Process Measures

and their Impact on Care Transitions

Sponsored by:
Wyoming Dept. of Health,
Healthcare Licensing and Surveys
Mountain-Pacific Quality Health

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Outcome versus Process

- Outcome Measures
  - The reason why OASIS data set was developed
  - Reflects how our care impacted the patient
    - Health status/function
  - Improvement, stabilization or decline
  - Based on data items included in OASIS-C
- Process Measures
  - How systems work
  - Are you performing clinically relevant, evidenced based interventions?
  - Based on data items included in OASIS-C

Process Measures Defined

- Measures processes of care particularly relevant for home health care and under agency control
  - High-risk, high-volume, problem prone populations
- Can be used to "give credit" to agencies
- Enhances the range and usefulness of quality information available to consumers and providers
  - Publicly reported data useful to consumers
  - PBQI reports useful to providers

Process Measures

- Process measures determine if certain processes are in place that promote good outcomes – best practices
  - How many patients were immunized?
  - How many diabetics received a foot exam and teaching?
- Process measures suggest that good patient outcomes are being pursued & may eventually be obtained

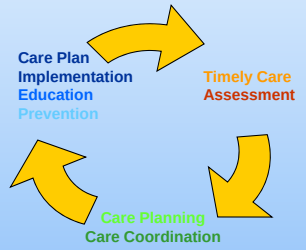
Promoting the Use of Specific Evidence-based Care Practices

Process measure items

- Assess the degree to which clinicians are using specific evidence-based practices that can affect clinical outcomes
  - PBQI report reveals only 60% of the eligible patients had their pressure ulcers treated based on moist wound healing principles
    - What happened to the other 40% who needed and didn't get moist wound healing?

OASIS-C Based Process Measures

- 47 process measures included on agency reports
- 13 are reported publicly
- All are reported to agencies via CASPER
- Represent 7 domains



- Some measures have 3 different episode break-outs
  - Short-term = 60 days or less (do not include a Recert or Other Follow-up)
  - Long-term = exceeds 60 days (do include a Recert or Other Follow-up)
  - All episodes of care = episodes of any length

Impact on Care Transition

- Care Transition Initiative
- Services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use and prevent health status decline
- Process measures focus on specific evidenced-based interventions critical to this goal

(CO Foundation for Medical Care Bridging Nursing Support / Transitional Care Model)

PROCESS MEASURE DOMAINS *(List does not include the "All" & "Long Term" episode variations of some measures)*

Domain	Measure Title (HHC *Publicly reported on Home Health Compare*)
Timely Care (1)	Timely Initiation Of Care HHC
Care Coordination (1)	Physician Notification Guidelines Established
Assessment (4)	Depression Assessment Conducted HHC Multifactor Fall Risk Assessment Conducted For Patients 65 And Over HHC Pain Assessment Conducted HHC Pressure Ulcer Risk Assessment Conducted HHC
Care Planning (6)	Depression Interventions In Plan Of Care Diabetic Foot Care And Patient Education In Plan Of Care Pain Interventions In Plan Of Care Falls Prevention Steps In Plan Of Care Pressure Ulcer Prevention In Plan Of Care HHC Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care
Care Plan Implementation (5)	Depression Interventions Implemented Diabetic Foot Care And Patient/Caregiver Education Implemented During Short Term Episodes HHC Heart Failure Symptoms Addressed During Short Term Episodes HHC Pain Interventions Implemented During Short Term Episodes HHC Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented
Education (2)	Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Episode Drug Education On All Medications Provided To Patient/Caregiver During Short Term Episodes HHC
Prevention (6)	Influenza Immunization Received For Current Flu Season HHC Pneumococcal Polysaccharide Vaccine Ever Received HHC Potential Medication Issues Identified And Timely Physician Contact At Start Of Episode Potential Medication Issues Identified And Timely Physician Contact Falls Prevention Steps Implemented Pressure Ulcer Prevention Implemented During Short Term Episodes HHC

Process Measures Impacting the Care Transition

Timely Initiation Of Care

Physician Notification Guidelines Established

Depression Assessment Conducted
Multifactor Fall Risk Assessment Conducted For Patients 65 And Over
Pain Assessment Conducted
Pressure Ulcer Risk Assessment Conducted
Depression Interventions In Plan Of Care

Diabetic Foot Care And Patient Education In Plan Of Care
Pain Interventions In Plan Of Care
Falls Prevention Steps In Plan Of Care
Pressure Ulcer Prevention In Plan Of Care

Drug Education On High Risk Meds Provided To Pt/Caregiver At Start Of Episode
Potential Med Issues Identified And Timely Physician Contact At Start Of Episode

Publicly Reported Measures

9 Outcome Measures

13 Process Measures

OASIS OUTCOME MEASURES	PROCESS MEASURES
Improvement in Bathing	Timely Initiation of Care
Improvement in Dyspnea	Depression Assessment Conducted
Improvement in Ambulation/Locomotion	Multifactor Fall Risk Assessment Conducted for Pts 65 & Over
Improvement in Bed Transferring	Pain Assessment Conducted
Improvement in Management of Oral Meds	Pressure Ulcer Prevention in Plan of Care
E.D. Use w/o Hospitalization (2012)	Diabetic Foot Care and Pt/CG Education Implemented During Short Term Episodes of Care
Improvement in Pain Interfering w/ Activity	Pressure Ulcer Prev. Implemented During Short Term Episodes
Acute Care Hospitalization	Pressure Ulcer Risk Assessment Conducted
Improvement in Status of Surgical Wounds	HF Symptoms Addressed During Short Term Episodes
	Pain Interventions Implemented During Short Term Episodes
	Drug Education on All Meds Provided to Pt/Cg During Short Term Episodes of Care
	Influenza Immunization Received for Current Flu Season
	Pneumococcal Polysaccharide Vaccine Ever Received

HHC

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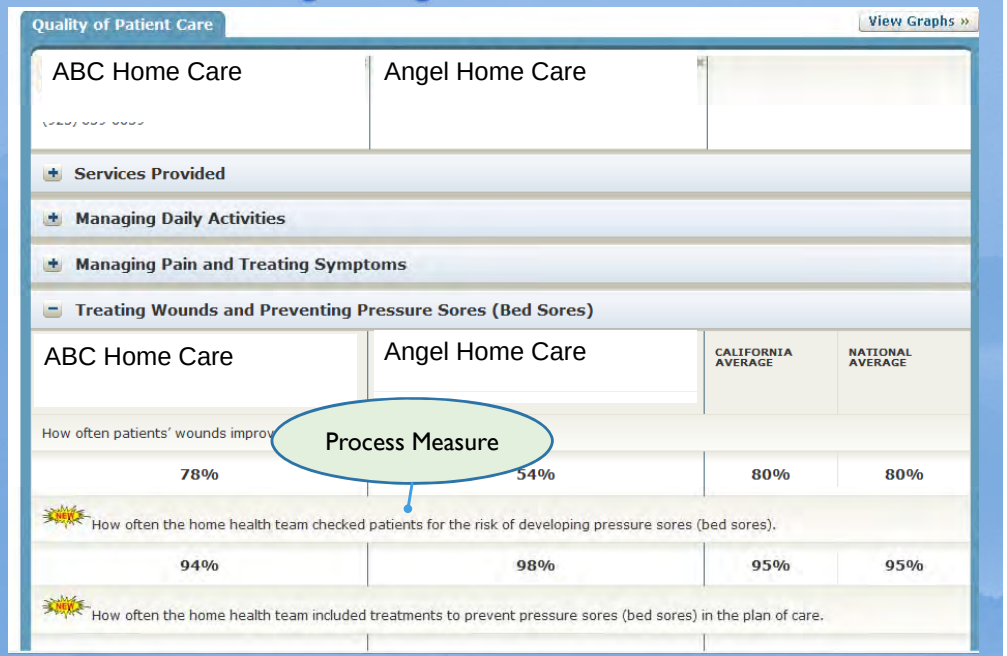
Home Health Compare Consumer Language

Process Measure	As Listed on Home Health Compare
Timely initiation of care	How often the home health team began their patients' care in a timely manner.
Influenza immunization received for current flu season	How often the home health team determined whether patients received a flu shot for the current flu season.
Pneumococcal polysaccharide vaccine ever received	How often the home health team determined whether their patients received a pneumococcal vaccine (pneumonia shot).
Heart failure symptoms during short-term episodes	How often the home health team treated heart failure (weakening of the heart) patients' symptoms.
Diabetic foot care and patient education implemented during short-term episodes of care	For pts. with diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care.
Pain assessment conducted	How often the home health team checked patients for pain.
Pain interventions implemented during short-term episodes	How often the home health team treated their patients' pain.
Depression assessment conducted	How often the home health team checked patients for depression.
Drug education on all medications provided to patient/caregiver during short-term episodes	How often the home health team taught patients (or their family caregivers) about their drugs.
Multifactor fall risk assessment conducted for pts. 65 and over	How often the home health team checked patients' risk of falling.
Pressure ulcer risk conducted	How often the home health team checked patients for the risk of developing pressure sores (bed sores).
Pressure ulcer prevention included in the plan of care	How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care.
Pressure ulcer prevention implemented during short term episodes of care	How often the home health team took doctor-ordered action to prevent pressure sores (bed sores).

HHC

Publicly Reported Measures



Process Measure

Comparing Outcomes Identifies Strengths and Areas for Improvement

- How do our measures look?
  - When compared against another agency?
  - When compared against my state average?
  - When compared to the national reference?

Example: Pressure Ulcer Risk Assessment Conducted

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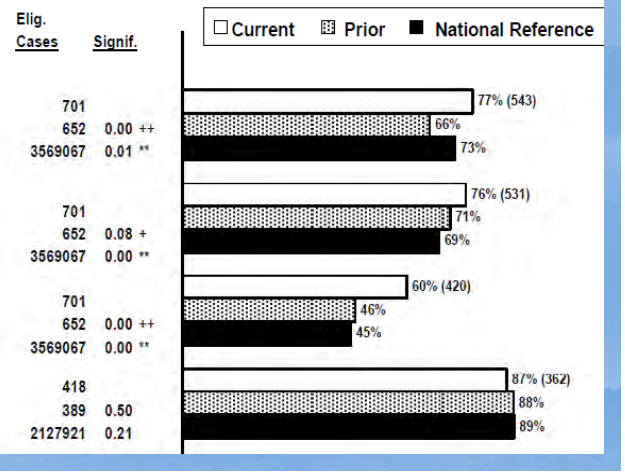
Sample Process Quality Measure Report (Based on Hypothetical Data).

Page

Agency Name: FAIRCARE HOME HEALTH SERVICES
Agency ID: HHA01
Location: ANYTOWN, USA
CCN: 007001 Branch: All
Medicaid Number: 999888001
Date Report Printed: 03/21/2012

Requested Current Period: 01/2011 - 12/2011
Requested Prior Period: 01/2010 - 12/2010
Actual Current Period: 01/2011 - 12/2011
Actual Prior Period: 01/2010 - 12/2010
Cases: Curr 646 Prior 601
Number of Cases in Reference Sample: 3569067

All Patients' Process Quality Measure Report



Using Process Measure Reports

- Agency level reports may identify needs for staff education or oversight
- Example: Multifactor Falls Risk Assessment for Patients 65 and older
  - Agency rate: 87%
  - Prior rate: 88%
  - National rate: 89%
- What if agency policy requires a fall risk assessment?

Using Process Measure Reports

- Are there related outcomes that may be affected by that care process?
- For example, what if the HHA had a low adherence rate for Pressure Ulcer Risk Assessment Conducted AND also had a high rate of Increase in Number of Pressure Ulcers (an OBQM outcome)?
- Are these findings related?

Process Quality Measure Investigation

- Develop and Implement a Plan of Action to improve rate of use of best practices
- Need to identify/implement ways to evaluate whether the plan is working
- Go to Resource: PBQI Manual located at CMS Quality Initiatives website

Moving Through the Measures

- Start with the Measure
- Detail what goes into the calculation
- OASIS items used
- Current CMS scoring guidance
- What you need to succeed
- Did you miss the Mark

Measure Title (HHC *Publicly reported on Home Health Compare*)
Timely Initiation Of Care HHC
Influenza Immunization Received For Current Flu Season HHC Pneumococcal Polysaccharide Vaccine Ever Received HHC
Heart Failure Symptoms Addressed During Short Term Episodes HHC
Potential Medication Issues Identified And Timely Physician Contact At Start Of Episode Potential Medication Issues Identified And Timely Physician Contact Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Episod Drug Education On All Medications Provided To Patient/Caregiver During Short Term Epis
Physician Notification Guidelines Established
Diabetic Foot Care And Patient Education In Plan Of Care Diabetic Foot Care And Patient/Caregiver Education Implemented During Short Term Episode
Multifactor Fall Risk Assessment Conducted For Patients 65 And Over HHC Falls Prevention Steps In Plan Of Care Falls Prevention Steps Implemented
Depression Assessment Conducted HHC Depression Interventions In Plan Of Care Depression Interventions Implemented
Pain Assessment Conducted HHC Pain Interventions In Plan Of Care Pain Interventions Implemented During Short Term Episodes HHC
Pressure Ulcer Risk Assessment Conducted HHC Pressure Ulcer Prevention In Plan Of Care HHC Pressure Ulcer Prevention Implemented During Short Term Episodes HHC Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented

HHC

(List does not include the "All" & "Long Term" episode variations of some measures)

Let's move through a few measures! Prevention Domain

Influenza Immunization Received for Current Flu Season

Consumer Language	How often the home health team determined whether patients received a flu shot for the current flu season.
Measure Description	Percentage of episodes during which patients received influenza immunization for the current flu season.
Numerator	Number of episodes during which the patient a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider.
Denominator	Number of episodes ending with a discharge or transfer to inpatient facility during the reporting period, minus excluded episodes
Exclusions	Episodes for which no care was provided during October 1 - March 31, or the patient died, or the patient does not meet age/condition guidelines for influenza vaccine.
OASIS-C Items Used	(M0030) Start of Care Date (M0032) Resumption of Care Date (M0906) Discharge/Transfer/Death Date (M1040) Influenza Vaccine (M1045) Reason Influenza Vaccine not received

HHC

Influenza Process Measure Items

Collected at Transfer Discharge

OASIS ITEM

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
0 - No
1 - Yes ***[Go to M1050]***
NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

OASIS ITEM

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
1 - Received from another health care provider (e.g., physician)
2 - Received from your agency previously during this year's flu season
3 - Offered and declined
4 - Assessed and determined to have medical contraindication(s)
5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
6 - Inability to obtain vaccine due to declared shortage
7 - None of the above

OASIS ITEM

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
0 - No
1 - Yes **[*Go to M1050*]**
NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

- You must understand these definitions:
- This year's flu season = the current season (2010-2011)
  - The CDC recommends timeframes for administration of vaccine
  - You'll know it is flu season when the vaccine is available for administration
- Episode of care = a quality episode
  - You only include the time from the Transfer or Discharge back to the ROC or SOC, which ever was most recent
- October 1 through March 31 is not the flu season
  - It's the 6 month period the measure will be calculated and will determine whether or not you can select 'NA"

OASIS ITEM

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
0 - No
1 - Yes **[*Go to M1050*]**
NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

- **Step 1** – Can I mark NA?
  - Mark "NA" if no part of the quality episode (from most recent SOC/ROC to transfer or discharge) is between October 1 through March 31
- **Step 2** – If it's not NA, can I answer Yes?
  - Select "**1-Yes"** if patient **received the influenza** vaccine **from your agency** during **this episode of care**
  - Even if it was given before 10/1
- **Step 3 – If it's not Yes, select "No"** and move to M1045

-(CMS Q&As Cat 4b Q62.2)

OASIS ITEM

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
1 - Received from another health care provider (e.g., physician)
2 - Received from your agency previously during this year's flu season
3 - Offered and declined
4 - Assessed and determined to have medical contraindication(s)
5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
6 - Inability to obtain vaccine due to declared shortage
7 - None of the above

- Select Response 2, if your agency provided the flu vaccine for this season prior to this episode of care
  - Example: You gave the vaccine in September and discharged in November. You are now discharging in February after an admission in January.
    - Same flu season, vaccine given in prior episode
  - Example: You are discharging in December, vaccine was provided by your agency prior to the patient's hospitalization and ROC in September
    - Same flu season, but vaccine given in prior quality episode

-(Ch.3)

OASIS ITEM

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
1 - Received from another health care provider (e.g., physician)
2 - Received from your agency previously during this year's flu season
3 - Offered and declined
4 - Assessed and determined to have medical contraindication(s)
5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
6 - Inability to obtain vaccine due to declared shortage
7 - None of the above

- **Select Response 3**, "Offered and declined", if patient and/or healthcare proxy **refused the vaccine**
  - **Not required that your agency offered the vaccine**

-(Ch. 3)

- **Select Response 4**," Assessed and determined to have medical contraindication(s)", if flu vaccine is **contraindicated for medical reasons**
  - **Contraindications** include:
    - anaphylactic hypersensitivity to eggs or other components of the vaccine,
    - history of Guillain-Barre Syndrome within 6 wks after a previous flu vaccination,
    - bone marrow transplant within 6 months
    - Physician medical restriction

-(CMS OASIS QA Cat. 4b Q62.3)

OASIS ITEM
(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason: 1 - Received from another health care provider (e.g., physician) 2 - Received from your agency previously during this year's flu season 3 - Offered and declined 4 - Assessed and determined to have medical contraindication(s) 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine 6 - Inability to obtain vaccine due to declared shortage 7 - None of the above

- **Select Response 5, "**Not indicated; patient does not meet age/condition guidelines for influenza vaccine", **if indicated by the age/condition guidelines** available at www.cdc.gov/flu
  - Tip: CDC updates age/condition guidelines from time to time, verify what they are each year
- **Select Response 6, "**Inability to obtain vaccine due to declared shortage"

This will exclude the patient from the computation

What Did I Need to Succeed?

Measure: Influenza Immunization Received for Current Flu Season

OASIS ITEM
(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes ***[Go to M1050]*** NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

OR

If M1040 = No

OASIS ITEM
(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason: 1 - Received from another health care provider (e.g., physician) 2 - Received from your agency previously during this year's flu season 3 - Offered and declined 4 - Assessed and determined to have medical contraindication(s) 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine 6 - Inability to obtain vaccine due to declared shortage 7 - None of the above

Did We Miss the Mark?

Measure: Influenza Immunization Received for Current Flu Season

OASIS ITEM
(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes ***[Go to M1050]*** NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

This combo

OASIS ITEM
(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason: 1 - Received from another health care provider (e.g., physician) 2 - Received from your agency previously during this year's flu season 3 - Offered and declined 4 - Assessed and determined to have medical contraindication(s) 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine 6 - Inability to obtain vaccine due to declared shortage 7 - None of the above

NA marked incorrectly

OASIS ITEM
(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes ***[Go to M1050]*** NA- Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. ***[Go to M1050]***

If NA was marked incorrectly, meaning NA was chosen when there was at least one day that overlapped October through March, the episode will still be included in the computation and have the same result as selecting "No", the patient did not receive the vaccine.
Example: Admitted August 2nd and Discharged October 1st, "NA" would be incorrect response

Why Three Influenza Measures?

Influenza Immunization Received for Current Flu Season

These Measures explain the "Received" number

- Influenza Immunization Offered and Refused
- Influenza Immunization Contraindicated

Also true for the measures regarding Pneumococcal Vaccine

Measure Title (HHC Publicly reported on Home Health Compare)

Timely Initiation Of Care HHC

Influenza Immunization Received For Current Flu Season HHC
Pneumococcal Polysaccharide Vaccine Ever Received HHC

Heart Failure Symptoms Addressed During Short Term Episodes HHC

Potential Medication Issues Identified And Timely Physician Contact At Start Of Episode
Potential Medication Issues Identified And Timely Physician Contact
Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Epis
Drug Education On All Medications Provided To Patient/Caregiver During Short Term E

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Diabetic Foot Care And Patient Education In Plan Of Care
Diabetic Foot Care And Patient/Caregiver Education Implemented During Short Term Episodes HHC

Multifactor Fall Risk Assessment Conducted For Patients 65 And Over HHC
Falls Prevention Steps In Plan Of Care
Falls Prevention Steps Implemented

Depression Assessment Conducted HHC
Depression Interventions In Plan Of Care
Depression Interventions Implemented

Pain Assessment Conducted HHC
Pain Interventions In Plan Of Care
Pain Interventions Implemented During Short Term Episodes HHC

Pressure Ulcer Risk Assessment Conducted HHC
Pressure Ulcer Prevention In Plan Of Care HHC
Pressure Ulcer Prevention Implemented During Short Term Episodes HHC
Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care
Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented

HHC

(List does not include the "All" & "Long Term" episode variations of some measures)

Moving through the measures! Care Plan Implementation Domain

Heart Failure Symptoms Addressed During Short Term Episodes Of Care

Consumer Language	How often the home health team treated heart failure (weakening of the heart) patients' symptoms.
Measure Description	Percentage of short term episodes during which patients exhibited symptoms of heart failure and appropriate actions were taken.
Numerator	Number of episodes during which patients exhibited symptoms of heart failure and appropriate actions were taken.
Denominator	Number of episodes ending with a discharge or transfer to inpatient facility during the reporting period, minus excluded episodes.
Exclusions	Episodes for which patient does not have heart failure diagnosis, OR Heart failure symptoms were not assessed, OR No heart failure symptoms exhibited since the previous assessment, OR A recert or Other follow-up was conducted between SOC/ROC and transfer or discharge, OR Patient died.
OASIS-C Items Used	(M0100) Reason for Assessment (M1500) Symptoms in Heart Failure Patients (M1510) Heart Failure Follow-up

HHC

Heart Failure Process Measures

Collected at Transfer Discharge

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 - No ***[Go to M2004 at TRN; Go to M1600 at DC]***
1 - Yes
2 - Not assessed ***[Go to M2004 at TRN; Go to M1600 at DC]***
NA - Patient does not have diagnosis of heart failure ***[Go to M2004 at TRN; Go to M1600 at DC]***

OASIS ITEM

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

0 - No action taken
1 - Patient's physician (or other primary care practitioner) contacted the same day
2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
3 - Implement physician-ordered patient-specific established parameters for treatment
4 - Patient education or other clinical interventions
5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Heart Failure Process Measures

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 - No ***[Go to M2004 at TRN; Go to M1600 at DC]***
1 - Yes
2 - Not assessed ***[Go to M2004 at TRN; Go to M1600 at DC]***
NA - Patient does not have diagnosis of heart failure ***[Go to M2004 at TRN; Go to M1600 at DC]***

Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at time of or since the most recent oasis assessment

Heart failure symptoms can be found in clinical heart failure guidelines

Consider any new or ongoing heart failure symptoms that occurred **at or since the previous OASIS assessment**

Heart Failure Process Measures

OASIS ITEM
(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment? 0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]** 1 - Yes 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]** NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

You do not need to have a HF diagnosis in any specific OASIS items

- If the patient has a diagnosis of heart failure, you will select either "0-No", "1-Yes", or "2-Not assessed"
- If no diagnosis of heart failure, select "NA"

- (Ch.3)

OASIS ITEM
(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment? 0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]** 1 - Yes 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]** NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

- **"No"** means there is a **diagnosis** of heart failure **AND** the patient had **no symptoms** of heart failure at any point at or since the previous OASIS
- **"Not assessed"** means there is a diagnosis of heart failure and you **did not assess for symptoms of heart failure** at any point at or since the previous assessment
- **"NA"** means there is **no HF diagnosis**

All three responses will exclude the patient from measure

Heart Failure Follow-up

OASIS ITEM
(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)** 0 - No action taken 1 - Patient's physician (or other primary care practitioner) contacted the same day 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room) 3 - Implement physician-ordered patient-specific established parameters for treatment 4 - Patient education or other clinical interventions 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Include **ANY** action **taken at least one time in response to heart failure symptoms identified at or since** completion of the **last OASIS assessment**

OASIS ITEM
(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)** 0 - No action taken 1 - Patient's physician (or other primary care practitioner) contacted the same day 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room) 3 - Implement physician-ordered patient-specific established parameters for treatment 4 - Patient education or other clinical interventions 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

- When **communicating** heart failure symptoms for M1510, or communication to report/resolve medication issues for M2002
  - Communication can be directly to/from the physician, or indirectly through physician's office staff on behalf of the physician, in accordance with the legal scope of practice
  - "Legal scope of practice" refers to State requirements defining who can take orders from physicians
    - Each HHA should have policy & procedure consistent with State law
- **Important to understand – ALL orders** must come from the physician and eventually be signed by the physician.

-(CMS Q&As Cat 4b Q116.5; Cat 4a Q23)

OASIS ITEM
(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)** 0 - No action taken 1 - Patient's physician (or other primary care practitioner) contacted the same day 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room) 3 - Implement physician-ordered patient-specific established parameters for treatment 4 - Patient education or other clinical interventions 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

- **Select 0**, No action taken, if **no actions were taken** at any time in response to symptoms
  - If you select "0", no other responses should be selected

Example when "0" may be selected:

- Patient with HF diagnosis develops symptoms of HF, goes to ER and is admitted. You are never called, only notified of qualifying stay in hospital. You must complete the Transfer OASIS.
- **Select 0, No action taken.** Only appropriate response. You never had an opportunity to take an action.

-(Ch. 3; CMS OASIS Q&As Q116.1.5)

Heart Failure Follow-up

- **Select Response 1**, Patient's physician (or other primary care practitioner) contacted the same day, if there was:
  - **Communication** with MD/primary care practitioner by phone, VM, electronic means, fax, or any other means that appropriately conveys the message of the patient's status
  - **On the same day** symptoms were identified **AND**
  - **MD responds** with acknowledgment of receipt of information and/or further advice or instructions on the same day

-(Ch. 3)

Heart Failure Follow-up

- **Select Response 3**, "Implemented physician-ordered patient specific established parameters for treatment"
  - Specific physician ordered parameters or guidelines for implementing treatment for the patient based on the patient's condition

Example: Order for an additional 2 mg dose of a diuretic if the patient gains 3 lbs in 2 days or develops bilateral rales.

- Select "3" if the home care **clinician reminds** the **patient to implement** OR is **aware that the patient** is **following physician-established parameters** for **treatment**

-(Ch. 3)

Heart Failure Follow-up

- **Response 4**, Patient education or other clinical interventions were provided
  - Just handing a patient printed material w/o assessment of their understanding of the material is not considered an educational intervention
- **Response 5**, Obtained change in care plan orders (e.g. increased monitoring by agency, change in visit frequency, telehealth, etc.)

- **Note:** Interventions provided via the telephone or other telehealth methods utilized to address HF symptoms could be reported in M1510

-(Ch.3; CMS Q&As Cat 4b Q116.2.2)

What Did I Need to Succeed?

Measure: Heart Failure Symptoms Addressed During Short Term Episode

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]**
1 - Yes
2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**
NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

OASIS ITEM

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

0 - No action taken
1 - Patient's physician (or other primary care practitioner) contacted the same day
2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
3 - Implement physician-ordered patient-specific established parameters for treatment
4 - Patient education or other clinical interventions
5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Just one of these!

Did We Miss the Mark?

Measure: Heart Failure Symptoms Addressed During Short Term Episode

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]**
1 - Yes
2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**
NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

This combo

OASIS ITEM

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

0 - No action taken
1 - Patient's physician (or other primary care practitioner) contacted the same day
2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
3 - Implement physician-ordered patient-specific established parameters for treatment
4 - Patient education or other clinical interventions
5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Pain Interventions Implemented During Short Term Episodes Of Care

Consumer Language	How often the home health team treated their patients' pain.
Measure Description	Percentage of short term episodes during which pain interventions were included in the physician-ordered plan of care and implemented.
Numerator	Number of episodes during which pain interventions were included in the physician-ordered plan of care and implemented.
Denominator	Number of episodes ending with a discharge or transfer to inpatient facility during the reporting period, minus excluded episodes.
Exclusions	Episodes for which patient did not have pain between the previous assessment and discharge/transfer assessment OR A Recert or Other follow-up was conducted between SOC/ROC and transfer or discharge, OR Patient died.
OASIS-C Items Used	(M0100) Reason for Assessment (M2400) d. Intervention(s) to monitor and mitigate pain

HHC

Collected at TRF/DC

Pain Interventions Implemented

M2400 Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	0	1	na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	0	1	na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	0	1	na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	**0**	**1**	**na**	Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	0	1	na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	0	1	na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

oasisanswers

Pain Interventions Implemented

PAIN INTERVENTION EXAMPLES:

- New medications,
- Adjustments to already-prescribed medications
- Massage
- Visualization
- Biofeedback, etc.

Interventions provided **by staff other than the assessing clinician** can be included in M2400

- Example: RN assesses the patient to be in severe pain, PT implements TENS unit and biofeedback interventions

Pain Interventions Implemented

- My patient had mild pain. Can I answer "Yes" to 2400d if I had an order to monitor and mitigate pain, but the patient never needed the prn analgesic?
- If record review reveals pain was assessed and the analgesic was offered, but never taken because of documented lack of need, M2400 d may be answered "Yes".
  - The order was implemented when the attempt to provide it was made, and the lack of need identified.

- (CMS OASIS QA Cat 4b 182.6)

Pain Interventions Implemented

M2400 Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

d. Intervention(s) to monitor and mitigate pain
0 -No X -Yes
NA-Formal assessment did not indicate pain since the last OASIS assessment

When should "Yes" be reported?

At or since the last OASIS assessment:

The POC contains **interventions to monitor AND mitigate** pain

AND

the **clinical record** shows the **interventions were performed**

Pain Interventions Implemented

M2400 Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

d. Intervention(s) to monitor and mitigate pain
0 -No 1 -Yes
X NA-Formal assessment did not indicate pain since the last OASIS assessment

When should "NA" be reported?

At or since the last OASIS assessment:

Formal assessment

DID NOT

indicate pain

If more than one formal assessment was completed, all must have been negative for pain.

Pain Interventions Implemented

M2400 Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

d. Intervention(s) to monitor and mitigate pain

X –No 1 - Yes

NA-Formal assessment did not indicate pain since the last OASIS assessment

When should "No" be reported?

At or since the last OASIS assessment:

There are NO interventions to monitor or mitigate pain

There is an intervention to monitor pain but NO intervention to mitigate pain

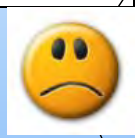
There is an intervention to mitigate pain but NO intervention to monitor pain

Did We Succeed?

Measure: Pain Interventions in Plan of Care

M2250 Plan of Care Synopsis: (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
e. Intervention(s) to monitor and mitigate pain	0	1	na	No pain identified



Measure: Pain Interventions Implemented During Short Term Episode of Care

M2400 Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
d. Intervention(s) to monitor and mitigate pain	0	1	na	Formal assessment did not indicate pain since the last OASIS assessment

Measure Title (HHC Publicly reported on Home Health Compare)
Timely Initiation Of Care HHC
Influenza Immunization Received For Current Flu Season HHC Pneumococcal Polysaccharide Vaccine Ever Received HHC
Heart Failure Symptoms Addressed During Short Term Episodes HHC
Potential Medication Issues Identified And Timely Physician Contact At Start Of Episode Potential Medication Issues Identified And Timely Physician Contact Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Episo Drug Education On All Medications Provided To Patient/Caregiver During Short Term Epis
Physician Notification Guidelines Established
Diabetic Foot Care And Patient Education In Plan Of Care Diabetic Foot Care And Patient/Caregiver Education Implemented During Short Term Episod
Multifactor Fall Risk Assessment Conducted For Patients 65 And Over HHC Falls Prevention Steps In Plan Of Care Falls Prevention Steps Implemented
Depression Assessment Conducted HHC Depression Interventions In Plan Of Care Depression Interventions Implemented
Pain Assessment Conducted HHC Pain Interventions In Plan Of Care Pain Interventions Implemented During Short Term Episodes HHC
Pressure Ulcer Risk Assessment Conducted HHC Pressure Ulcer Prevention In Plan Of Care HHC Pressure Ulcer Prevention Implemented During Short Term Episodes HHC Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented

(List does not include all 47measures)

Moving through the measures! Assessment, Care Planning, & Care Plan Implementation Domains

HHC

Depression Assessment Conducted

Consumer Language	How often the home health team checked patients for depression.
Measure Description	Percentage of episodes in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care.
Numerator	Number of episodes in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care.
Denominator	Number of episodes ending with discharge, death, or transfer to inpatient facility during the reporting period, minus excluded episodes.
Exclusions	Episodes for which the patient is nonresponsive.
OASIS-C Items Used	(M1730) Depression Screening (M1710) When Confused (M1720) When Anxious

HHC

Depression Assessment Conducted

Collected at SOC/ROC

OASIS ITEM
(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool? 0 - No 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	0	1	2	3	na
b) Feeling down, depressed, or hopeless?	0	1	2	3	na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

M1730 Depression Screening asks if the patient been screened for depression, using a standardized depression tool?

Four possible responses:

0 – No
1 - Yes, patient was screened using the PHQ-2©* scale
2 - Yes, with a different standardized assessment – and the patient meets criteria for further evaluation for depression.
3 – Yes, patient was screened with a different standardized assessment – and the patient does not meet criteria for further evaluation for depression

Select "1 - Yes, patient was screened using the PHQ-2©* scale"

First, assess to determine if the PHQ-2 is an appropriate tool, If so:

Ask the patient this question:"Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2© *	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	0	1	2	3	na
b) Feeling down, depressed, or hopeless?	0	1	2	3	na

Depression Assessment Conducted

- **PHQ-2**
  - **Total score = 3 or higher** indicates **need for further evaluation**
    - **Results for row a & b are for agency use only** and not transmitted
  - The patient is the source
    - Not to be administered by asking caregiver the questions or based on clinical observation
  - If assessment revealed PHQ-2 appropriate for patient, but then clinician cannot elicit responses, select Response 1 with NA as answer
- If PHQ-2 is not appropriate for patient due to their cognitive status or communication deficits, may choose a different tool
  - Select Response 2 or 3
- If agency provides no appropriate tool, Select Response 0-No

-(Ch. 3; CMS Q&As Cat 4b Q124.5)

Depression Assessment Conducted

M1730 Depression Screening:
Has the patient been screened for depression, using a standardized depression tool?

0 – No
1 - Yes, patient was screened using the PHQ-2©* scale
2 - Yes, with a different standardized assessment – and the patient meets criteria for further evaluation for depression.
3 – Yes, patient was screened with a different standardized assessment – and the patient does not meet criteria for further evaluation for depression

- If patient was **screened** with **a different standardized assessment**
- **Select "2-Yes" if** the **patient meets criteria for further evaluation** for depression
- **Select "3-Yes"** if patient **does not** meet criteria for **further evaluation** for depression

Depression Measures Exclusion

NA excludes patient from all depression measures

OASIS ITEM	
(M1710) When Confused (Reported or Observed Within the Last 14 Days):	
0	Never
1	In new or complex situations only
2	On awakening or at night only
3	During the day and evening, but not constantly
4	Constantly
NA	Patient nonresponsive

OASIS ITEM	
(M1720) When Anxious (Reported or Observed Within the Last 14 Days):	
0	None of the time
1	Less often than daily
2	Daily, but not constantly
3	All of the time
NA	Patient nonresponsive

Nonresponsive means the patient is unable to respond or responds in a way that you can't make a clinical judgment about the level of orientation

-(CMS Q&As Cat 4b Q124.2)

What Did I Need to Succeed?

Measure: Depression Assessment Conducted

OASIS ITEM
(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool? 0 - No 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems") 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression. 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression. **Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.*

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	0	1	2	3	na
b) Feeling down, depressed, or hopeless?	0	1	2	3	na

Measure Title (HHC *Publicly reported on Home Health Compare*)
Timely Initiation Of Care HHC
Influenza Immunization Received For Current Flu Season HHC Pneumococcal Polysaccharide Vaccine Ever Received HHC
Heart Failure Symptoms Addressed During Short Term Episodes HHC
Potential Medication Issues Identified And Timely Physician Contact At Start Of Episode Potential Medication Issues Identified And Timely Physician Contact Drug Education On High Risk Medications Provided To Patient/Caregiver At Start Of Episo Drug Education On All Medications Provided To Patient/Caregiver During Short Term Epi
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Moving through the measures! Assessment, Care Planning, & Prevention Domains

HHC

(List does not include the "All" & "Long Term" episode variations of some measures)

Multifactor Fall Risk Assessment Conducted For Patients 65 And Over

Consumer Language	How often the home health team checked patients' risk of falling.
Measure Description	Percentage of episodes in which patients 65 and older had a multi-factor fall risk assessment at start/resumption of care.
Numerator	Number of episodes in which patients 65 and older had a multi-factor fall risk assessment at start/resumption of care.
Denominator	Number of episodes ending with discharge, death, or transfer to inpatient facility during the reporting period, minus excluded episodes.
Exclusions	Episodes for which the patient is NOT age 65 or older at the start of care/resumption of care
OASIS-C Items Used	(M1910) Multi-factor Fall Risk Assessment (M0066) Birth Date (M0030) Start of Care Date (M0032) Resumption of Care Date

HHC

Falls Risk Process Measure

Collected at SOC/ROC

OASIS ITEM
(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? 0 - No multi-factor falls risk assessment conducted. 1 - Yes, and it does not indicate a risk for falls. 2 - Yes, and it indicates a risk for falls.

Falls Risk Assessment Tool

- Must include **at least one standardized tool** that has **been scientifically tested** in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, non-institutionalized adults with disabilities, etc.), and **includes a standard response scale**
  - Tool must be administered using the accompanying validated protocol
    - Including any validated protocol or scoring variations
  - Agency's responsibility to determine if tools used meet the requirements and is appropriate for the patient
- **May be a single standardized assessment tool** that **addresses 2 or more factors**, or **may be a standardized screen** (like the Timed Up and Go or Functional Reach), **coupled with evaluation of at least one more fall risk factor**, such as:
  - fall history (M1032), polypharmacy (M1032), impaired vision (M1200), incontinence (M1610)

-(Ch.3; CMS Q&As Cat 4b Q159.2 -159.6)

OASIS ITEM
(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? 0 - No multi-factor falls risk assessment conducted. 1 - Yes, and it does not indicate a risk for falls. 2 - Yes, and it indicates a risk for falls.

- **Select "0-No multi-factor falls risk assessment conducted"**, if:
  - **NO** multi-factor falls risk **screening** conducted by assessing clinician
  - A multi-factor falls risk **screening WAS** conducted but **NOT during the required time frame**
    - SOC – within 5 days after SOC date
    - ROC – within 2 calendar days after inpatient DC date
  - The **patient was unable to participate** in tasks required by tool
    - You can't use a tool validated for ambulatory patients on the non-ambulatory
    - A single tool may not meet the fall risk assessment needs of all the agency patients

-(Ch.3; CMS Q&As Cat 4b Q159.6)

OASIS ITEM
(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? 0 - No multi-factor falls risk assessment conducted. 1 - Yes, and it does not indicate a risk for falls. 2 - Yes, and it indicates a risk for falls.

- Response "1"
  - Standardized response scale rates patient as at no-risk, low risk, or minimal risk
- Response "2"
  - Standardized response scale rates patient at anything above low/minimal risk
- If you combine a validated tool with a non-validated tool to make your assessment multi-factorial
  - Use the results of the validated tool

-(Ch.3; CMS Q&As Cat 4b Q159.5)

What Did I Need to Succeed?

Measure: Multifactor Fall Risk Assessment Conducted For Patients 65 And Over

Either One!

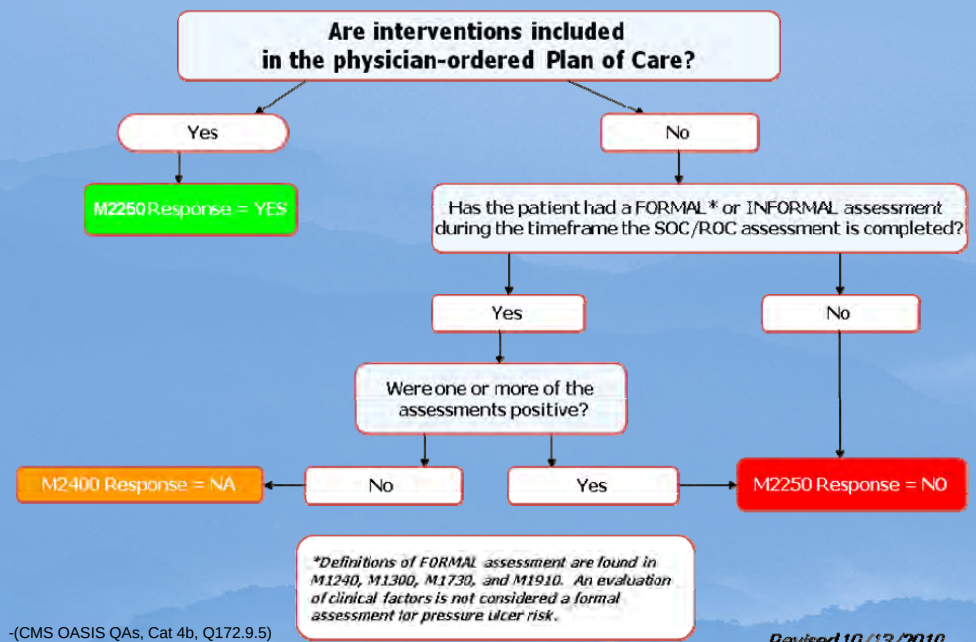
OASIS ITEM
(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? 0 - No multi-factor falls risk assessment conducted. 1 - Yes, and it does not indicate a risk for falls. 2 - Yes, and it indicates a risk for falls.

No Formal Assessment Performed

- CAN 'T select "NA" unless **formal assessment, as defined in M1240, M1300, M1730 and M1910,** was completed.
- True for Pain, Depression, Pressure Ulcers, and Falls Risk
- CAN select "Yes" if:
  - Specified interventions were included on POC AND
  - Implemented at time of or since previous OASIS assessment
  - Regardless of whether or not formal assessment was conducted

-(Ch. 3; CMS Q&As Cat. 4b, Q172.9.7, Q182.1)

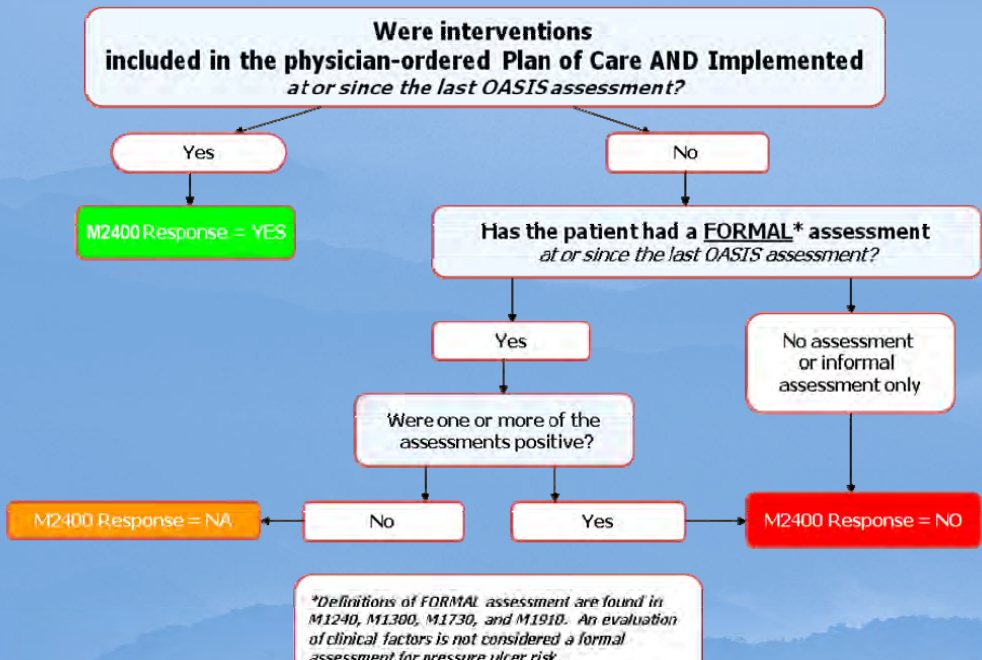
Determining response for M2250 c - f at SOC/ROC



-(CMS OASIS QAs, Cat 4b, Q172.9.5)

Revised 10/13/2010

Determining response for M2400 b – e at TRF/DC



-(CMS OASIS QAs, Cat 4b, Q172.9.5)

Revised 10/13/2010

Process Measure & Care Transition Success

- Understanding what's required
- Incorporating best practices
- Educating staff
- Evaluating reports to determine adherence rates
- Implementing plans of action when below the benchmark
- Providing the highest quality of care possible to the population we serve!

Got a questions? Can't find an answer in existing guidance?

Send it to the CMS OASIS Q&A Mailbox:

cmsoasisquestions@oasisanswers.com

Questions??

Thank You!

References

TECHNICAL DOCUMENTATION OF PROCESS MEASURES
www.cms.gov/HomeHealthQualityInits/10_HHQIQualityMeasures.asp#TopOfPage

PBQI MANUAL
www.cms.gov/HomeHealthQualityInits/15_PBQIProcessMeasures.asp#TopOfPage

OASIS-C GUIDANCE MANUAL
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COLORADO FOUNDATION FOR MEDICAL CARE – CARE TRANSITIONS PROVIDER RESOURCES
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CMS OASIS Q&As
www.qtso.com/hhadownload.html