Outcomes – Common Questions

- What should we focus on to improve agency outcomes?

- What are 5 Star outcomes? What are VBP outcomes?

- What is from OASIS? What is Claims Based?

- What are best strategies to improve outcomes?

- How should we educate staff for improving outcomes on each patient?

- How can we involve staff in improving agency outcomes?

5 Star Outcomes

- Managing daily activities
  - Ambulation
  - Transfer in and out of bed
  - Bathing
- Treating symptoms
  - Dyspnea
- Preventing Harm
  - Timeliness of admission
  - Oral medications
- Preventing unplanned hospital care – CLAIMS BASED
  - Pts admitted to acute care hospital - CLAIMS BASED

VBP Measures

- OASIS based Measures
  - Discharged to Community
  - Improvement in Dyspnea
  - Improvement in management Oral Meds
  - Total Normalized Composite (TNC) Change in Mobility
  - Total Normalized Composite (TNC) Change in Self-Care

- Claims-based Measures
  - Acute Care Hospitalizations
  - ER without Hospitalization

- HHCAHPS Survey based Measures
  - Care of Patients
  - Communications between Providers & Patients
  - Specific Care Issues
  - Overall Rating of HH Care
  - Willingness to Recommend the Agency

Care Compare - Home Health

- REMEMBER- 5 Star outcomes are on this public website!

- Purpose is for the Public to choose quality HHA's

- ….AND Referral Sources USE THIS!
  - Have seen many drop HHA's with less than 3 Stars

- Tip: Can use this information for Marketing your agency when your Outcomes are better for patients than other agencies

OASIS Strategies

OASIS Guidance Manual

- M1830 Bathing Example:
- Item Intent
  - Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower.
- Response-Specific Instructions
  - Observation/demonstration is the preferred method for coding this item.
  - The assessing clinician may also interview the patient and/or caregiver, conduct environmental assessment and may consider available input from other agency staff who have had direct patient contact.
- Coding Instructions
- Code 4, 5 or 6, depending on the patient's ability to participate in bathing activities: If a patient is medically restricted from stair climbing, and the tub/shower requires climbing stairs
- Coding Tips: For Response 4, the patient must be able to bathe outside the tub/shower safely and independently, including independently accessing water at the sink, or setting up a basin at the bedside, etc.

OASIS Accuracy Strategies

- Audit of all of your clinicians completing OASIS time points for SOC, ROC, DC

- Drill down to issues – ex: inconsistent scores to narrative documentation

- Assess if commonalities in errors
  - Customize education
    - If common problems, educate all OASIS clinicians Or
    - If specific clinicians, then one on one or specific focused group for full OASIS education.

- Educate quarterly on changes from CMS Q&A's

- Recommend annual OASIS training class for all OASIS clinicians
  - Done quarterly in sections

- Repeat OASIS Audits. Decrease frequency for best performers.

OASIS Consistency

- Every OASIS clinician must perform the assessment in the Same and Correct manner   for all timepoints!

- Strategies:

- Set expectation for performing assessments and hold clinicians accountable

- Mock Assessment education is a FUN way to educate *and* is great to engage staff!

- How to assess - Clinicians must walk with patient around the house to "SEE" how the patient does and have patient SHOW you activities.

- Examples:
  - Walk with patient to the bathroom
  - Have patient sit on toilet and get up
  - Go down front steps to go out of house
  - Have patient take off shoes and socks and put back them back on
  - Have patient bring you their meds, a drink. Have them tell you about each med

Discharge OASIS Assessment

- Remember, Outcomes are from SOC or ROC to Transfer or DISCHARGE!

- Ensure appropriate amount of time is scheduled for Discharge OASIS visits.
  - Example: Weight 1.5 units if routine is weight of 1 and SOC weight of 2

- Set Expectation for Discharge OASIS assessment and hold staff accountable

- Recommend auditing percentage of each OASIS clinician's Discharge OASIS in real time on an ongoing basis.

- Recommend supervisory visit on Discharge OASIS visit with all OASIS clinicians initially and then annually to ensure assessment is being done in proper manner.

Improving Bathing

Bathing - M1830

- Identifies the patient's ability to bathe **entire body** and the assistance that may be required to **safely** bathe, **including transferring** in/out of the tub/shower

- **Observation/demonstration** is the preferred method for coding this item.

- Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to get into it safely.

- Have patient demonstrate how they wash themselves to check for safety and ability.

- The assessing clinician may consider available input from other agency staff who have had direct patient contact.

Strategies To Improve Bathing Outcome

- SN to identify if additional disciplines are necessary based on assessment.
- Can the patient transfer in and out of shower, and then bathe themselves Safely?
  - If No, obtain orders for PT, OT and Aide as able.
- If no orders given, must work with caregiver and patient to Improve bathing outcomes- related to safety, techniques, assistive devices.
- Always work with patient and caregiver on goals related to improving bathing outcomes
  - In order for bathing outcomes to improve, must be specific on *what* we want to improve

Strategies To Improve Bathing Outcome - Aide

- SN or PT communicate directly (Email, phone and/or in person) with Aide at beginning of aide service to review care plan
  - Ensure Bath Type is specific – Shower, bed, chair
  - How to transfer and ambulate the patient to location of bath
  - Review all patient safety issues
- Discuss the plan with the aide. Example:
- Patient needs chair bath now by her bed- primarily done by the aide;
- After PT/OT works with patient and gets assistive device, the aide care plan will be revised to shower on shower chair – Aide will walk with the patient to the shower, fully assist in transferring patient into shower and onto shower chair, then perform most of shower for the patient;
- Then on week 6, the patient will be able to transfer self and primarily perform the bath, with aide assisting.

Strategies To Improve Bathing Outcome - Aide

- Utilize the Aide supervisory visits to communicate with the aide to identify changes in the patient that would warrant a revision to the aide care plan.

- The patient care team should be working with the aide on assisting on improving patient outcomes.

- When SN is not seeing the patient, recommend having the Therapist supervise the aide. This allows for the PT or OT to continue to work with the aide on improving outcomes.

- EX: OT work with aide to see what grooming and bathing tasks the patient should now be doing, rather than the aide doing for her.

- The OT may update the aide care plan accordingly.

- If SN is still on the case, then SN would update the care plan and supervise the aide as required, but the whole team would work with the aide.

Strategies To Improve Bathing Outcome - Aide

- Aide must work with the team and follow written Aide care plan exactly.

- Aide must communicate with Clinician Before any change is made.

- Discharge Oasis Assessment
  - Clinician to have the patient show them how they get in and out of shower and bathing.
  - Observing vs asking the patient will mean accuracy in scoring.

Improving Dyspnea

M1400 - When Is The Patient Dyspneic or Noticeably Short of Breath

- Report what is true on the day of assessment

- Interview - 24 hours preceding assessment and during the assessment

- Observe the patient during assessment, while walking, doing ADLs

- Use clinical judgment to determine the level of effort required to complete a task
  - Particularly distinguishing between minimal and moderate for eating, talking, etc.

- Consider the effort required

- If the patient uses oxygen continuously, code the response based on assessment of the patient's shortness of breath while using oxygen.

- If the patient uses oxygen intermittently, code the response based on the patient's shortness of breath without the use of oxygen.

Strategies To Improve Dyspnea Outcome

- Scoring of M1400 must be done the Same by all OASIS clinicians

- Avoids skewing of the data and outcome

- Ex: SOC - M1400 is scored 0 by RN,
  - DC- M1400 scored 1 by PT
  - The PT may think the patient's dyspnea improved from SOC condition!
  - But since the SOC was scored with no dyspnea, the patient shows decline on OASIS.
  - This can be the result of inaccurate assessment and scoring.
  - Shows importance of frequent inservice on how to perform OASIS assessments and how to follow the guidelines for scoring OASIS items

Strategies To Improve Dyspnea Outcome

- Important to have the patient team working together on the same page

- Each visit by SN and Therapy should include respiratory assesment;

- If differences from the OASIS are identified and as the encounter progresses, this would warrant coordination of care to the team.

- This shows the need for the full team to review the scores for OASIS at SOC and ROC, and then keep updated via the coordination of care when changes occur.

- When the team sees any SOB over and above what was on SOC or ROC OASIS, they must report to the team, and notify the physician as necessary.

- Remember, when coordination of care is done, DOCUMENT IT!

Strategies To Improve Dyspnea Outcome

- Recommend all patients have POC orders for pulse oximeter PRN with parameter for when to contact physician.

- If a patient is found to Never be SOB, after the first visits, then the pulse oximeter may not warrant being done every visit.

- If a patient on M1400 is scored 1-4, the pulse oximeter is recommended for every visit by SN and therapy.
  - Important for therapy to do pulse oximetry before and after exercises.

- When a patient has dyspnea, particularly from a diagnosis – respiratory or cardiac- such as CHF- have an OT visit the patient for energy conservation techniques if allowed.

Strategies To Improve Dyspnea Outcome

- When Oxygen is ordered, ensure staff know the orders and document this on visits.

- Document if patient is wearing the O2 at correct liter and if its effective
  - Note: Frequently seen missing and/or inconsistent on record reviews.

- Ensure the team documents when there are improvements.

- This supports the outcome improvement for the patient
  - Ex: from score 3 to 0 in M1400 dyspnea from SOC to DC has supporting documentation for the improvement.

Improving Oral Medications

Management of Oral Medications

- Patient's **current ability** to prepare & take **all** oral meds **reliably & safely,** including administration of the **correct dosage** at the **appropriate times/intervals.**

- Includes assessment of the patient's ability:
  - to obtain the medication from where it is routinely stored
  - to read the label
  - open the container
  - select the pill/tablet or milliliters of liquid and
  - orally ingest it at the correct times

Guidance – Oral Medications

- Observation/ **demonstration** preferred method, followed by pt / cg interview and review of referral info

- Ability can be temporarily or permanently limited by: physical impairments (for example, limited manual dexterity);

  - Sensory impairments (for example, impaired vision, pain);

  - Environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).

Guidance – Oral Medications

- …Continued

- Includes assessment of the patient's ability to **obtain the medication from where it is routinely stored,** the **ability to read the label** (or identify the medication correctly- special mark), **open** the container, **select the pill** and **orally ingest it at the correct times**.

- If an oral medication is ordered PRN and the med is needed by the patient on the day of assessment – and the patient needed a reminder to take this PRN medication on the day of assessment, **Code 2**, Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.

Strategies To Improve Oral Medications Outcome

- A review of guidance is necessary as frequently scored incorrectly on OASIS as it is not understood.
  - Ex: the patient cannot ambulate to the kitchen to get water to take the medications.

- Key: The patient team works together!
  - Each clinician on each visit should ask if the patient has any new or dc'd meds, including OTCs.
  - Ask if the patient is having any side effects, or problems with meds.
  - Check the pill planner to identify if patient took todays meds.
  - Ask the patient if they are having any difficulties taking their own meds.

Guidance – Oral Medications

- **Patients in a facility - ALF** where the facility holds or locks up the patient's medications:

- STILL MUST Report the patient's ability to take the correct oral med, including proper dosage reliably and safely at the correct times.

- Determine ability based on observation and assessment of the complexity of the patient's drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility.

Guidance – Oral Medications

- Assessment includes consideration of whether a patient:
  - can get to the location where the medications are routinely stored at the correct times
  - can recognize the correct medication dose(s) and take their oral medications
  - recognizing that someone would need to make the medication available to the patient once they are at the location (e.g., nursing office or medication cart)

- Select response depending on the level and timing of assistance required on the day of assessment to allow the patient to take the correct dose(s) of all oral medications reliably and safely at the correct times.

Strategies – Improving Oral Medications

- At OASIS Assessments:

- Ask the patient to gather all of their meds including OTC - Assess their physical ability and safety to get to meds.

- Ask patient to walk to where they would get water to take meds – Assess their ability to be able to walk, if necessary, and obtain a glass and water.

- Ask patients to Read the Medication bottles or list – Assess the vision and cognitive state.

- Assess if patient knows what the drugs are for and what to report.

- If med planner present, check that is accurately filled for times meds are due.

- If the Clinician makes changes on the SOC visit to improve meds, do not count what you did! The way the patient was when you walked in the home is scored. Then you improved it for the next OASIS timepoint.

Strategies – Improving Oral Medications Aides

- Aides can gather facts re: med compliance of patients to report to the Clinician:

- Patient or caregiver say they bought new meds at the local store to help them sleep
  - Aide can check what it is and report this to the nurse

- Aide can let the nurse know if they find pills in bed sheets, under bed, etc. when helping patient bathe and dress.

Strategies – Improving Oral Medications Aides

- If pill boxes are in use, check for any unopened slots

- Patient may feel more comfortable with aide than nurse or therapist about concerns re: meds, such as side effects.

- Aide should Not Assume the nurse or therapist is aware of these issues!

- Aide is a member of the interdisciplinary team and their role in reporting issues about meds is important!

Reducing Hospitalizations and Emergent Care Visits

HOSPITAL

Strategies To Improve Hospitalization Outcome

- Frontloading visits

- Physician notification – early and timely!

- Communication with patient between visits
  - Continuing Education on when to notify home health

- Proper utilization of services

- Medication reconciliation

- All clinicians – Know the Plan of Care, Comorbidities

- Continuity of care

Strategies - Identify High Risk Patients

- **At intake and SOC OASIS assessment identify issues with patient**:
  - Frequent readmissions to home health, ER and hospital
  - Prior Non-compliance
  - Socioeconomic and/or Psychosocial factors
  - Cognitive status
  - No Caregiver with patient; Patient frequently alone
- **Plan of care to prevent ER / Hospitalizations for High Risk Patients:**
  - Schedule visits on alternating days so patient is seen by someone most days following the SOC for the first 7-14 days
  - Be each other's eyes and ears – COMMUNICATE to each other!
  - Communicate with On Call staff on high-risk patient with pertinent data
  - Telehealth and/or Telephone between visits

Physician Notification – Early and Timely!

- **Identify patient changes quickly and report in Real Time!**
  - Report to members of the patient's care team
  - Appropriate clinician contacts physician promptly for Any new or worsening symptoms

- **Customize physician parameters for patients**
  - POC – Notify physician for BS <60, >400
    - For this patient, 400 may be too high - Query provider
- **Hindsight:** Clinical record reviews post ER, Hospitalization often show lack of coordination with the other disciplines and/or NO Physician Notification for changes in patient

Patient Communication Between Visits - Telephone Calls

- In between visit days, including evening and weekends for high-risk patients.

- Follow up on previous visit information, Ex: Pain of 5- are they now taking pain meds?

- Continue to remind patient/Cg to call the HHA before going to the ER (unless emergencies)

- Detail types of events to call HHA for- even changes that they think may be minor. (Ex: A CHF patient notes increased edema in feet and ankles.)

- Inform them to contact HHA right away **after** ER visit, or if hospitalized.

Patient Communication Between Visits

- Telehealth

- Identify frequent diagnoses with hospitalizations for your agency

- Common diagnoses- wounds, CHF, COPD, CVA, post surgery, etc.

- Customize peripherals to pt risk and/or disease.

- Video Conferencing on non visit days

Visit Frequency and Utilization of Services

- **Frequencies** – ensure appropriate for patient situations
  - Frontload visit– ex: appropriate diagnoses, if nursing only
  - When there is a change in patient, evaluate the need to increase visits
  - Stagger discipline days to have patient seen most days
- **Utilization of Services** -
  - On assessment and throughout course of home health, identify when other disciplines are needed
  - OT– discipline to help increase outcomes, especially ADL/IADLs!
  - MSW- whenever psychosocial issues, etc, identified by the team
  - Aide - Work with aide on improving outcomes

On Call

- **Assess On Call process:**
- Call tree - Triage
  - When is supervisor notified
  - Who determines when visit is to be made
- Adequate and appropriate (skill level) staffing
  - For Visits to be made after hours – IV, Wounds
- Process /script for disease management when on call notified
  - Questions to query pt/ cg
- Provide additional training to On-Call staff:
  - Regarding new On Call procedures and process
- **Stress to On Call staff that many patients have ER visits and Hospitalizations after hours – Goal is to Prevent that!**

Critical Thinking
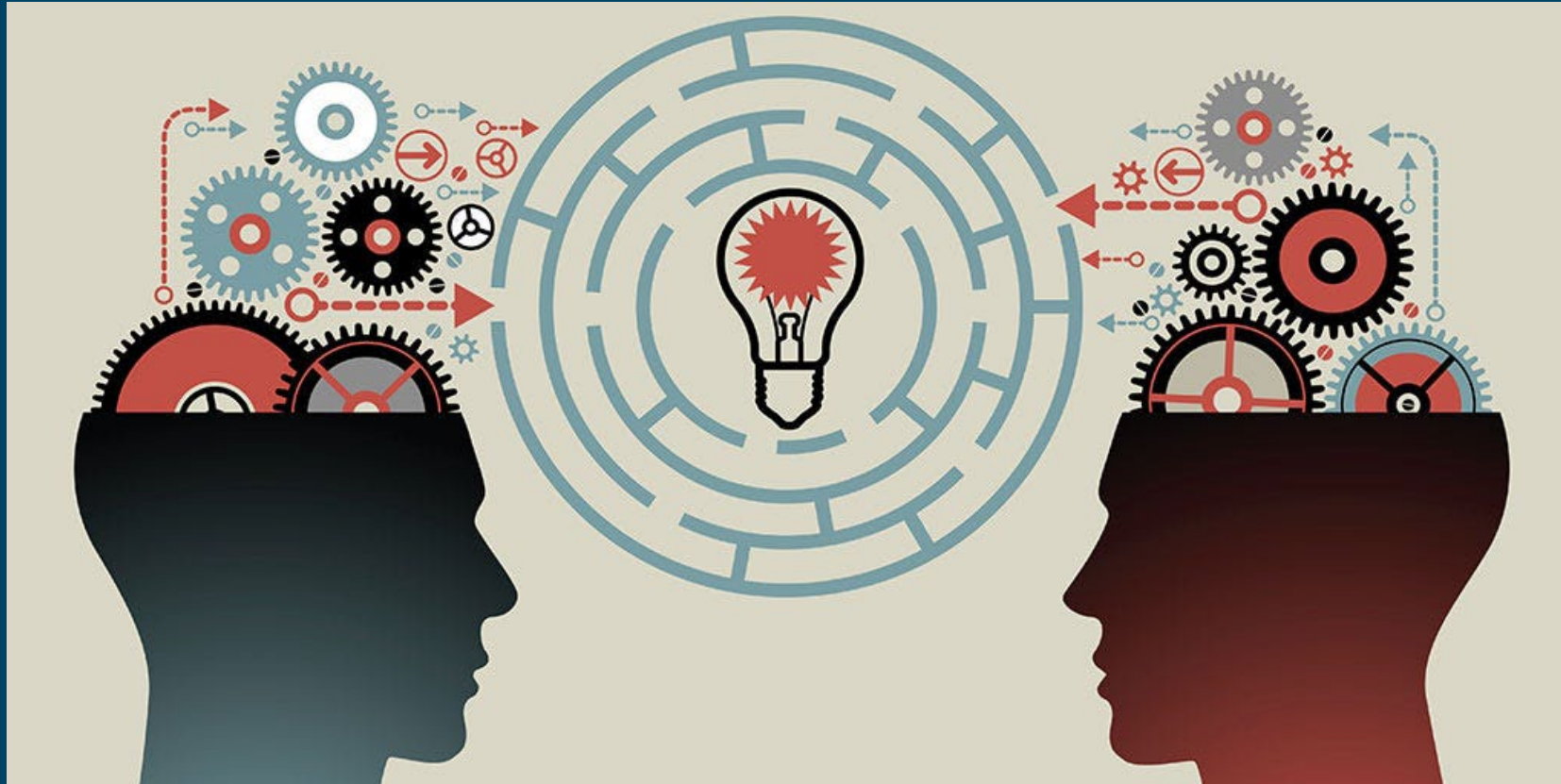
Critical Thinking

- Home Health Clinicians on the Front Line
  - First to identify issues with patients

- A Patient Care Team is not to just do tasks as wound care, Home Exercise programs……but to be Outcome Oriented

- Not to just Assess……
  - But to evaluate, collect data, interpret, analyze

- Interdisciplinary collaboration

- Be effective in presenting to the provider

QAPI

- Recommend Real Time Audit after hospitalizations to identify if HHA could have done something to prevented it:

- Identification of initial signs and symptoms

- Physician Notification

- Additional Visits

- Increased medication education

- Education re contacting HHA prior to going to ER unless emergency

- Care team not reporting signs and symptoms to each other

- Critical Thinking!

Interdisciplinary Coordination of Care

Interdisciplinary Coordination of Care Key Strategy To Improve Outcomes

- Team works together to improve specific patient outcomes
  - Patient/Team work on improving bathing, ambulating, pain*
  - *Pain management and will allow patient to improve in all other outcomes

- Report issues to each other in real time

- Be each other's eyes and ears !
  - Ex: If patient tells COTA she has not been sleeping and feels groggy and dizzy during day, the whole team needs to know
  - This would warrant a call to RN as well as a note in the coordination section of the EHR
  - RN would contact physician

- Team Includes Contractors and Aides

Interdisciplinary Coordination of Care Communication

- Needs to be pertinent information between the entire team

- Does not have to be time consuming!

- All coordination of care must be documented in the medical record

- Have a user-friendly location in EHR where all staff on patient care team document coordination of care.
  - All staff can easily read daily. Do not put in visit notes – this will not get communicated to the team!

- Checking a box on a visit note alone is not coordination of care documentation

- Method of communication based on Urgency – ie, phone call and/or EMR

Key Strategies to Improve Outcomes
Conclusion

- Interdisciplinary Coordination of Care – Team Works Together!

- Physician Notification – Early

- Frequent communication with patient / cg
  - Stagger visits
  - Telephone calls between visits
  - Telehealth

- Understand Guidance in OASIS Manual when assessing and scoring

- All OASIS clinicians do OASIS assessments in Same manner at All timepoints (Discharge too!)

Any Questions?

Thank you

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