



# Home Health Value-Based Purchasing (HHVBP)



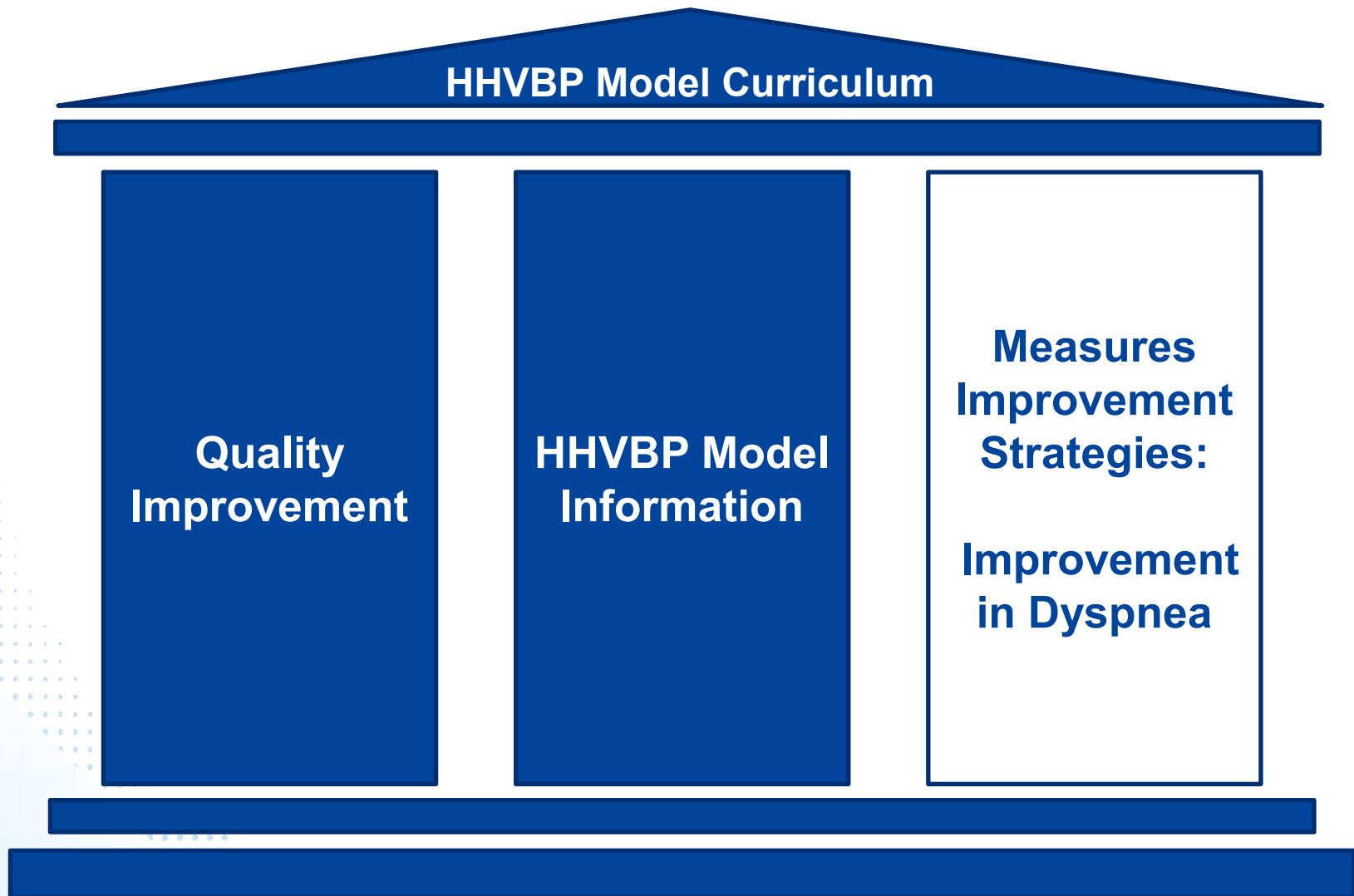
## OASIS Measure: Improvement in Dyspnea

March 23, 2017

Prepared for CMS by the HHVBP Technical Assistance, contract number HHSM-500-2014-0033I. If you have suggestions for additional topics, please email the helpdesk at [HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov).



# HHVBP Learning Event Structure



# Agenda

- Review the OASIS-based quality measure of Improvement in Dyspnea
- Discuss clinical and operational processes and interventions to impact this measure
- Provide resources and support for quality improvement
- Highlight high performing HHAs for collaborative learning



# Handouts & Questions

## Handouts

- Presentation slides
- COPD Zone Tool (Patient Self-Management Tool)
- Improvement in Dyspnea Care Path
- Available via the green “Resources” widget for live presentations and on HHVBP Connect if viewing a recording

## Questions

- Questions may be submitted through the Q&A feature on your screen OR HHVBP Help Desk at [HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov)

# Webinar Console Overview

**Resource List**

- Text Alternative
- Slide Download


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**Q&A**


Refresh Now






Submit

Slides



## Home Health Value-Based Purchasing



Navigation icons:   **Chat**   

# Important Updates and Reminders

- **New Measures Data Submission**
  - » **April 1<sup>st</sup> (12:01am ET) through- April 17<sup>th</sup> (3:00 AM ET)**
    - 1<sup>st</sup> quarter of 2017 (data collection for January 1, 2017 – March 31, 2017)
      - Advance Care Plan
      - Herpes Zoster
    - Annual reporting (data collection for October 1, 2016 through March 31, 2017)
      - Influenza Vaccination Coverage for Home Health Care Personnel
- **Help Desk Assistance**
  - » Hours: Monday- Friday, 8:30am-7:30-m ET
  - » Closed weekends and federal holidays

# Questions to Consider

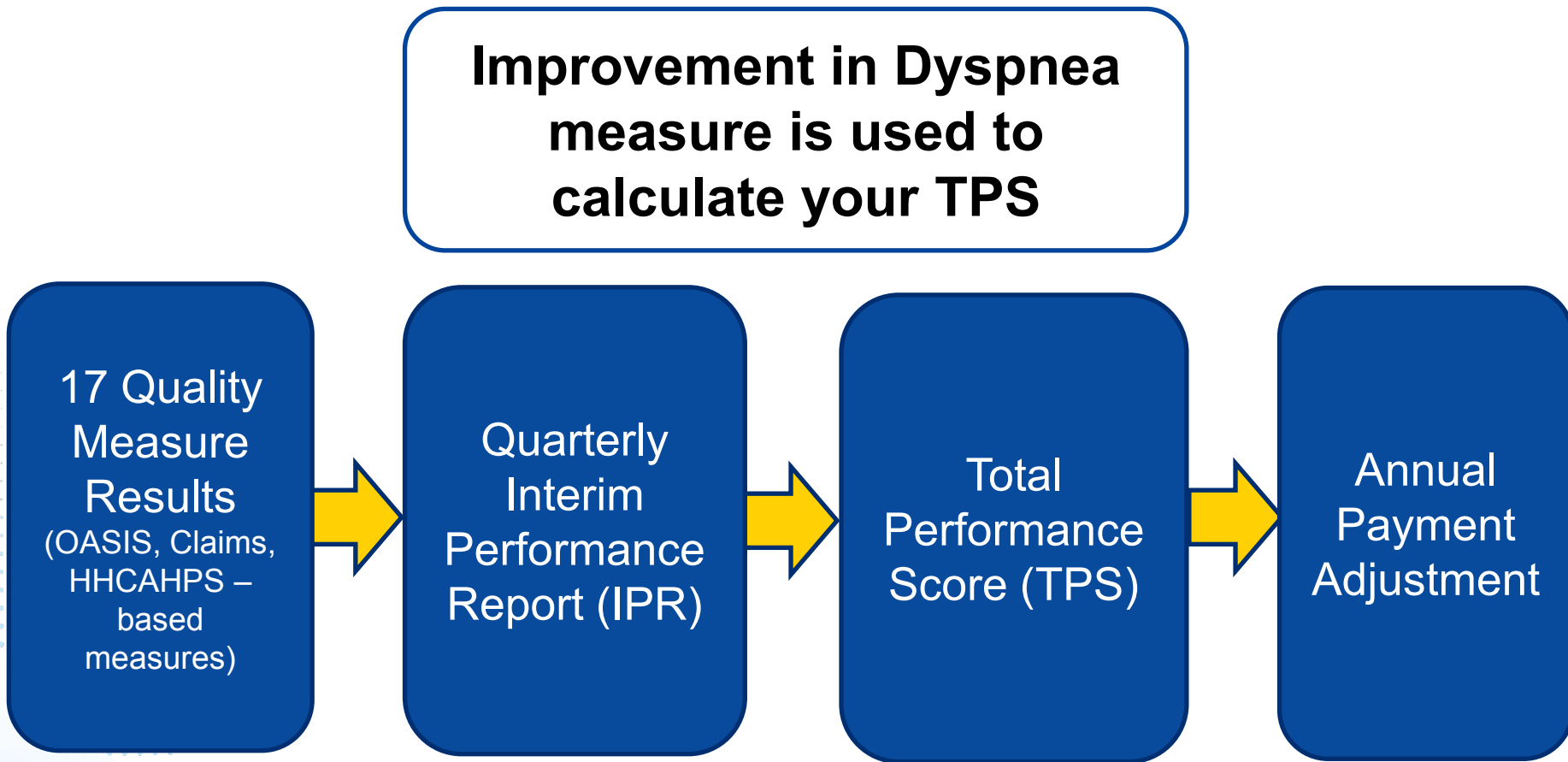
1. What are your current strategies for managing patients with dyspnea?
2. What are ways in which your current strategies for managing patients with dyspnea could improve?

The slide features a white background with decorative blue dot patterns in the corners. The top-right corner has a pattern of dots that tapers towards the top-right. The bottom-left corner has a pattern of dots that tapers towards the bottom-left. The text is centered in a bold, blue, sans-serif font.

# Measure Review: Improvement in Dyspnea



# TPS & Annual Payment Adjustments



# Improvement in Dyspnea

<b>Measure Description</b>	<b>Percentage of home health episodes of care during which the patient became less short of breath or dyspneic.</b>
Numerator	Number of home health quality episodes where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care
Denominator	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Measure-specific Exclusions	Home health quality episodes for which the patient, at start/resumption of care, was not short of breath at any time, episodes that end with inpatient facility transfer or death.
OASIS-C2 Item(s) Used	(M1400) When is the patient dyspneic?

# OASIS Guidance: Improvement in Dyspnea

Collected  
at  
SOC/ROC  
& Discharge

## OASIS ITEM

(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 (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)

3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation

4 - At rest (during day or night)

- **Level of Exertion Causing Dyspnea**

- » Report what is true on the day of assessment

- 24 hours immediately preceding the home visit and the time spent by the clinician in the home

- » Refer to examples included in response to determine the amount of effort it took to cause dyspnea (examples are illustrative, not absolutes)

# OASIS Guidance: Improvement in Dyspnea (cont.)

- **Oxygen Use**
  - » If patient uses oxygen *continuously*, assess **with** oxygen
  - » If oxygen is used *intermittently*, assess **without** oxygen
  - » Assessment based on patient's **use** of oxygen, not physician's order
- **Modifications of the Patient's Environment**
  - » Environment may have been modified to address dyspnea:
    - E.g., Sleeps in recliner or sleeps with two pillows
  - » If patient has not demonstrated or reported shortness of breath during the “day of assessment” timeframe,” select “0” even though the environment or patient activities were modified in order to avoid SOB

# What We Need to Succeed?

## *Measure: Improvement in Dyspnea*

### OASIS ITEM

(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 (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)

3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation

4 - At rest (during day or night)



Score is  
numerically  
lower at DC

### **“IMPROVEMENT Achieved”**

Discharge OASIS score is numerically lower when compared to SOC/ROC

Example: SOC – “2” and DC – “1” = Improvement

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# Measure Improvement Strategies

# Measure Improvement Strategies (cont.)

Basic Clinical Education

Tools and Interventions

Peer-to-Peer Collaboration

# Measure Improvement Strategies: Basic Clinical Education

**Basic Clinical Education**

**Tools and Interventions**

**Peer-to-Peer Collaboration**



# Sample Clinical Staff Education Resources

Topic	Sample Resource
1. Measure Specifics	<ul style="list-style-type: none"><li>• <a href="#">CMS Home Health Quality Measure Tables</a></li></ul>
2. OASIS Data Accuracy	<ul style="list-style-type: none"><li>• <a href="#">OASIS C-2 Guidance Manual</a></li><li>• <a href="#">OASIS Q&amp;As</a></li></ul>
3. Basics of Chronic Disease Management	<ul style="list-style-type: none"><li>• <a href="#">HHQI Basics of Chronic Disease Management Course (free with CEUs)</a></li></ul>
4. Clinical Best Practices	<ul style="list-style-type: none"><li>• <a href="#">VNAA Blueprint for Excellence: Clinical Conditions &amp; Symptom Management: Chronic Obstructive Pulmonary Disease—COPD</a></li><li>• <a href="#">COPD Zone Tool</a></li></ul>
5. Teach-Back	<ul style="list-style-type: none"><li>• <a href="#">10 Elements of Competency for Using Teach-Back</a></li></ul>

# 1. CMS Home Health Quality Measure Tables



The screenshot displays the CMS.gov website's "Quality Measures" page for the Home Health Quality Initiative. The page features a navigation menu with categories like Medicare, Medicaid/CHIP, and Private Insurance. A sidebar on the left contains links for Educational Resources, Spotlight, Reporting Requirements, Quality Measures, and Star Ratings. The main content area is titled "Quality Measures" and includes an "Updates" section dated March 01, 2017, which mentions a Public Comment Summary Report for the Home Health Functional Status Process Measure. Below the updates is a list of downloadable documents, including various manuals and tables. A red box highlights the document "Home Health Outcomes Measures Table OASIS-C2\_02\_03\_17.Final [PDF, 162KB]".

Home | About CMS | Newsroom | FAQs | Archive | Share

Learn about your health care options

Medicare Medicaid/CHIP Medicare-Medicaid Coordination Private Insurance Innovation Center Regulations & Guidance Research, Statistics, Data & Systems

Home > Medicare > Home Health Quality Initiative > Quality Measures

### Home Health Quality Initiative

- Educational Resources
- Spotlight
- Home Health Quality Reporting Requirements
- Quality Measures**
- Home Health Star Ratings

### Quality Measures

#### Updates

**March 01, 2017**

The Public Comment Summary Report for the Home Health Functional Status Process Measure is now available in the "Downloads" section below. This cross-setting function quality measure is an application of the quality measure of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan Addresses Function (NQF #2631). This process measure reports the percent of patients with a start of care/res of care and a discharge functional assessment and a treatment goal that addresses function. The treatment go...

Measures to be Removed from the Home Health Quality Initiative [PDF, 88KB]

HHQRP TEP Final Summary 11-13-16.sxf [PDF, 2MB]

2016\_04\_06\_mspb\_pac\_hha\_service\_exclusions [XLSX, 64KB]

2016\_04\_06\_mspb\_pac\_measure\_specifications\_for\_rulemaking [PDF, 867KB]

Proposed Measure Specifications for Measures Proposed in CY 2017 HH QRP NPRM [PDF, 1MB]

Risk Adjustment Models, Updated September 11, 2015 – OASIS [ZIP, 2 MB] [ZIP, 2MB]

How To Risk Adjust Compare Method [PDF, 12KB]

Outcome-Based Quality Improvement (OBQI) Manual [PDF, 2MB]

Outcome-Based Quality Monitoring (OBQM) Manual [PDF, 1MB]

Process-Based Quality Improvement Manual [PDF, 1MB]

Integumentary\_OASIS\_final\_2017.pdf [PDF, 274KB]

Home Health Process Measures Table OASIS-C2\_02\_03\_17.Final.Revised.(1).pdf [PDF, 322KB]

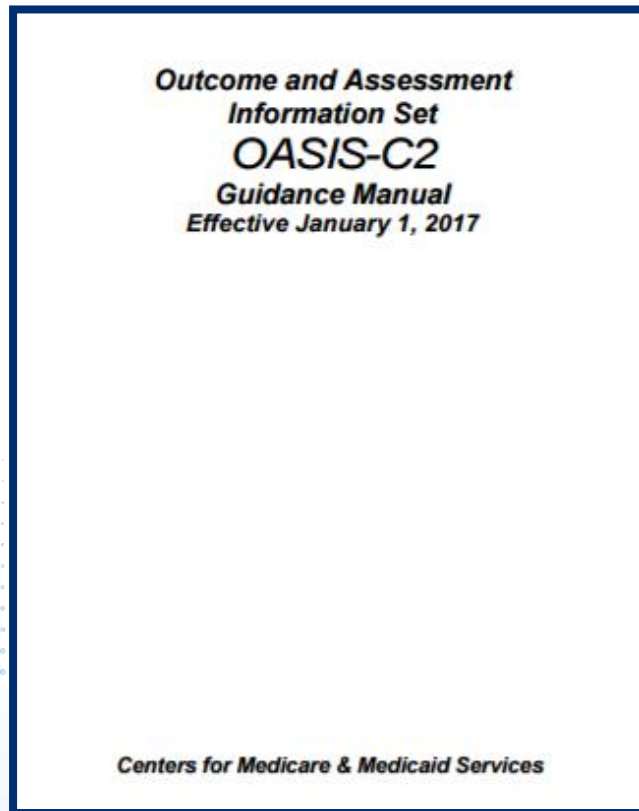
Home Health Outcomes Measures Table OASIS-C2\_02\_03\_17.Final [PDF, 162KB]

Technical Documentation of OASIS-Based Measures for OASIS-C, OASIS-C1, OASIS-C2\_02\_03\_2017 final [ZIP, 2MB]

Home Health PAE Measures Table OASIS-C2\_02\_03\_17.Final [PDF, 66KB]

# 2. CMS OASIS Guidance

## OASIS-C2 Guidance Manual



## OASIS Q&As

**OASIS User Guides & Training**

Skip Navigation

Download **OASIS User Guides & Training** FAQ Automation Coordinators Education Coordinators

**OASIS Quarterly Q & A's**

- [October 2016 Quarterly CMS Q&As \(PDF 493 KB\)](#)
- [July 2016 Quarterly CMS Q&As \(PDF 119 KB\)](#)
- [April 2016 Quarterly CMS Q&As \(PDF 110 KB\)](#)
- [January 2016 Quarterly CMS Q&As \(PDF 132 KB\)](#)
- [October 2015 Quarterly CMS Q&As \(PDF 103 KB\)](#)
- [July 2015 Quarterly CMS Q&As \(PDF 72 KB\)](#)
- [April 2015 Quarterly CMS Q&As \(PDF 120 KB\)](#)
- [January 2015 Quarterly CMS Q&As \(PDF 241 KB\)](#)
- [October 2014 Quarterly CMS Q&As \(PDF 135 KB\)](#)
- [July 2014 Quarterly CMS Q&As \(PDF 120 KB\)](#)
- [April 2014 Quarterly CMS Q&As \(PDF 182 KB\)](#)
- [January 2014 Quarterly CMS Q&As \(PDF 163 KB\)](#)
- [October 2013 Quarterly CMS Q&As \(PDF 94 KB\)](#)
- [July 2013 Quarterly CMS Q&As \(PDF 96 KB\)](#)
- [April 2013 Quarterly CMS Q&As \(PDF 180 KB\)](#)
- [January 2013 Quarterly CMS Q&As \(PDF 165 KB\)](#)

**OASIS-C1/ICD-10 Q & A's** 04/2015

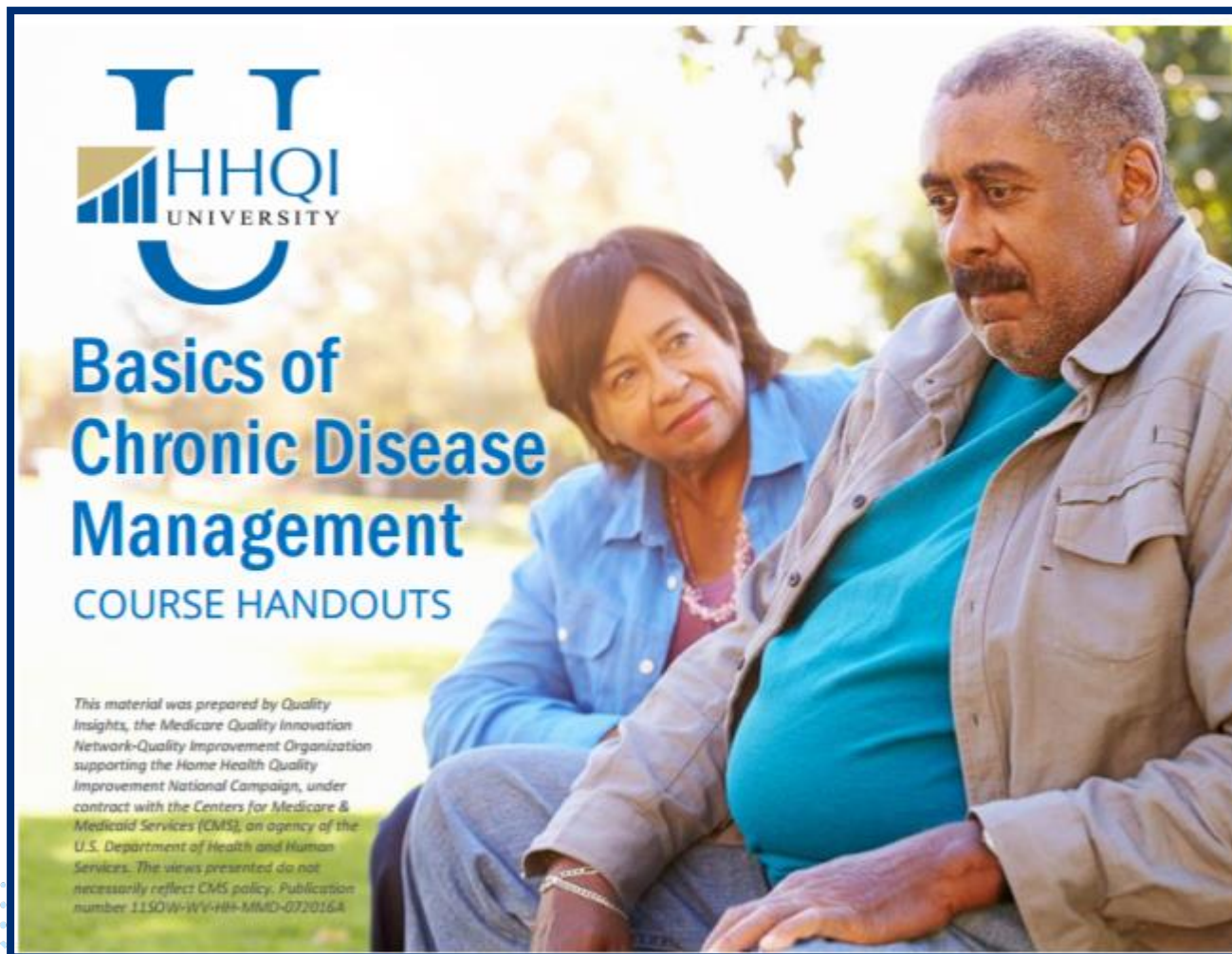
**OASIS-C2 Q & A's** 10/2016

**Guides and Manuals**

**OASIS Submission User's Guide**

**CASPER Reporting User's Manual**

# 3. Basics of Chronic Disease Management



**HHQI**  
UNIVERSITY

## Basics of Chronic Disease Management

COURSE HANDOUTS

*This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SDW-WV-HH-MMD-072016A*



# 4. VNAA Blueprint for Excellence

## **VNAA Blueprint for Excellence**

PATHWAY TO BEST PRACTICES

Clinical Conditions & Symptom  
Management: Chronic Obstructive  
Pulmonary Disease—COPD

VNAA Best Practices for Home Health

# 5. COPD Zone Tool

## Chronic Obstructive Pulmonary Disease (COPD) Management ZONES

[Insert Agency Logo]

References: GOLD, 2012; GOLD, 2014; [American Lung Association, 2014](#)

<b>GREEN ZONE</b>	<p><b>ALL CLEAR (GOAL)</b></p> <ul style="list-style-type: none"> <li>No cough, wheezing, or shortness of breathing; able to do usual activities</li> <li>No need to use rescue inhalers</li> <li>No changes in cough and sputum (phlegm)</li> <li>Appetite is good</li> </ul>	<p><b>Doing Great!</b></p> <ul style="list-style-type: none"> <li>Your symptoms are under control</li> <li>Actions:               <ul style="list-style-type: none"> <li>Take medicines as ordered</li> <li>Keep all doctor appointments</li> <li>Follow healthy eating habits</li> <li>Continue regular exercise</li> <li>Use oxygen as ordered</li> <li>Stop smoking or being around others who smoke</li> <li>Get annual flu shot</li> </ul> </li> </ul>
<b>YELLOW ZONE</b>	<p><b>CAUTION (WARNING)</b> If you have any of the following:</p> <ul style="list-style-type: none"> <li>Sputum (phlegm) increases, color changes, or it thickens</li> <li>Cough increases or wheezing even after taking your medicines</li> <li>More trouble breathing or more coughing with activity</li> <li>Extra pillows to sleep</li> <li>Medicine is not helping</li> <li>Appetite not very good</li> </ul>	<p><b>Act Today!</b></p> <ul style="list-style-type: none"> <li>Means you may need your medicines changed</li> <li>Actions:               <ul style="list-style-type: none"> <li>Use oxygen as ordered</li> <li>Take your "quick relief medicine" (rescue inhaler)</li> <li>Call <b>your home health nurse</b></li> </ul> </li> </ul> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>(agency's phone number)</i></p> <ul style="list-style-type: none"> <li>Or call <b>your doctor</b></li> </ul> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>(doctor's phone number)</i></p>
<b>RED ZONE</b>	<p><b>EMERGENCY</b></p> <ul style="list-style-type: none"> <li>Trouble breathing or wheezing at rest               <ul style="list-style-type: none"> <li>Hard to walk or talk</li> </ul> </li> <li>Rescue medication isn't working</li> <li>Chest pain or tightness that does not go away</li> <li>Must sit up to breathe</li> <li>Lips or finger nails turn blue or gray</li> <li>Confusion/anxiety</li> </ul>	<p><b>Act NOW!</b></p> <ul style="list-style-type: none"> <li>Means you need to be seen by a doctor <u>right away</u></li> <li>Actions:               <ul style="list-style-type: none"> <li>Call <b>your doctor right away</b></li> </ul> </li> </ul> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>(doctor's phone number)</i></p> <ul style="list-style-type: none"> <li>Or call <b>911</b></li> </ul>

# 6. 10 Elements of Competency for Using Teach-back Effectively



## 10 Elements of Competence for Using Teach-back Effectively

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

### What is Teach-back?

- A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.
- Asking a patient (or family member) to explain **in their own words** what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes<sup>1</sup>.

<sup>1</sup> Schillinger, 2003



# Measure Improvement Strategies: Tools and Interventions

Basic Clinical Education

**Tools and Interventions**

Peer-to-Peer Collaboration



# Clinical Best Practices: Sample Paths to Improvement

Best Practice  
Staff  
Education

Patient Workbook



Care Path

# Sample Patient Workbook

## Living Well **COPD**<sup>TM</sup> with

Chronic Obstructive Pulmonary Disease

*A plan of action for life*

A Learning Tool for Patients and Their Families

### Being Healthy with COPD

- Preventing your symptoms and taking your medications
- Managing your breathing and saving your energy
- Managing your stress and anxiety
- Adopting and maintaining a healthy and fulfilling lifestyle
- Developing and integrating a plan of action into your life

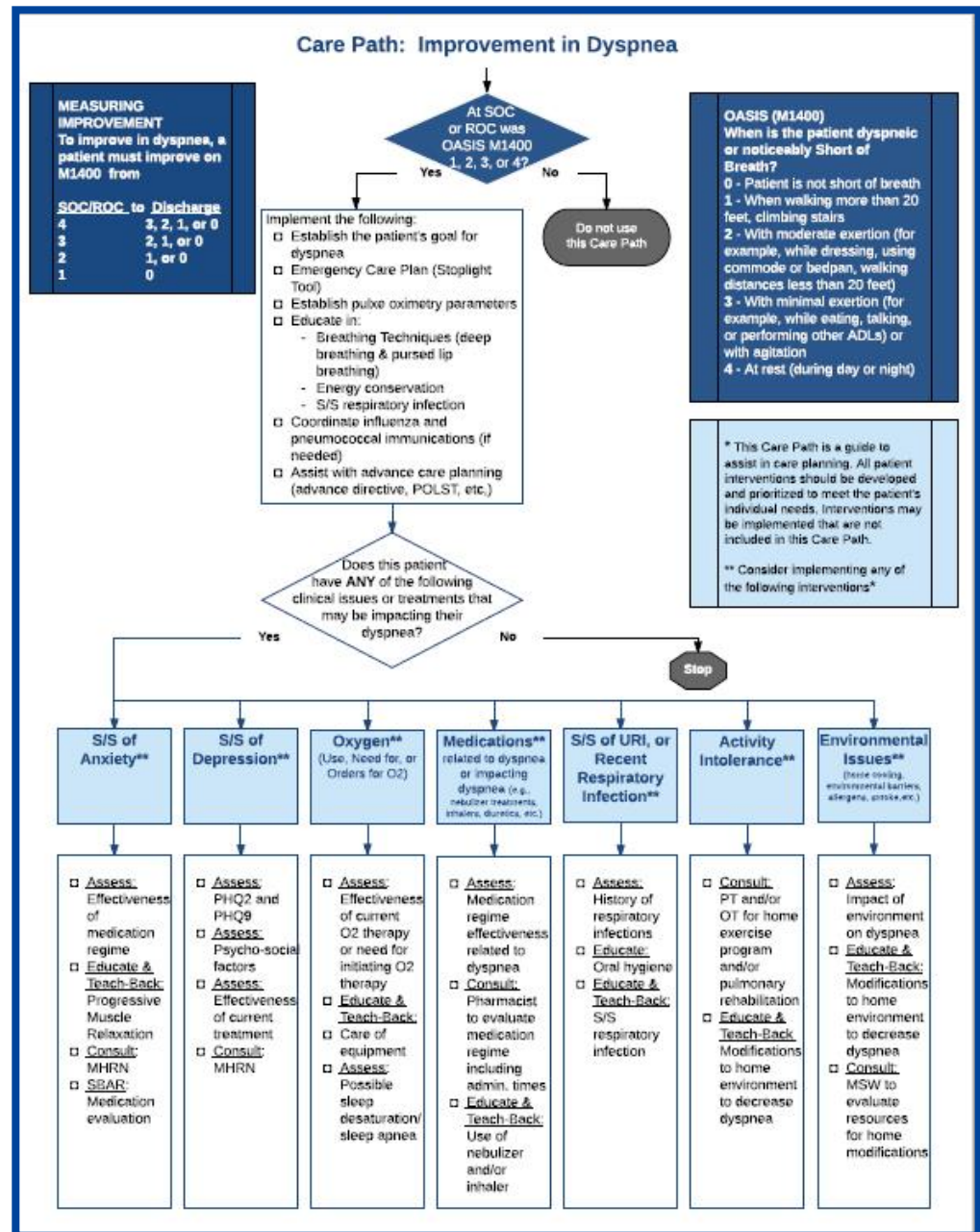
This guide belongs to:

Healthcare professional:

Institution:

March 2012, adapted from the 2<sup>nd</sup> edition

# Care Path & Intervention Examples



# Care Path & Intervention Examples (cont.)

## OASIS (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)

1

2

## MEASURING IMPROVEMENT

To improve in dyspnea, a patient must improve on M1400 from

### SOC/ROC to Discharge

4	3, 2, 1, or 0
3	2, 1, or 0
2	1, or 0
1	0

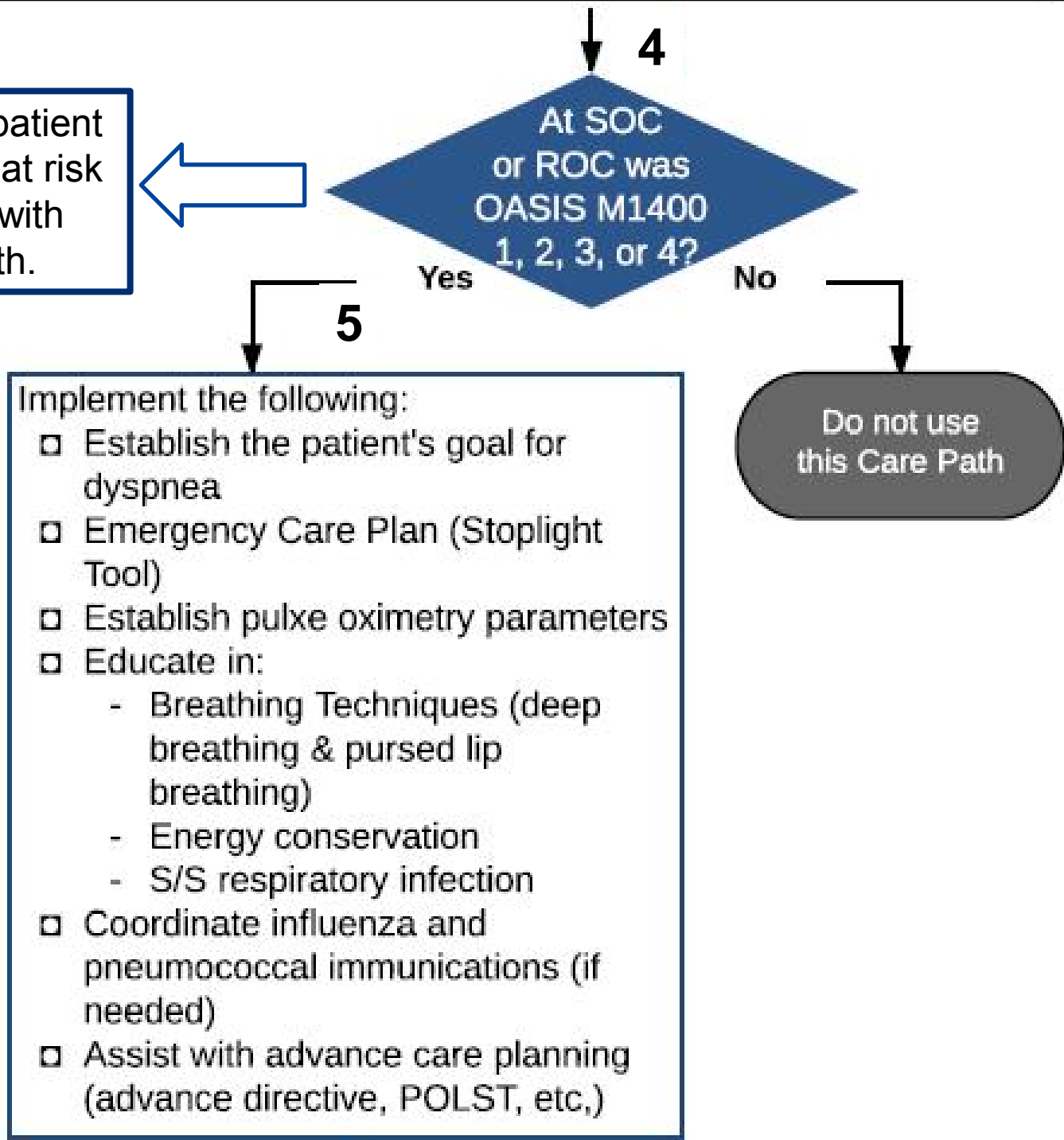
3

\* This Care Path is a guide to assist in care planning. All patient interventions should be developed and prioritized to meet the patient's individual needs. Interventions may be implemented that are not included in this Care Path.

\*\* Consider implementing any of the following interventions\*

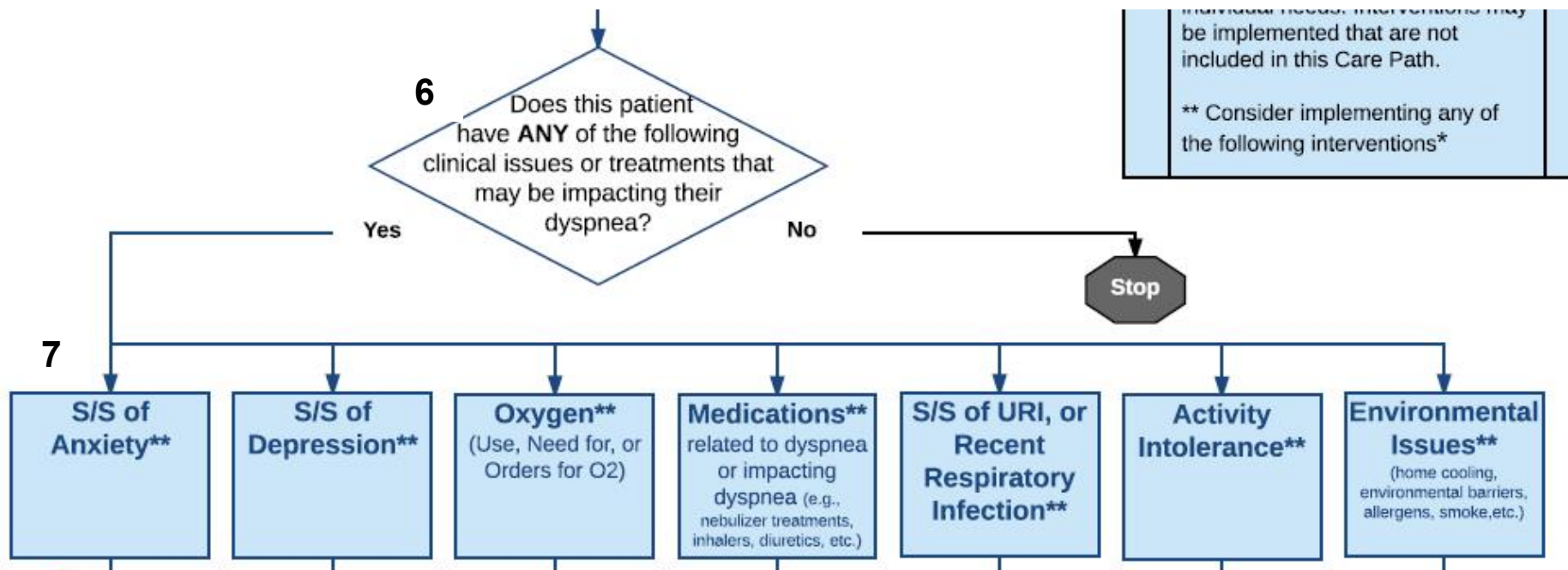
# Care Path

Consider: Is the patient short of breath or at risk for having issues with shortness of breath.

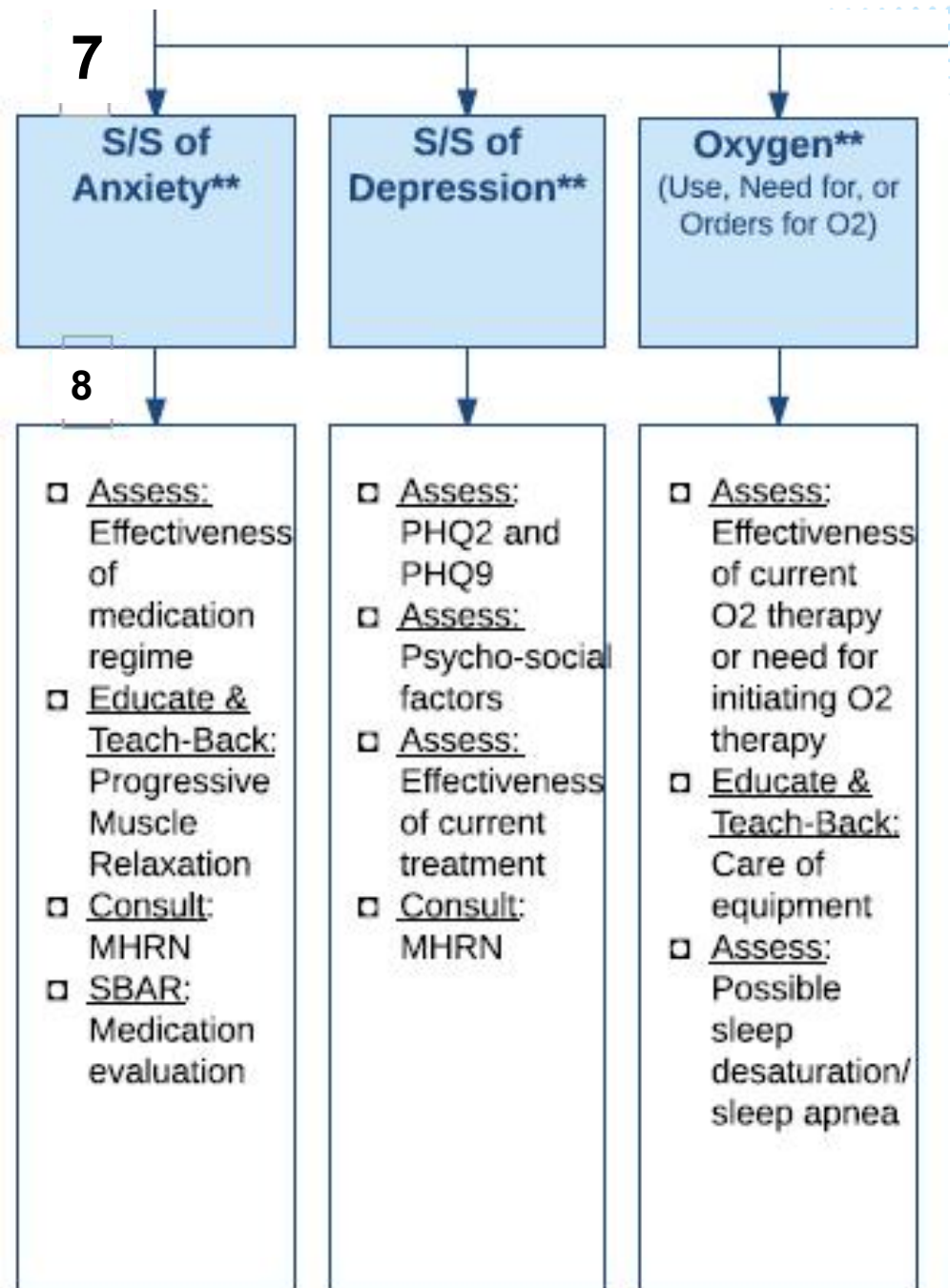




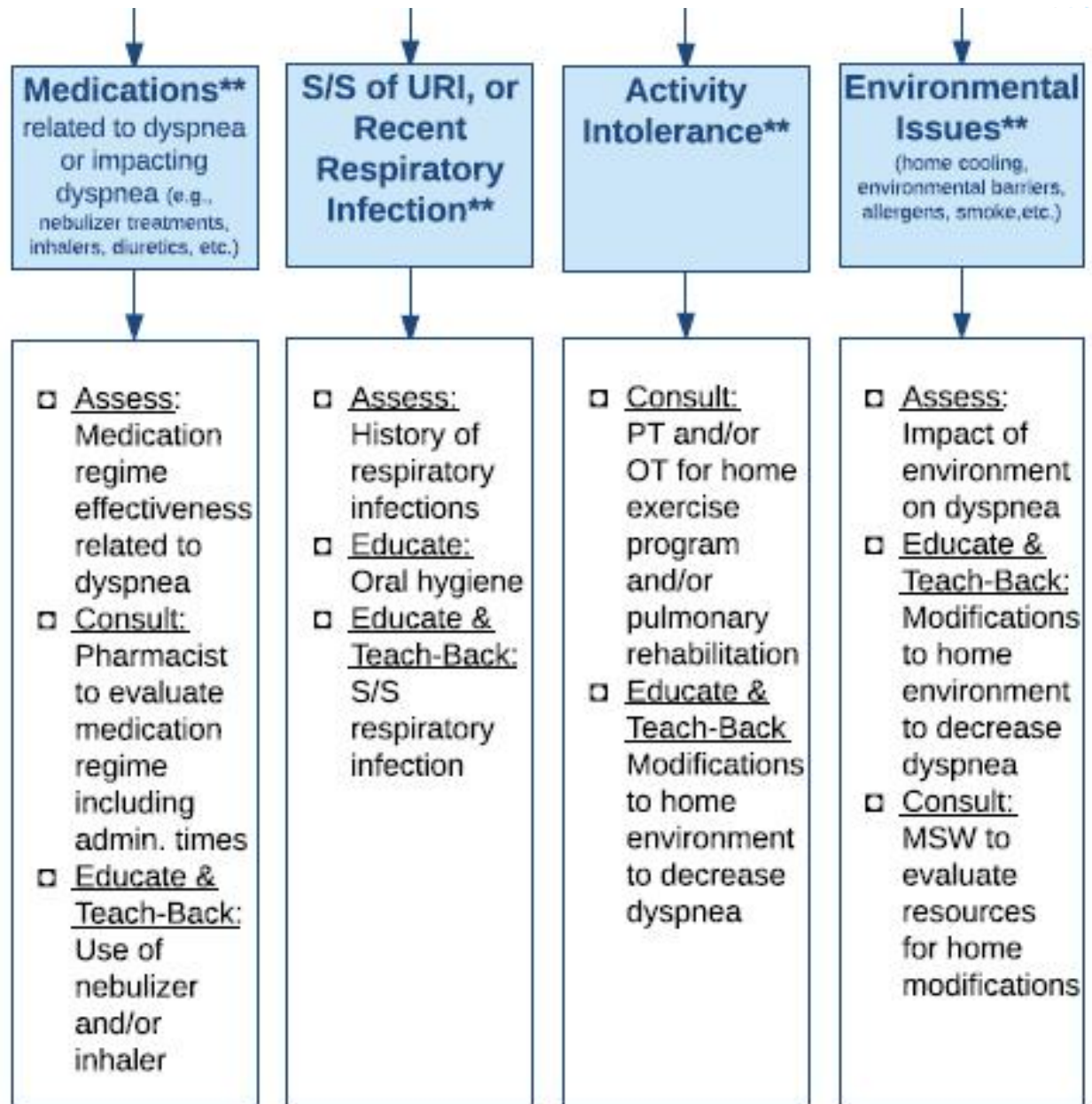
# Care Path (cont.)



# Care Path: Interventions



# Care Path: Interventions (cont.)





# Home-Based Pulmonary Rehab: What does it look like?

- **Aerobic training**
  - Set goal for walking distance
  - Record distance using a pedometer
  - 30 minutes, 5 times per week
  - Record completion in home diary
- **Upper and lower limb strength training**
  - Functional tasks: stair training, sit to stand from chair, etc.
  - Free weight training
- **Patients contacted by clinician (weekly, e.g., for approx. 7 weeks)**
  - Review the home diary
  - Progress the exercise prescription
  - Deliver disease-specific self-management training
  - Explore and build motivation for change
  - Move towards commitment and action



# Today's Discussion

Basic Clinical Education

Tools and Interventions

**Peer-to-Peer Collaboration**

# Nemaha County Home Care

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**Jere Gravatt, RN, Director  
Nemaha County Home Care  
Auburn, Nebraska**

# Elite Home Health and Hospice

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**Sheri Osburn, Director of Clinical Services  
Elite Home Health and Hospice  
Clarkston, Washington**

# Discussion!



# Resources & Reminders

# Mark Your Calendars

Upcoming Learning Event Topic	Date	Time
OASIS and HHCAHPS Measure: Improvement in Medication-Related Measures	April 6, 2017	2:00 PM ET
Learning from the Literature: Highlights from the Environmental Scan	April 20, 2017	2:00 PM ET

**All learning events will be held at 2 PM, Eastern Time.  
Please register via the *HHVBP Connect* Calendar.**

# Questions

**Do you have questions about the HHVBP Model?**

**Contact the HHVBP Model Help Desk at**

**[HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov)**.

**If you are experiencing technical issues with gaining access to the HHVBP Secure Portal or**

***HHVBP Connect*, please call:**

**(844) 280-5628.**

***Stay on the line until your issue is resolved.***



# HHVBP Connect Chatter

- Join the discussion!
  - » Engage with your peers on *HHVBP Connect* by liking and commenting on their posts
- If you would like to ask a question of your peers:
  - » Log into the *HHVBP Connect* site at <https://app.innovation.cms.gov/HHVBPConnect/CommunityLogin>
  - » On the Chatter page, select “Post” at the top and type in your question and post to the group
- To request access to *HHVBP Connect*, visit the *HHVBP Connect* site and select the new user registration link
  - » Follow the on-screen instructions
  - » The CMMI Help Desk will contact you to complete the registration process



# Thank you!

Prepared for CMS by the HHVBP Technical Assistance, contract number HHSM-500-2014-0033I. If you have suggestions for additional topics, please email the helpdesk at [HHVBPquestions@cms.hhs.gov](mailto:HHVBPquestions@cms.hhs.gov).

