OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

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Telehealth nursing

Clinical and tech expertise are key to realizing effectiveness of telehealth programs

Agencies that wish to improve productivity and reduce readmissions for CHF patients by incorporating a telehealth program should make certain a nurse with cardiovascular expertise is helping manage it.

That expertise will allow nurses to more effectively triage patients over the phone as they monitor vital signs and symptoms through a telehealth program and keep patients from returning to the hospital,

(*see* ***telehealth***, *p. 8*)

PPS final rule

Meet the new 70% minimum threshold for OASIS submission or face payment cuts

Your agency's quality and clinical managers better get familiar with the OASIS validation logs generated by CMS' new Assessment Submission and Processing (ASAP) system. Those reports will be the key to preventing reduced payments for failure to meet minimum OASIS submission requirements.

All agencies must submit an admission and discharge OASIS for at least 70% of all patients with episodes between July 1, 2015 and June 30, 2016. Failure to comply will result in a 2% cut in the 2017

(*see* ***OASIS***, *p. 10*)

In This Issue

ASAP transmission

Look to vendors for ASAP readiness before rollout for transmitting OASIS data

Agencies will want to make sure they contact their vendors, who will be handling most of the transition to CMS' new Assessment Submission and Processing (ASAP) system, to ensure they are ready for the transition on 12 a.m. EST Jan. 1, 2015.

Agencies should ask vendors to write statements about their readiness. Agencies can refer to this should any future disputes arise, says Ann Rambusch, president of Rambusch3 Consulting, Georgetown, Texas.

The change means agencies will need to look for reports of errors and warnings that will be available within 24 hours in final validation reports in the CASPER reporting application, CMS says in its OASIS submission user's guide.

CMS also has responded to the National Association for Home Care & Hospice to provide more details about the switch to ASAP. Below are some of the details about ASAP:

- **Don't forget the OASIS data transmission blackout at the end of the year.** The OASIS submission system will shut down and no OASIS assessment data files can be submitted from 6 p.m. EST Dec. 26 through 11:59 p.m. EST Dec. 31.
- **Follow new submission specifications.** OASIS data files submitted on or after Jan. 1 using ASAP must follow version 2.10 (which supports OASIS-C) and version 2.11 (which supports OASIS-C1) of the OASIS data submission specifications.
- **Watch for changing submission link.** The submission link from agencies' states will change to the CMS QIES Systems for Providers.
- **Look for CMS software that transmits OASIS data to change.** The jHAVEN software will replace HAVEN, the software CMS currently provides agencies to transmit OASIS data to it, on Jan. 1 and be available to users prior to Jan. 1 on at: *http://tinyurl.com/n64xenk*.
- **Look for new validation utility tool (VUT).** The VUT will replace the system from HAVEN on Jan. 1. The VUT is a software utility that can be used to validate OASIS submission files in XML format. It was released on Oct. 6 and can be found at *www.qtso.com/vendoroasis.html*.
- **Use existing identifications.** Agencies' existing identifications (both in CMSNet and QIES) will work for the new submission process.
- **Upgrade software to submit OASIS data.** Agencies will need a software upgrade since they will be submitting an XML file and not a text file, but their software vendor will supply this change. Kinnser, for

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example, is already using the CMS testing tools to confirm successful OASIS transmissions. So agencies using its system will be ready to transmit Jan. 1, says Russ Krengel, product manager, home health. — *Nicholas Stern (nstern@decisionhealth.com)*

COPs: Infection control

Make plans to implement your agency's infection control program as CoPs change

News of disease outbreaks and flu season mark a perfect time to update your agency's infection control program.

That will be a priority in order to avoid new surveyor scrutiny now that CMS plans on requiring agencies to more closely track and analyze infection control data, according its new, proposed conditions of participation (CoPs) released Oct. 6. *(See related insert)*.

With the new CoPs, CMS is clearly indicating the need for a more systematic approach to this issue in home health and for all health care providers, says Barbara Citarella, RN, BSN, MS, CHCE, CHS-V, president and CEO of RBC Limited, a health care and management consultancy located in Staatsburg, N.Y.

Currently, there is no requirement for an agency-wide infection control program, though agencies already must comply with accepted professional standards and principles that include infection control practices, and most include such a program as part of their quality assessment and performance improvement (QAPI) work, say Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA approved ICD-10 trainer, and owner of Transitions Health and Wellness Solutions in Harlingen, Texas and CMS in the proposed CoPs.

Under the proposed regulation, agencies will have to maintain an agency-wide program to survey, identify, prevent, control and investigate infectious and communicable diseases.

Examples of some areas to look to for infection prevention include catheter-associated urinary tract infections (UTIs), skin and soft tissue infections and central line associated blood infections, says Mary McGoldrick, MS, RN, CRNI, home care and hospice consultant with Home Health Systems, Saint Simons Island, Ga.

Also, make sure your QAPI staff checks every day or week and alert clinicians to new disease outbreaks like Ebola, Middle East Respiratory Syndrome (MERS) and certain strains of tuberculosis, Citarella says. Visit the Centers for Disease Control and Prevention (CDC) website frequently for this purpose.

Make this a part of your QAPI infection control plan, she says.

Begin with hand washing

For agencies that don't have any infection prevention and control plan in place, it's best to start with teaching clinicians and patients about proper hand washing technique, she says. Have QAPI staff educate clinicians on standard precautions, monitoring and field observations.

Then, on a quarterly basis, choose a group of employees and observe them hand washing in the field, Citarella says. Use the results of this field test to further educate employees. Another method of testing on technique is to have peers demonstrate and review one another at in-service meetings.

For agencies with infection control plans already in place, have QAPI staff look again at the type of data your agency is collecting related to infection control and make sure it is still relevant to your patient population, she says.

For example, does your agency have specific plans in place to make sure patients with COPD and especially prone to exacerbation following respiratory infections are properly immunized, she says.

Also, agencies should have an annual review of their programs to evaluate whether infection controls to say, reduce respiratory infections for COPD patients, were met, Citarella says.

If those goals weren't met, agencies should describe why that was the case and what can be done to prevent further infections in the future, McGoldrick says.

Inquire about use of antibiotics

Clinicians will want to inquire about the reasons why any home health patients are using antibiotics as part of their infection control plan, she says. This can help identify and potentially prevent disease outbreaks.

Agencies will also want to track if a patient, group of patients or clinician at your agency or group of clinicians suddenly comes down with some unexplained illness that may be something new, Citarella says.

Paraprofessionals are often the first in an agency to hear of such outbreaks and they too should be instructed

to note on patient charts information about antibiotics or spreading illnesses, she says. This should be done by paraprofessionals or clinicians in the same timeframe they are required to submit documentation for visits.

If something appears unique or out of the norm, have staff call a QAPI manager immediately, Citarella says.

Establish role for infection manager

Make sure the person overseeing infection control for your agency is someone who is familiar with the clinical issues involved, such as a registered nurse with training and education in the field of infection control and prevention, says McGoldrick.

And QAPI staff like a quality manager will need to spend as much as a third of their time managing the agency's infection control program, estimates Citarella.

Use free resources to develop plan

CMS also expects agencies to collaborate with local health departments to develop their plans, though currently, many are likely preoccupied with efforts to educate and prepare for Ebola and other outbreaks, she says. Their websites still typically have plentiful information about infection control best practices.

Agencies can check out the One and Only Campaign, which is sponsored by the CDC to help promote safe injections and prevent outbreaks from injections. It can be found here: *http://www.oneandonlycampaign.org*.

A few other good sources are:

- The Association for Professionals in Infection Control and Epidemiology: *http://www.apic.org;*
- The World Health Organization: *http://www.who.int/en;*
- The Society for Healthcare Epidemiology of America: *http://www.shea-online.org. — Nicholas C. Stern (nstern@decisionhealth.com)*

Anatomy & Physiology

Study colonization in cellulitis and MRSA to prepare for the increased detail in ICD-10

Clinicians need to pay close attention to specific details in referral source documents such as diagnosis lists and history and physical notes for reports and codes associated with cellulitis and the colonization of antibiotic resistant bacteria like *Methicillin-Resistant Staphylococcus Aureus* (MRSA) after ICD-10 begins Oct. 1, 2015.

That's because for ICD-10, CMS has removed from payment categories non-specific codes whenever a clinician should be able to identify a more specific diagnosis code based on clinical assessment, the federal Medicare agency reiterated in a Nov. 5 national provider call presentation.

Also, these more specific details will help you quickly identify and prevent infectious diseases that could spread among your patients and staff.

As with many diagnoses in ICD-10, agencies need to pay attention to the increased level of detail such as laterality and other locations of infection associated with cellulitis to ensure accurate payment, Johnsen says.

For instance, ICD-10 will contain new, more detailed codes for colonization of infectious bacteria, such as Z22.322 (Carrier or suspected carrier of MRSA), says Susan Johnsen, RN, MSN, COS-C, BCHH-C, AHIMA-approved ICD-10 trainer, home health education and informatics specialist at the Loma Linda University Medical Center in Loma Linda, Calif.

Cellulitis as a primary or other diagnosis, which is listed in the final PPS 2015 rule under the diagnosis category "Skin 2 — Ulcers and other skin conditions," is worth from two to 17 case-mix points, according to the final rule.

In ICD-10, cellulitis (LO3.--) has a number of new codes that include laterality and more parts of the body not present with distinct coding options in ICD-9 (681--), such as for the toe, chest wall, groin or perineum.

Understanding colonization vs. infection

When ICD-10 begins, agencies may be surprised to see more codes related to MRSA colonization, such as a weeping wound related to cellulitis, and think they're suddenly getting more cases of MRSA infection, though that might not be the case, Johnsen says.

Agencies should thus ensure they train clinicians on the differences between colonization and infection, in part, because it will impact their infection control policies — a new requirement in CMS' proposed conditions of participation — that deal with treating patients with infectious diseases, she says.

Bacterial colonization in humans is common and typically asymptomatic, Johnsen says. The transition to a bacterial infection like MRSA usually occurs as its symptoms appear, like a painful skin irritation.

Moreover, home health referral sources like physicians at hospitals will culture a wound and, if bacterial counts are low, the wound may be considered colonized. Be sure clinicians clarify this with the physician before coding.

However, technically that does not mean the MRSA isn't still contagious, she says. With MRSA, a doctor may decide to treat it regardless of whether it's colonized or infectious.

Either way, agencies will need to include in their infection control plans guidance for clinicians to initiate antibiotic resistant precautions if MRSA colonization is reported for a patient, Johnsen says.

Such guidance may entail having nurses bring disposable blood pressure cuffs and stethoscopes to treat patients to avoid transmission of MRSA, she says.

Further, agencies need to demand from their referral sources information such as discharge summaries, history and physical notes and notes from infectious disease specialist reports, and provide them to clinicians in e-mails, faxes or electronic health records (EHR) reports so they are aware of any antibacteria resistant colonization or infection, says Johnsen.

Clinicians should also look for medication lists that include antibiotics like Vancomycin, as clues to potential antibiotic-resistant infections like MRSA, she says.

To foster more information sharing, agencies can point out to referral sources like hospitals that sharing such information will help them prove their meaningful use of EHR as required by CMS, she says.

Coding scenario

A 74-year old patient is admitted to home health with cellulitis of her right index leg. The leg is red and inflamed. The patient is taking post-operative antibiotics. Hospital records show the wound culture grew out significant amounts of Group A streptococcus with a small number of colonies of Staph aureus. The Staph was further identified as MRSA. Physician documentation states the cellulitis is caused by Group A strep but was colonized with MRSA. He is treating the Group A strep infection.

Coding in ICD-9

Primary and Secondary Diagnoses		M1024 Case Mix	
		3	4
M1020a: Cellulitis and abscess of the leg, except foot	682.6		
M1022b: Bacterial infections in conditions classified elsewhere: Group B Streptococcus	041.02		

Coding in ICD-10
(OASIS-C1 numbers for this category are M1021 for OASIS-C's M1020 and M1023 for OASIS-C's M1022, in column 1 and M1025 for M1024 in column 3)

Primary and Secondary Diagnoses		M1025 Case Mix	
		3	4
M1021a: Cellulitis of right lower limb	L02.415		
M1021b: Streptococcus, Group B, as the cause of diseases classified elsewhere	B95.1		
M1021c: Carrier or suspected carrier of MRSA	Z22.322		

(Case-mix diagnoses have yet to be determined in ICD-10.)

Discussion: Remember, clinicians need to dig into physician's notes and gather specific details to code accurately and avoid losing payment related to unspecified codes. This scenario shows that level of detail, including for suspected carriers of infections. And while there is an ICD-9 code for colonization or carrier of other specific bacterial diseases, MRSA (V02.54), it is rarely seen or used because of the rules that surround use of V codes and often lack appropriate documentation.

ICD-10 adds not only specific codes for colonization or carrier status with more diseases than ICD-9, such as meningococci or HTLV-1, it adds new codes for antimicrobial resistance. These include antiviral drugs, anti-tubercular drugs, and antifungal drugs. — *Nicholas Stern (nstern@decisionhealth.com)*

Grouper released

CMS releases Grouper with final payment details for 2015

Agencies wishing to ensure accurate payment for OASIS-C1/ICD-9 assessments beginning Jan. 1, 2015 will need to make sure their quality managers, educators and clinical directors study and understand that four diagnosis groups will no longer be used in scoring in the PPS Grouper released by CMS Nov. 10.

The diagnosis groups that no longer will be used in scoring, as also delineated in the final PPS 2015 rule, will be blindness and low vision, Psych 1, Psych 2 and pulmonary disorders, according to the Grouper.

CMS' Grouper overview document is also useful to agency managers and billers in understanding and reviewing the rules for scoring diagnoses and can be used by billers to help determine why a payment may be rejecting, says Ann Rambusch, president of Rambusch3 Consulting, Georgetown, Texas.

Quality and clinical managers also need to pay attention to Table 4 in the Grouper overview that lists the case-mix adjustment variables and scores as also stated in the 2015 PPS final rule, Rambusch says. For instance, agencies no longer will earn points for diabetes or gastrointestinal disorders as a primary diagnosis in early episodes, whereas currently these diagnoses earn five and two case-mix points, respectively.

Related link: *The Home Health PPS Grouper v4415 is available for download here: http://tinyurl.com/p8awmmp.*

Face-to-face documentation

Face-to-face narrative requirement is gone: So who needs to document what?

Have admitting clinicians from your agency write a clinical summary based on their assessment of a patient, and make sure the patient's physician signs off on it.

Doing so can help your agency get necessary documentation within a patient's clinical record since, for episodes beginning Jan. 1, 2015, the face-to-face narrative requirement will be eliminated for the home health industry.

Even without a physician narrative to read, CMS has made clear it expects to see documentation verifying why a patient is eligible for home health services. The documentation, which would justify homebound status and the need for skilled care, would be added to medical records.

One smart way to get that information documented, industry experts contend, is to have admitting clinicians from your agency write a clinical summary after assessing each patient.

The summary would be an abbreviated version of what a patient assessment states, says Kathy Roby, a home health and hospice consultant with Qualidigm, a management consulting company. It should be such a clear explanation of the patient's condition that Medicare contractors who analyze it would determine the patient was indeed homebound and needed skilled care.

When providing the summary, it's important to be succinct, clinical and patient-specific, Roby adds.

Agencies would supply summaries to physicians as part of a patient's plan of care. Physicians would review the documentation and sign it, says Attorney Robert Markette of Hall, Render, Killian, Heath & Lyman in Indianapolis.

Then doctors would incorporate the documentation within the patient's medical record and provide agencies with a copy for agency records, Roby says.

Instead of providing a summary, agencies could give doctors a stack of documentation from the patient assessment. But doctors might object to all that paperwork, Markette says.

Writing clinical summaries already has been a requirement in some states and for some accrediting bodies, Roby says. But now it should be common practice for agencies not only to perform this task but to make sure doctors receive and sign off on copies of these summaries for the patient record, she adds.

Modify your face-to-face forms

Even after the narrative requirement is eliminated, agencies still will need a doctor to certify he had a face-to-face encounter with the patient and that the patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy.

In advance of episodes beginning Jan. 1, 2015, agencies should modify existing face-to-face forms, advises Laura Montalvo, chief clinical officer for SelectData of Anaheim, Calif.

Montalvo recommends agencies remove the space asking doctors for narratives.

She also suggests agencies add a statement by the certifying physician that says the physician provided the agency additional information to support the patient's homebound status and need for skilled care. Examples of that information would include: "Physician progress notes, discharge summaries, history and physical forms, operative reports, referral orders, etc."

This statement indicates ongoing communication between the agency and certifying physician to aid in the patient's care and establishment of eligibility, she contends.

How agencies, docs should comply

Beginning Jan. 1, 2015, agencies and doctors should use this process to get the proper documentation they'll need for face to face.

Step 1: The doctor performs a face-to-face encounter.

Step 2: After deciding the patient qualifies for home health services, the doctor refers the patient to an agency. The agency should ask the doctor to submit documentation from the visit leading to the referral. Documentation the doctor provides should be placed within the patient's file at the agency.

If information is quickly provided by the doctor, when the admitting clinician goes to visit the patient, she will have key information available so she is aware of the problems the patient is experiencing, Montalvo says.

Step 3: An admitting clinician from the agency performs a patient assessment and writes a clinical summary. Agencies should alert clinicians that summaries should explain thoroughly what makes the patient homebound and why the patient requires skilled care, Montalvo says. The clinician would contact the physician to communicate and collaborate on the plan/assessment and receive verbal approval of the proposed plan of care.

Step 4: The agency includes the clinical summary within the plan of care it creates. It provides that documentation to the doctor's office.

Step 5: The doctor analyzes and signs the plan of care.

Step 6: The doctor incorporates the documentation into clinical records and provides a copy to the agency.

Step 7: Agencies merge that documentation into patient files.

Step 8: The doctor still must sign face-to-face documentation. This could be on a separate face-to-face form or it could even be within the plan of care. Doctors must list the date of the encounter and certify the encounter is related to the primary reason for home health services.

Step 9: Agencies must take exceptions into account. If the patient received a face-to-face visit at an inpatient facility, for instance, and a different physician is signing the plan of care, the prior procedures have a gap, Montalvo says. In that situation, the agency should request the face-to-face encounter form and review as much of the inpatient facility's documentation as possible to ensure there was enough detail to qualify the patient for home health.

If detail is lacking, Montalvo says, an agency administrative reviewer or quality assurance employee should communicate with and provide information about the patient's homebound status and need for skilled care for the certifying physician. The physician would incorporate this information into his medical record for the patient. He also would provide a signed copy this information to the agency, Montalvo says.

Step 10: If an agency receives an additional documentation request, it should provide the contractor with all information requested and any supplementary material backing up why the patient is homebound and requires skilled care. That would include things like the doctor's visit note and face-to-face documentation the doctor signs after your agency sends it to him. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

2015 PPS rule

CMS to relax therapy reassessments to every 30 days

CMS is following through with plans to simplify therapy reassessment requirements, and the final 2015 PPS rule is less stringent than what was proposed.

A qualified therapist — not an assistant — from each discipline must provide the needed therapy service and functionally reassess the patient at least once every 30 calendar days, according to the rule released Oct. 30.

The rule replaces CMS' existing requirements that therapy reassessments must be performed on the 13th and 19th therapy visits for patients receiving just one type of therapy and every 11 to 13 visits and every 17 to 19 visits for patients receiving multiple therapies. Concurrent with the counting based reassessments, subsequent reassessments would need to occur at least every 30 days for each individual therapy, says Cindy Krafft, chief executive officer of consultancy Kornetti and Krafft Health Care Solutions.

The new requirements are better for agencies in terms of visit costs and office productivity than existing requirements, says Kenneth Miller, physical therapist and clinical educator at Catholic Home Care in Farmingdale, N.Y.

Worrying about specific visit numbers for reassessments required a lot of coordination and communication in terms of scheduling, Krafft believes.

"When the 13th and 19th visit occurs depends on all disciplines completing their visits as scheduled," says Lisa Kidd, administrator of Baptist Home Health Care in Jacksonville, Fla. Visits might not occur for a variety of reasons, and that "would require coordination and communication in order to recalculate and determine when the 13th or 19th visit was going to occur."

In many cases, Miller says, the new requirement will eliminate the need for one reassessment per discipline during an episode of care. A therapy assistant potentially might be able to perform that visit since a reassessment wouldn't be required.

Under existing requirements, a patient receiving physical therapy three times a week and occupational therapy two times a week receives reassessments on visits 11, 12 or 13 and on visits 17, 18 or 19 by each discipline, Krafft says.

That patient would have to be reassessed twice in the first month of care by each discipline — four reassessments total.

Under the new rule, however, that same patient only would need to be reassessed once by each discipline within those first 30 days — two reassessments total.
— Josh Poltilove (jpoltilove@decisionhealth.com)

telehealth

(*continued from p. 1*)

says Joanne Porter, RN, RRT, telemonitor coordinator at AtlantiCare HomeCare, Egg Harbor Township, N. J.

Careful triaging by Porter and another part-time LPN helped AtlantiCare HomeCare to reduce readmission rates for all patients on telehealth to 4.7% in 2013 from 5% in 2012, says Porter. The agency has also seen referrals to its telehealth program from AtlantiCare Regional Medical Center's Heart Failure Resource Center increase to 14 from January to June of 2014, compared to 14 for all of 2013, Porter says.

Nursing expertise like that of an experienced RN who can read and interpret data related to vital signs will also better position agencies taking part in what industry analysts believe will be a significant rise in the use of telehealth.

About 425,000 patients in 2014 are being monitored in the United States by a telehealth device, and by the end of 2018, some 3.3 million will be, says Roeen Roashan, analyst of medical devices and healthcare IT with IHS Technology of El Segundo, Calif.

Roashan also predicts some 1.7 million patients with CHF will be monitored with telehealth technology in 2018, compared to about 140,000 in 2013.

Drill down into data with a patient call

At AtlantiCare HomeCare, Porter says she and her colleague monitor seven days a week patients with CHF for vital signs and symptoms like weight gain and rising blood pressure. If a patient gains two pounds in a day or five in a week, the system's software alerts her with a flashing red sign that the patient may be at risk for an exacerbation of her condition and vulnerable to readmission.

But Porter's nursing experience treating heart failure patients taught her she needs to then call the patient and ask more specific questions, including whether there were any recent changes in diet; it could be a patient ate something unusual or rich that led to a sudden weight gain and doesn't necessarily need an immediate visit with a nurse or doctor, she says.

And in addition to clinical skills, the telehealth nurse will also have to be able to deftly use other agency software, particularly its EHR system, to maximize the productivity gains and efficiencies telehealth can provide, Porter says.

Using the example above, Porter will enter the agency's EHR system and review the most recent nursing notes on the patient as well as determine when the next nursing visit is scheduled.

She could determine, for instance, what topics the visit nurse educated the patient on regarding reading nutrition labels for sodium content and then reinforce that lesson during her upcoming phone conversation with the patient.

After a conversation with a patient, Porter could also determine she needs to be seen by a nurse to reconcile a medication issue before the next scheduled visit in a couple of days, for example, and will notify the nurse through phone or email.

She'll also fax a printout of the patient's vital signs for the past week to the patient's doctor using the telehealth software. He'll then have the information before the nurse calls him during her visit with the patient and thus reduce the amount of back and forth time between the nurse and doctor by up to a half hour.

Such nursing visit declines in turn can help an agency pay for the costs associated with telehealth, says Karen Thomas, MBA, CMA, president of home health and hospice agency Oxford HealthCare and telehealth outsourcing firm Advanced Telehealth Solutions in Springfield, Mo.

In general, an average of two fewer nursing visits per episode of care — which typically average between $130 and $150 per visit — can cover the typical cost of providing telehealth monitoring, says Thomas.

Utilizing telehealth allows her agency to average between six and seven visits per episode for its CHF patients, nearly half the average number of visits per home health episode without telehealth.

Install, clean and troubleshoot

An experienced nurse in charge of a telehealth program will also need to be tech-savvy and know or quickly learn how, for instance, to efficiently set up a telehealth device in a patient's home or use telehealth software systems to quickly send vital sign reports to nurses in the field or to patients' physicians, says Porter.

The agency's telehealth monitors are phone-line based, so the manager needs to be prepared for patients that only have a cellular phone service; AtlantiCare HomeCare has about 15 modems that came with the monitors that can be used as a workaround to connect the telehealth monitors, she says.

Effective telehealth managers also need to track, in programs like Excel, how many monitors are in circulation at any one time in order to ensure the agency is making the most effective use of its investment in the technology, say Porter and Thomas.

AtlantiCare HomeCare has about 80 to 85 of its 100 monitors in use at any one time, says Porter. The rest are in a state of transition between patients, cleaning, installation or repairs; all tasks for which nursing staff in an agency telehealth program will be responsible.

Thomas says agencies that keep about 85% of their monitors in use at one time are using the technology effectively.

Getting nurse buy-in

One of the biggest obstacles in the successful operation of a telehealth program is convincing nurses it will help and not hinder their work with patients, Thomas says.

Here are a few tips to help agencies do so:

- **Show nurses that fewer nursing visits will not be harmful to patients.** Share data from your program with your nurses that demonstrates telehealth is still keeping close track of the patient's condition on a daily basis and can reduce readmission for vulnerable, at-risk patients, Thomas says. The data should be tailored to the diagnosis and can be sent in graphs or charts in an email or a paper printout.
- **Reassure nurses their expertise is still vital to your agency's success.** Nurses can worry their jobs may be in jeopardy with fewer visits per episode, Thomas says. But in her experience, there are few agencies that don't need all the nurses they have in the field. Fewer nursing visits per episode can also free up nurses to take on more referrals and help the agency grow, she says.
- **Provide specialty training for nurses.** Thomas's telehealth consulting firm has its nurses trained by other nurses who specialize in endocrinology for diabetes or cardiology for CHF patients, she says. This sharpens telehealth nurses' clinical judgment and confidence when monitoring patients with these diagnoses and improves the quality of the program overall, Thomas says. If your agency is focusing on treating a specific condition like CHF in telehealth, seek out CHF nursing expertise.

— Nicholas Stern (nstern@decisionhealth.com)

Related links: *Nurses curious about earning a certification in telehealth through the American Academy of Ambulatory Care Nursing: https://www.aaacn.org/telehealth-nursing-certification.*

OASIS

(*continued from p. 1*)

market basket update, the federal Medicare agency stated in the final 2015 PPS rule, released Oct. 30.

This marks the first time CMS is penalizing agencies for failure to submit a specific percentage of correct OASIS assessments.

Agencies have been required to submit OASIS data before submitting a final claim since 2010, and failure to do so has resulted in a 2% loss in payments. The HHS Office of Inspector General found 6% of agencies it looked at did not submit required OASIS data in 2009, and it recommended the federal Medicare agency "identify all agencies that failed to submit OASIS data and apply the 2% payment reduction to them," CMS says.

With the final PPS rule, CMS is also changing where agencies submit their OASIS assessments. Rather than submitting them to state health and human services agencies, they will be sent to CMS' new ASAP system, starting Jan. 1.

Agencies not proactively monitoring their validation logs in the ASAP system and correcting for them could ultimately be hit by the cut, says Ann Rambusch, president of Rambusch3 Consulting, Georgetown, Texas.

But unlike in the proposed rule, where CMS stated it would ramp up the compliance rate to 90% over the following two years, CMS has decided in the final rule to monitor provider agency performance from July 1, 2014 through June 30, 2015.

The federal Medicare agency will then make a determination about what the compliance threshold will be in the second and subsequent years. CMS said it made the change because the threshold requirement is new and can have a significant financial impact on any agency not able to meet the requirements.

However, CMS says in the rule it still anticipates implementing threshold rates of at least 80% or higher, not to exceed 90%, in years two and three.

Turn in accepted quality assessments

So how will CMS measure whether OASIS submissions are acceptable?

Each agency is expected to submit a minimum set of two "matching" OASIS assessments for each patient admitted to the agency. These assessments create what CMS considers a "quality episode of care," which would ideally consist of a start of care (SOC) or resumption of care (ROC) assessment and an end of care assessment, CMS says. That quality episode will be used to calculate the threshold.

However, there are other types of assessments that CMS also will factor into the "quality episode of care" and thus be used to calculate the performance threshold. These could include an SOC/ROC that could begin a quality episode of care but occur in the last 60 days of the yearlong performance period running July 1 to June 30, says CMS.

Agencies should not worry that re-certifications or other follow-up assessments as noted in responses "4" and "5" in M0100 (This assessment is being conducted for the following reason) will count against them, CMS says.

Such assessments would be considered neutral and would not count toward or against the requirement, CMS says.

Tips to track OASIS submissions

- **Have quality managers track fatal errors.** Fatal errors can include a misspelled name or an incorrect Medicare identification number entered for a patient, as well as warnings such as an OASIS submission sent out of sequence, like a resumption of care assessment sent in before a transfer, says Judy Adams of Adams Home Care Consulting in Asheville, N.C.
- **If the number of such errors increases month-to-month,** the quality manager needs to look closer at what caused the error and make plans to resolve such errors in the future, Rambusch says.
- **Look out for potential transmission errors.** CMS says in the rule that if one or more OASIS assessments is rejected due to an IT or server issue caused by CMS, the agency may excuse the non-submission of OASIS data.
- **Don't forget to document transmission errors.** Agencies will need to provide documentation or other proof that demonstrates a transmission error was in fact caused by CMS, the federal Medicare agency says. Documentation of this sort should include the day the error occurred, who was involved, what sort of message was received and any other circumstances surrounding the error, Adams says. — *Nicholas Stern (nstern@decisionhealth.com)*

Related links: *The OASIS submission user's guide can be found at https://qtso.com/hhatrain.html.*