IMPROVING HOME HEALTH STAR RATINGS

KANSAS HOME CARE ASSOCIATION

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Objectives

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- Understand HH Star rating system and how ratings impact your agency
- State OASIS item guidance for Star measures
- Identify strategies and best practices to improve your agency's Star rating

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Introduction to STAR Measures

Why does Home Health need Star Ratings?

- ***Home Health Compare*** **information overwhelming to consumers**
- 27 outcome and process measures provide information on quality performance to allow informed choice of a home health agency
- **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

Types of Star Ratings

Quality of Patient Care Star Ratings

- Formerly called the "Home Health Compare STAR ratings"
- Posted on *Home Health Compare* website since July 2015
- Based on OASIS data submitted by agencies for outcome and process measures, and claims data for acute care hospitalization

Types of Star Ratings

Patient Survey Star Ratings

- New as of January 28, 2016
- Based on Home Health Consumer Assessment of Healthcare Providers and Services (HHCAHPS) – measures currently reported on *Home Health Compare*

Patient Survey Star Rating Measures

Care of Patients
Questions: Q9, Q16, Q19, Q24

Communication between Agencies and Patients
Questions: Q2, Q15, Q17, Q18, Q22, Q23

Specific Care Issues
Questions: Q3, Q4, Q5, Q10, Q12, Q13, Q14

Overall Rating of Care provided by the agency
Question: Q20

Quality of Patient Care Star Rating Measures

Outcome Measures

- Improvement in Ambulation
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Pain Interfering with Activity
- Improvement in Shortness of Breath
- Acute Care Hospitalization

Quality of Patient Care Star Rating Measures

Process Measures

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

Criteria for Measure Selection

- Measure applies to a substantial portion of home health patients and has sufficient data to report for a majority of home health agencies.
- Measure should show some variation between agencies, and agencies should be able to show improvement in performance for the measure.
- Measure should be clinically relevant.
- Measure should be relatively stable and should not show substantial random variation over time.

Home Health Star Rating: Agency Eligibility

- All Medicare-certified agencies are eligible to receive a Star Rating.
  - Must have at least 20 completed quality episodes for data on a measure to be reported on *HHCompare.*
  - *M*ust have reported data for 5 of the 9 quality and process measures.
- Eligible agencies must have data for 40 or more patient surveys in the reporting period.
- Eligible episodes must have a discharge date within the 12-month reporting period.

Home Health Star Rating: Calculation

- Each measure is rated and assigned a decile rating. Adjusted ratings are averaged across the 9 measures, and rounded to the nearest 0.5
- Each of the 9 measures carry the same importance in the Star Rating
- Overall Star Ratings range from 1.0 to 5.0, reported in half-star increments, with 3.0 stars as the middle category
- Updated quarterly in January, April, July and October

Why should I care about Star ratings?

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- 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

Quality of Care Star Rating

15

Your Agency	Kansas State Average	National Average
	***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 staff to "*Do it better*" is not a quality or performance improvement plan!

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Timely Initiation of Care

Timely Initiation of Care

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Your Agency	Kansas State Average	National Average
	94.2%	92.5%

Timely Initiation of Care Process Measure

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- 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 date
- Initial assessment vs. SOC visit dates

Timely Initiation of Care Process Measure

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

M0102 Date of Physician-ordered SOC/ROC

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

__ __ /__ __ /__ __ __ __ [*Go to M0110, if date entered*]
month / day / year

☐ NA - No specific SOC date ordered by physician

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

M0102 Date of Physician-ordered SOC (or ROC)

- Must be a single specific date to initiate care, not a range of dates.
- If the originally ordered SOC date is delayed due to patient condition or physician request (example: 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.
- Because the State Operations Manual requires a visit for resumption of care within 48 hours following hospitalization, mark **NA** if the physician orders a ROC date that extends beyond 2 calendar days of the inpatient facility discharge date.

M0104 Date of Referral

(M0104) **Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

__ __ /__ __ /__ __ __ __
month / day / year

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

M0104 Date of Referral

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

M0104 Date of Referral

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

3rd Q. 2014

M0104 Date of Referral

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

3rd Q 2014

M0102 and M0104 for late F2F – Jan. 2016 Q&A #2

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

M1005 Inpatient Discharge Date (most recent)

(M1005) Inpatient Discharge Date (most recent):

__/__/____

month / day / year

☐ UK - Unknown

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

Example 1

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

Example 2: Patient Requests Delay

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

Best Practices for Timely Initiation of Care

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

Best Practices for Timely Initiation of Care

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

Best Practices for Timely Initiation of Care

Field staff practices (cont'd):

- When completing the SOC or ROC OASIS items:
  - Check the referral: was there a specific date for SOC? **M0102**
  - Check the referral: what is the referral date? **M0104**
  - Is the date in M0104 more than two days ago? If it is >2 days ago, investigate if there was updated/revised information from the referral source about a delay or change in plan that didn't get documented on the referral? Does the physician need to be contacted to inform him/her of the circumstances of the delayed SOC?
- Document all communication regarding delays in SOC or ROC visits.
- Remember: the ROC visit cannot be delayed past 48 hours after the inpatient discharge or you are out of compliance with CoPs!

Best Practices for Timely Initiation of Care

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

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Improvement in Pain

Interfering with Activity

Improvement in Pain Interfering with Activity

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Your Agency	Kansas State Average	National Average
	70.4%	71.2%

Diagnoses associated w/pain

- Arthritis or degenerative joint diseases
- Osteoporosis w/compression fractures
- Peripheral vascular disease, angiopathy
- Neuropathy
- Immobility or contractures
- Pressure ulcers
- Amputations
- Injuries, post-op aftercare

Assessment: Intake / Referral

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

Pain Assessment - Verbal

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

Pain Assessment - Nonverbal

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

Barriers to Pain Assessment

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

Pain Assessment Guide for Non-Communicative Patient

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

Additional Areas of Pain Assessment

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

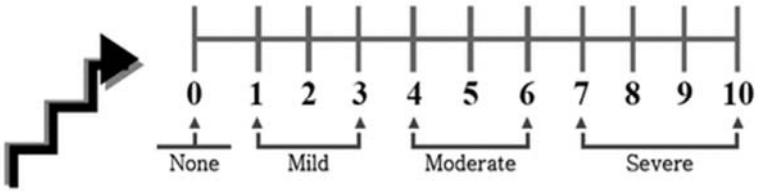
M1240 Pain Assessment

POM (M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized, validated assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

Captures *intensity* of pain - Presence of pain at the time of the formal assessment, not the 'day of assessment.' 4b-Q70.3

Numerical Pain Rating Scale



Now put on your Data Collection hat!

Separate *OASIS data collection* for M1242 from the *clinical* pain assessment in M1240

M1242 Frequency of Pain Interfering with Patient's Activity or Movement

PAIN (M1242) **Frequency of Pain Interfering** with patient's activity or movement:

- ☐ 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**

M1242: Frequency Pain Interfering with Activity

- 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

M1242: Assessment Techniques

- Ask if pain prevents or discourages them from doing anything. What activities are impacted? Does it take longer to do activities? Do they need help with activities due to pain?
- Observe non-verbal signs of pain/discomfort
- How does patient currently treat pain? Do they take analgesics? Do meds help relieve the pain so the patient can do more?
- Score before you teach pain management

Example

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

Best Practices for Pain

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

Principles of Pain Medication Management

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

Principles of Pain Medication Management

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

Interventions - Pharmacological

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

Interventions – Non-Pharmacological

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

Interventions – Non-Pharmacological

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

Patient Empowerment

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

Physician Communication Re: Pain

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

Follow-up Reassessment

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

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Improvement in Dyspnea

Improvement in Dyspnea

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Your Agency	Kansas State Average	National Average
	68.3%	70.1%

Cost of COPD and Heart Disease

- More than 236,000 home care patients had COPD as a primary or secondary diagnosis; 75-78% of Medicare home health patients have a cardiac or circulatory system diagnosis
- Emergent care needed by 39% of COPD patients seen by home care agencies; 16-21% of acute care hospitalizations of HH patients are for cardiac-related reasons
- $280 billion annual cost to healthcare system

Clinical Symptoms of COPD

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

Clinical symptoms of heart failure

Left-sided heart failure

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

Right-sided heart failure

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

M1400 When is the Patient Dyspneic or Noticeably Short of Breath?

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

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

M1400

- Time points: SOC/ROC/FU/Discharge
- Used for payment, quality outcomes, risk adjustment
- How to assess?
  - If patient ***uses*** oxygen continuously
    - Assess with oxygen in use
  - If the patient ***uses*** oxygen intermittently
    - Assess *without* the use of oxygen
  - What if ***ordered*** continuously but only ***used*** intermittently? Assess without oxygen
- Sleep apnea ≠ dyspnea

M1400

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

Chairfast or bedbound patient:

- Response 1 (When walking more than 20 feet…):

  Appropriate response 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

- 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**?

- ☐ 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.

Intake/Referral Information for COPD

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

Intake/Referral Information for CHF

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

Comprehensive SOC Assessment

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

Respiratory Assessment

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

COPD / HF Assessment Every Visit

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

Best Practices for COPD

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

Best Practices for Heart Failure

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

Medication Mechanisms for COPD

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

Medication Mechanisms for CHF

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

Medication Best Practices

- Review medication list in home q visit
- Evaluate compliance with med regimen
  - Can patient demonstrate or state administration?
    - Inhalers, oxygen, tapering steroids
- Assess med knowledge, educate as needed
  - Identify/document knowledge deficit if present, watch OASIS responses!
    - M2020 for oral meds, M2100c for inhalers
  - After education, use teach-back to assess pt/cg understanding
  - Instruct who to call for problems or med issues
- Assess for s/sx adverse effects or interactions

Environmental Modifications for Energy Conservation

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

Assess for Exacerbation

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

Physician Follow-up

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

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Improvement in Bathing

Improvement in Bathing

86

Your Agency	Kansas State Average	National Average
	73.3%	71.5%

Importance of Bathing Performance

- Diagnoses that potentially impact bathing performance
- Impact of poor hygiene on patient health
- Uses of Outcome measure for Improvement in Bathing

Assessment: Intake / Referral

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

OASIS Assessment Conventions for ADL Items

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

OASIS Assessment Conventions for ADL Items (con't)

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

M1830: Bathing

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

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

M1830: Bathing

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

M1830: Assessment Techniques

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

M1830: Assessment Techniques

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

M1830: Bathing

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

M1830: Bathing

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

M1830: Bathing

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

Examples

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

- M1830: 4

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

- M1830: 4

Example

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

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

Example

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

- M1830: 2

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

Which score is correct?

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

Best Practices to Improve Bathing

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

Best Practices to Improve Bathing (Con't)

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

Best Practices to Improve Bathing (Con't)

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

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Improvement in Ambulation-Locomotion and Transfers

Impact of Impaired Mobility

- Fall risk and consequences of falls
- Loss of independence for patients
- Challenges to improvement
- Impact for agencies

Diagnoses Impacting Mobility

- Degenerative joint diseases
- Sequela of CVA
- Neurological disorders
- Injuries
- Amputations or contractures
- Residual weakness from surgery or hospitalization

Assessment: Intake / Referral

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

Comprehensive Assessment and Initial Evaluation

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

Assess Factors Affecting Mobility

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

Assess Factors Affecting Mobility (Cont'd)

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

Barriers to Mobility Assessment

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

Bedfast as Defined by CMS

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

Improvement in Bed Transferring

115

Your Agency	Kansas State Average	National Average
	65.3%	63.9%

M1850 Transferring

OM **(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- ☐ 0 - Able to independently transfer.
- ☐ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- ☐ **2 - Able to bear weight and pivot during the transfer process but unable to transfer self.**
- ☐ **3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.**
- ☐ **4 - Bedfast, unable to transfer but is able to turn and position self in bed.**
- ☐ **5 - Bedfast, unable to transfer and is unable to turn and position self.**

Time points: SOC ROC F/U DC

M1850 Assessment Techniques

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

M1850 Transferring

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

M1850 Transferring

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

M1850 Transferring

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

M1850 Transferring

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

M1850 Transferring

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

M1850 Transferring

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

Improvement in Ambulation-Locomotion

Your Agency	Kansas State Average	National Average
	67.4%	67.6%

M1860 Ambulation/Locomotion

OM P

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

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

M1860 Assessment Techniques

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

M1860 Ambulation / Locomotion

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

M1860 Ambulation / Locomotion

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

M1860 Ambulation/Locomotion

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

M1860 Ambulation/Locomotion Example

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

- M1860: 2

M1860 Ambulation/Locomotion Example

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

- M1860: 3

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

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

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

M1860 Ambulation/Locomotion Example

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

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

M1860 Ambulation/Locomotion Examples

Patient has no devices and is not safe ambulating, even with assistance from another person all the time.

- M1860: 5-Chairfast, unable to ambulate and is unable to wheel self

Patient ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home.

- Depends on how many hands are needed for the patient to use the stair lift: If she needs two hands to use the stair lift, M1860 is Response 2. If she only needs one hand to safely use the stair lift, M1860 is Response 1.

Best Practices for Transfers and Ambulation

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

Best Practices for Transfers and Ambulation (con't)

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

Tailored Interventions to Improve Mobility

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

Interventions to Improve Mobility

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

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Influenza Vaccine Received

Process Measures

- Purpose of Process Measures
  - Whose score is it?
  - Why do we need a process?
- Influenza Vaccine Received
  - Benefits of vaccination
  - Challenges to improving vaccination rates

Influenza Vaccine Received

142

Your Agency	Kansas State Average	National Average
	79.6%	72.7%

Assessment: Intake/Referral

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- Influenza Immunization is tracked by all healthcare provider settings
- Ask for influenza vaccination history and information at time of referral
- Document at SOC and/or ROC visit
  - Where? Responsibility?

M1041 Influenza Vaccine

(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

- ☐ 0 - No *[Go to M1051]*
- ☐ 1 - Yes

An "episode of care" includes both SOC/ROC and Transfer/DC

If no part of the care episode (from SOC/ROC to Transfer or Discharge) occurred during the time period from October 1 and March 31, mark "No."

Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 - March 31).

M1046 Influenza Vaccine Received

(M1046) **Influenza Vaccine Received**: Did the patient receive the influenza vaccine for this year's flu season?

- ☐ 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
- ☐ 3 - Yes; received from another health care provider (for example: physician, pharmacist)
- ☐ 4 - No; patient offered and declined
- ☐ 5 - No; patient assessed and determined to have medical contraindication(s)
- ☐ 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
- ☐ 7 - No; inability to obtain vaccine due to declared shortage
- ☐ 8 - No; patient did not receive the vaccine due to reasons other than those listed in Responses 4 - 7.

M1046 Influenza Vaccine Received

- For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why.
- Response 1 -your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge).
- Response 2 -your agency provided the flu vaccine for this year's flu season prior to this home health episode
- Response 2 -a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year's flu season.

M1046 Influenza Vaccine Received

- Response 3 -patient or caregiver reports (or there is documentation in the clinical record) that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic, a pharmacy, or health fair providing influenza vaccines, etc.
- Responses 1 or 2 or 3 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (that is, flu vaccine was made available early).
- Response 4 -patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.
  - Note: It is not required that the agency offered the vaccine. Select Response 4 only if the patient was offered the vaccine by any provider and he/she refused.

M1046 Influenza Vaccine Received

- Response 5 - influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months, or other physician medical restriction.
- Response 6 - age/condition guidelines indicate influenza vaccine is not indicated for this patient.
- Response 7 - only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Response 8 - only if the patient did not receive the vaccine due to a reason other than Responses 4-7.

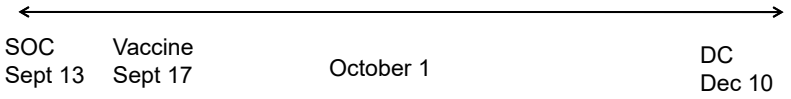
Example

- Patient admitted to HH on Sept 13 and given the vaccine on September 17. You are now discharging from HH on December 10.
- How would you answer M1041 at Discharge? M1046?

(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

☐ 0 - No *[Go to M1051]*

☐ 1 - Yes



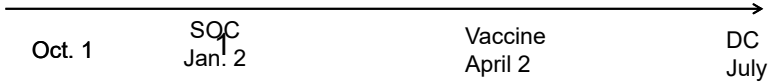
Example

- Patient admitted to home care on January 2. The flu season is bad this year and is lingering on. He is given the flu vaccine on April 2. You are discharging from HH in July.
- How would you answer M1041 at DC? M1046?

(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

☐ 0 - No *[Go to M1051]*

☐ 1 - Yes



Example

- Flu vaccine given on Sept. 15th and there was a Transfer date (M0906) of Sept. 30th, but the date the Transfer OASIS was completed (M0090) was Oct. 2nd.

4bQ62.2.2.

- How would you answer M1041 at Transfer? M1046?

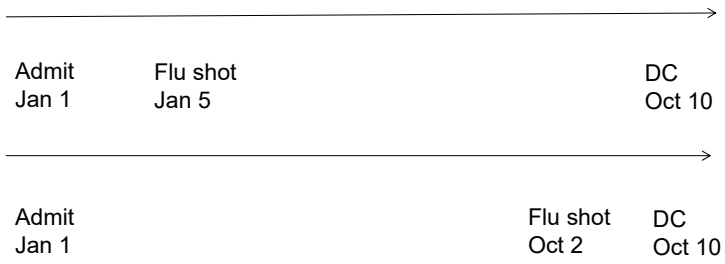
(M1041) **Influenza Vaccine Data Collection Period:** Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

☐ 0 - No *[Go to M1051]*

☐ 1 - Yes

More than one flu season in the episode

- If a patient's quality episode overlaps more than one influenza season, M1046 should be answered based on whether or not the agency gave the influenza vaccine for the *current* flu season.



Best Practices to Improve Influenza Vaccination Rate

- The AFIX Approach from CDC:
  - **A**ssessment of the immunization status of HH patients
  - **F**eedback of diagnostic information to improve service delivery of vaccinations
  - **I**ncentives to motivate providers to change immunization practices
  - e**X**change of information among providers

Best Practices to Improve Influenza Vaccination Rate

- Assessment and Tracking
  - Request influenza immunization information from referral source
  - If admitting patient to HH October through March, ask at SOC visit: has the patient had a flu vaccine for the current flu season?
  - For patients currently on service as of October 1, ask patient and family members if they have had flu vaccine yet?
  - Document immunization status in medical record
  - Flag patients that have not had a flu vaccine and are candidates under CDC guidelines
  - Follow up re-evaluation of unvaccinated patients
  - Increases clinician awareness of need for immunization

Best Practices to Improve Influenza Vaccination Rate

- Immunization education
  - Standardized educational materials for clinicians to use for patient education on need for flu vaccination
  - Identify patients at high risk for influenza, or adverse events from influenza infection, and prioritize for education
  - Re-educate at periodic intervals for patients that have not been vaccinated
  - Provide educational inservice for clinical staff on flu vaccination benefits, available tools and resources, current CDC recommendations for flu vaccination, criteria for vaccination and medical restrictions (changes each year)

Best Practices to Improve Influenza Vaccination Rate

- Keep up to date on CDC current information:

  http://www.cdc.gov/flu/index.htm
- Coordination with other providers
  - Contact physician to verify patient meets criteria for flu vaccination and has no medical restrictions
  - Request order to administer flu vaccine to patient
  - Obtain supply of vaccination for agency administration
  - Encourage patient families and caregivers to receive flu vaccine from their physician or community resources

Best Practices to Improve Influenza Vaccination Rate

- Reduction of barriers to immunization
  - Raise patient and family/caregiver awareness of benefits of flu vaccination and risks of not receiving vaccine.
  - In September, remind patients that influenza immunizations are due soon and make plan to receive
  - Address concerns related to vaccine side effects, cost, complications or vaccine safety concerns
  - Agency provide vaccine administration for patients in their home, with protocols and equipment as required
  - End of November, notify all patients that have not received vaccine that flu vaccine is past due

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Education on Medications

Process Measures

- Purpose of Process Measures
- Education on all Medications
  - Impact of medication errors
  - Challenges to medication education

Education on All Meds

160

Your Agency	Kansas State Average	National Average
	95.3%	96.3%

Assessment: Intake / Referral

- Medication Education
  - Obtain home medication list
  - Identify new or changed medications
  - Ask what brought patient into hospital – was medication mis-management a factor?

M2015/2016 Patient/Caregiver Drug Education Intervention

(M2015) **Patient/Caregiver Drug Education Intervention:** At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

(M2016) **Patient/Caregiver Drug Education Intervention:** At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?	
Enter Code ☐	0 No 1 Yes 9 NA – Patient not taking any drugs

Drug Education Intervention

- Identify if clinicians instructed the patient and/or caregiver(s) on ALL medications
  - ALF staff are considered caregivers 4b-Q162.3, 162.4
  - Education can occur over the phone 4b-Q161.4
- How to manage meds effectively and safely through knowledge of:
  - Medication effectiveness
  - Potential side effects
  - Drug interactions or adverse effects
  - When to contact the appropriate care provider

Patient/Caregiver Drug Education Intervention

- No--
  - Interventions are not completed as outlined in this item
  - Care provider should document rationale in the clinical record
- Yes—
  - Includes education by any agency staff
  - Has to be all 4 components
- NA—
  - Patient takes no prescription or OTC medications

Patient/Caregiver Drug Education Intervention

- If assessment of the patient/caregiver's baseline knowledge reveals the patient received the education from the pharmacist, you can include this education in M2015.
  - This would require that the pharmacist educated the patient/caregiver to monitor the effectiveness of all drug therapy (prescribed, as well as all OTC), drug reactions, and side effects, and how and when to report problems that may occur to the appropriate care provider.
- ***Note that just including written materials in the bag with the medications at the time the medication is dispensed may not provide the specified education.*** The education of the patient may also be a collaborative effort, in which the pharmacist may provide part of the education, with other healthcare providers. 4b-Q162.

M2015 Example

Mr. Walt's ROC was completed November 8. The SN documented education on all of the patient's meds (high risk and non-high risk) was completed at that time.

Mr. Walt is transferred to the hospital on November 10. How will you complete M2015? 4b-Q162.2

NO?

YES?

M2015 Example

- M2015 would be "Yes" if, at the time of or since the previous OASIS assessment, the patient and/or caregivers were educated regarding *ALL* their medications (not just the high risk medications), including how and when to report problems that may occur. If this specified education was accomplished for all medications at the time of the previous OASIS assessment, the appropriate response for M2015 would be "Yes."
- If review of the documentation on the ROC visit showed the clinician taught only *some* of the medications, or taught only *some* of the information on medication effectiveness, potential side effects, adverse drug reactions, and who and what to report about problems, then the appropriate response for M2015 would be "No."

M2016

- How does this change with M2016 on January 1, 2017?
  - In this example, there would be no difference in assessment and response chosen for M2015 or M2016

M2015 Q&A

- Mrs. Washington was opened to home care on Jan. 1, and agency staff provided complete education on all medications during the first certification period. Mrs. Washington was recertified for home care services with a follow-up for recert on Feb. 26. At the recert visit, documentation of the Drug Regimen Review stated the patient had no new medications.
- At the discharge assessment visit on March 28, look-back at visit documentation showed there was no education in the second certification period because the patient had no new medications and there was no need to re-teach on all medications. Do you have to answer “No” for M2015 at Discharge?

M2015 Q&A

- The Condition of Participation 484.55 requires a Drug Regimen Review (DRR) at every comprehensive assessment time point. *When performing the DRR at the Recertification, if the assessing clinician evaluated the patient's retention of prior teaching and determined and documented that the patient possessed all the required knowledge related to all medications, then M2015 would be answered "Yes"* at Transfer/Discharge.
- If the assessing clinician had not re-assessed the patient's medication knowledge and found the patient to be fully knowledgeable or not provided drug education related to all medications at the time of or since the previous OASIS assessment, the M2015 response would be "No" at Transfer/Discharge

M2016

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- How does this change with M2016 on January 1, 2017?
- In this example, the assessment and response will be different!
  - Look back period changes to “at the time of or since the most recent SOC/ROC”
  - Is there documentation of education on all meds at or since the SOC?
  - What’s the correct response for M2016?

Medication Knowledge: Assess – Teach – Evaluate

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

Teaching Points for Medications

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

Med Teaching Tips

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

Best Practices to Improve Medication Education

- Obtain current medication list at referral
- Perform drug regimen review and medication reconciliation to resolve any issues identified
- Develop a medication teaching protocol for clinicians to follow: assess-teach-evaluate
- Address “Teaching Points for Medications”
- Utilize “Medication Teaching Tips”
- Document all medication teaching in designated location in patient record
- Assess medication knowledge at DC visit, provide education on any meds patient does not know

Patient Empowerment

- Comprehensive patient education
  - Benefits of influenza immunization
  - Medication administration: drug, dose, frequency
  - Medication purpose, s/sx of ineffective therapy
  - Medication potential side effects, adverse reactions
  - When, how, who to report problems to

Patient Empowerment

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- Patient self-management
  - Personal Health Record includes current medication list
  - Personal Health Record lists all vaccinations, including influenza

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Reducing ACH

Acute Care Hospitalizations

Claims-Based ACH Rate

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Your Agency	Kansas State Average	National Average
	17.5%	16.2%

Importance of Reducing Hospitalizations

- Hospitalizations consume 31% of the $2 trillion in total healthcare expenditures in the U.S.
- 25% of hospitalizations are avoidable
- Medicare is reducing reimbursement to hospitals by 3% for excess readmissions
- MedPAC recommends adjusting payments to skilled nursing facilities to incentivize reducing hospital readmissions
- Acute Care Hospitalization rate is a factor in the HH STAR rating, and part of the Home Health Value Based Purchasing pilot project currently underway in 9 states

Transitions in Care

- The term “care transitions” refers to the movement of patients between healthcare practitioners and settings as their condition and care needs change during the course of a chronic or acute illness
- “Care transitions is a team sport, and yet all too often we don’t know who our teammates are, or how they can help.”

  Eric Coleman, MD, MPH

Research Shows

- 80% of patients will forget what their providers say
- Almost 50% of what patients remember is recalled incorrectly
- 33% of patients are unable to read basic health care material
- 42% of patients do not understand directions for taking medications on an empty stomach

OASIS-Based ACH Rate Calculation

- Percentage of home health episodes of care that ended with the patient being admitted to the hospital
- Based on OASIS Transfer to Inpatient Facility with or without Discharge (RFA 6 or 7)
- OASIS items:
  - M0100 – Reason for Assessment
  - M2410 – Inpatient Facility Admission
  - M2430 – Reason for Hospitalization

Claims-Based ACH Rate Calculation

- Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.
- Based on Medicare FFS claims data
- The ACH rate publically reported on HHCompare and used for HH STAR measure calculation is the Claims-based ACH rate, not the OASIS-based ACH rate.

So why does the OASIS-based ACH rate matter?

- Submitting a Transfer OASIS then requires a new ROC OASIS assessment when the patient returns home.
- Each ROC OASIS starts a new quality episode – what's the impact of that on end-result outcome measures? On process measures?
- Make sure transfer criteria are met BEFORE completing transfer OASIS
  - Admission to acute inpatient facility
  - For 24 hours or longer
  - For reasons other than just diagnostic testing

Readmission Driver: Diagnoses

- Heart failure
- Pneumonia
- COPD
- Psychoses
- Gastrointestinal problems

Readmission Driver: Medications

- Of 366 patients discharged from hospital with a follow up PCP appointment within two months:
  - 64% used at least one med not ordered at discharge
  - 73% failed to use at least one med ordered at discharge
  - 32% did not take meds ordered at discharge at all

Readmission Driver: Care Delivery

- Inadequate patient education
  - Medical condition
  - Treatment interventions
- Premature hospital discharge
- Poor communication
  - Between patient and physician
  - Between hospital and community physician

Readmission Driver: Follow-up Care

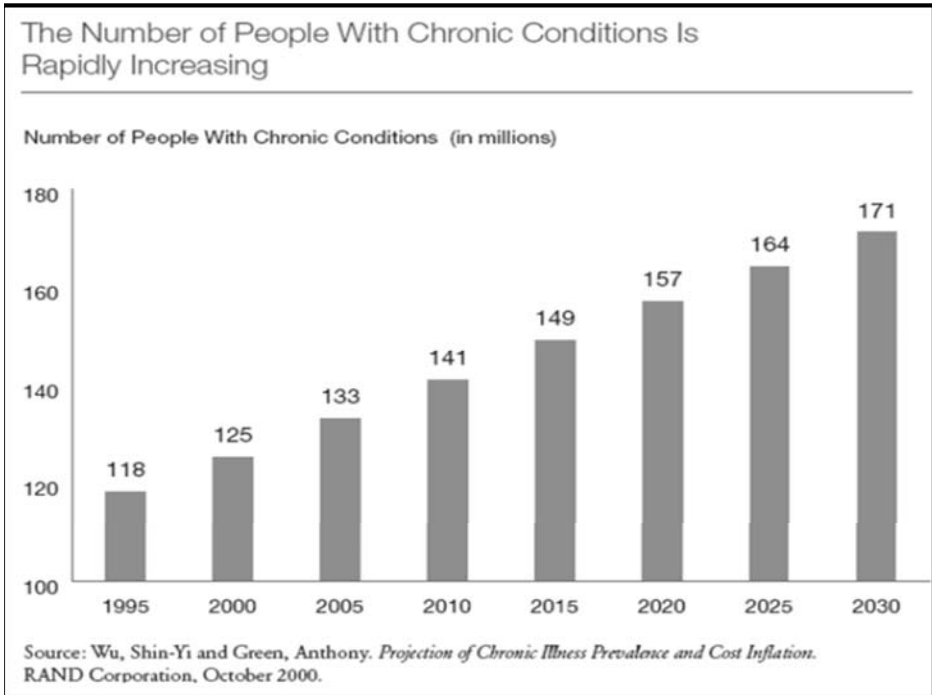
- Inadequate monitoring of illness and/or treatment
- No emergency contact number provided to patient
- Patient unable to get prescribed meds immediately
- Inadequate home/community services/resources
- Delay in follow-up PCP care or post-discharge testing
- Of Medicare beneficiaries readmitted within 30 days:
  - 64% do not receive any post-discharge care before readmission
  - 50% have no physician follow up visit before readmission

Barriers to Readmission Reduction

- Need for correct financial incentives
- Need for IT reform to facilitate information transfer
- Need to overcome “silo mentality”
- Fragmentation between healthcare settings
- Lack of access to primary care
- Lack of communication

Barriers to Smooth Transitions

- Lack of information and knowledge
- Lack of coordination between care settings
- Lack of communication
- Lack of community-wide approach
- Lack of patient engagement/resources
- Increased chronic conditions in Medicare beneficiaries



"Real" Problems Emerge Post-Transition

- Sick
- Overwhelmed
- Pain management issues
- Literacy issues
- It's not "real" until patient is home, on their own, self-managing their health

Best Practices to Reduce ACH

- Intake/Referral:
  - Obtain complete referral information from inpatient facility or physician office
  - Verify physician that will sign plan of care and assume responsibility for patient's care oversight
  - Obtain current medication list
  - Obtain contact info for next of kin or emergency contact
  - Ask: What brought the patient into the hospital for this admission? Does patient have a history of recent re-hospitalizations?

Best Practices to Reduce ACH

- At SOC / ROC visit:
  - Perform Drug Regimen Review and medication reconciliation, determine method for safe administration
  - Perform fall risk assessment and address immediate concerns for safety, therapy and equipment needs
  - Identify date of PCP follow up appointment and verify patient/family have transportation arranged
    - If no appointment scheduled, intervene to get appointment made within recommended time

Best Practices to Reduce ACH

- At SOC/ROC visit (con't):
  - Perform knowledge assessment r/t disease management
  - Assess patient's support system, needs for assistance with community resources
  - Establish Emergency Care Plan
  - Complete Hospitalization Risk Assessment tool
    - Tool must be part of medical record
    - Interventions to address risk factors identified

Best Practices to Reduce ACH

- Every visit:
  - Verify medication regimen and compliance
  - Ensure pain is effectively managed
  - Provide self-management training on diagnoses, address risk factors
  - Care coordination between disciplines
  - Review Emergency Care Plan
  - Reminders for physician follow up appointments, lab work and testing as ordered
  - Plan for discharge expectations and arrangements
  - Maintain communication to coordinate care with family and caregivers, ongoing assessment of support systems

Best Practices to Reduce ACH

- Enhanced information transfer at handovers
  - Complete, accurate, current info to receiving provider
  - Discharge summary to PCP timely
  - Identify personnel for liaison responsibility
  - Standardized tool and process for info transfer
- Home Health Agency transfer TO:
  - Emergency Department
  - Physician office for follow up visits and at agency discharge

Best Practices to Reduce ACH

- Medication Management at transition
  - Reconcile discharge meds with prior home meds and medications in home at SOC/ROC visit
  - Educate patient/caregiver on med regimen
  - Ensure how meds will be obtained
  - Address pain management interventions/meds
- Plan of Care
  - Collaborative development of post-acute care plan includes history, strategies to mitigate patterns of ER and hospital use, preferences for end-of-life issues

Best Practices to Reduce ACH

- Telemedicine
  - Remote monitoring and care delivery to detect warning s/sx
- Telephone follow-up
  - Calls made before or shortly after acute setting discharge to prepare for HH admission
  - Provide info/education, symptom management, early monitoring of complications, reassurance
  - Call on days clinician does not visit

Best Practices to Reduce ACH

- Clinical protocols, best practices, guidelines
  - Ensures best practice standards within and across settings
  - Ensure consistency between multiple clinicians
  - Front-load visits for high risk patients
- Palliative care consultation/support
  - Improved assessment of needs, patient/family preferences for end-of-life care, appropriate referrals for hospice care

Best Practices to Reduce ACH

- Patient/Family/Caregiver Education
  - Materials at appropriate literacy level
  - Include disease self-management, treatment options, expectations, available resources
- Coaching
  - Improved patient-centeredness, self-reliance
  - Ensure common understanding of treatments and support needs among patient, family members, etc.
  - Use scenarios to practice possible events that might lead to hospitalization

"Patient Education" vs "Patient Self-management"

Bodenheimer, Lorig, Holman, and Grumbach (2002) compare traditional patient education and self-management education.

What is taught?
Traditional Patient Education: Information and technical skills about the disease
Self-management Education: Skills on how to act on problems

Relation of education to the disease
Traditional Patient Education: Education is disease-specific and teaches information and technical skills related to the disease
Self-management Education: Education provides problem-solving skills that are relevant to the consequences of chronic conditions in general

What is the goal?
Traditional Patient Education: Compliance with the behavior changes taught to the patient to improve clinical outcomes
Self-management Education: Increased self-efficacy to improve clinical outcomes

Best Practices to Reduce ACH

- Personal Health Record (PHR)
  - Inpatient staff assist patient to establish PHR before inpatient discharge
  - Improved access to current personal medical information
  - Home Health teach patient to maintain info and provide PHR to healthcare personnel at transitions
- Community supports
  - Establish communication links with community resources prior to discharge, appropriate referrals to needed services and equipment; HH assess at SOC

Plan of Care Components

- Diagnosis List
  - Include all diagnoses pertinent to Plan of Care
  - Make sure all diagnoses are documented in the medical record, referral info, or confirmed with physician (document confirmation)
- Medication List
  - All prescribed and OTC medications listed with complete dose, frequency, max dose in 24 hours
  - List reason and parameters for all PRN medications

Plan of Care Components

- Functional Limitations
  - List all limitations, describe "other"
- Activities Permitted
  - Correlate with DME/equipment list
- Mental/Behavioral Status
  - List all limitations present

Plan of Care Components

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

Plan of Care Components

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

Other Considerations

- Link with community based organizations
- Facilitate timely therapy evaluation for patients at risk for falls
- PCP follow-up appointment
  - Make PCP appointment at SOC/ROC visit if not done prior to inpatient DC
  - Make appointment for within 5-7 days
- Aggressive management of chronic conditions
  - Clinical pathways/protocols, coaching, telehealth
- Address homecare to hospice transition

Everyone's Problem

- Rehospitalization may be better viewed as a health care system problem than a hospital problem, because care fragmentation is a property of the whole system. Almost every institution and individual involved in a patient's care can contribute to preventing rehospitalization.

Jencks, 2010

What Questions do you have?

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