Clinical "Hot Topics"

for Home Care 2020

Day 2

KHCHA Winter Conference

December 2019

Teresa Northcutt, BSN, RN, COS-C, HCS-D, HCS-H

Selman-Holman & Associates
A Briggs Healthcare Company

Home Health Insight—Consulting, Education and Products
CoDR—Coding Done Right
CodeProU
5800 Interstate 35 North, Suite 301
Denton, Texas 76207
214.550.1477
972.692.5908 fax
Lisa@selmanholman.com
Teresa@selmanholman.com
www.selmanholmanblog.com
www.selmanholman.com
www.CodeProU.com

Learning Outcomes

- Identify one new feature of OASIS-D1
- State who can approve OASIS item corrections
- List who can collaborate on assessment and care planning
- State one principle of case management
- Identify one quality measure that is publicly reported (HH Star or IMPACT Act measures)

OASIS-D1 Changes

OASIS-D1 Changes

- Addition of M1033 and M1800 to the **Follow-Up** assessment instrument (with corresponding revisions to the All Items instrument).
- Guidance revisions include a change from required to optional data collection at certain time points for 23 items
- ***No revised version of the OASIS-D Guidance Manual for 2020.***
- The changes to the OASIS data set and data collection guidance are effective for OASIS assessments with an M0090 Date Assessment Completed of January 1, 2020 or later.

OASIS-D1 Changes

- The new valid response of an equal sign is optional for certain OASIS items at specified time points. By coding an item with an equal sign, HHAs are indicating that they are treating the allowed item as optional and *have chosen not to report on the item.*
- When a clinician/agency chooses not to report on an optional item, the only valid response is an equal sign. An equal sign and a blank or dash are not the same.
- ***Remember the CoPs still require a comprehensive assessment.***

"Optional" Items on Recert FU

- M1021/M1023
- M1030
- M1200
- M1242
- M1311, M1322, M1324
- M1330, M1332, M1334
- M1340, M1342
- M1400

M1910

M2200

=

"Optional" Items on Recert FU

- M1030: Are these therapies documented (site of IV, rate of flow, enteral nutrition orders, instructions)
- M1200: Is the patient's vision functionally impaired? Are there adaptations in the care plan for his lack of vision? Is safety a concern because of vision?
- M1242: Pain assessment documented? Severity, locations, type, acute/chronic, triggers, relieveing factors?
- M1600s: Elimination issues identified that impact plan of care, incontinence impact on mobility, skin integrity, safety, need for assistance

"Optional" Items on Recert FU

- M1300s: skin integrity, wounds
  - Pressure ulcer stages, locations, appearance, response to treatment (don't overlook Stage 1)
  - Stasis ulcer locations, description, drainage, progress toward healing
  - Surgical wound locations, primary/secondary healing, appearance, any s/sx infection, healing status
  - Treatment on all wounds, teaching pt/cg
- M1400: respiratory rate, pO2, use of accessory muscles, endurance, triggers for dyspnea
- M1910: fall risks identified and documented

M0110 – Not used in PDGM

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?	
Enter Code [NA]	1	Early
	2	Later
	UK	Unknown
	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.

Wording of item still works but guidance manual still refers to 60-day episodes

M0110

- Will not change and will not be optional (no equal sign)
- May mark NA on all Medicare (traditional/FFS) assessments (not optional)
- Will still be used for other payers who use the 60-day definition.
- October 2019 OASIS Q&A #s 11 & 12

M2200 =

(M2200) **Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

January 1—Agencies may enter = sign *at the Follow-Up time point only.*
October 2019 Q&A 27 and 28

M2200

- No longer used for PDGM
- May be used for other payors
- MAY code NA for all assessments that do not require data for payment including Medicare FFS
- However, ***data is used for risk adjustment for OASIS-based functional outcomes***, so may elect to enter estimated therapy visits planned for **60-day certification period.**

OASIS Action Items

- Evaluate current OASIS scoring accuracy
- Evaluate documentation to support scoring
  - OASIS responses should be supported by other documentation within the comprehensive assessment, with therapy evaluations, with visit notes and consistent with other documentation in the medical record
- Additional training as necessary on OASIS guidance and documentation requirements
- Implementation of OASIS-D1

Resources for OASIS Accuracy

- OASIS-D1 data set
- OASIS-D Guidance Manual, Ch. 1 and Ch. 3
- CMS OASIS Static Q&As Category 1-4
  - Updated last October 2018
- CMS Quarterly Q&As, resumed April 2018
- OASIS Considerations for PPS Patients
- WOCN Guidance for OASIS Wound Items
- OASIS Education Coordinator for your state

Quality Resources

- Home Health Quality Reporting Program website

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

  - Spotlight and Announcements
  - Home Health Quality measures, Star Measures
  - OASIS data sets and Guidance Manuals
  - HH Quality Reporting Training
- Home Health Quality Help Desk email: homehealthqualityquestions@cms.hhs.gov
- References and Manuals

https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals

OASIS-D1

- OASIS-D will be updated to the **OASIS-D1** data set, effective January 1, 2020
- The OASIS-D Guidance Manual will not be revised in 2020 for OASIS-D1 – **all updates and changes will be explained in the CMS Quarterly OASIS Q&As**
- So remember…

So remember…

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

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

If there's no information in the Q&As – consider submitting a question to CMS

Homehealthqualityquestions@cms.hhs.gov

Effective January 1, 2020

- 60-day episodes beginning *on or before* December 31, 2019 and end on or after January 1, 2020 payment will be based on the current 60-day episode rate.
- Home health periods of care that begin *on or after* January 1, 2020, the unit of service will be a 30-day period and claims will be required every 30 days.
- The changes to the OASIS data set and data collection guidance are effective for OASIS SOC assessments with an M0090 Date Assessment Completed of 1/1/2020 or later. (Exception: special rule for FU for Recertification)

OASIS-D1

- To allow for the 5-day recertification window for episodes of continuous care that begin 1/1/2020 through 1/5/2020, there may be cases where the RFA 4 - Recertification assessment is completed in the last five days of 2019. In these cases, CMS is temporarily waiving the requirement that HHAs enter the actual OASIS completion date in M0090, and ***instead enter the M0090 date of 1/1/2020***.
- HHAs should be aware that in the event they attempt to submit the RFA 4 - Recertification assessment with an artificial M0090 date of 1/1/2020 prior to 1/1/2020, they will receive a fatal error preventing the transmission of the assessment. Therefore, ***HHAs should not transmit these assessments until 1/1/2020.***

OASIS-D1

- This waiver will not be applicable to any other assessment performed either before or after this brief period, when all existing OASIS instructions regarding item M0090 apply.
- CMS is issuing this waiver, which is essentially a one-time exception, to facilitate the transition to the Patient-Driven Groupings Model (PDGM).
- CMS will alert State surveyors of this one-time exception.

OASIS-D1

Transition Recertifications:
Recertification (RFA 4) with M0090 date of 12/27/19 – 12/31/19 for an episode where that assessment must provide the HIPPS code for a PDGM payment episode that begins January 1, 2020 or later

HHA Action:

- Assess using the OASIS-D1 Follow-up Assessment instrument and submit the RFA 4 Recertification assessment with the artificial M0090 date of 1/1/2020.
- Submit this assessment no earlier than 1/1/2020.

Transition Recertification Example

- SOC date November 3, 2019
- Recertification assessment (using OASIS-D1 Follow-up instrument) is completed on December 29, 2019 (for the subsequent episode of continuous care beginning January 2, 2020)
- Report artificial M0090 date of 1/1/2020
- Submit this assessment no earlier than 1/1/2020.
- If a RAP or claim with a PDGM HIPPS code is submitted between 01/01 and 01/05 will be held for processing after implementation.

OASIS Corrections

Collaboration

Assessment and Care Planning

Expansion of the One Clinician Rule

- CMS is promoting a team approach to data collection, as present in other PAC settings
- Comprehensive assessment includes OASIS items and is part of legal HHA clinical record. While only the *assessing clinician is responsible for accurately completing and signing comprehensive assessment*, s/he may collaborate to collect data for all OASIS items, as agency policy allows. (per CoPs)
  - Signature is attestation that to the best of his/her knowledge, the document reflects the patient status as assessed, and supported as documented.

Expansion of the One Clinician Rule

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

CMS Q&A July 2019

- **QUESTION 3: How does the General OASIS Convention that "the time period under consideration includes the 24 hours immediately preceding the visit, plus the time in the home for the comprehensive assessment" work with using collaboration within the assessment timeframe?**
- **ANSWER 3:** When collaboration is used, other agency staff may provide information to the assessing clinician on what he/she assessed during a visit conducted during the ***assessment timeframe***. Each person collaborating may provide information that was collected utilizing the existing conventions, including the "day of assessment." For example, if desired, the PT who visited on Wednesday may provide information that was relevant to the PT's "day of assessment" (the 24 hours that proceeded the PT's visit, and the time the PT was in the home) to the RN for consideration when coding the SOC/ROC assessment items.

Quiz

- The aide visited the patient on Monday, discovered the patient had been hospitalized for two days and came home on Sunday. The RN visits the patient on Tuesday to do the ROC assessment, the PT visits on Wednesday, and the OT visits on Thursday. Based on the expanded collaboration allowed effective January 2018, the nurse could use information from which visits to complete ROC OASIS items?

What's the ROC date?

a. RN visit only
b. RN, PT, OT since all are qualified clinicians
c. HHA, RN, PT because all 3 visits are within timeframe
d. HHA, RN, PT and OT because collaboration is allowed

A B C D

Quiz--OASIS Quarterly Q&A April 2018

- The aide who visited the patient on Monday, discovered the patient had been hospitalized for two days and discharged home on Sunday. The RN visits the patient on Tuesday to do the ROC assessment and the PT visits on Wednesday, and the OT visits the patient on Thursday. Based on the expanded collaboration allowed effective January 2018, could the nurse use information from the aide and the PT and OT visits to complete ROC OASIS items?

a. RN visit only
b. RN, PT, OT since all are qualified clinicians
c. HHA, RN, PT because all 3 visits are within timeframe
d. HHA, RN, PT and OT because collaboration is allowed

A B **C** D

Details Re: Collaboration

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

Collaboration with Nursing

- Drug Regimen Review
- Identification of focus of home care (primary dx determined with input from therapy and nursing)
- Skill mix to ensure best discipline for right actions
- Education on disease processes and management, medications, post-discharge follow up needs
- WOCN for complex wounds

Collaboration with Therapy

- Functional performance of ADLs, IADLs
- Status of current assistive devices, need for others
- Mobility and safety in home environment
- Fall prevention plan
- Ability to evacuate home in case of emergency
- Scoring of OASIS M1800 and GG items
- POC: reinforce interventions (not duplicate), consider treatment for typical chronic conditions beyond "muscle weakness"

Collaboration with Aide, MSW

- Home care aide
  - Pain, dyspnea, incontinence data
  - Compliance with meds, interventions
  - Patient/family concerns
- MSW
  - Evaluate how patient's ability and need for assistance impacts family members' roles and responsibilities – is your goal really going to make a difference in care?
  - Linkage with community resources
  - Payment options for post-discharge care

Collaboration Considerations

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

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

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
- Recertification: reason for continuation, order changes, approval of POC
- ANY changes in patient condition or adverse s/sx, complications, use of PRN visits
- 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 – LPN
- Nursing – Therapy
- PT – OT – PTA – COTA
- Home Health Aide (personal care)
- MSW

Who Does What?

RN, PT, OT, SLP

- Comprehensive assessment
- Develop Plan of Care interventions and goals
- Evaluate progress toward goals, determine effectiveness of POC
- Revise interventions and/or goals with physician input

LPN, PTA, COTA, HHAide

- Perform individual treatments / interventions
- Determine patient response to treatments performed at visit
- Provide information to RN or therapist about the effectiveness of treatment activities

Interdisciplinary Coordination

- 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 Conference Points

- Primary diagnosis, focus of care
- Other diagnoses impacting POC
- Problem issues
  - Pain, meds, wound care, fall risk
- Patient coping, understanding, motivation
  - Patient's goals for home care services
- Support / caregiving situation, ID roles
- Risk for hospitalization, interventions
- Coordination to meet problem issues
- Homebound status and medical necessity

ROC Conference Points

- Reason for hospitalization
- Interventions to reduce re-hospitalization risk
  - Changes needed to prevent repeat
- Primary and other 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 Conference 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 Conference 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 Conference 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

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?

Interdisciplinary Coordination

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

Care Coordination Tools

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

Put the pieces together…

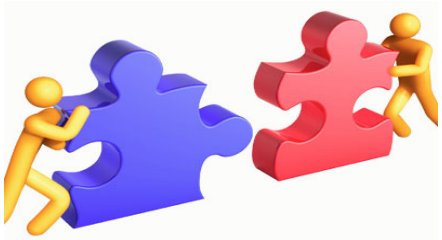
- *Identify the problems that are most important to the patient's health and safety, then establish and implement a plan of care to address and resolve those problems to the satisfaction of the patient, caregiver/family, and physician.*
- *Focus on patient's ability to function safely in the home environment*
- *Ultimate goal: highest quality care delivered to meet patient needs and achieve goals, patient able to manage self care after discharge*

Care Planning Process

Collaboration is the key to success!

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



Steps in Care Planning

- Intake and referral process
- Initial assessment of eligibility
- Comprehensive assessment
- Identification of patient needs
- Identification of patient/caregiver considerations
- Collaboration with applicable disciplines
- Centralized management of Plan of Care
- Communication with physician

Care Planning starts with 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
  - F2F reason for referral = acceptable primary diagnosis?
  - Query process started, coder involved?
- Availability of intake data to clinicians at SOC
- How are referral orders/info transferred to POC?
  - Collaboration with agency staff, others
  - Correction of any errors on intake information, verify with physician if needed

Diagnosis Specificity Intake Sheet

- **ARTHRITIS-circle applicable description(s)**

- Osteoarthritis
  - Primary
  - Secondary
  - Post-Traumatic
  - Generalized
  - Localized
- Rheumatoid
  - Seronegative
  - Seropositive
  - Juvenile type
  - Organ involvement?

- Joints affected
  - Hip
  - Knee
  - Other (specify)
- Laterality
  - Right
  - Left
  - Bilateral

Initial Assessment: Certification Points

1. The patient needs intermittent SN, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   - a. *Occurred* no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   - b. ***Was related to the primary reason the patient requires home health services; and***
   - c. Was performed by a physician or allowed non-physician practitioner

Comprehensive Assessment

- Identify patient's eligibility for the home health benefit and continuing need for home care services
- Identify patient's medical, nursing, rehabilitative, social and discharge planning needs
- Physical assessment, focus on referral diagnoses, identify any additional conditions
- Perform Drug Regimen Review, identify issues
- Collect OASIS data to accurately reflect patient's status at the time of assessment, document supporting info for key items
- Hospitalization and ED risk assessment, other risk assessments (falls, pressure ulcers, depression, etc)

Comprehensive Assessment con't

- Advance directives, identify type
- Hazard assessment, emergency preparedness plan
- Assess education needs, knowledge deficits
- Evaluate caregivers, support system, available resources for care and missing components
  - Next physician appointment or follow up needs
- Discuss discharge plan with patient and family
  - Prior level of function? achievable?
- Determine patient's goals, agency goals and set measurable outcomes for home care
  - Reasonable, necessary, achievable

Collaboration on Assessment

- Appropriateness of orders on referral for evals
  - Adding disciplines? Questioning those ordered?
- Timing of evaluations
- Method(s) for collaboration between disciplines
  - Pros and cons of centralized collaboration/coordination
- What information is shared?
  - Validation of OASIS data collection
  - Patient problems, goals, barriers to outcomes
- How is collaboration documented?

Assessment → Care planning

- Functional status, abilities, impairments
- Safety issues, medication administration
- Other concerns of patient, family, clinicians
  - Barriers to implementing plan of care, achieving goals
- Risk factors for hospital re-admission or ED use
- Educational needs of patient, caregivers
- Discharge plans, community resource needs

Key: identify priorities!

Diagnosis Considerations

- Select the primary diagnosis ***after*** completing the comprehensive assessment, collaborating
  - Is it the focus of HH care/services? For all disciplines?
  - Does it reflect the patient's needs identified on assessment?
  - Is it an acceptable primary diagnosis in PDGM?
    - If not, can you choose a different primary diagnosis?
    - What query or approval is needed?

Diagnosis Considerations

- Verify with intake and referral documentation
  - Is the diagnosis documented by the physician or other approved provider?
  - On the F2F encounter note, *is the primary diagnosis the reason for referral to home care?*
  - May need a new F2F encounter to change diagnosis?
- If not in referral documentation:
  - Verify diagnosis with provider
  - Document confirmation of diagnosis
- Sequence diagnoses by importance to the POC
  - Don't forget coding guidelines!

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

Disciplines

- What does the patient really need?
- Which discipline(s) can ***best*** provide needed interventions? Most effective utilization?
- Utilization of therapy services
- Utilization of home health aide services
- Benefits of MSW utilization
- Appropriate skilled reason for all disciplines
- Address any refusal of care/disciplines

Frequencies and durations

- Plan visit frequencies
  - Front loading for nursing, therapy
  - Staggering to meet priorities of patient, POC
- Time frame for home care
  - Physician protocols, ACOs, outpatient services
- Scheduling of LPN, PTA and COTA visits, oversight by RN, PT, OT
- Indications for reduced frequency or discharge of a discipline – value of the "return demo"

Physician Coordination

- ***CMS expects the Plan of Care (485) to be a transcription of agency communication with the patient's physician***
  - Verification of additional diagnoses
  - Address drug regimen review issues
  - Obtain orders for necessary interventions
  - Approval for patient/caregiver/agency goals
  - Establish discharge plan

  Any diagnoses/orders/goals that are not included in referral information must be approved by physician

Review the Plan of Care

- Does the POC address a recent change in patient's condition? New/exacerbated diagnosis?
- Does the POC focus on the patient's problems identified on assessment?
- Does the POC include interventions and goals related to the primary diagnosis? Other pertinent diagnoses?
- Are all necessary disciplines involved in POC? Appropriate interventions? Frequencies?
- Are goals for all disciplines reasonable, necessary, achievable? Focused on function and safety? Include avoiding hospital/ED admission?

Consideration of 30 day periods

- Timing of visit frequencies, durations
- Get in and out quickly within first 30 days?
- Continue into second 30 day period?
- What about LUPAs?
- Will we ever recertify a patient in PDGM?

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

Case Management in PDGM

How does PDGM impact case management?

PDGM Key Points

- 30 day payment units within 60 day episode of care (i.e. certification period)
- LUPA structure change: 2-6 visits, varies by payment group, based on 30 day unit of payment
- RAP continues for 2020 (except for new HHAs)
- Billing requirements unchanged, but now every 30 days instead of 60 days
- Penalizes inefficiencies: LUPAs, missed visits, excessive number of visits especially those not supported by functional need

Case Management is…

- Coordination of care between disciplines, and with other community services
- Communication with patient, caregivers, nurses, therapists, aides, other providers
- Identifying needs, setting goals, solving problems
- Progress toward goals, outcome improvement
- Organization, prioritization, time management
- Meeting regulatory requirements
- Quality and reimbursement impact considerations
- Patient advocacy

Case Management Model

- Care is goal oriented, rather than task oriented
- All disciplines and clinicians communicate with each other to plan the episode care
- All disciplines and clinicians work together in a coordinated way to improve patient outcomes, meet goals
- The patient/family are partners in care
- **Two levels of case management**:
  - Clinical Manager oversees healthcare teams and agency services
  - Primary Case Manager manages individual patient caseloads and visits

Case Management Oversight

- Facilitate collaboration between clinicians
- Validate OASIS scoring
- Assist in determining focus of care (principal dx)
- Ensure all SOC information is available to all clinicians same day of visit
- Initiate approval of POC with physician at SOC, follow up on any physician communications
- Manage SOC/ROC scheduling to reduce late SOC visits, avoid missed visits, manage use of PRN visits, reduce unexpected LUPAs

Case Management Oversight

- Monitor interventions by all disciplines, progress toward goals, accountability for care delivery, effectiveness of services
- Support care coordination, order management
- Manage supply usage
- Track quality measures for team, identify staff development needs
- Improve financial outcome by doing what's right for the patient's needs – no more, no less

PDGM Challenges

- Timely completion of key requirements for RAP submission and filing of claim
- Reduce duplication and waste of services
- Appropriate therapy utilization
- Selection of diagnoses that support care
- Management of LUPA episodes, visit frequencies
- Maintain quality measure performance

Request for Anticipated Payment

- Requirements for submitting RAP unchanged
  - Verbal orders for home care have been received and documented
  - First billable visit completed (and documented)
  - Plan of Care (485) sent to physician
  - OASIS ready to transmit
- Median length of time to RAP submission is 12 days
  - 10% of RAPs are not submitted until 36 days after the start of a 60-day episode of care
  - 5% of RAPs are not submitted until the end of a 60-day episode of care

RAP Considerations

- What are days to RAP in your agency?
- Where is your bottleneck?
  - Staff completing OASIS? (SOC + 5 days to complete *assessment*)
  - OASIS review?
    - Actual review time by QA
    - Clinicians completing inaccurately, time for corrections
  - Coding?
    - Getting enough info to code specific/acceptable diagnoses
    - Who is doing the coding?
    - "Matching" the F2F
  - Plan of Care development?
    - Therapy eval and plan done? Collaboration?

What About Second RAP?

Second 30 Day Unit of Payment (every other time)

- Plan of Care is already done
- OASIS has already been transmitted (the one at the beginning of the 60 days—SOC or recert)
- Claims data system will look for most recent assessment so may be a ROC or Other FU (has to be ready to be transmitted)
- Make that first billable visit and send RAP

Case Management of SOC and Recert Processes to RAP

- Gathering complete information at intake
- Scheduling of SOC visit within 48 hours
- Completion of SOC and Recertification visits
- Completion of therapy evals to allow collaboration
- Timely completion of documentation and OASIS
- QA review of comprehensive assessment/OASIS
- Diagnosis coding completed, reduce need to query for specific details
- Development of POC, ready to send to physician
- Scheduling of first visit in second 30 day period

Intake Key Information (Checklist)

- Primary diagnosis for home health
- Query if unspecified dx, symptom, or questionable encounter diagnosis
- Check F2F encounter note: reason for referral to HH must align with primary diagnosis on POC
- Source of referral: community or facility (14 days)
- Services requested: validated by diagnoses/conditions
- Referral documents to support the need for HH and services ordered
- Call patient to schedule SOC visit, priority in 24 hours

Example Case: Referral received

- Mrs. Markum, 78 year old female with two venous stasis ulcers on her left lower leg, requiring wound care by SN
- Additional diagnoses: diabetes, OA of right knee and both hips, hx left total knee replacement (2017)
- Patient has been hospitalized for fever, stasis ulcer wound infection with Pseudomonas, wound treatment change, new po antibiotic, change in Insulin dose due to hyperglycemia.
- Had a fall in the hospital with lacerations on her forehead and right hand. SN to assess, change daily dressing and remove stitches on Wednesday March 20. Agency intake asked for and got approval for PT eval due to recent fall.
- Hospital sending H&P, F2F, med list, face sheet, etc.

Face-to-Face Encounter documentation

- Hospitalist progress note prior to patient discharge home, signed by MD and dated 3/13
  - Legible signature and date? By certifying physician?
  - Date within 90 days before or 30 days after SOC date?
- Homebound reason: “due to taxing effort to leave home” and “limited mobility”
- Reason skilled home care services needed: “SN for dressing changes to diabetic ulcer”

What’s wrong with this F2F?

What can we do to “fix” it?

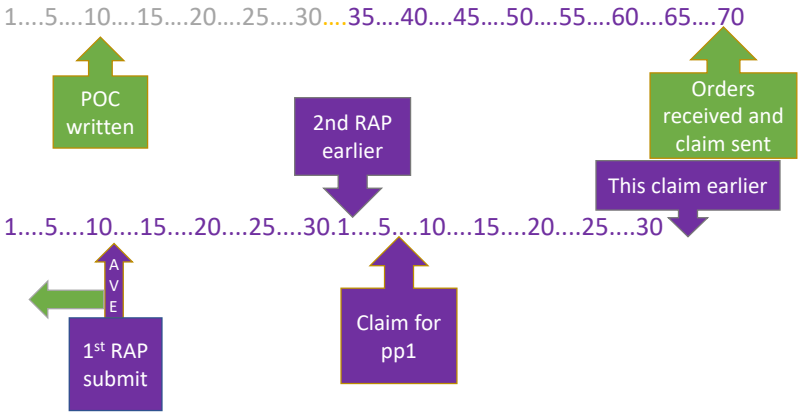
F2F Addendum - information needed

- Homebound status better explained with more specific reasons based on comprehensive assessment findings
- Primary diagnosis for home care clarified: is this a diabetic ulcer or a venous stasis ulcer?
- Add to reason for SN skilled need: assess wounds and diabetic status, response to new/changed medications, teach new meds and wound care and s/sx to report. Add PT to eval for fall risk, home safety and instruct in fall prevention measures
- Requires approval by certifying physician for HH (unless hospitalist will oversee POC and sign 485)

Claim Requirements Unchanged

- Before a provider submits a final claim, HHA must have:
  - A completed OASIS assessment transmitted within 30 days of M0090 date,
  - Signed plan of care with certification statement,
  - Signed interim orders,
  - All visit documentation completed
- CMS expectation is that the HHA will obtain the signed physician certification and plan of care timely
- How long does it take after the 60-day episode before the final claim can be submitted in your agency? How will 30-day claim cycle impact timing?

Orders Management



Case Management to Complete Episode and File Claim

- Submit OASIS assessments at least weekly
- Tracking of orders
  - Reduce missed orders that are written late
  - Avoid orders written days 25-30 if possible
  - Watch frequency orders that run out near the end of the 30-day period and require physician approval to resume care
- Follow up with physician offices to get orders signed, preferred method of communication, physician education on HH requirements

New/changed diagnosis at mid-point of certification episode

An OASIS is not required to change the diagnoses on the RAP and 30-Day claim.

- The Other FU is not required if the patient does not meet the agency criteria for a SCIC.
- At the end of Day 30, assuming the POC is returned signed and all other billing requirements are met, the claim for the first 30-Day payment unit can be billed.
- The interim order identifies an updated diagnosis that will be placed on the RAP for the *second* 30-Day payment unit, which can be filed after the first visit is made on/after Day 31.

Case Management to Reduce Duplication and Waste

- Appropriate utilization of disciplines
  - RN – LPN, PT – PTA, OT – COTA, MSW, HHAide
- Effective discharge planning
- Determination of recert vs discharge
- Evaluation of progress toward goals, avoid "early" discharge
- How to incentivize physicians to continue home care vs advance to outpatient services?

LUPAs

- Low Utilization Payment Adjustment
- Currently 4 or fewer visits per 60 days, all visits count (even HHAide)
- Payment is Per Visit instead of Per Episode
- Approximately 8% of claims are currently LUPAs
  - Visits cluster around 5 visits to avoid LUPAs
- Reducing payment period to 30 days will result in significantly more LUPAs
- LUPA thresholds of 2 – 6 visits per 30-day payment period depending on clinical group (HIPPS code)

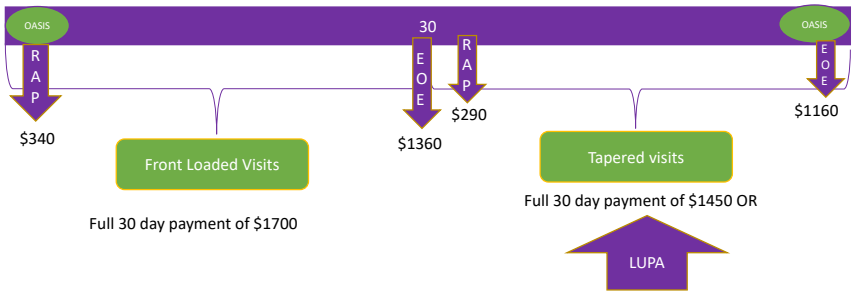
Change in Threshold Definition

PPS	PDGM
Threshold is 4: meaning 4 or fewer visits is paid on LUPA basis.	Threshold is 2-6
5 visits per episode is paid the episode rate.	2 = 1 visit
	3 = 2 or fewer visits
	4 = 3 or fewer visits
	5 = 4 or fewer visits
	6 = 5 or fewer visits

LUPA Payment

- Reducing payment period to 30 days will result in significantly more LUPAs
- CMS expects the provision of services to be made to best meet the patient's care needs
- Monitor utilization patterns, beneficiary impact, and provider behavior
- Why is this an issue?
  - 1 wk 9 means 4-5 visits in 30 days
    - Must manage the care better
    - Is this frequency meeting the patient's needs?
      - ACH rate and ED rate
      - HHCAHPS satisfaction

2--30 Day Payment Periods with Tapered Visits



Action Item

- What is your LUPA claim percentage?
- Manage those patients—what number of visits is medically necessary to treat condition and keep them safe?
- What kind of patients usually result in LUPA episodes?
- Foley catheter patients
  - Z46.6 as primary (complex)
  - LUPA thresholds 2-4 (Complex with late community medium functional is 2)

Action Item

- Problem: Missed visits (Frequency and duration in POC are doctor's orders). Why are the visits being missed?
  - CoPs requirement to communicate with patient/family re: POC
  - Particular staff?
  - When is the agency notified?
  - Could the visit be made up? Usually visit on Tues and Thurs. Patient has a Dr appt on Thursday so nurse writes missed visit note and plans to visit next Tuesday. What should have been done?
  - Patient is not homebound?
  - Services you're providing not really medically necessary?
    - (This is what it looks like to a medical reviewer.)
  - When can/should you try to prevent a LUPA?

Action Item

Problem: RN Admit and 4 therapy visits

- 2 Issues
  - RN just to admit is not a billable visit
  - If RN's visit to complete the OASIS is before the therapist visits, (first billable visit) then SOC may be deemed invalid.
- MS Rehab and Neuro Rehab (admit for therapy)
  - Variety 2 – 6 visit threshold

Action Item

- **Problem:** Non-billing visits that are billable
- **Example:** HHAide visits patient on Tuesday and reports that the patient was in the hospital over the weekend. You send a RN out on Wednesday to complete the ROC assessment. You non-bill the aide visit because the RN had not seen the patient yet.
- **Reality:** The aide's visit was in the orders and she/he provided the care. ***It is a billable visit*** and Tuesday's date is M0032 (first visit by anyone from your agency). If the RN completed the assessment on Wednesday, then Wednesday is M0090. (You have 2 calendar days from date of knowledge to complete the Transfer and the ROC.)

Category 2 Static Q&As

- **Q15.1.1. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?**
- [Q&A ADDED to Cat. 2 01/12; ADDED to Cat. 4b 08/07 as Q&A #23.3; Previously CMS OCCB 07/06 Q&A #5]
- A15.1.1. When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

Action Item

- Are those extra visits to avoid a LUPA, truly medically necessary visits?
  - Review what makes a visit medically necessary
  - Example: SN teaching on a diagnosis that is not verified with the physician
  - Example: SN teaching on a diet not on the POC
  - Example: Simple wound care that does not require the skills of a nurse
  - Example: Cut and paste notes from the therapist indicating no progression (and the patient is not maintenance)

PDGM and Therapy

- Each primary diagnosis group + OASIS functional scores will lead to payment points
- Check the functional groupings and variation in payment points between high end of low range and the low end of the high range – so…
- PDGM does "pay for therapy" - but it's based on NEED, not UTILIZATION and the number of therapy visits made
  - $300 approximate increase in average payment from low to medium impairment
  - $250 approximate increase in average payment from medium to high impairment

Does therapy have a role in PDGM?

- Therapy visit thresholds removed; no incentive to provide more therapy visits.
- Musculoskeletal and neurological rehab clinical groups recognize the unique needs of patients with MS and neuro conditions who require therapy as the primary reason for home health.
- The functional impairment level adjustment, in conjunction with the other case-mix adjusters, aligns payment with the costs of providing services, including therapy.

Value of Therapy

- Impact on Publicly Reported Outcomes/5 Star Ratings
  - Self-Care, ADLs, Mobility/Locomotion
  - Fall reduction, prevent wounds/injuries
- Reduction in use of Higher Cost Centers of Care
  - Urgent, Emergent Care Centers
  - Unplanned Physician Office Visits
  - ED, (re-) Hospitalizations
- Positive Patient Experience

Problem: what diagnosis to use?

- Symptom codes (R codes) not acceptable as the primary diagnosis
  - Hospital acquired deconditioning?
  - Weakness after an illness that itself is resolved?
  - Decline in ADL performance?
  - Repeated falls?
- What's the value of maintaining independence and safety in the home environment?

Impact of Fall Risk

- "Falls were the leading reason for readmission among patients whose initial hospitalization was related to a fall, and who were discharged home, even with home care."

Think Beyond Visit Numbers

- Collaborate with and support other disciplines
- Monitor and ensure patient progress
- Ensure holistic care
- Proactive re-admission reduction
- Become better patient managers
- Optimize cost effectiveness
- Add value to home care

Requirement for Other Follow-Up

- 484.55(d) states that a marked improvement or worsening of a patient's condition, which changes, and was not anticipated in the patient's plan of care would be considered a "major decline or improvement in the patient's health status" that would warrant update and revision of the comprehensive assessment.
  - Within 2 days of the change
  - Change the assessment completion date on the second 30-day claim if the assessment changes the case mix group (functional score only)
  - *If only the primary diagnosis changed, no need to complete an other follow- up*
  - *What's your agency's policy for a SCIC?*

Other Follow-Up (RFA 5)

- *Not required to update diagnoses.*
- SCIC: Major improvement or decline in a patient's condition that was not envisioned in the original POC.
- If a significant change in condition occurs that was not anticipated and warrants a change in the POC, complete the Other Follow-Up.
- If completed before the start of a subsequent contiguous 30-day period and results in change in the functional level, the second 30-day claim would have a change in the case-mix group.
- Do not update the *current* 30-day claim. Update the assessment completion date (M0090) on the *second* 30-day claim.
- Oct 2019 Q&A #s 8, 9 & 10

Action Item

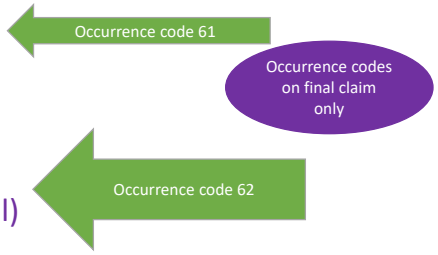
- What is your agency's policy for a SCIC?
- How often do you do an RFA 5?
- Do you need to reconsider the criteria to trigger a SCIC?
  - What's the purpose of doing an Other Follow Up?
  - What types of events or circumstances might result in a change in functional score?

Institutional or Community

Depending on whether an acute or post-acute healthcare setting was utilized in the 14 days prior to home health

Institutional

- Inpatient acute care hospitals
  - NOT observation stays
  - NOT ER visits
- SNF (Skilled Nursing Facility)
- IRF (Inpatient Rehab Facility)
- LTCH (Long Term Care Hospital)
- IPF (Inpatient Psych Facility)
- Rationale for higher payment: Sicker upon admission, being discharged rapidly back to community and are more likely to be re-hospitalized, have more functional decline



Inpatient Admission

- If the patient is discharged from an acute hospital, SNF, LTCH, Rehab or Psych hospital within 14 days of the beginning of the initial HH 30-Day payment period = institutional
  - Must be an acute admission (not observation or emergency dept. only)
- Once patient is admitted to HH, if readmitted to ACH, do a Transfer *without* DC and ROC. If the ACH discharge date is within 14 days of the subsequent 30-Day payment period, that payment period = institutional

Inpatient Admission

- If patient in a HH episode is admitted to a PAC facility (SNF, IRF, LTCH, Rehab or Psych), the agency should do a Transfer *with* Discharge. A new admission SOC would be done when the patient returns home = institutional
  - The codes for the claim that identifies it as institutional for PAC facilities can ONLY be used on an initial 30-Day claim when it is a SOC.
- **New admission (SOC) = institutional**
- **ROC = community**
- Also see October 2019 CMS Quarterly Q&As #6, #7

Examples

1. Patient goes to ER and is admitted on day 17 of 30-day period. Discharged after 4 days. A ROC is completed.

   The ROC will determine Institutional payment and functional score for next 30-day period (late). Any changes in diagnoses may come from ROC order. (EMR pulls diagnoses from ROC for claim)

2. Patient goes to ER and is admitted for observation. Released 2 days later. No ROC and no change to Institutional payment.

3. Patient is admitted to hospital on day 28 and is discharged home on day 2 of new 30-day payment period. This ordinarily requires RFA 7 Transfer with DC and new SOC when patient is hospitalized at the end of the 60-day certification period. (Institutional if stay within 14 days of new SOC). What happens if not at recert time?

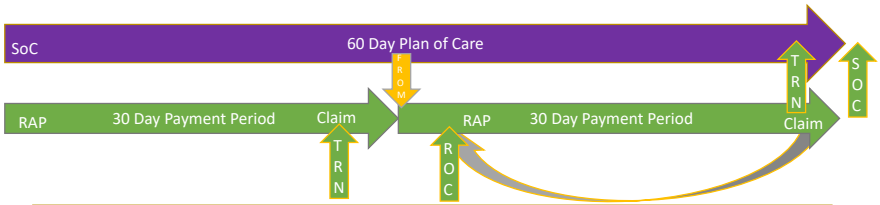
Update (09/30/2019) regarding IP stays

After reconsidering and discussing with CMS OASIS folks:

- **Stay spans day 30**: HHA completes a ROC assessment, which does not change the on-going assessment schedule. To keep the claims in line with that schedule, the HHA should submit the RAP and claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the IP stay and a first visit date after the hospital discharge. Medicare systems will allow that, because our edit for inpatient overlaps uses HH visit dates of service, not the HH From/Through dates.
- **Stay spans day 60**: The current process continues. The HHA completes a new SOC and submits new admission RAP and claim.

Also see October 2019 CMS Quarterly Q&As #6

60-Day Plan of Care vs 30-Day Payment Period



When the patient transfers into the hospital at the end of the 1st 30 day period, no need to discharge. Complete a ROC. 2nd 30 day period claim will recognize ROC (Occurrence code 50 with M0090 date).
Transfer at end of certification requires new SOC.

Quality Performance

- Monitor agency performance on ADL outcome measures
  - Quality of Patient Care Star rating
- How many patients achieve functional goals?
- How many patients return to their prior level of function?
- Monitor agency fall incidents: is there an increase?
- Monitor HH-CAHPS scores on questions:
  - Did agency help set up home to move more safely?
  - Did agency provide services you needed?

Clinical Considerations

- Accurate complete referral information at intake
  - Diagnoses specific, acceptable primary, verified by physician documentation
  - Compliant F2F documentation
- Timeliness of agency processes
- Timeliness of getting signed POC and IPOs
- Selection of appropriate primary diagnosis
- OASIS accuracy on functional items
- Avoiding LUPA adjustments if possible

Clinical Considerations

- Episode management
  - Interdisciplinary care planning
  - Skill mix and therapy utilization
  - Effective case management, care coordination
  - Oversight of care team by clinical manager(s)
- Clinical team skills and competencies
  - Accurate and complete assessments, details, functional impairments, OASIS accuracy
  - Timeliness of assessment, communication
  - Collaboration between disciplines, patient/family, physician, community resources

Action Items

- Agencies need to educate the clinicians about the importance of documentation and how it may affect the HHA's reimbursement
- There are 432 possible case-mix adjusted payment groups to accurately align payment with each specific patient's characteristics
- Diagnoses need to be verified
- Functional item responses need to be supported
- The rest of the scoring is out of our hands

Quality Improvement

Don't forget the importance of quality measures!

Home Health Compare

- Created by CMS for consumers, to help choose a quality home health agency that has the skilled services needed by patients
- Provides information about the quality of care provided by "Medicare-certified" home health agencies nationwide
- The information on Home Health Compare:
  - Reports how well home health agencies care for their patients
  - Shows how often each agency used best practices when caring for its patients and whether patients improved in certain important areas of care
  - Shows what other patients said about their recent home health care experience from the agency
- Website for HH Compare:

https://www.medicare.gov/homehealthcompare/search.html

Features of HHCompare

- Identifies agencies that provide care within a zip code area or within a town/city/state
- Lists general information and the services provided by each agency
- Provides quality of care information
  - Outcome of care measures
  - Process of care measures
- Reports ratings from the Patient Experience of Home Health Care Survey (HHCAHPS) about the care other patients received from the agency's staff
- Allows comparison of performance between up to 3 agencies and the state and national averages, guides consumers to tools to make an informed choice

Why does Home Health need Star Ratings?

- ***Home Health Compare*** **information can be overwhelming to consumers**
- 13 outcome measures, 8 process measures and 1 "value of care" measure provide information on quality performance to allow informed choice
- **Consumers are accustomed to using a "star" rating system to compare and choose products and services**
- Home Health Star Ratings offer a simple tool to aid consumers' healthcare decision making

Quality of Patient Care STAR Rating

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

Utilization Measure

- Acute Care Hospitalization – claims based

Home Health Star Rating: Calculation

- Each measure is rated and assigned a decile rating. Adjusted ratings are averaged across the 8 measures, and rounded to the nearest 0.5
- **Each of the 8 measures carry the same importance in the Star Rating calculation**
- Overall Star Ratings range from 1.0 to 5.0, reported in half-star increments
- Updated quarterly in January, April, July and October

Why should I care about Star ratings?

- Patient choice, Referrals
  - Used by customers, referral sources and payers to choose homecare providers
- Mergers and Acquisitions
  - Used by large agencies to influence decisions on mergers and acquisitions
- Value-Based Purchasing
  - VBP pilot project active in nine states now
  - Uses ongoing performance on outcome and process measures to impact payment for pilot states up to 5% (up or down) in 2018 and up to 8% in 2022

Current Star Ratings

- Quality of Patient Care Star Ratings on Home Health Compare, October 2019 update

Your agency	KS State Average	National Average
	***1/2	***1/2

How can Star Ratings improve?

- Focus on OASIS accuracy at **all** assessment time points
  - Discharge and transfer as important as SOC!
- When choosing a QAPI project, target a measure that impacts your Star Rating if possible
- Just telling your staff to "*Do it better*" is not a quality or performance improvement plan!

OASIS Outcome Measure Calculation

Numerator: number of episodes where values indicate less impairment at DC than at SOC or ROC

Denominator: number of episodes ending with DC, excluding:

1- episodes with value 0 on item at SOC or ROC

2 – episodes that end with Transfer or Death

3 – episodes where patient is non-responsive at SOC or ROC (M1700=04 or M1710=NA or M1720=NA)

OASIS-Based Outcomes

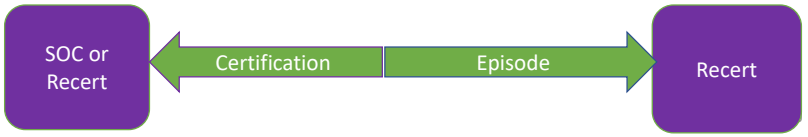
- OASIS data items are arranged from least impaired or independent, to most impaired or dependent.

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.
- Only have to improve by one response level for positive credit on the outcome score!

The Definition of an Episode Can Be Different

For OASIS purposes, a quality episode must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer, Discharge, Death at Home assessment) to be considered a complete quality episode.



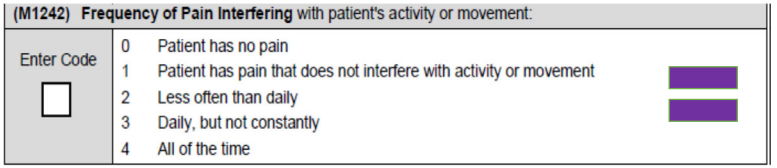
Current Scores

- Improvement in Pain interfering with activity

Your agency	KS State Average	National Average
	79.2%	80.6%

SOC
ROC
FU =

M1242 Frequency of Pain Interfering with 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?
- 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? What other treatment?

M1242 Assessment Techniques

- The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.
- Assessing pain in a nonverbal patient involves observation of facial expression (for example, frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (for example, FACES).

Response 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.
- Use clinical judgment based on observation and patient interview to determine if pain is interfering all the time. July 2013

Example

- Your patient reports that her pain doesn't bother her as long as she moves slowly and doesn't sit in the same position for long. Once she takes her sleeping medication at night, she rests well.

(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

Current Scores

- Improvement in Shortness of Breath

Your agency	KS State Average	National Average
	80.3%	**79.8%**

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 the patient or family/caregiver
What is status on the day of assessment?

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
- Environmental modifications: If patient restricts an activity to remain free of dyspnea, can be a "0"
  - Key: did the patient make the modification BEFORE the SOC visit?
- Go up stairs 2 steps at a time to avoid dyspnea can still be a 0

Current Scores

- Improvement in ability to take oral medications

Your agency	KS State Average	National Average
	69.5%	**69.4%**

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.

Concern with M2020 replacing M2016

- Specific concern for patients that reside in ALFs
- CMS studied episodes from 2017 and identified that patients living in a congregate setting were less likely to show improvement in management of oral medications
  - M1100 = 11, 12, 13, 14 or 15
- Risk adjustment for improvement in management of oral medications excludes patients that reside in a congregate setting from the denominator (based on M1100)

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 considered po 4b-Q167.8
- Does not include filling/reordering 4b-Q166
- Swallowed and absorbed through GI system!!

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.

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

- 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 another person to develop 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 med is taken
- What about a device that provides reminders?
  - Who sets up the device? 4b-Q167.5

Examples of Response 3

- Patient who didn't understand how to take med
- Patient who wasn't able to take med at correct time even though reminded
- Patient who was unable to safely swallow oral med on day of assessment
- If medication not in the home, you cannot make assumptions about patient's ability to take the med
- Patient requires someone to assist them at medication administration time to walk to the location where meds are routinely stored, or someone must retrieve the medications and bring them to the patient

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
  - Risk adjustment: M1100 responses 11-15 remove episode from denominator

Current Scores

- Timely Initiation of Care

Your agency	KS State Average	National Average
	97.0%	95.1%

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 or ROC date
- Initial assessment vs. SOC visit dates
- 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)
- Also considers M0030 SOC date, M0032 ROC date

Jan. 13, 2018

M0102 Date of Physician-ordered SOC (or 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 physician orders do not specify SOC/ROC date, or requested/revised SOC/ROC order received **after** originally ordered SOC/ROC date,
  or order for requested/revised SOC/ROC date received **after** the 48 hour time frame

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 originally ordered SOC/ROC date is delayed due to patient condition or physician request (example: extended hospitalization), enter new ordered SOC/ROC date in M0102
- If specific SOC/ROC date not given and a specific SOC/ROC date beyond the 48 hours is requested, must receive order/approval for new date **on or before** the end of the 48 hour initial assessment time frame

SOC
ROC

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

- Specifies the most recent date that verbal, written, or electronic authorization to begin home care was **received** by the home health agency
- General order to “Evaluate for Home Care services” (no discipline(s) specified) received from a physician who will be following the patient is valid referral date
- Skipped if date entered in M0102

M0104 Date of Referral

- Update/revise the M0104 date:
  - If SOC is delayed due to the patient’s condition or physician request, and agency received **updated/revised** information
  - If a hospitalist (or other referring physician) is not going to provide orders and follow the patient, this is not a valid “referral" for completion of M0104
  - 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).

What *isn't* the M0104 date

- 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).

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 received)
  - 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

Can't Find the Patient

- **Q23.11.2.2. M0102 & M0104. We received a referral for home care but were unable to reach the patient for several days. We notified the physician of the problem. When we finally reached the patient, he requested we start care a week after the original order date. We sent a fax to the MD 5 days after the original order was received requesting a delay in the SOC with a specific date 3 days from then. If we received the order back from the MD prior to that new date, how do we answer M0102, Physician-ordered SOC date and M0104, Date of Referral?** [Q&A EDITED 04/15; ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #5]

Can't Find the Patient

- A23.11.2.2. "If the originally ordered start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician\ordered start of care (resumption of care)."
- In order to report this new updated/revised physician's ordered start of care date in M0102, ***it must have been received before the end of the 48 hour initial assessment time frame (or before the date of the previous physician's ordered start of care date, if one was provided)***. If the order to extend the physician's ordered start of care date is received ***after*** the 48 hour initial assessment time frame (or after the date of the previous physician's ordered start of care date, if one was provided), **report NA for M0102 and report the original referral date in M0104.**

Current Scores

- Claims-based Acute Care Hospitalization of patients receiving home care services

Your agency	KS State Average	National Average
	16.7%	**15.6%**

Acute Care Hospitalization

- Uses **Medicare claims based** information
- The "ACH" and "ED Use without Hospitalization" measures evaluate patient admission to an acute care hospital and emergency department (without hospitalization), respectively, during the 60 days following the start of home health stay
- Planned hospitalizations are not counted
- **OASIS based** ACH rates will not be reported after 2019

IMPACT Act: PAC Standardization

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 includes formulation of new **Standardized Patient Assessment Data Elements (SPADEs):** identical standards and definitions which will be utilized across all post-acute care providers to enable cross setting data collection, *calculation of standardized quality measures*, and interoperable data exchange
  - HH – Home Health (OASIS)
  - SNF—Skilled Nursing Facility (Minimum Data Set)
  - IRF—Inpatient Rehab Facility (Patient Assessment Instrument)
  - LTCH—Long Term Care Hospital (Continuity Assessment Record and Evaluation (CARE) Data Set)

IMPACT Quality Measures

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

- New standardized items J1800, J1900 - **Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF # 0674)**
- New standardized items GG0130, GG0170a-b, d-s - **Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)**
- Modification to OASIS item M1311 to support a new standardized pressure ulcer measure to replace the current standardized pressure ulcer measure. The new measure is **Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.**

TRF
DAH
DC

J1800: Any Falls Since SOC/ROC

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

Review: home health clinical record, visit notes
incident reports,
other relevant clinical documentation (fall logs)
Interview: patient and/or family/caregivers about occurrence of falls since most recent SOC/ROC

J1800 Definition of Fall

- **Unintentional** change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.
- CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Unwitnessed Fall

- The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. Kim and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** This item addresses unwitnessed as well as witnessed falls.

Intercepted Fall

- An incident report describes an event in which Mr. Stevens appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.
  - **Rationale:** An intercepted fall is considered a fall.

Balance Training – Challenge Balance

- Mr. Woods is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging his balance, anticipating a loss of balance. Mr. Woods has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow him to maintain standing.
  - **Coding:** J1800, Any Falls since SOC/ROC, would be coded 0, No.
  - **Rationale:** The patient's balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.

Unanticipated Fall During Therapy

- Mrs. White is ambulating with a walker with the help of the physical therapist. She stumbles and the therapist has to bear some of her weight in order to prevent a fall.
  - **Coding:** J1800, Any Falls since SOC/ROC would be coded 1, Yes.
  - **Rationale:** The patient's stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

TRF
DAH
DC

J1900: Number Falls Since SOC/ROC

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

A "—" dash is a valid response for any row in this item

J1900 Definitions

INJURY RELATED TO A FALL Any documented or reported injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

- **NO INJURY** No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.
- **INJURY** (EXCEPT MAJOR) Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.
- **MAJOR INJURY** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Response Specific Instructions

- Review record and interview patient/family to determine the number of falls that occurred since the most recent SOC/ROC, and, identify the level of fall-related injury for each fall.
- Code falls no matter where the fall occurred, IF it occurred during the quality episode.
- Code each fall only once.
  - If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

Example

Review of the patient record, incident reports and patient /caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes. First fall: Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink, RN assessment identified no injury. Second fall: Mr. G, was coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

Coding:

- J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.
- J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.
- J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.
- Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

Jan. 2019 Q&A #31

- J1800 and J1900 reflect falls that occurred at any time during the quality episode, regardless of where the fall occurred. A fall that occurred at the doctor's office during the HH quality episode would be reported. If a HH patient has a qualifying inpatient facility transfer (e.g. hospital or SNF), and falls in the facility, that fall would not be reported by the home health agency, as it did not occur within a HH quality episode (the fall would have occurred after the transfer and before the ROC).

Answer J1800 and J1900

- The patient fell at the doctor's office and sustained a shoulder dislocation.
  - J1800 Any falls? And J1900?
- The patient fell at the hospital after transfer from home health, abrasion on forehead.
  - J1800 Any falls? And J1900?

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

Info Obtained Later

- Mr. Norman fell and complained of severe pain in his hip. He went to the ER and was admitted. We completed the transfer OASIS the next day but information was not available until 4 days later that the hip is fractured. Since that knowledge was obtained after the timeframe, how should M1900 be coded?
- Since injuries can present themselves later than the time of the fall, or the agency may not learn of the level of injury until after the OASIS/assessment is completed, agencies are encouraged to correct errors as accurate information regarding fall-related injuries becomes known. Errors should be corrected following the agency's correction policy and M0090 would not necessarily be changed. Jan. 2019 Q&A #32

Falls Quality Measure

- Reports the percentage of quality episodes in which the patient experiences one or more falls with **major injury** (bone fractures, joint dislocations, closed head injuries with altered consciousness or subdural hematoma)
- Adopted for calendar year 2020 HH Quality Reporting Program, data for measure calculation submitted via OASIS Jan-Dec 2019
  - J1800 gateway item, J1900C data item for measure
- This measure is not risk-adjusted

Falls Quality Measure

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

Denominator = All quality episodes *except*:

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

Current Scores

Incidence of falls with major injury

Your agency	KS State Average	National Average
	na	**1.04%**

Not publicly reported until 2020. See your Patient Characteristics report on CASPER

TRF
DC

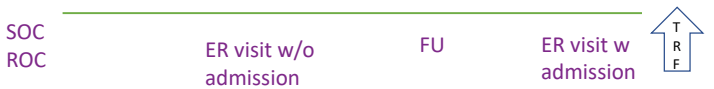
M2310: Reason for Emergent Care

(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
- ☐ 10 Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 Other than above reasons
- ☐ UK Reason unknown

M2301 Emergent Care

- Identifies whether the patient was seen in a hospital emergency department at the time of or at any time since the most recent SOC/ROC OASIS assessment. Responses to this item include the entire period at or since the last time SOC/ROC OASIS data were collected, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. *This item includes current events.*



M2301 Emergent Care

- Response 0—No
  - No emergent care in hospital emergency dept since most recent SOC/ROC OR
  - Patient is direct admitted to the hospital
    - Patient was not treated or evaluated in the emergency room
    - Patient had no other emergency department visits since the last SOC/ROC OASIS assessment.

M2301 Emergent Care

- Response 1 or 2--Yes
  - Patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider 4b-Q179
- Response 2—Yes with admission
  - Patient went to a hospital emergency department and was subsequently admitted to the hospital
  - An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing).

M2301 Emergent Care

- What if a patient went to a hospital emergency department, was “held” at the hospital for observation, then released?
  - The patient did receive emergent care.
- The time period that a patient can be "held" without admission can vary
- An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility.

Dies in the ER

- A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. **In this situation, a Transfer assessment, not an assessment for "Death at Home," should be completed**. For M2301, select Response 1 - Yes, used hospital emergency department WITHOUT hospital admission.

Current Scores

- Urgent, unplanned use of hospital Emergency Department without admission to the hospital

Your agency	KS State Average	National Average
	12.2%	12.8%

Closing the Practice Gap

- Working together as a group from intake to discharge and that includes a discharge plan that addresses care after discharge, so the patient doesn't come back in a few weeks.
- A plan that addresses the patient remaining safely in their home, able to function as independently as possible with or without a device or helper.
- Working to meet the mandates of the IMPACT Act, CMS has identified that the various health care providers work within silos. That translates to poor communication at the patient's expense.

Closing the Gap

- Home care clinicians know how hard it is to assess and create a realistic care plan for a patient when the transfer paperwork is lacking a history and physical or there are multiple medication lists, none of which match.

Closing the Gap

- With PDGM, agencies will need to work closely with EMR vendors to meet needs associated with data analysis, guided coding alignment, and transitioning to the new billing cycle, while not losing sight of the need to improve the patient's experience.
- Outside of the agency walls, clinicians need to interact with providers to ensure they receive complete medical records and when needed to query the physician for diagnostic information and/or orders etc.

One Last Thought

- Agencies need to educate the clinicians about the importance of documentation and how it may affect the HHA's reimbursement.
- There are 432 possible case-mix adjusted payment groups to accurately align payment with each specific patient's characteristics.
- Diagnoses need to be verified
- Functional item responses need to be supported
- The rest of the scoring is out of our hands

SELMAN HOLMAN
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What questions do you have?