use of front-loading, telehealth, telephone calls?
- Education, coaching, validation of understanding?
- Community support services?

Assessment: Other Key Points

- Other Pertinent Diagnoses (up to 25 total)
- Vaccination status
- Pain: frequency, triggers, pain meds/interventions
- Trauma wounds, diabetic ulcers, etc.
- Risk factors for falls
- Medication list, knowledge of all meds
- Current family/caregiver/community resources, unmet needs in specific areas

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

Goal Setting

- Patient's goal(s) for home care
- Agency goals for treatment
- Measurable outcomes to achieve
- Physician input related to goals
- Are goals reasonable and able to be achieved by patient, family, and caregiver(s)?
  - Key point in payment!

Goal Setting

- Does the patient have to identify ALL the goals for the POC?
- Who else sets goals?
- Does the physician have to approve the goals on the POC?
- How do we show patient helped set goals and outcomes for care?

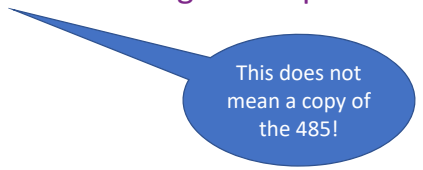
Goal Setting List

Measurable Outcomes

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

Care Planning

- Patient has the right to accept or refuse disciplines and/or treatment
- Each discipline should document discussion of their interventions and goals with patient and caregivers
  - Include patient and caregiver/family goals
  - Consider Goal Setting List
- Individualized written Plan of Care given to patient



Plan of Care Components to reduce ACH

- Orders and Interventions
  - Order for parameters for physician notification
  - Consider front-loading visits for patients at risk for hospitalization
  - Implement telehealth if available and appropriate
  - Order to assess patient's response to medications, monitor effectiveness, instruct on medication regimen
  - Request PRN orders for likely complications
  - Implement disease-specific protocols to address current diagnoses

Plan of Care Components

- Goals
  - Patient and/or caregiver(s) will be able to state steps in disease management for …
  - Patient will be knowledgeable of medication regimen and demonstrate ability to take as ordered
  - Patient will follow up with ordered medical care
  - Reasonable expectation goals achievable?

Interventions

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

Medication Interventions

- Review medication list in home
  - Current and up-to-date? Matches med record?
  - If Dr. appointment or ER visit, any changes?
  - If changes, confirm with Dr. and write order (P&P)
- Evaluate compliance with med regimen
  - Check med planner, bottles, refills ordered/due
  - Can patient demo/state administration?
  - Check for barriers to med compliance
  - Assess need for compliance aids

Medication Interventions

- Assess med knowledge, educate as needed
  - Identify initial knowledge, document knowledge deficit if present, watch OASIS responses!
  - After education, use teach-back to assess understanding of purpose, dose, schedule, how to take medications, side effects, etc.
  - Instruct who to call for problems or med issues
  - Continue to assess recall of medication regimen
- Assess for s/sx adverse effects or interactions

Educational Interventions

- Education based on knowledge deficits identified by assessment, pt/cg goal setting
- Education on:
  - Disease process
  - Medications, side effects
    - Use of inhaler, oxygen, tapering steroids
  - Dietary guidelines and fluid recommendations
  - Activity guidelines, energy conservation, home safety
  - Monitoring related to disease process
  - S/sx of complications to report

Care Planning is Critical!

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

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

Coordination of Care

- Communication with physician
- Communication between different clinicians visiting patient
- Communication among disciplines
- Communication w/pt, cg, family

Physician Coordination

- SOC: patient status, medication reconciliation, approval of POC (including interventions in M2250)
- Recertification: reason for continuation, order changes, approval of POC
- ANY changes in patient condition or adverse s/sx, complications
- ALL missed visits by all disciplines
- Progress updates on wounds
- Goals: progress, revisions to POC
- At transitions: DC plan, office visits, ED and inpatient admissions

Interdisciplinary Coordination

RN, LVN, PT, PTA, OT, COTA, SLP, HHAide, MSW

- SOC (within 5 days)
- ROC (within 2 days)
- Prior to recertification
- Discontinuation of a discipline
- Prior to discharge
- Any problems, complications, s/sx of exacerbations or adverse events

SOC Coordination Points

- Primary diagnosis, focus of care
- Top 5 other diagnoses
- Problem issues
  - Pain, meds, wound care, fall risk
- Patient coping, understanding, motivation
  - Patient's goals for home care services
- Support / caregiving situation, emergency plan
- Risk for hospitalization, interventions to address
- Coordination to meet problem issues
- Homebound status and medical necessity

ROC Coordination Points

- Reason for hospitalization
- Interventions to reduce re-hospitalization risk
  - Changes needed to prevent repeat
- Primary and other diagnoses, new diagnoses
- Problem issues
- Support situation and patient coping, etc.
- Revisions to plan of care and goals
  - Focus and responsibilities of each discipline
- Homebound status, medical necessity

Recertification Coordination Points

- Verify Homebound status
- Evaluate progress toward goals on POC
- Review scores on SOC/ROC OASIS items for outcome measures, evaluate current scores
- Determine if outcome improvement possible and interventions needed to achieve
- Medically necessary skilled care
- Revise goals and plan of care if indicated
- Identify specific responsibilities for each discipline to prepare pt/cg for discharge, evaluate if achievable within this cert period
- Decide if recert or discharge

Discharge of Discipline Coordination Points

- Goals for discipline achieved
- Identify any unachieved goals, reasons
- Review specific improvement on OASIS items related to outcome measures
- Identify any other changes in plan of care as a result of discipline discharge
  - Plan for PT/INR, dc home health aide, etc.

Discharge Coordination Points

- Review goals on POC, evaluate if achieved
- Review scores on OASIS items, assess if improvement achieved on outcomes
- Identify if teaching done, understanding level:
  - All medications
  - Diabetes and foot care if DM diagnosis
  - Pain management
  - Prevention of falls, pressure ulcers
- Assess readiness for discharge and follow up, link to community resources

Patient/Family Coordination

- Identification of significant players, defining “caregivers” requiring coordination role
- Determining areas of coordination, align goals
- Patient performance, caregiver assist needed
- Focus on training and education
- Prepare for transitions and discharge

Patient/Family Education Process

- Identification of education needs (knowledge deficits)
  - Knowledge assessment of patient, caregiver
  - Identify learners and learning styles
- Setting educational goals
- Identify information to be taught
- Provide teaching using appropriate educational resources and materials
- Assess recall, understanding and ability to apply information taught; teach-back, return demo
- Re-educate as needed, or revise goals
- Include education on healthcare follow up post discharge
  - PCP appointments, med refills, labwork, s/sx to report, who to call for problems
- Document everything!

Care Planning and Coordination Expectations

- Comprehensive assessment, identify problems, patient preferences for care, strengths/weaknesses
- Coordinate care between disciplines, and with other services in community
- Communicate with patient, caregivers, nurses, therapists, aide, physician and other providers
- Assess, identify and solve problems
- Evaluate progress toward goals, outcome improvement
- Organization, prioritization, time management
- Meeting regulatory requirements
- Reimbursement impact
- Patient advocacy

CoPs cut to the chase…

- Develop an interdisciplinary team working together towards collaborative goals and coordinating patient care in a proactive manner
- *So…identify the problems that are most important to the patient's health and safety, then establish and implement a plan of care to address and resolve those problems to the satisfaction of the patient, caregiver/family, and physician.*
- *Ultimate goal: patient able to manage self care*

So let's put it all together…

Step 1: Intake

- Accurate intake data collection
  - Who takes referral?
  - What information is obtained?
    - H&P, med list, family/rep contact info, POA, referring physician, F2F documentation, contact info for certifying physician
  - Identify primary language, arrange interpreter if needed
  - How are orders and info transferred to POC?
- Availability of intake data to clinicians
- Correction of any errors on intake information
- Verify with physician if needed
- Schedule initial visit within 48 hours

Step 2: Admission Visit

- Initial assessment for eligibility, appropriate for HH
- Notice of Patient Rights, consent signed, written copies
- Comprehensive assessment, OASIS data collection, med reconciliation and DRR, caregiver situation, request advance directives, ED/ACH risk assessment, EPP info
- Identify *patient's* problems, expectations, goals, need for services/community resources, knowledge deficits
- Communicate with physician, verify any diagnoses or interventions, discuss proposed POC and DC plan with pt/family
  - What is focus of home care? Disciplines needed?
- Provide written agency contact, hotline, resource list, post "Call Agency First" and essential instruction, tasks

Step 3: Second Visit

- Provide verbal explanation of Rights, if not done
- Provide and review written POC (med list, visit schedule, and description of care)
- Complete any missing areas of assessment
- Instruct "Call Agency First" and check recall of first visit teaching, begin other instructions
- Therapy evaluations, if ordered
- Collaborate to ID problems, POC, goals
- Evaluate discharge planning with patient/family

Step 4: Develop the Plan of Care

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

Step 5: Implementation at Visits

- Plan each visit, be flexible to patient's needs
  - Clinical Pathways, teaching checklists, protocols
- Follow visit routine, assessment, follow POC, check meds
- Address the primary diagnosis every visit; other diagnoses at least once during episode (more if problems); be specific on teaching topics, infection control/prevention
- Evaluate progress toward goals at each visit
  - Teach, assess recall, have patient "teach back"
- Revise POC as needed, deal with problems, supervise prn
  - Interventions and goals, keep family involved, update DC plan
- Ongoing progress toward discharge, link to resources
- Communication between disciplines, with patient

Discharge Planning

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

Recert or Discharge?

- Skilled need?
  - Observation and Assessment
  - Skilled, qualifying, ongoing task
  - Management and Evaluation of care plan
- Unmet goals?
  - Reasonable and achievable?
  - Functional reason for goal?
  - Does goal need to be revised if recerting?

Transfer and Discharge

Criteria for transfer, discharge or termination of care:

- HHA can no longer meet patient's acuity needs
- Patient or payer can/will no longer pay for HHA services
- Physician and HHA agree patient no longer needs HHA services due to improved/stabilized health status
- Patient refused services or elected to be transferred or discharged (including to hospice)
- When there is cause
- When patient dies
- When HHA ceases operations

Discharge/Transfer Summary

- HHA must compile a discharge or transfer summary for each discharged or transferred patient
- Summary must be supplied to other healthcare providers as patient transitions from HHA services to another appropriate health care setting
  - DC Summary within 5 business days of agency's Discharge of patient from services
  - Transfer Summary within 2 business days of planned transfer to a health care facility, or of agency becoming aware of unplanned transfer

Care Planning and Coordination for Dyspnea

Strategies to Manage COPD and Heart Failure

Intake/Referral Information for COPD

- Identify types of COPD diagnosed
- History of exposure to causes of COPD
  - Smoker? Exposure to secondhand smoke?
- Current medication list
  - Oxygen is considered a medication
  - Dosage on nebulizer and MDI medications
- Any events that exacerbated conditions that led to recent hospitalization

Intake/Referral Information for Heart Failure

- Identify all type(s) of heart failure
  - LVEF (left ventricular ejection fraction)
- History of MI or other events that might cause heart muscle damage or lower cardiac output
  - Rehab potential?
- Current medication list, any recent changes in cardiac meds
- Any exacerbating events for recent hospitalization, family/support situation, weight

Goals of COPD and CHF Management

- Prevent disease progression
- Relieve symptoms
- Improve exercise/activity tolerance
- Improve health status, reduce risk factors
- Prevent and treat complications
- Prevent and treat exacerbations
- Reduce mortality
- Prevent/minimize side effects of treatment

HF Interventions by Stage

Stage A and B:

- Monitoring of blood pressure, lipid and cholesterol levels
- Education on:
  - Measures to control hypertension and diabetes
  - Measures to reduce high lipid or cholesterol levels
  - Measures to reduce weight if obese
  - Smoking cessation
  - Medication regimen

Stage C:

- Education on:
  - Medication regimen
  - Monitoring HF symptoms, daily weights
  - Dietary sodium restriction, control fluid intake
  - Exercise/activity

HF Interventions by Stage

Stage C (con't)

- Social support to reduce stress, promote compliance with treatment and lifestyle changes
- Treat sleep disorders
- Surgical interventions

Stage D:

- Medications
- Palliative and Hospice Care
  - Symptom management and comfort measures
  - Support quality of life choices
  - Caregiver support

Comprehensive SOC Assessment

- Medical history, diagnoses, conditions potentially exacerbating CHF or COPD
- Vital signs, lung sounds, respiratory rate, O2 sat, s/sx of exacerbation, use of accessory muscles
- Physical condition, activity level, daily activities and need for modification due to energy /tolerance
- Appetite, diet and fluid intake, weight gain/loss
- Medication compliance, response and effectiveness, side effects (includes oxygen)
- Smoking history, willingness to quit smoking
- Knowledge of disease process and management (meds, diet, activity, s/sx report), cognition, ability to learn/recall
- Support system, family/cg involvement, resources, DC plan
- Scheduled physician follow-up appointment

Best Practices for COPD

- Take medications, use inhaler/O2 as ordered
- Smoking cessation, keep air clean
- Proper breathing: pursed lip, abdominal breathing, controlled coughing; positions to aid breathing
- Get regular daily exercise
- Eat healthy foods, drink enough fluids, control weight
- Modify home and activities to conserve energy
- Keep physician appointments
- Get flu and pneumonia vaccinations
- Learn to recognize s/sx to report, emergency plan

Best Practices for Heart Failure

- Front load visit schedule
- Medication management as ordered
- Physician follow up
- Monitor symptoms and weight
- Follow diet and fluid recommendations
- Adapt exercise and activity level: PT and/or OT referral for strengthening, energy conservation, ease performance of ADL's
- Limit alcohol, caffeine; stop smoking
- Know s/sx to report and emergency plan using ZONE tool: physician or 911
- Discuss practice scenarios to improve self-management skills for COPD or HF

Monitoring and Management

- Assess knowledge of s/sx of COPD and HF, evaluate baseline performance
- Create Plan of Care interventions to address deficits
- Use educational materials appropriate for patient/caregiver learning level
- Practice decision making skills using scenarios and emergency plan tools, with pt and family
- Correlate symptoms to adherence with treatment guidelines (meds, exercises, activity, etc.)
- Set patient specific goals, patient centered POC
- Evaluate progress toward goals for all disciplines, every visit; discuss ongoing progress (or lack) with patient and family, revise plan and/or goals if necesssary

Monitoring and Management - COPD

- Daily check of respiratory rate, cough
  - Cough productive, reduced activity tolerance
- Daily check of sputum characteristics
  - Color, amount, consistency
  - If color changes, check temperature
  - Parameters to report, use of PRN medications
- Daily check of lips, fingernail beds
- Daily pulse check

Monitoring and Management - HF

- Daily weights to identify fluid retention
  - Scale, log record, compliance
  - Parameters to report, use of PRN diuretic
  - Clinician assess weight log EACH VISIT, practice scenarios with pt/cg, associate with sodium intake
- Pulse check
  - Teach radial pulse check, use teach-back return demo, parameters to report

Monitoring and Management - HF

- Blood pressure
  - Teach procedure using appropriate equipment, parameters to report, associate with sodium intake
- Edema
  - Teach pt/cg to check edema daily, elevate LE's
  - Report increased edema or edema in AM
- Abdominal girth
  - Measure abdominal girth at baseline, teach pt to report if waistband/belt gets tight

COPD / HF Assessment Every Visit

- Vital signs: pulses, respiratory rate, BP, O2 sat, weight log
- Lung sounds, cough, wheeze, sputum changes
- Episodes of orthopnea, increased dyspnea
- Appetite, diet and fluid intake history and compliance
- Changes in activity tolerance
- Medication compliance, response and effectiveness, any side effects or adverse effects
- Progress with smoking cessation
- Knowledge, recall, understanding of disease process and management (meds, diet, activity, s/sx to report)
- Caregiver involvement, DC plan still appropriate

Respiratory Assessment

Term	Description
Auscultation	Listening to sounds in the body
Percussion	Tapping on surface to determine a difference in density
Pleural rub	Scratchy sound produced by motion of inflamed /irritated pleural surface rubbing against each other
Rale (crackle)	Fine crackling sound caused by bronchi that are obstructed by mucus or fluid
Wheeze	Continuous high pitched whistling caused when air is forced through a narrow space during inspiration or expiration
Stridor	Strained high-pitch squeal on inspiration, associated with an airway obstruction

Medication Interventions

- Review med list in home each visit
- Evaluate compliance with medication regimen
- Assess medication knowledge, identify deficits, educate as needed, use teach-back to assess understanding of key information
- Assess for effectiveness, s/sx adverse effects or interactions
- Assess compliance, continue to assess recall

Medication Mechanisms for COPD

- Bronchodilators: relax smooth muscle to open air passages
- Mucolytics: reduce amount of mucus produced, thin secretions to allow expulsion
- Anti-tussives: suppress or control coughing
- Steroids: reduce inflammation in air passages
- Nicotine replacements: assist with smoking cessation
- Anti-anxiety medications: help manage stress

Medication Mechanisms for Heart Failure

- Diuretics: reduce sodium retention in renal tubules, reduces blood volume
- Digitalis: slows heart rate, increases contractility and cardiac output
- Beta-blockers: block sympathetic nervous system stress response
- ACE inhibitors: block action of angiotensin converting enzyme on the renin-angiotensin aldosterone system, reduces afterload

Exercise and Activity

- Physician exercise/activity orders, restrictions
- Referral to PT or pulmonary rehab to improve strength, stamina and safety for ADL's
  - Strengthen muscles used for breathing, activities
- Referral to OT for energy conservation, pace activity, environmental adaptations to ease performance of ADL's and IADL's
- Teach simple exercises for limited mobility patients – yoga, chair exercises, low impact senior workout, stretches

Environmental Modifications for Energy Conservation

- Keep things needed for dressing, grooming, cooking, etc., together in easy to reach place
- Simplify routines for cooking, cleaning, chores
- Use a small table or rolling cart to move things around, avoid carrying heavy items, sit
- Do things slowly, pace activities, rest after meals
- Arrange home to avoid climbing stairs often
- Keep home air clean, avoid sprays and fumes
- Wear loose clothes, slip-on shoes
- Avoid going to stores during busy times, crowds
- Avoid very cold, windy or very hot, humid days

Emergency Plan

- Check with physician for parameters
- Identify patients at high risk of hospitalization
- Teach emergency care plan
  - Zone (Stop sign) tool
- Discuss practice scenarios to help patient and family/caregivers gain confidence in identifying and managing s/sx of COPD or HF exacerbation

COPD Education

- Disease process, symptoms, causes
- Management:
  - Procedures for daily respiratory status check
  - Daily exercises
  - Diet, fluid intake
  - Pacing activities, energy conservation
- Medications
- Keep physician appointments
- Risk Reduction to prevent exacerbation
- Complications of COPD, who to report problems

COPD Materials

- COPD Patient Handbook
- Ways to Save your Energy
- Safe Use of Oxygen at home
- Zone (Stop sign) tool
- How to Use an Inhaler
  - With or without spacer

Heart Failure Education

- Disease process, symptoms, causes
- Management:
  - Procedure for daily weight log, pulse check
  - Low sodium diet, fluid restriction (if applicable)
  - Measures to control LE edema, conserve energy, and avoid temperature extremes
  - Keep physician appointments
- Medications
- Diet, fluids, exercise
- Risk Reduction to prevent exacerbation
- Complications of CHF, who to report if problems

Heart Failure Materials

- Heart Failure Patient Handbook
  - Heart Talk: Living with Heart Failure (BPIP)
- Diuretic Medications
- Heart Medications
- Aspirin and aspirin-like Medications
- How to Take a Pulse
- Ways to Save your Energy
- Low Sodium Diet Guide
- Daily Weight Log
- Zone (Stop sign) tool

Assess for Exacerbation

- Increased shortness of breath, lung crackles, wheezes, cough, sputum changes, orthopnea
- Increased peripheral edema, abdominal girth, JVD, weight gain parameters
- Chest pain/tightness worse with breathing
- Lips/nailbeds dusky or bluish color
- Pulse and/or respiratory rate elevated
- Decreased appetite for >2 days
- Nocturia, oliguria
- Fatigue, lethargy, activity intolerance
- Increased confusion, irritability, sleepiness

Physician Follow-up

- At SOC and ROC visit, ask about follow up appointments with physicians
  - Recommended 7-14 days from hospital DC
- Assist with scheduling appointments if needed
  - Communicate with family or caregivers
- Identify and resolve barriers to keeping appointments
- Review med list every visit, keep list up to date, report decreased effectiveness
- Follow up to make sure appointments kept
- Notify physician if parameters met

Documentation Points at SOC

- Patient's native language and ability to comprehend and effectively communicate in English
  - Use of interpreter (name and contact)
  - Offer and refusal of professional interpreter
- Patient disabilities that affect communication and understanding
  - Offer of alternate formats/aids specific to disabilities
- Patient verbal understanding of patient rights information, validated by signature on form

Document at SOC

- Provision of HH hotline info and list of resource organizations
- Provision of agency policy on admission, transfer and discharge
- In cases of partial/full incompetence or request for another to exercise rights:
  - Description/reason for incompetence
  - Designated representative and rights they will be responsible for exercising

Document at Comprehensive Assessment and Visits

- Patient's identified problems based on assessment
- Patient's goals and preferences for care delivery
  - Relate goals to functional ability and safety
  - Objective measurements to evaluate progress
- Copy of individualized POC provided to patient (ensure copy in home folder) covering 484.60(e)
- Updates or changes to POC – make sure changes are made on home copy), document patient (and their representative if necessary) were informed of changes and their agreement to changes

Document the Following

- Applicable forms for ABN, NOMNC
- In cases of discharge for cause:
  - Description of problem(s)
  - Notification of patient, representative, certifying physician, PCP or other health care provider responsible for services after HHA discharge that discharge for cause is being considered
  - Steps taken to resolve safety and/or noncompliance issues prior to DC and patient/family's response to efforts

Document for Informed Refusal

- Must document in medical record:
  - Information provided to patient on services recommended
  - Discussion and questions addressed, explanation of benefits and potential risks of not receiving services
  - Circumstances of refusal – use patient's own words and reasons refusing care
  - Physician informed of patient's refusal and why
- Always leave the door open for patient/family to change their mind!

Document for Complaints

- The complaint, who made it, date/time
- The investigation process and findings
- Any action taken to prevent further potential abuse while investigating
- Outcome of investigation:
  - Resolution of complaint, or inability to resolve issues and circumstances
  - Communication back to person who made complaint with satisfaction or other action
- Notification of authorities if indicated

Documenting Care Planning, Coordination

- Focus of care?
- Other problems to address?
- Goals?
- Disciplines needed? Frequency?
- Interventions? Patient response to interventions?
- Evaluate progress toward goals *every visit*
  - Compare to last visit: progress as expected? Why not?
- Outcome measures?
- Anticipated final outcome for episode?

Discharge and Transfer Summaries

- Admission and transfer/discharge dates
- Physician responsible for HH Plan of Care
- Reason for admission to home care
- Types of services provided, frequency of services (what was done by whom, summary, not a cut and paste of the POC orders)
- Description of patient's clinical, mental, psychosocial, cognitive and functional status at SOC and at end of care; events that led to Transfer
- Laboratory data
- Current Medication profile at end of care
- Patient outcomes in meeting Plan of Care goals
- Patient and family instructions and recommendations for follow up care
- Additional documentation that assists in post-discharge or transfer continuity of care, or as requested by the receiving provider

Home Health CMS Coverage/Eligibility

Documentation Requirements

Medicare Requirements for the Home Health Benefit

- To qualify for the Medicare Home Health benefit, under 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, a Medicare beneficiary must meet all of the following requirements:
  - Be confined to the home at the time of services
  - Be under the care of a physician
  - Receive services under a POC established and periodically reviewed by a physician
  - Be in need of skilled services
  - Have a face-to-face encounter with a medical provider as mandated by the Affordable Care Act

Homebound Definition

- An individual is considered "confined to the home" if the following 2 criteria are met:

  Criteria-One (ONE must be met):
  - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

    OR
  - Have a condition such that leaving his/her home is medically contraindicated

Homebound Definition

- After the patient meets ONE of the Criteria-One conditions, the patient must ALSO meet two additional requirements defined in *Criteria Two (BOTH must be met)*:
  - There must exist a normal inability to leave home

    AND
  - Leaving home must require a considerable and taxing effort

If the patient does leave home…

- Absences must be infrequent or for periods of relatively short duration, or to get health care treatment, including but not limited to:
  - Attendance at adult day centers to receive medical care
  - Ongoing receipt of outpatient kidney dialysis
  - Receipt of outpatient chemo or radiation therapy
- Absences to attend a religious service
- Occasional trips to the barber, a walk around the block or a drive
- Attendance at a family reunion, funeral, wedding, graduation or other infrequent or unique event

CMS Examples

- Paralyzed due to stroke
- Blind and senile
- Loss of UE use
- Last stages of neurodegenerative disabilities
- Post-op weakness/pain, restrictions
- End-stage ASHD
- Psychiatric illness

CMS says…

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of this reimbursement unless they meet one of the above conditions.

Homebound Status

- May use check boxes with CMS criteria
  - Must use supportive devices to leave home
  - Requires assistance of another person to leave home
  - Requires special transportation to leave home
  - Leaving home is medically contraindicated
  - Has a normal inability to leave home
  - Requires considerable and taxing effort to leave home
- Must add narrative requirements
  - Support check box statements
  - Must include details specific to patient visit
  - Avoid repetitive statements

Homebound Specific Details

- Requires supportive device to leave home
  - Requires assist of one with transfers and uses wheeled walker to ambulate short distances of 10-15 feet
  - Gait unsteady without use of cane, history of 2 falls in past week
  - Wife must remind patient to use walker for ambulation
  - PT plan of care includes gait training with crutches as pt currently unsafe with use of device w/o assistance

Homebound Specific Details

- Unable to leave home unassisted
  - Patient requires supervision to leave home due to mental status, confusion and forgetfulness
  - Requires hands-on assist of 1-2 people to negotiate seven steps in/out of home
  - Patient needs assist of son and use of wheelchair to get to physician appointments
  - POC includes PT for gait training and strengthening as patient must be able to walk 150 ft to ALF dining room and to evacuate building in case of emergency
  - SN called Para-quad and set up handicapped assisted van to transport patient to physician appointment

Homebound Specific Details

- Leaving home medically contraindicated
  - Pt cannot leave home w/out respiratory barrier due to risk of infection while on chemo
  - Pt at high risk for infection/complications due to long-term steroid treatment for repeated asthma exacerbations, hx of recurrent pneumonia
  - Pt under physician order to keep LLE elevated at all times due to DVT
  - Pt NWB on RLE due to explantation right knee prosthetic joint for infection, w/c bound due to inability to ambulate while maintaining NWB status

Homebound Specific Details

- "Normal inability" to leave home
  - ALS limits any coordinated movement of UE and LE, and patient unable to tolerate sitting more than a few minutes
  - Patient must stop to rest and catch her breath during dressing activities, takes almost an hour to complete sponge bath and dressing due to severe CHF
  - Requires assistance with meal prep, must stop and rest while eating meal due to dyspnea; SOB while talking, must pause during conversation to catch her breath
  - Patient's agoraphobia prevents her from leaving her house, suffers panic attacks when she attempts to go outside home

Homebound Specific Details

- Taxing effort to leave home
  - Requires assist of daughter to go to physician appointments, riding in car causes severe back pain partially relieved by Percocet, on return home patient has to rest in bed due to pain and exhaustion
  - Able to ambulate short distances in home with walker, but requires wheelchair and assist of one to leave home, POC includes PT for gait training with walker and transfer training in/out of wheelchair, safety measures to lock w/c
  - Daughter took pt to doctor appointment yesterday and pt refuses PT visit today since too tired and still in bed

Skilled Care Requirement

- Based on objective clinical evidence regarding patient's individual need for care
- All services must be reasonable and necessary related to the patient's condition
- Care must be provided by professional nurse or therapist to be *safe* and *effective*
- Skill can be determined by:
  - Complexity of the care
  - Condition of the patient
  - Accepted standards of practice

Reasonable & Necessary Requirement

- Care must be consistent with nature and severity of patient's illness/injury and accepted standards of practice
- Consider condition of patient at time services were ordered and reasonable expectation of appropriate treatment for illness/injury during certification period

Patient Condition Considerations

- Structural impairments
- Functional impairments
- Activity limitations
- Performance limitations
- Complexity of patient's condition
- Comorbidities and secondary diagnoses

Failed Medical Necessity Examples

- New medications ordered, but no documentation of teaching on new meds or any side effects or adverse reaction or difficulty taking meds
- Recert for patient with chronic dx and agency has had ample time for teaching, especially if pt/cg has demonstrated understanding and ability to manage care
- Repeated teaching and documentation patient is non-compliant with following instructions
- After repeated instruction, pt/cg will not or is not able to be taught/trained

Reasonable and Necessary Examples

- Type II Diabetes 4 years, recent UTI's and high blood sugars, no med changes
  - OR DM for 4 years, no changes in condition or tx
- Parkinson's w/ increase in falls, med changes
  - OR w/falls 1-2 times a wk past 3 months, has had PT and it helped but decline since last HH because he doesn't do HEP

Reasonable and Necessary Examples

- TKR, 10 days in SNF, now home
  - unable to safely use walker without cues or negotiate steps in/out of home
  - OR incision slightly swollen w/drainage
  - OR safely able to use walker, incision re-epithelialized, no co-morbidities

Reasonable and Necessary Examples

- Alzheimer's, more confused, now needs reminders for ADL's, increased difficulty feeding self, recent choking and risk for aspiration
  - OR gradual decline, requires additional care, unable to participate in therapy, caregiver knows how to provide care to dependent patient
- *What about skin tears??*

Skilled Care Interventions

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

Goals for Skilled Care

Set appropriate goals

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

Skilled Care Documentation

- CMS says: "it is expected that the home health records for every visit will reflect the need for the skilled medical care provided."
  - The history and exam pertinent to the day's visit including response or changes in behavior from prior teaching or skilled services
  - The skilled services provided at the visit
  - The patient/caregiver's immediate response to the skilled service provided
  - The plan for the next visit based on rationale of prior results and to achieve progress toward goals

Skilled Care Documentation

- Detailed rationale explaining need for skilled service in light of patient's overall medical condition and situation
- The complexity of the services to be provided
- Any other pertinent characteristics of patient or home environment situation
- Clear picture of treatment provided and "next steps" – avoid vague or subjective descriptions of care provided to patient

Skilled Care Documentation

- Do not be judgmental – avoid documenting statements like "patient non-compliant with low sodium diet."
- Instead, document "patient ate hot dogs and sauerkraut for dinner last night, stated he didn't know it was high in sodium. When asked to identify some high sodium foods to avoid, patient was only able to name potato chips and canned soup."
- Your follow up intervention would be to instruct patient in low sodium diet guidelines and examples of "eat this, not that" to illustrate how to make better food choices. At the next visit, see if patient can recall teaching and name foods to avoid.

Poor Documentation

- "Patient tolerated treatment well"
- "Caregiver instructed on med regimen"
- "Continue with POC"
- "Normal," "within normal limits," "no change from prior assessment" or "N/A"

Good Documentation

- "Caregiver doesn't know how to safely transport patient to physician appointment because patient is unsteady, has poor balance and difficulty walking the 25 feet to the car, and patient has had two falls trying to negotiate down steep front steps to driveway."
- Better than "patient requires assist of one, taxing effort to leave home."

Physician Orders

- All skilled nursing and therapy services must have a physician order that contains:
  - The type of services to be provided
  - The professional who will provide the services
  - The frequency of the services
  - The duration of the services
  - Details needed to provide the appropriate services

  Per CMS IOM Publication 100-02, Chapter 7, Section 30.2.2

Therapy Visit Notes

- Must include measurable therapy treatment goals that are related to the patient's illness or injury or impairment
- Therapy services must be reasonable and necessary appropriate to the patient's illness or injury or impairment
- Therapy services must be at a level of complexity which requires the skill of a qualified therapist to provide safely and effectively

More CMS Requirements

- Patient must be under the care of a physician
  - Doctor of Medicine;
  - Doctor of Osteopathy; or
  - Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).
- In addition, the physician must be enrolled as a Medicare provider
- Patient must receive services under a Plan of Care established and periodically reviewed by a physician

Plan of Care

- A plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA
- The HHA must be acting upon a physician plan of care the meets the requirements of the Medicare Benefit Policy Manual, chapter 7, section 30.2.1 for HHA services to be covered
- Issues: Hospitalist? Wound care clinic?

Initial Certification POC

- Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where *there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.*

Recertification POC

- Must be signed and dated by the physician who reviews the plan of care
- Must indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services)
- Must estimate how much longer the skilled services will be required in a stated length of time (days, weeks, months)

Recertification

- Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where *there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.*
- However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

Certification for M&E

- If a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential non-skilled care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.
- If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

Coordination of Care

- Communication with physician
- Communication between different clinicians visiting patient
- Communication among disciplines
- Communication w/pt, cg, family

Face-to-Face Encounter

- F2F encounter with physician or approved designee must occur either within 90 days prior to HH SOC date or within 30 days after SOC date (SOC = day 0)
- The certifying physician’s and/or the acute/post-acute care facility’s medical record must contain the actual clinical note for the F2F encounter that justifies the referral for Medicare home health services and includes:
  - Date of the encounter with an allowed provider type
  - Need for the skilled services: ***encounter must be related to the primary reason the patient needs HH services***
  - Homebound status description

Additional Information for Review

- HH agencies may send information to the certifying physician to support the F2F requirements:
  - Documentation created/generated by the HHA
  - Other information created/generated by and obtained from the acute/post-acute facility clinicians and staff
- The certifying physician may consider and/or use any information sent by the HHA, that has been incorporated into the medical record, as the basis for certification of patient's eligibility for HH services
- Information from the HHA must not conflict with other medical record entries and align with the time period in which services were rendered.

Additional Information

- The *certifying physician* must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- The MAC shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination.
  - Additional documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to the time of claim submission.

Additional Information

- Any information provided to the certifying physician from the HHA and incorporated into the patient's medical record held by the physician or the acute/post-acute care facility's medical record could include, but is not limited to:
  - Comprehensive SOC assessment (all or parts)
  - Summary narrative on SOC: patient's problems, goals for discharge, what skilled disciplines will do to reach goals
  - Plan of Care
  - Inpatient discharge summary or H&P
  - Multi-disciplinary clinical notes
  - Certification/recertification statement

Who reviews your F2F documentation?

- Assign a responsible person and a back-up (team)
  - Intake? QA? Clinical manager?
- Verify date of encounter within allowed time period
- Verify encounter was with appropriate provider
- Make sure signature is legible/authenticated, dated
- Make sure the reason for the encounter with physician office/inpatient facility is the same reason patient is receiving home care
  - ICD-10 codes don't have to match, but diagnosis itself should be the same, assessment should address dx
- Verify any additional documentation from HHA
- Do you have a Tracking Tool to verify every F2F?

Watch out for F2F Pitfalls!

- A "F2F Form" is not required and not enough! Must have a progress note or similar encounter note
- Documentation should describe patient condition and functional impact of symptoms, not just list diagnoses
- Enough specific details to support homebound, skilled need
  - Why is assessment needed? Why is teaching needed? Why is therapeutic exercise or functional restoration (gait/ADL training, swallowing or cognitive training, HEP) needed?
- New problem/exacerbation, not just chronic condition
- Identify need for skilled therapy: restore function, design/establish a therapeutic maintenance program, perform maintenance therapy (careful here!)

Medical Review Top Denials

- Lack of Medical Necessity
  - Why did this patient need home care for their medical condition?
- Lack of Skilled Care provided
  - Why did the treatment or education provided require the skills of a professional nurse or therapist?
- Face-to-Face insufficient
- Homebound status not supported

And Review Choice Demonstration will make eligibility documentation even more essential!

Home Health Resource Group

- OASIS is the basis for payment
  - Payment episode vs. quality episode
- HHRG produced through grouper software
  - Determined by 20 OASIS items
  - Three domains
    - Clinical Severity
    - Functional Status
    - Service utilization
- C1F1S1 to C3F3S5 for four different equations to determine HHRG and case-mix weight

HHRG and OASIS

- Assess using appropriate techniques
- Choose accurate OASIS item response(s)
- Provide supporting information for the OASIS response in narrative documentation
- Make sure interventions and goals in POC
- Visit note documentation:
  - Support for OASIS responses
  - Implement interventions, note effectiveness
  - Track progress toward goals, revise as needed

Support OASIS responses

- OASIS items used to determine PPS episode payment require supporting documentation in the clinical record
- Supporting information doesn't have to be documented *every visit,* but should be documented more than just in the OASIS item, including interventions on POC, actions by clinician, documentation of patient response to interventions

Potential Areas of Concern

- Selection of appropriate primary diagnosis
- Inclusion of pertinent other diagnoses
- Accurate ICD-10-CM coding of validated diagnoses
- Identification and consistent documentation of wounds (watch out for skin tears!)
- Teaching that does not address knowledge deficits
- Inconsistencies between disciplines
- Repetitive visits without changes in patient condition or abilities, lack of follow through on problems
- Lack of evaluation of progress toward goals

Quality of Care Star Rating Measures

OASIS Guidance and Best Practices for Improvement

Quality of Patient Care STAR Rating Measures

Outcome Measures

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

Process Measures

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

Utilization Measure

- Acute Care Hospitalization

Adding in 2019

Remove in 2019

Removed in 2018

Outcomes

- OASIS data items are arranged from least impaired or independent, to most impaired or dependent.
  - Except for GG- items

Tip: read responses from bottom up

- The answer at SOC/ROC is compared to the answer at Transfer/DC to determine if there has been improvement, decline or stabilization on that particular outcome.

Expansion of One Clinician Rule

- Comprehensive assessment includes OASIS items and is part of legal HHA clinical record. While only the *assessing clinician is responsible for accurately completing and signing comprehensive assessment*, s/he may collaborate to collect data for all OASIS items, as agency policy allows.
- Collaboration may consider information from others such as patient, caregivers, physician, pharmacist, *and/or other agency staff* who have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection.
- M0090 = last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including OASIS items.

Frequency of Pain Interfering with Activity

Assessment: Intake / Referral

- Identify any diagnoses at risk for pain symptoms
- Ask about patient's pain experience during inpatient stay, any parameters for reporting
- Obtain current medication list
  - Complete orders for pain medications (dose, number of tabs, frequency, 24-hr max dose)
- Ask about non-pharmacological measures for treatment, effectiveness, side effects

Pain Assessment - Verbal

- Location by anatomical site
- Description, quality of pain
- Intensity and severity using standardized tool/scale
  - Present, worst/best in past 24 hours
  - Patient's acceptable level of pain
- Onset, duration, patterns
- Causes, triggers, relieving factors

Pain Assessment - Nonverbal

- Pain noises
- Facial expressions
- Body language
- Changes in typical behavior
- Changes in vital signs

Pain Assessment Guide for Non-Communicative Patient

Verbal	Body Movement	Facial	Touching
0-1: Positive "no pain"	0-1: Moves easily	0-1: Smiling	0-1: Neutral
2-4: Whimper, moan, grunt, sigh	2-4: Restlessness	2-4: Neutral	2-4: Intermittent rubbing, holding
5-7: Tears, crying	5-7: Shifting, pacing, rocking	5-7: Frown, grimace	5-7: Patting, hard rubbing, guarding w/ movement
8-10: Screaming	8-10: Tense, rigid, not moving	8-10: Clenched teeth, severe grimace	8-10: Tight clenched muscles, avoiding any pressure or touch

Barriers to Pain Assessment

- Inability to speak
- Cognitive impairment
  - Poor memory
  - Depression
  - Sensory impairment
- Inaccurate reporting of pain by patient
  - Cultural bias
  - Fear of disease progression
  - Jeopardizing patient's independence

Additional Areas of Pain Assessment

- Measures used to relieve pain
- How effective is pain relief intervention? Be specific, compare to patient's goal
- What side effects bother patient? How severe and does it keep patient from using the interventions for relief?
- Pain affect on physical and social functioning

SOC
ROC
FU

M1242 Frequency of Pain Interfering with Activity or Movement

(M1242) **Frequency of Pain Interfering** with patient's activity or movement:		
Enter Code ☐	0	Patient has no pain
	1	Patient has pain that does not interfere with activity or movement
	2	Less often than daily
	3	Daily, but not constantly
	4	All of the time

- Pain interferes with activity when the pain results:
  - in the activity being performed less often than otherwise desired,
  - requires the patient to have additional assistance in performing the activity, or
  - causes the activity to take longer to complete.

M1242: Assessment Techniques

- Review of diagnoses
- Review of activities
  - Is there any interference with activity or movement?
  - What is the frequency of this interference with activity or movement?
- Evaluation of ADLs and IADLs
  - Avoidance or delay of ADLs and/or IADLs
  - Need for assistance, increased time to perform/rest
- Evaluation of other activities
  - Does pain affect eating, sleeping, hobbies, family interaction or socialization?

M1242: Assessment Techniques

- Ask if pain prevents or discourages them from doing anything. What activities are impacted? Does it take longer to do activities? Do they need help with activities due to pain?
- Observe non-verbal signs of pain/discomfort during assessment activities
- Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk).

M1242 Assessment Techniques

- Check the medication list: the presence of medication for pain or joint disease is a cue to assess the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement.
- How does patient currently treat pain? Do they take analgesics? Do meds help relieve the pain so the patient can do more?
- Score before you teach pain management

4--All of the Time

- “All of the time" means constantly throughout the day and night with little or no relief.
- Pain is also considered to be interfering if a patient stops performing an activity in order to avoid the pain. For the pain to be interfering "all the time" the frequency of the activity that was stopped in order to avoid pain must collectively represent all the hours of the day/night. Pain must wake them frequently at night.
- The clinician must use judgment based on observation and patient interview to determine if pain is interfering all the time. July 2013

Example

- At the initial assessment, patient rates her pain at a 2/10. When the nurse asks her to walk back to the bedroom to complete the assessment, patient states she sleeps in her recliner because she doesn’t climb stairs and limits walking distances due to knee pain. The patient does agree to walk to the bathroom, when rising she grabs her left knee and grimaces, takes limping steps using a cane, and when asked to rate her pain when she gets to the bathroom, she reports a 7/10. She takes analgesic at bedtime and sleeps ok.
- M1240: 2 – yes, and it indicates severe pain
- M1242: 3 – Daily but not constantly

Best Practices for Pain

- Screen for pain every visit; if pain present, conduct comprehensive pain assessment
- Implement an individualized pain management POC, monitor effectiveness, revise if needed
- SN assess need for PT/OT, address functional deficits related to pain, interdisciplinary goals
- Educate patients on pharmacological and non-pharmacological measures for pain control
- HHAide care plans include notification of SN, PT or OT if pain s/sx observed

Principles of Pain Medication Management

- Choose best analgesic for individual
- Use lowest effective dose
- Administer via least invasive route
- Adopt most appropriate administration schedule to fit patient's lifestyle
- Increase dose/strength to achieve control
- Add supplemental med for breakthrough pain
- Prevent and treat side effects
- Assess for s/sx of adverse effects

Principles of Pain Medication Management

- Consider WHO step-wise approach for multi-drug therapy
- Combining different interventions is often more effective than a single approach
  - Consider medication and non-pharmacological
- Constantly re-evaluate efficacy of pain control
- Suspected addiction or drug diversion should be addressed

Interventions - Pharmacological

- Medications: OTC or prescription
  - Adjunctive meds: muscle relaxers, antidepressants
- Provide specific administration information
  - Dosing schedule and limits, interactions
- Explain side effects and management
- Address fears related to addiction
- Encourage patient/family to provide feedback on effectiveness, concerns
- Teach s/sx of adverse effects to report

Interventions – Non-Pharmacological

- Breathing, relaxation
- Distraction
- Environmental modification
- Heat/cold application
- Positioning/repositioning
- Physical therapy, exercise, stretching, yoga
- Music therapy

Interventions – Non-Pharmacological

- Guided imagery, meditation
- Biofeedback
- Massage
- Acupuncture, acupressure
- Electrical stimulation, TENS
- Spiritual practices, prayer
- Nerve block, surgery
- Activity guidelines and modification

Patient Empowerment

- Comprehensive patient education
  - Pharmacological and non-pharmacological interventions
  - Use and safety (pain handouts)
  - Management of side effects
  - Signs and symptoms to report
  - Monitoring ongoing effectiveness of interventions
- Patient self-management
  - Daily pain diary or flowsheet
  - ZONE tool for pain
  - Emergency plan

Physician Communication Re: Pain

- Report any pain that patient considers as unacceptable to physician; must treat pain as reported by patient
- Provide current vital signs, objective info about pain - SBAR
- Review current analgesic regimen, patient response and side effects experienced
- Explore alternatives, patient preferences
- Consider referral to pain specialist for unresolved pain management issues

Follow-up Reassessment

- Perform at regular intervals, w/any complaints of increased pain, increased use of PRN meds
  - RFA 5 Other Follow-up
- Include all elements of comprehensive pain assessment
- Compare to initial pain assessment, evaluate effectiveness of interventions
- Revise plan based on this monitoring

Improvement in Dyspnea

Clinical Symptoms of COPD

- Chronic cough intermittently or daily
- Chronic sputum production
- Dyspnea present every day
  - Increased effort to breathe, heaviness, gasping for air, increased respiratory rate, wheezing at rest or with exertion, or "air hunger"
  - Progressively worsens over time
  - Worsens with exercise
  - Worsens with respiratory infections

Clinical Symptoms of Heart Failure

Left-sided heart failure

- Pulmonary congestion
- Dyspnea, orthopnea
- Paroxysmal nocturnal dyspnea
- Fatigue
- Caused by HTN, aortic or mitral insufficiency or stenosis, left ventricle MI, left atrial thrombus, resistance in aorta

Right-sided heart failure

- Venous congestion in systemic circulation
- Dependent LE edema
- Distended neck veins, hepatomegaly
- Caused by tricuspid regurgitation, right ventricle MI, corpulmonale, or left-side heart failure

SOC
ROC
FU
DC

M1400 Shortness of Breath

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?		
Enter Code ☐	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)

May be observed during assessment or reported by patient or family/caregiver
Key: can you judge 20 feet?

M1400 Assessment Techniques

- Assess with activity if safe for patient to demonstrate
- If patient *uses* oxygen continuously, assess with oxygen on
- If the patient *uses* oxygen intermittently, assess *without* the use of oxygen
- If oxygen used at night due to positional dyspnea, report level of exertion that causes dyspnea without oxygen
- Sleep apnea ≠ dyspnea
- Ask about any shortness of breath in past 24 hours
  - Don't answer solely based on *patient's* report of dyspnea

M1400 Shortness of Breath

- Chairfast or bedbound patient:
  - Evaluate the level of exertion required to produce shortness of breath
  - The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest
    - Response 0
      - Patient has not been short of breath during the day of assessment

M1400 Shortness of Breath

- Chairfast or bedbound patient:
  - Response 1 (When walking more than 20 feet…)
    - Appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).
  - Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.

M1400 Shortness of Breath

- Assess and report what caused the patient to experience dyspnea on the day of the assessment.
- The examples included in Responses 2 and 3 are used to illustrate the degree of effort represented by the terms moderate and minimal.
- Response 3 - With minimal exertion or agitation includes the examples of eating, talking or performing other ADLs. The reference to other ADLs means activities of daily living that only take minimal effort to perform like grooming.

Example

The patient is not short of breath sitting in her chair at rest. When the SN asked her to walk into the bedroom, she became short of breath and had to stop and catch her breath after rising from her chair and ambulating a few feet. After catching her breath in the bedroom, the SN helped her remove her shirt to assess breath sounds. The patient became short of breath attempting to put her arm in the sleeve of her shirt when getting re-dressed.

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?		
Enter Code ☐	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)

M1400 Q&A to Note

- **Q113.1. M1400. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.**
- A113.1. Since the patient's supplemental oxygen use is not continuous, M1400 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)." It would be important to include further clinical documentation to explain the patient's specific condition.

More Examples

- Patient sleeps with 2 pillows or in recliner and currently not short of breath at rest and otherwise not SOB with any activities
- Environmental modifications: If the patient restricts an activity to remain free of dyspnea, they can be a "0"
- Go up stairs 2 steps at a time to avoid dyspnea can still be a 0

OASIS Assessment Conventions for ADL Items

- Identify ***ability***, not actual performance or willingness
- Assess patient's ability to ***safely*** complete the specified activities listed in the OASIS item
- Consider what the patient is able to do on the day of assessment; if ability varies over the 24 hour period, select the response that describes the patient's ability more than 50% of the time
- Assess only for the specific tasks included in the item
- If patient's ability varies between multiple tasks included in the item, report ability to perform a majority of the included tasks, giving more weight to tasks that are performed more frequently
- Do not assume the patient would be able to safely use equipment that is not in the home at the time of assessment

OASIS Assessment Conventions for ADL Items (con't)

- Consider medical restrictions when determining ability
- While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's ability to perform a task
- Ability can be temporarily or permanently limited by physical or emotional or sensory impairments, or by environmental barriers
- Response scales present the most optimal (independent) level first, then proceed to less optimal (most dependent) levels. ***Read the responses from the bottom up!***
- "Assistance" means help from another human being
- Service animals are considered "devices" not "assistance"

Key to Remember

- **What is the difference between "willingness" and "adherence" (which do not impact OASIS scoring) and "cognitive/mental/emotional/behavioral impairment" (which may impact OASIS scoring)?**
- In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush his teeth infrequently because he doesn't value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

Key to Remember

- A patient may demonstrate that they can safely ambulate while using a walker, but then as a *matter of choice*, decide to walk without it. Another patient may demonstrate that they can safely ambulate while using a walker, but then consistently walk without it, *forgetting* that they have a walker. For the purposes of OASIS scoring, non-conformity or non-adherence should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient's actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk.

Access is Excluded

- Patient's ability to access needed items and/or location where the task occurs is INCLUDED, unless specifically excluded in guidance
- M1845 Toileting hygiene—excludes getting to the location where the toileting occurs
- M1870 Feeding/Eating—Excludes getting to location where meal is consumed and excludes transporting food to the table
- M1880 Planning and Preparing Light meals—excludes getting to location where meal prepared
- M1890 Telephone use—Excludes getting to the location where the telephone is stored

Improvement in Bathing

Assessment: Intake / Referral

- Identify any diagnoses with potential impact on bathing
  - Fall history
  - Medical, post-op restrictions
- Gather information about patient's living situation and availability of assistance or supervision for personal care
- Request orders for therapy and/or home health aide if indicated

M1830 Bathing

(M1830) **Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**	
Enter Code ☐	0 Able 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 Able 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 Able 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. 6 Unable to participate effectively in bathing and is bathed totally by another person.

M1830: Bathing

- Time points: SOC ROC F/U DC
- Specifically excludes washing face and hands, and shampooing hair.
- The focus is on the patient's ability to access the tub/shower, transfer in and out, and bathe the entire body once the needed items are within reach. The ability to access bathing supplies and prepare the water in the tub/shower are excluded from consideration when assessing the patient's bathing ability.

CMS Q&A April 2016

Question 8: Please confirm something I heard during OASIS training at my office. They said that getting to the bathroom for bathing is also included in the data collection for bathing even though the responses for M1830 Bathing only address the transfer in and out of the shower/tub and washing the body. Is that true? For example, my patient needs assistance to get down his hallway to the bathroom, but once he is in the bathroom he can safely transfer in and out of the shower and wash his body without assistance or equipment. Until the meeting today, I would have scored him a 0 for independent, but now it seems I should be scoring him a 2-needs intermittent assistance.

Which score is correct?

CMS Q&A April 2016

Answer 8: The OASIS ADL/IADL items consider the patient's ability to access the needed items and/or location where the task is performed unless item guidance specifically excludes these from consideration. *For M1830 Bathing, the amount of assistance the patient requires to get to the location bathing occurs would be considered*. In the scenario cited, the patient requires assistance (another person to provide verbal cueing, stand-by or hands-on assistance) to safely ambulate down the hallway and no other assistance with transfer and bathing. This is intermittent assistance, therefore M1830 Response 2 - Able to bathe in shower or tub with the intermittent assistance of another person should be reported.

M1830: Assessment Techniques

- Use a combined interview and observation approach
- Does the patient have a functioning bath tub or shower? Sink?
- Ask the patient how they currently bathe, and what type of assistance is needed to wash entire body
- Do they have the necessary safety equipment in the home?
- Does the patient have medical restrictions that affect bathing?
- Observe the patient's general appearance in determining if the patient has been able to bathe self independently and safely

M1830: Assessment Techniques

- Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely
- Ask the patient to demonstrate the motions involved in bathing the entire body .
- Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device.
- Consider safety: home setting, equipment, ability
- Score at SOC/ROC before you teach or get equipment

M1830: Bathing

- If patient is able to bathe in the tub or shower with no assistance from another person for getting in/ out of the tub or bathing any part of their body, choose Response 0 or 1
- Response 0 – no assistance from another person and no assistive devices are used; patient is totally independent in bathing
- Response 1 – no assistance from another person, and patient independent bathing with devices in the home and used correctly

M1830: Bathing

- If patient requires standby assistance to bathe safely in tub or shower or requires verbal cueing or reminders, then select Response 2 or 3, depending on whether the assistance needed is intermittent (“2”) or continuous (“3”).
- If patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, select “2”. If patient requires one, two, or all three types of assistance listed in Response 2, but not continuous presence of another person as in Response 3, then “2” is the best response.

M1830: Bathing

- The patient’s status should not be based on an assumption of a patient’s ability to perform a task with equipment they do not currently have.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower.
  - Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.

M1830: Bathing

- Response 4: patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water safely at a sink, or setting up a basin at the bedside, etc.
- Response 5: patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode
- Response 6: patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs

Examples

The patient's tub is nonfunctioning or unsafe for use. His wife lays out bath supplies on the counter and patient bathes himself at the sink without any additional help.

- M1830: ?

What if he can't get to the sink and his wife has to set up a basin at the bedside for the patient to bathe himself?

- M1830: ?

The patient is ordered not to shower until 7 days after surgery when the sutures will be removed. When the nurse arrives, he is just getting out of the shower and his dressing is soaking wet. He showered without any assistance except his wife helped him get into the shower.

- M1830: ?

Examples

The patient's tub is nonfunctioning or unsafe for use. His wife sets up bath supplies on the counter and the patient bathes himself at the sink without any additional help.

- M1830: 4

What if he can't get to the sink and his wife has to set up a basin at the bedside for the patient to bathe himself?

- M1830: 5

The patient is ordered not to shower until 7 days after surgery when the sutures will be removed. When the nurse arrives, he is just getting out of the shower and his dressing is soaking wet. He showered without any assistance except his wife helped him get into the shower.

- M1830: 4

Examples

The patient is on physician-ordered bed rest.

- M1830 = ?

The patient chooses not to navigate the stairs to the tub/shower.

- M1830 = ?

Examples

The patient is on physician-ordered bed rest.

- M1830 = 4, 5 or 6

The patient chooses not to navigate the stairs to the tub/shower, and sponge bathes at the sink in the kitchen.

- M1830 = 2 or 3. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. 4bQ134

Example

The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.

- If due to fear, she refuses to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe her ability.

Example

The patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on over the cast, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower.

- M1830: ?

Example

The patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on over the cast, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower.

- M1830: 2

Best Practices to Improve Bathing

- Assess bathing ability using both interview and direct observation
- Assess the need for assistive devices, the safe operation of any devices present, and facilitate obtaining any devices needed
- Assess environmental factors that may affect bathing ability, need for modifications
- Assess cognition and judgement, and impact on bathing safety

Best Practices to Improve Bathing (Con't)

- SN obtain order for PT if mobility deficits are identified and OT orders if there are deficits in upper body strength/mobility, cognitive ability, or need for assistive devices for bathing
- Nursing and therapy assessments are consistent r/t bathing ability, and M1830 is answered correctly using OASIS guidance
- HH Aide care plans include specific instructions on type of bath and assistance needed from the aide

Best Practices to Improve Bathing (Con't)

- Therapy plans include interventions and instruction to address functional deficits that impact bathing ability and safety
- The patient, family and/or caregiver are included in teaching on bathing skills and safety
- Patient and family participated in setting bathing goals, and are involved in ongoing evaluation of bathing ability and progress
- If goals are not achieved, there is documentation physician was informed of reason for unmet goals
- If goals unmet, post-DC assistance needs are addressed in discharge planning

Improvement in Bed Transferring, Ambulation

Assessment: Intake / Referral

- Identify any diagnoses at risk for mobility problems
- Ask about patient's fall history
- Obtain current medication list
  - Identify meds potentially impacting mobility
  - Identify if pain management is an issue
- Orders for therapy disciplines and interventions for gait and transfer training, fall prevention and home safety assessment

Comprehensive Assessment and Initial Evaluation

- Identify diagnoses and conditions that potentially affect mobility
- Perform pain assessment
- Perform fall risk assessment - standardized tool
- Obtain fall history: location, timing, circumstances, any devices used (or not used), causes/triggers for falls
- Assess patient's transfers and ambulation or wheelchair use – consider safety!

Bedfast as Defined by CMS

- "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time.
- The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.

SOC
ROC
FU
DC

M1850 Transferring

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code ☐	0 Able to independently transfer.
	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

M1850 Assessment Techniques

- Observe the patient lie down on their back in bed or on their usual sleeping surface. Assistance needed?
- Observe the patient rise to a sitting position on the side of the bed. Assistance needed?
- Identify the nearest sitting surface and observe patient perform some type of transfer to that surface. The transfer may involve standing and taking a few steps to the chair or bench or bedside commode, a stand-pivot, or a sliding board transfer. Assistance needed? What type of assistance? How much assist? By whom?
- Observe patient transfer back onto the bed from the sitting surface.

M1850 Transferring

- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.
- The need for assistance with gait may impact the Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.

M1850 Transferring

- If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), assess the patient's ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.
- Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.

M1850 Transferring

- Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete task.
- Select Response 1 if:
  - Patient transfers ***either*** with minimal human assistance (but not device), ***or*** with the use of a device (but no human assistance)
  - Patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing or reminders
  - Patient requires another person to position the wheelchair by the bed and apply the brakes to lock the wheelchair for safe transfer from bed to chair

M1850 Transferring

- Response 2 - Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- Select Response 2 if:
  - Patient requires more than minimal assistance (more than 25% of the effort to transfer comes from another person helping)
  - Patient requires ***both*** minimal human assistance ***and*** an assistive device to be safe
  - Patient can bear weight and pivot, but requires more than minimal human assist,

M1850 Transferring

- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.
- A patient who can tolerate being out of bed is not "bedfast." If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient's circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer

M1850 Transferring

- If the patient is bedfast, select Response 4 or 5, depending on the patient's ability to turn and position self in bed.
- Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed. Responses 4 and 5 do ***not*** apply for the patient who is not bedfast.
- The frequency of the transfers does not change the response, only the patient's ability to be transferred and tolerate being out of bed.

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:	1. SOC/ROC Performance	2. Discharge Goal	
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.	↓Enter Response in Boxes↓		**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
Activity may be completed with or without assistive devices.			
06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.	☐☐	☐☐	
05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.			
04 **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.			
03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.			
02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.			
01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.			
If activity was not attempted, code reason:			
07 **Patient refused**			
09 **Not applicable**			
88 Not attempted due to **medical condition or safety concerns**			

NOT the same as M1850, but cannot contradict!

SOC
ROC
FU
DC

M1860 Ambulation/Locomotion

(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.

Enter Code ☐

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.

M1860 Assessment Techniques

- Observe the patient walk a reasonable distance
  - Does patient use a device? Correctly and safely? What type?
  - Does patient use walls or furniture for support?
  - Does patient demonstrate loss of balance or other actions that suggest additional support is needed for safe ambulation?
  - Does the patient demonstrate safe gait pattern?
- Observe the patient's ability and safety on stairs
- If chairfast, does the patient have a wheelchair? Power or manual? Do the brakes work properly? Can the patient demonstrate ability to wheel the chair independently? Across the floor? Through doorways? Up/down entrance ramp?

M1860 Ambulation / Locomotion

- Response 0: patient can safely walk on any surface in their environment, including stairs, without any device or any human assistance AT ALL.
  - If you mark this response, better document why the patient is homebound!
- Response 1: Safe on all surfaces and stairs with a one-handed device – NO HUMAN ASSISTANCE NEEDED AT ALL FOR ANY SURFACE.
  - Includes all kinds of canes, as long as they only require one hand to use safely and correctly.

M1860 Ambulation / Locomotion

- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether assistance required is intermittent ("2") or continuous ("3").
- If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, select Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).

M1860 Ambulation/Locomotion

- If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, ***unless the patient is chairfast.***
- Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance.
  - A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self
  - Wheelchair may be powered or manual version

M1860 Ambulation/Locomotion Example

Patient safely ambulates with a quad cane in all areas of the home except her bedroom and bathroom where she has shag carpet that tangles in the prongs of the cane. In those rooms, she switches to a walker to ambulate safely. The patient does not require any human assistance.

- M1860: 2

M1860 Ambulation/Locomotion Example

The patient does not have a walking device but is clearly not safe walking alone. PT evaluates him with a trial walker brought to the assessment visit and while he still requires assistance and cueing, PT believes he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he lives alone and usually is just up stumbling around on his own.

- M1860: 3

CMS Q&A April 2016

Question 10: My patient does not have an assistive device, but demonstrates the ability to walk safely constantly holding on to his caregiver. His neighbor loaned him a walker to try out during our assessment visit. My patient liked it and was safe walking on level surfaces with no help, but still needed help on the stairs. I have ordered a walker for the patient, and it will be delivered in 2 days.

How do I score M1860 for the day of assessment? With or without the use of a walker?

CMS Q&A April 2016

Answer 10: For M1860, the clinician must consider what the patient is able to do on the day of the assessment, which is the 24 hours that precedes the visit plus the time in the home. If at the time of assessment, (and prior to any teaching or interventions), the patient demonstrates the ability to ambulate safely with a walker and no assistance, then Response 2 - Requires use of a two-handed device to walk alone on level surfaces should be reported, as this is the patient's status on the day of assessment. This is true even if the walker does not belong to the patient and may not remain in the home. The clinician should not assume that the patient would be safe walking with a walker if no walker is available to allow assessment of the patient's status.

M1860 Ambulation/Locomotion Example

A patient is able to ambulate independently with a walker, but he chooses to not use the walker, therefore is not safe. Response #2, or Response #3?

- Report the patient's physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. If observation shows the patient is able to ambulate independently with a walker, without human assistance, *select Response 2 for M1860.*
- However, if the patient forgets to use the walker due to memory impairment, that impacts his ability. The clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, M1860 would be a "3". If the patient only needed assistance intermittently, the correct response would be a "2".

M1860 Ambulation/Locomotion

If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of "chairfast?"

- Item M1860 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose Response 0, 1, 2, or 3, whichever is the most appropriate.

M1860 Ambulation/Locomotion

- **Patient has no device in home and is not safe ambulating even with assistance from another person all the time**.
- "5-Chairfast, unable to ambulate and is unable to wheel self".
- **Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.**
- If the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.

M1860 Ambulation/Locomotion

- **Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist's assistance.**
- Still ambulatory—Response 3 unless able to take only a few steps
- Minimal assistance (like in transferring) vs maximum assistance doesn't apply with ambulation

Knee Scooter

- If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation?
- To determine the accurate response for M1860, the assessing clinician must determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then the clinician must determine if the patient is safe without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.

How safe are they?

Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, he/she is unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room, or could not self-evacuate in the event of an emergency). What response should be selected?

- The assessing clinician must consider the non-ambulatory patient's ability to safely use the wheelchair, given the patient's current physical and mental/emotional/cognitive status, activities permitted, and the home environment.
- In the scenario, the patient's advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; of if they use ambulation or wheelchair mobility with specific purpose, regularity, or efficiency). It is left to the judgment of the assessing clinician to determine the patient's ability (i.e., does the patient's mental status impacted his/her safety?) and select a response accordingly.

Assess Other Factors Affecting Mobility

- Vision, hearing impairments
- Weak muscles, stiff joints, foot problems, neuropathy, balance problems
- Home safety risks: clutter, throw rugs, poor lighting, bathroom inaccessibility, lack of stair rails, unsafe footwear, pets, O2 tubing
- Incontinence or rushing to bathroom
- Use of medical equipment (oxygen, wound treatment, walker, cane, crutches, wheelchair, hospital bed)

Assess Other Factors Affecting Mobility (Cont'd)

- Unsafe or inconsistent use of assistive device
- Environmental set up: type of bed or sleeping surface, width of doorways, flooring, presence of stairs
- Cognitive/memory impairments, impulsivity, or depression
- Regular use of alcohol
- Taking one or more high risk medications such as: sedative, tranquilizer, narcotic, hypnotic, diuretic, antihypertensive, cardiac med, anti-anxiety med, anticholinergic, or hypoglycemic agent.

Barriers to Mobility Assessment

- Inability to safely demonstrate walking at SOC/ROC
- Lack of appropriate device(s) at SOC/ROC visit
- Cognitive or sensory impairment
  - Inability to follow requests and perform activities
- Inaccurate reporting of mobility by clinician
  - Failure to have patient ***demonstrate*** mobility skills
  - Lack of understanding what is measured in OASIS items
  - Incorrect interpretation of OASIS guidance

Best Practices for Transfers and Ambulation

- Assess mobility with direct observation of transfer and gait, safety and ability, use of equipment, need for PT/OT
- Review OASIS guidance for items M1850-1860
- Conference with all disciplines to ensure OASIS responses are accurate – take advantage of the change in the One Clinician Rule!
- Perform a fall risk assessment, tailor interventions to address risk factors identified

Best Practices for Transfers and Ambulation (con't)

- Communicate fall risk level to agency staff, physician, patient, and caregivers/family
- Engage patient and family with a written prescription for safety
- Develop specific measureable goals that apply to the patient's home situation and assistance available
- Continuously evaluate progress with therapy interventions, modify if needed

Tailored Interventions to Improve Mobility

- Assessment of mobility, strength, balance, cognitive status, orthostatic blood pressure
- Exercises focused on balance, strength, gait and transfer training
- Adaptation/modification of home environment and elimination of hazards

Interventions to Improve Mobility

- Obtain (or repair) needed assistive devices
- Consider medication regimen changes
- Assess patient/family willingness to make recommended changes, and compliance with safety precautions for transfers and ambulation, and fall prevention measures
- Add MSW for community resources
  - Equipment, assistance, resources

Improvement in Management of Oral Medications

Assessment: Intake / Referral

- Medication management
  - Obtain discharge medication list
  - Identify new or changed medications
  - Ask what brought patient into the hospital or into the physician office – was medication mis-management a factor?

SOC
ROC
DC

M2020 Management of Oral Medications

(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.)**	
Enter Code ☐	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 person; 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.

M2020 Assessment Techniques

- Ask the patient to gather all medications. Is the patient able to access the medications where they are kept in the home?
- Verify all ordered medications are in the home.
- Ask the patient to explain how he/she takes each medication: time of day, number of pills/tabs, relative to food or other medications
- Ask the patient to demonstrate how to take a pill out of a med bottle (can he/she get the lid off, remove a small pill from the bottle, etc.). If patient uses a med planner, observe if he/she can open compartments and remove pills. Check compartments from day before to see if any pills remain that should have been taken.

M2020 Assessment Techniques

- If the patient has sensory deficits (impaired vision, pain, neuropathy), manual dexterity deficits, or cognitive/memory deficits, assess how patient takes medications safely.
- Assess environmental barriers or ask if the patient is able to access a beverage to swallow oral meds.
- Ask if the patient has difficulty swallowing large pills or other problems with ingesting medications.
- For patients that live in an ALF, assess vision, strength, manual dexterity and cognitive status, and use clinical judgement to determine ability to take correct dosage at the right time

M2020 Management of Oral Medications

- If patient's ability to manage oral meds varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

- If the medication is ordered prn, and on the day of assessment the patient needed a reminder for this prn, then the patient would be a "2". If on the day of assessment, the patient did not need any prn medications, therefore no reminders, then assess the patient's ability on all of the medications taken on the day of assessment. Ch 3

M2020 Management of Oral Medications

- Assess patient's ability to take medications reliably and safely *at all times*
- Identifies patient's ability, not willingness or compliance or actual performance
- Ability can be temporarily or permanently limited by:
  - Physical impairments (e.g. limited manual dexterity)
  - Emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
  - Sensory impairments, (e.g., impaired vision, pain)
  - Environmental barriers (e.g. access to kitchen or medication storage area, stairs, narrow doorways)

M2020 Management of Oral Medications

- Includes all prescribed and OTC oral meds included on the POC
- Excludes topical, injectable and IV meds
- Excludes inhalation meds and sublingual meds (Oct 2012)
- Excludes swish and expectorate meds (Jan 2013)
- Meds given per gastrostomy or other tube are not po 4b-Q167.8
- Does not include filling/reordering 4b-Q166
- Swallow and absorbed through GI system!!

M2020 Management of Oral Medications

- Response 0 Patient sets up her/his own 'planner device' and is able to take the correct med in the correct dosage at the correct time
- Response 1
  - Patient is independent in oral med administration, but requires
    - another person to prepare individual doses (e.g., sets up a planner device)
    - And/or if another person develops a drug diary or chart which the patient relies on to take meds appropriately

M2020 Management of Oral Medications

- Response 2
  - Patient requires another person to provide reminders at the time the medication is to be taken (not in advance)
- What about a device that provides reminders?
  - Who sets up the device? 4b-Q167.5

Examples of Response 3 4b-Q167.5.1

- A patient who decided not to take her new medications, because the varying doses worried her, and she was unsure of the instructions. There had not been a medi-planner set up, nor reminders tried. The clinician would select Response 3 because it is unclear until reassessment if the interventions will be successful.
- A patient who, upon assessment, was not able to take prescribed medications at the correct time and doses even though reminded.
- A patient who, on the day of assessment, was prescribed oral medications, but was unable to safely swallow.

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 appropriate response for 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".

4b-Q167.5.2

Example

Mrs. Wobble is unsteady while ambulating and requires supervision for ambulation. She possesses the knowledge to take her medications reliably and safely if the bottles are placed near, or if she has supervision while ambulating to the medication storage area. How would this patient be scored for M2020? The item intent instructions include guidance related to the patient's ability to access medications, how does this play into the question when the physical impairment causes the patient to require human supervision or assistance and not the cognitive aspect (such as for reminders)?

4b-Q167.5.3

Answer

M2020 reports a patient's ability on the day of the assessment to take the correct oral medications at all the correct times. This would include the tasks of accessing the medications from the location where they are routinely stored in the home, preparing the medications (including opening containers or mixing oral suspensions), selecting the correct dose and safely swallowing the medications, typically involving having access to a beverage. If someone other than the patient must do some part of the task(s) that are required for the patient to access and/or take the medication at the prescribed times, then the patient would NOT be considered independent (Response 0).

More Examples

- Medications are routinely stored in the refrigerator located downstairs. The patient requires someone to assist them at medication administration time to walk to the location where the medications are routinely stored, or someone must retrieve the medications and bring them to the patient; Response "3" would apply. In this situation, just someone preparing the doses in advance did not enable the patient to self-administer their medications.
- The patient requires someone to prepare the medication doses in advance (e.g. visually they can't discern the appropriate dose) and to walk with them at all times to be safe. Someone prepares the medi-planner and sets it within the patient's reach with the water they need to take the meds, the appropriate score is a "1", as the patient can access the medications from where they are routinely stored and has the water available to swallow the medication safely. 4b-Q167.5.3

More Examples

- If the medications were routinely stored in the kitchen and/or the water was not available for the patient to self-administer and the patient required someone to assist them to the location where the meds were stored and or to water, the appropriate score would be a "3".
- Scenario: Patient does not need doses prepared in advance, but the medications are routinely stored in a location that the patient cannot access due to a physical, sensory, or environmental barrier. The patient is scored a "3". During the episode, an environmental modification was made, e.g. changing the medication storage and water supply to a location that the patient can access, the patient could be scored a "0" at the next OASIS data collection time point. 4b-Q167.5.3

TRN
DC

M2016 Medication Education

(M2016) **Patient/Caregiver Drug Education Intervention**: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?	
Enter Code ☐	0 No 1 Yes NA Patient not taking any drugs

Still important to reduce ACH!

Medication Knowledge: Assess – Teach – Evaluate

- Comprehensive assessment at all OASIS time points includes learning assessment as well as assessment of current knowledge and ability to take meds
- Identify barriers to learning and ability
- Assess need for compliance aids or devices
- Teach with goal to improve overall medication knowledge, if realistic; if not, determine appropriate goal
- Evaluate and document patient and/or care-giver's response to teaching

Medication Best Practices

- Review medication list in home q visit
- Evaluate compliance with med regimen
  - Can patient demonstrate or state administration?
    - Inhalers, oxygen, tapering steroids
- Assess med knowledge, educate as needed
  - Identify/document knowledge deficit if present
  - After education, use teach-back to assess pt/cg understanding
  - Instruct who to call for problems or med issues
- Assess for s/sx adverse effects or interactions

Teaching Points for Medications

- Visual recognition of drug
- Purpose of drug
- Name (generic and brand names)
- Dose (mg, number of pills)
- Administration relative to meals, sleep, other meds
- Expected duration of medication therapy
- What to do if a dose is missed
- How to tell if condition treated becomes/remains a problem (medication ineffective), monitoring plan
- Potential side effects and s/sx to watch for
- Potential drug reactions or adverse effects
- If problems identified, who to call and how to report problems

Med Teaching Tips

- Assess current knowledge and identify knowledge deficit
- Identify the primary learner
- Include family or caregivers when appropriate
- Start med education at SOC visit, provide med review and/or education at every visit
- Always provide written drug information to pt/caregiver
- Utilize standardized medication teaching tools
- Always ask for return demo or "teach back"
- On-going evaluation of understanding of meds
- Pharmacy consult for med simplification, OT for devices/aids
- ID patients at risk for non-compliance/adherence with med regimen

Timely Initiation of Care

Timely Initiation of Care

- Conditions of Participation require the initial assessment to determine the patient's eligibility for home care services and immediate care needs; and must be conducted either:
  - Within 48 hours of the date of referral OR
  - Within 48 hours of return home from inpatient facility OR
  - On the physician-ordered SOC/ROC date
- Initial assessment vs. SOC visit dates

Timely Initiation of Care

- OASIS items used for measurement:
  - M0102 – Date of physician-ordered Start of Care (Resumption of Care)
  - M0104 – Date of Referral
  - M1005 – Inpatient Discharge Date (most recent)

M0102 Date of Physician-ordered SOC/ROC

(M0102) **Date of Physician-ordered Start of Care (Resumption of Care):** 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 M0110, if date entered*]
month / day / year

☐ NA - No specific SOC date ordered by physician

- Time points: SOC, ROC
- Specifies date HH services are ordered to begin or resume IF the date was specified by the physician
- Mark **NA** if the physician orders do not specify a SOC or ROC date

M0102 Date of Physician-ordered SOC (or ROC)

- Must be a single specific date to initiate or resume care, not a range of dates.
- If the originally ordered SOC/ROC date is delayed due to patient condition or physician request (example: extended hospitalization), then the date specified on the updated/revised order to start/resume home care services would be considered the date of physician-ordered start of care or resumption of care.

Effective January 13, 2018: New CoP

- The new Home Health Conditions of Participation revised § 484.55(d)(2) to allow for a physician-ordered Resumption of Care date as an alternative to the fixed 48 hour time frame for a post-hospital reassessment. This change allows physicians to specify a Resumption of Care date that is tailored to the particular needs and preferences of each patient.
- This means: if the agency has a specifically ordered (or approved) ROC date, M0102 may be completed to reflect that ordered date on a ROC (same as on SOC).

April 2018 Q&A #5

Q: Please clarify changes to M0102 as it relates to the physician-ordered ROC dates.

A: With the HH CoP, effective 1/13/18, the assessment time frame for completing a ROC assessment was expanded to include allowance of a physician-ordered ROC date that is later than 2 days post-discharge. Effective 1/13/18, M0102 may be coded with the physician-ordered ROC date, even if the physician-ordered ROC date is later than 2 days post discharge.

July 2018 Q&A #5

Q: Now that the physician can order a ROC date that goes beyond 48 hours from hospital discharge, can that date be extended? Our patient was discharged from the hospital on Tuesday and the referral included orders to resume care on Friday. When we called to arrange the time of the visit, he said he had other medical appointments on Friday and to come on Monday. We called the ordering physician Friday requesting a delay in the ROC and received a call back on Monday approving the delay in ROC. How do we answer M0102?

July 2018 Q&A #5

Any issues with this answer?

A: To report this new updated/revised physician's ordered ROC date in M0102, it must have been received on or before the date of the previous physician's ordered ROC. If the order to extend the physician's ordered ROC date is received after the date of the previous physician's ordered ROC date has passed, report **NA** for M0102 and report the original referral date in M0104. In your scenario, since you received the updated physician ordered ROC date after the original physician ordered ROC date had passed, report NA for M0102 and the original referral date (Tuesday) in M0104.

M0104 Date of Referral

(M0104) 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

- Time points: SOC, ROC
- Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was **received** by the home health agency.

M0104 Date of Referral

- If SOC is delayed due to the patient's condition or physician request, then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral.
- This does not include calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- The date authorization was received from the patient's payer is NOT the date of referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).

M0104 Date of Referral

- When an agency receives an initial "referral" or contact about a patient who needs service, the HHA must ensure this physician, or another physician, will provide the plan of care and ongoing orders.
- If a physician is willing to follow the patient, and provides adequate information (name, address/contact info, and diagnosis and/or general home care needs) regarding the patient, this is considered a valid referral.
- In cases where the referring physician is not going to provide orders and follow the patient, this is not a valid "referral" for M0104.

3rd Q. 2014

M0104 Date of Referral

- In the example of a hospitalist who will not be providing an ongoing plan of care for the patient, the HHA must contact an alternate, or attending physician, and upon agreement from this following physician, for referral and/or further orders, the HHA will note this as the referral date in M0104 (unless referral details are later updated or revised).
- If a general order to "Evaluate for Home Care services" (no discipline(s) specified) is received from a physician who will be following the patient, this constitutes a valid order, and per CoP §484.55 the RN must conduct the initial assessment visit to determine immediate care and support needs and eligibility for the Home Health benefit for Medicare patients.

3rd Q 2014

M0102 and M0104 for late F2F

- When a new Start of Care date is established based on the completion of a late face-to-face encounter for Medicare eligibility, report M0102 – Date of Physician-ordered SOC as **NA** and report M0104 – Date of Referral as the day prior to the new Start of Care date.

M1005 Inpatient Discharge Date (most recent)

(M1005) Inpatient Discharge Date (most recent):

__/__/____
month / day / year

☐ UK - Unknown

- Time points: SOC, ROC
- Identifies the date of the most recent discharge from an inpatient facility (within past 14 days)

Example 1

- HH Agency gets a referral from the hospital on Mr. Smith on Jan. 1, with an anticipated DC date of Jan. 3.
- Agency checks hospital census report daily and sees Mr. Smith is still in the hospital end of day on Jan. 3 and there's no answer at his home number. Contact with hospital: patient has a UTI and they are keeping him another day or two to make sure he responds to antibiotic.
- Patient is discharged from hospital to home on Jan. 7.
- Agency does initial assessment and SOC visit on Jan. 8.
  - M0102 – NA
  - M0104 – Jan. 3 (updated info)
  - M1005 – Jan. 7

Example 2: Patient Requests Delay

Physician Not Informed	Physician Informed & New SOC Approved
M0030: Jan. 4	M0030: Jan. 4
M0102: NA	M0102: Jan. 4
M0104: Jan. 1	M0104: skipped if date entered in M0102
M1005: skipped, no inpatient discharge in past 14 days	M1005: skipped

Best Practices for Timely Initiation of Care

- **Office staff practices:**
  - Record date on all valid referrals.
  - Monitor inpatient census daily to avoid missing discharges.
  - Update referral date on all patients with delayed discharge or change in discharge plan.
  - If patient/family refuses (or staffing issues prevent) the initial visit within 2 days of inpatient discharge, notify the referring physician and obtain order for a new SOC date. Document this communication and either add to the referral information or retain as a separate order.
  - Track all referrals, discharge dates, and communication from field staff if patients are not available for admission visit.

Best Practices for Timely Initiation of Care

- **Field staff practices:**
  - Educate patient/family to contact agency for all inpatient admissions.
  - For hospitalized patients, inform office so patient is tracked on daily census check.
  - When clinician is assigned a SOC/ROC, have a process to make sure there is acknowledgment that clinician has received referral info.
  - Clinician contact patient/family the night before to arrange time for initial/SOC visit. Document any problems with visit scheduling and communicate to office staff.
  - If unable to make the initial/SOC visit, communicate with office staff or physician to identify reason and obtain order to move SOC visit date.

Best Practices for Timely Initiation of Care

Field staff practices (cont'd):

- When completing the SOC or ROC OASIS items:
  - Check the referral: was there a specific date for SOC? **M0102**
  - Check the referral: what is the referral date? **M0104**
  - Is the date in M0104 more than two days ago? If it is >2 days ago, investigate if there was updated/revised information from the referral source about a delay or change in plan that didn't get documented on the referral? Does the physician need to be contacted to inform him/her of the circumstances of the delayed SOC?
- Document all communication regarding delays in SOC or ROC visits.
- Remember: approval to extend a physician-ordered SOC/ROC date must be obtained on or before the the date of the previous physician's ordered SOC or ROC. This is not something you can go back and "fix" later!

Best Practices for Timely Initiation of Care

- **Quality Assurance staff:**
  - Review all SOC and ROC assessments for compliance with the 48 hour requirement.
  - For all assessments with >2 days before the SOC or ROC date, investigate circumstances and obtain any omitted documentation from office or clinical field staff.
  - If the initial/SOC visit was delayed beyond the required time period identify the case for focus auditing.
  - Focus audit: on all cases where the initial SOC/ROC visit was not made within the 2 day time period, determine if best practices were followed; identify if this is a trend. Is this a process problem or a problem with individual staff member performance? Revise or remediate.

OASIS-D Coming 1-1-19

Analysis to Remove Items

- Items used to calculate a measure finalized for the Home Health Quality Reporting Program (HH QRP)
- Items used in the Home Health Prospective Payment System (PPS)
- Items used in the survey process for Medicare certification
- Items used to calculate a measure in the Home Health Value-Based Purchasing (HH VPB) demonstration
- Items used as a critical risk-adjustment factor
- Items incorporated into the OASIS to fulfill a data category as part of the Conditions of Participation

35 OASIS items removed would result in the collection of *247 fewer data elements* at specific time points within a home health episode

Removed Items

- M0903 Date of Last (Most Recent) Visit
- M1011 Inpatient Diagnosis
- M1017 Diagnoses Requiring Medical or Tmt Change
- M1018 Conditions Prior to Regimen Change
- M1025 Optional Diagnoses
- M1034 Overall Status
- M1036 Risk Factors
- M1210 Ability to Hear
- M1220 Understanding of Verbal Content
- M1230 Speech and Oral (Verbal)
- M1240 Pain Assessment
- M1300 Pressure Ulcer Assessment
- M1302 Risk of Developing Pressure Ulcers
- M1313 Worsening in Pressure Ulcer Status
- M1320 Status of Most Problematic Pressure

Still assess r/t POC

Best Practices

Removed Items

- M1350 Skin Lesion or Open Wound — Already in wound assessment
- M1410 Respiratory Treatments
- M1501 Symptoms in Heart Failure
- M1511 Heart Failure Follow-up
- M1615 When does Urinary Incontinence
- M1750 Psychiatric Nursing Services
- M1880 Ability to Plan and Prepare Light Meals
- M1890 Ability to Use Telephone
- M1900 Prior Functioning ADL/IADL
- M2040 Prior Medication Management
- M2110 How Often does the patient have assistance
- M2250 Plan of Care Synopsis
- M2430 Reason for Hospitalization

Best Practice

GG: Functional Abilities and Goals

- Alignment with standardized sections in other PAC assessment instruments
- “Patient” instead of “resident”
- SOC/ROC instead of admission
- Full assessment timeframe to complete data collection as part of comprehensive assessment

GG0100

Impact Act

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

↓ Enter Codes in Boxes	
☐	A. **Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illnesss, exacerbation, or injury.
☐	B. **Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
☐	C. **Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
☐	D. **Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Takes the place of M1900

GG0110

Impact Act

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply	
☐	A. Manual wheelchair
☐	B. Motorized wheelchair and/or scooter
☐	C. Mechanical lift
☐	D. Walker
☐	E. Orthotics/Prosthetics
☐	Z. None of the above

GG0130 Self-Care SOC/ROC

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:
Safety and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance –** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent –** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

GG0130 Self-Care SOC/ROC

Notice there is no D

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Activity D is "Wash Upper Body"

Contrast and Compare

		E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

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

Enter Code ☐

0 Able 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 Able 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 Able 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.

6 Unable to participate effectively in bathing and is bathed totally by another person.

GG0170 Mobility SOC/ROC

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

GG0170 Mobility

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode. Get to?
☐☐	☐☐	**G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88 →skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step .
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail.

GG0170 Mobility

☐☐	☐☐	**O. 12 steps:** The ability to go and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q. Does patient use wheelchair/scooter?** 0. No → *Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1.* 1. Yes → *Continue to GG0170R, Wheel 50 feet with two turns.*
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1. Indicate the type of wheelchair or scooter used.** 1. Manual 2. Motorized
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. Manual 2. Motorized

J1800/J1900 Transfer, Death at Home and DC

Section J	Health Conditions
J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent? 0. **No** → *Skip J1900* 1. **Yes** → *Continue to J1900. Number of Falls Since SOC/ROC, whichever is more recent*
J1900. Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**
☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Remember this one?

(M2102) **Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance

SOC/ROC retains only one row

(M2102) **Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Needed for HHVBP

Discharge will have three more rows

(M2102) **Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Collected for survey purposes	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Gone from M2102

Enter Code	
☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code	
☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code	
☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

M2310 Reason for Emergent Care

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

OASIS C

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

OASIS D

Resources for OASIS Accuracy

- OASIS-C2 data set, OASIS-D effective 1/1/2019
- OASIS-C2 Guidance Manual, Ch. 3
  - Update for 2018, draft version of OASIS-D available
- CMS OASIS Q&A's
  - Oct. 2016, effective Jan. 2017
- CMS "Quarterly" Q&A's resumed
  - April and July 2018 available
- OEC for your state

When guidance from two CMS resources conflicts – use the most recent.

When unable to find an exact answer – use clinical judgement.

What questions do you have?

- Lisa@selmanholman.com
- Teresa@selmanholman.com
- Selman-Holman & Associates, LLC
- www.selmanholman.com
- CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
- www.Codingdoneright.com
- CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice
- www.codeprou.com