OASIS-C & Outcomes Solutions

Resources to achieve accurate assessments and quality outcomes

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Proposed CoPs: QAPI

Prepare for costs of developing quality programs that meet CMS' proposed standards

CMS' proposed conditions of participation (CoPs) could cost your agency thousands of dollars and as much as six months developing a quality assessment and performance improvement (QAPI) plan.

As CMS announced Oct. 6, the CoP changes pertain to four major categories: QAPI, patient rights, infection prevention and control and revision of patient assessment requirements to reflect patients' physical, mental and psychosocial conditions.

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

OASIS-C1 Q&As

Get orders from doctor following patients through episodes or lose payments

It's not enough to rely on the referral of a hospitalist to begin caring for a patient in home health. Agencies that fail to reach out to the physician in charge of the patient's care compromise payments for those services made prior to contacting the doctor.

In cases where the hospitalist is not going to provide orders and follow the patient through the episode, CMS does not consider a referral from him valid for M0104 (Date of referral), CMS clarified in question No. 2, one of 13 questions addressed in its latest OASIS Q&A, released Oct. 22.

(*see **OASIS**, p. 9*)

CMS is revamping the CoPs: Prepare for some big changes

CMS has proposed a new set of CoPs that could dramatically change the way surveyors review your practices. Gather your clinicians to learn from DecisionHealth's Nov. 11 webinar, **Prepare now to comply with new home health CoPs.** Sign up today at: *www.decisionhealth.com/conferences/A2556.*

In This Issue

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Infection control

Develop your agency's intake protocols immediately and stay prepared for Ebola

As health care responders across the country prepare for the possibility of coming into contact with the deadly Ebola Virus Disease, agencies should begin revising intake protocols to ask patients and their caregivers about recent travel history.

Agencies should follow infection control best practices and avoid potential lawsuits from patients or caregivers for not doing so, says health attorney Vanessa Reynolds with Broad and Cassel in Fort Lauderdale, Fla.

Prior to any in-person visit, intake employees must ask patients or caregivers if they've had recent travel to a country where Ebola transmission is widespread. That includes Guinea, Liberia or Sierra Leone, says Mary McGoldrick, home care and hospice consultant with Home Health Systems, Saint Simons Island, Ga.

McGoldrick is developing a protocol for agencies to care for patients with Ebola.

Intake staff should ask whether the patient or caregiver recently has had contact with a person with Ebola or with objects contaminated with the blood or bodily fluids of a person sick with Ebola, McGoldrick says.

Staff also should ask those patients and caregivers if they've had symptoms suggestive of Ebola. This may include fever, chills, myalgia, malaise, headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage. If the answer to any of these questions is yes, instruct intake staff to contact his or her manager and to not make a visit to the person's home until directed and approved by the manager, she advises.

Athens Regional Home Health, a hospital-based agency in Athens, Ga., created a similar decision tree for intake staff and clinicians calling patients before visits, says Pamela Hall, executive director of the agency. (*See sample screening tool in the* OOS *PDF version.*)

If any answer raises the agency's concern level about a potential Ebola infection, the agency will not enter the patient's home until that patient has been cleared as safe for treatment by medical staff from the local hospital, she says.

Clinicians who go into a home and find a risk for exposure to Ebola exists are instructed to leave immediately and contact Hall or another supervisor immediately for further instructions.

Athens Regional developed its Ebola decision tree and Ebola screening protocols in recent days. The University of Georgia is nearby along with a local population of immigrants from African countries, Hall says.

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Train employees early and often

Hall trained intake employees and clinicians on the rapidly developed protocols, spending about 15 minutes just reading through the decision trees. She'll continue to update employees as needed and as Centers for Disease Control and Prevention (CDC) recommendations are released.

Ebola and the upcoming flu season led DNA Home Health Services of Loredo, Texas, to start re-training nurses on infection control procedures like hand washing and nursing bag hygiene, says Dora Sanchez, RN, MSN, the agency's administrator, director of nursing and owner.

Nursing and intake employees also met for about an hour and discussed how to don and doff personal protective equipment and the latest in CDC recommendations for patient screening before visits, Sanchez says.

Sanchez also reminded employees of the ethical priority to quarantine themselves if they believe they have been potentially exposed. Clinical staff will attend a local health department training session on Ebola in the upcoming month.

Follow standard of care with Ebola

Acute care settings, not home health care, is the suitable environment for treating a patient with Ebola symptoms, McGoldrick says.

But in an outbreak, pandemic situation where care in an appropriate hospital facility is not available, only select, highly trained and competent staff should provide care in the home for a patient with Ebola using the most current guidelines from the CDC.

From a liability perspective, agencies always want to make sure they're taking sufficient precautions and following best practices to prevent the spread of disease among their patients and staff and to avoid any tort claims, Reynolds says.

In the case of Ebola, make sure your agency closely follows CDC protocols, she says. If you think you have an exposure to Ebola and are not contacting the CDC and not following its guidance, it could be considered a departure from the standard of care and potentially expose your agency to a tort claim.

At this point, there is no precedent for such a claim.

But agencies that engage in practices that are harmful to patients or the community are also potentially subject to fines or even closure by state licensing boards, Reynolds says.

Generally, agencies can refuse to treat patients who have or may have been exposed to Ebola as long as the refusal is not based on a specific prohibition or a patient's protected status such as race, religion, nationality or, depending on the jurisdiction, sexual orientation, Reynolds says.

Websites to check for updated guidance

- **Check with the CDC first.** It released revised and stricter guidelines Oct. 20 for health workers donning and doffing personal protective equipment, according to protocols developed in part by Doctors Without Borders *www.cdc.gov/vhf/ebola/index.html*.

- **Stay in touch with your local health department.** South Carolina's Board of Health and Environmental Control and Department of Health and Environmental Control issued a public health order requiring all health care providers and facilities in the state, including licensed agencies and hospices, to register with the Health Preparedness Network by Oct. 31 for updates and information regarding Ebola. Email: *RESPONDER-join@lists.CIO.SC.GOV*.

- **Contact your state home care association for updates and guidance.** The Visiting Nurse Association of Indiana County, of Indiana, Pa., is keeping track of new information on how to prepare for and treat Ebola through the Pennsylvania Homecare Association, says Mary Lady, its quality and compliance coordinator.

— Nicholas Stern (nstern@decisionhealth.com)

Reduce readmissions

Teach clinicians to be persistent when calling docs, decrease rehospitalizations

When your clinicians call physicians to tell them about patients' exacerbating symptoms, make sure they're following prompts meant for acute care providers to ensure patients get the quick attention they need.

Blessed Trinity Health Enterprises of Bonner Springs, Kan., has found this to be an important step to achieving and maintaining a 9% readmission rate for heart failure patients.

Before the agency rolled out its care transitions program in 2008, clinicians calling doctor's offices with important

information would leave messages where patients had as well, and wouldn't get a response for at least a day, says Alice Moore, RN, MSN, CHCA, founder and CEO.

In cases where the provider is a smaller doctor's office, nurses are now instructed to wait on the phone until the physician can be reached directly, Moore says.

Patients with heart failure who've recently been hospitalized and begin to show signs of exacerbation, like edema or sudden weight gain, can decline quickly and need prompt medical attention in a matter of hours, she explains.

Moore first started this care transition program in 2007, well before hospitals were being penalized for rehospitalizations. After a successful pilot project that reduced heart failure readmissions by 14.8% in 2011, a local hospital the agency works with now uses aspects of her agency's care transitions program as a way to evaluate preferred home health partners in the metropolitan Kansas City area, she says.

The criteria include an agency's use of telehealth. Indeed, having a telehealth program that can maximize the efficiency of staff at your agency is a key ingredient to reducing readmissions, says Joseph Ebberwein, CPA and principal of value-based purchasing consultants Longitudinal Health, Savannah, Ga.

The hospital maintains an updated list of agencies it's looking to refer to based on ability to treat at-risk patients. Since starting this care transition program, Blessed Trinity has seen an 8% reduction in rehospitalizations for these patients and referrals have grown 7%, a benefit the agency attributes, at least in part, to this program.

Give more detail to doctors

After conversations about ways to improve care coordination with doctors at a local hospital, Blessed Trinity also decided its clinicians needed to provide doctors with more detailed information about heart failure patients at risk for readmission, Moore says.

Aside from exacerbating risk factors like sudden weight loss or shortness of breath, the nurses now have to give physicians patients' recent history of hospitalization, what they were hospitalized for and when they were discharged by phone, she says.

Letting doctors know about recent rehospitalization history, which is itself a readmission risk factor for heart failure patients, ensures that doctors respond to these patients with a greater sense of urgency, Moore says.

Recent hospitalization information about a patient is conveyed to doctors even if it's the second time in a week the home health nurse speaks with the same doctor about the same patient.

Make calls between visits

For patients with complicated conditions, such as heart failure, nurses at Blessed Trinity also now make telephonic visits with patients entering home care, Moore says.

A typical heart failure patient is seen in person by an agency nurse between seven and nine times in an episode. But between visits, particularly during the first few weeks, nurses also now call the patient and run through a series of questions the agency developed into a decision tree to help nurses decide whether patients need to be seen that day, she says.

The nurse will check information relayed through telehealth monitors for each at-risk patient, but also ask questions by phone that help nurses pinpoint whether the patient's condition is worsening, Moore says.

A typical question could be asked to find out whether a patient had to sleep in a chair the previous night because she couldn't breathe well.

Patients who gain two or more pounds in a day or five or more in a week, for instance, are at high risk of rehospitalization and need an immediate visit from a home health nurse, she says. On the other hand, patients who can complete their activities of daily living (ADLs) without difficulty and are complying with their diets don't need immediate attention.

The nurse can also determine through the brief conversation — it only has to last a couple of minutes — if the patient has slurred or incoherent speech and may need to be seen right away.

Every nurse now hired by Blessed Trinity undergoes extensive training during orientation to identify patients who have exacerbating symptoms related to diagnoses that put them at high risk for readmission, Moore says.

A couple of hours of classroom training during the agency's six-week orientation process is dedicated to instructing nurses to follow the triage decision tree the agency developed when speaking with patients on the phone. (*See decision tree under "Free Tool" at: homehealthline.decisionhealth.com*).

Use diagnosis data to target partners

The following tips will help your agency better understand the pain points of referral sources like hospitals or accountable care organizations (ACOs) and thus improve your communications with them as you help them reduce rehospitalizations.

- **Tally your agency's costs per patient by diagnosis.** Hospitals looking to reduce the burden of CMS penalties imposed by rehospitalizations by partnering with your agency will want to know its cost as a means of comparison with other agencies before choosing you as a referral partner for its patients, Ebberwein says.

- **Identify whether and where your referral source is receiving penalties for readmissions.** An efficient way to do this is to pay a firm to complete a market research study, Ebberwein says. It should cost between $500 and $750, and include information about the diagnoses for which your local hospital or ACO is receiving high readmissions. — *Nicholas Stern (nstern@decisionhealth.com)*

Coding Corner

Coding Basics: Learn to code stasis ulcers in ICD-10 with greater detail

The way you'll code stasis ulcers in ICD-10 is similar to how you code them now, as your code choice will depend on the specific cause of the ulcer, either varicose veins or venous insufficiency. However, the ICD-10 environment will demand an enhanced level of detail, including identifying laterality, location and severity of the ulcer.

ICD-10 codes for stasis ulcers are found in two chapters: Chapter 9 (Diseases of the circulatory system) and Chapter 12 (Diseases of the Skin and Subcutaneous Tissue). In a change from ICD-9, all stasis ulcers, regardless of etiology, will require two separate codes in ICD-10, one for the disease causing the ulcer (found in Chapter 9) and one for the ulcer's severity (found in Chapter 12).

A basic understanding of what stasis is and what it does is vital for accurate code assignment. Stasis refers to the stoppage or slowdown in the flow of blood, and stasis ulcers, which can also be called venous or varicose ulcers, develop in an area where the circulation is sluggish and the return of venous blood toward the heart is poor.

These ulcers develop because venous valves, usually in the legs, don't function properly. The body tries to compensate and fluid leaks from the veins into the surrounding soft tissue, leading to ulceration. Stasis ulcers are usually shallow, have irregular margins and produce moderate to heavy exudate. They may have a ruddy red base and may also present with yellow slough or with granulation tissue.

Codes come down to etiology

As with any diagnosis, you must have physician confirmation that the patient's wound is a stasis ulcer, and the confirmation must further specify whether the ulcer was caused by varicose veins or venous insufficiency. This specific information is crucial because stasis ulcers with different etiologies are coded differently. Additionally, determining the ulcer's specific etiology will impact home health interventions and goals. Here are your options:

- **If the etiology is varicose veins**, begin your search in the Alphabetic Index under the term "Varix" and then follow it to "leg" and then "ulcer." Then, in the Tabular you'll code from options for ulcers of various parts of the leg, such as I83.002 for the calf. Additional code choices are available if the patient has ulcers with inflammation, such as I83.202 for an ulcer of the calf with inflammation.

In a change from ICD-9, where only one code is required for a stasis ulcer caused by varicose veins, an additional code from category L97 (Non-pressure chronic ulcer of lower limb, not elsewhere classified) is required to denote the severity of the ulcer.

- **If the etiology is venous insufficiency,** look in the Alphabetic Index under the term "Stasis," then to "ulcer" and then to "without varicose veins" and you'll find code I87.2 (Venous insufficiency (chronic) (peripheral)).

Just like with stasis ulcers caused by varicose veins, you'll also need to assign an additional code from L97 for the severity of the ulcer, such as L97.222 (Non-pressure chronic ulcer of left calf with fat layer exposed).

Note that ICD-10 will require more detailed documentation about the ulcer. To choose the right code, you'll need to know:

- Location (thigh, calf, ankle, heel, etc.; specified by the fourth digit);
- Laterality (right, left, bilateral; specified by the fifth digit);

- Severity of the ulcer in regards to the tissue damage involved (limited to breakdown of the skin, fat layer exposed, necrosis of the muscle and necrosis of bone; specified by the sixth digit).

Scenario: Venous stasis ulcer

A patient is admitted to home care for teaching and training for wound care to a stasis ulcer of his left ankle with fat layer exposed. The stasis ulcer was caused by venous sufficiency.

Code the scenario in ICD-9:

Primary and Secondary Diagnoses		M1024 Case Mix 3	M1024 Case Mix 4
M1020a: Venous (peripheral) insufficiency, unspecified	459.81		
M1022b: Ulcer of ankle	707.13		

Rationale:

- The stasis ulcer caused by venous insufficiency is captured first with the code for underlying disease (459.81) followed by the code for the location of the ulcer (707.13).

Code the scenario in ICD-10:

Primary and Secondary Diagnoses		M1025 Additional Diagnoses	
M1021: Venous insufficiency (chronic) (peripheral)	I87.2		
M1023: Non-pressure chronic ulcer of left ankle with fat layer exposed	L97.322		

Rationale:

- Similar to scenario coded in ICD-9, this scenario requires a code for the etiology of the ulcer (the venous insufficiency) and the location of the ulcer. Note that the ICD-10 ulcer code offers a much greater level of detail including the depth of tissue the ulcer has affected.

About the author: *Brenda Beasley BSN, RN, HCS-D, COS-C, BCHHC, is a senior manager for Transpirus Coding Solutions. Brenda has worked in all facets of home care during her 23 years in the industry. Her experience includes direct patient care, agency management/administration and educational consulting.*

Wound care

Take notes on how patients should make Dakin's solution, apply it to wounds

Make sure your agency's clinicians document their instructions to patients on the proper use and mixing of Dakin's solution to treat chronic, infected surgical wounds or pressure ulcers and have them sign the written instructions to acknowledge they were provided.

That step is important because some state Nurse Practice Acts may prohibit nurses from mixing the solution for patients themselves, says Dea Kent, MSN, NP-C, CWOCN, director of quality assurance for Indianapolis-based Community Health Network.

The use of Dakin's in home health is possible in all 50 states, she says. In some cases, doctors also will prescribe the solution to treat an infected wound in home health following a surgery, for example. And in an age of antibiotic-resistant bacteria that is difficult to treat, Dakin's solution still can be used effectively.

Kent, a wound expert who advises various providers including agencies, says in Indiana, the Nurse Practice Act is silent on this issue, while other states may require a pharmacy to mix the solution.

Kent has prescribed Dakin's solution to hundreds of patients in Indiana and provided them the formula to mix it themselves. She's never heard of any problem associated with home health patients using the solution.

She's also advised many home health clinicians to use the solution for infected wounds following a surgery, for example, as it works well as an antiseptic and chemical debrider of wounds, Kent says.

Community Home Health, the Community Health Network's associated home health agency, has a 93% score improving pressure ulcers after surgery, compared to an 89% national average. The agency also has a 100% score for including treatments to prevent pressure ulcers in the plan of care, compared to the 97% national average.

Barbara Dale, CWOCN, director of wound care at Quality Home Health in Jamestown, Tenn., has been using Dakin's solution as an alternative to wound Vacuum-Assisted Closure therapy when it doesn't seem to be making progress.

She also uses it in some cases along with SANTYL ointment, as Dakin's is one of few antimicrobial agents that doesn't adversely impact the use of SANTYL, Dale says.

Dale only uses the solution after a doctor prescribes it, typically for a couple of days, she says. She sometimes will provide a recipe for making it and make sure the patient or a caregiver makes the solution correctly. She'll also follow up with the patient to make sure he is using it correctly. Instructions and visit notes are documented, she says.

Use mostly quarter-strength solution

Dakin's solution, an antiseptic developed by English chemist Henry Dakin to treat battlefield wounds in the early 20th century, is essentially made up of household bleach and distilled water, Kent says. The solution also may be buffered with sodium bicarbonate, commonly known as baking soda.

Its use is an appropriate treatment for select wounds, and clinicians must consider the patient's condition and tolerance of the treatment, dilution strength, protection of the periwound skin, frequency of dressing change and the duration of treatment when using the solution, according to a literature review and case study by Patricia Cornwell and others in the January/February 2010 issue of the *Journal of Wound Ostomy & Continence Nursing*.

For the most part, Kent advises clinicians and patients to use quarter-strength Dakin's solution. To make a solution of that strength, pour off 4 ounces of distilled water from a one-gallon jug and pour 4 ounces of bleach back into the container, Kent says. If using a buffer, add one teaspoon of baking soda and then shake the solution.

To store safely, label it clearly with a danger warning, put it out of the reach of children and store it outside the kitchen, she says. It does not need to be refrigerated.

In general, the solution will be used in short, limited courses, typically for up to 14 days. It can also be used at any wound staging. The solution can be used to treat infections in venous or arterial ulcers as well, Kent says.

The solution is cheap, simple to make at home and is stable for seven days, she says. After that, it must be discarded and made fresh again.

Apply at room temperature

Follow these extra tips when treating patients with Dakin's solution:

- **Make sure you use it at room temperature.** If refrigerated, the solution will cool the wound, which delays healing, Dale says. Wounds heal best at room temperature.
- **Make sure you use bleach with 5.25% hypochlorite solution.** That's the widely available recipe given by the University of Virginia. Find here: *www.virginia.edu/uvaprint/HSC/pdf/09024.pdf*. Anything more concentrated would mean a different formulation, Dale says.
- **Reassure patients some drainage after use is acceptable.** In some cases after applying the solution, wound drainage will take on different colors, but that's part of the healing process as bacteria dies off, she says.

— Nicholas Stern (nstern@decisionhealth.com)

ACA initiatives

New ACA initiative designed to support budding ACOs

CMS is announcing the availability of a new accountable care organization (ACO) initiative to better coordinate care in rural and underserved areas as part of the Affordable Care Act (ACA).

The new ACO Investment Model is providing up to $114 million in upfront investments in infrastructure and redesigned care processes to up to 75 ACOs across the country to help them better coordinate care, says CMS in a press release. CMS will recover these payments through an offset of an ACO's earned shared savings.

Eligibility is targeted to ACOs who joined the Medicare Shared Savings program in 2012, 2013, 2014 and to new ACOs joining the program in 2016, CMS says.

The application deadline for organizations that started in the Shared Savings program in 2012 or 2013 will be Dec. 1, 2014.

Applications will be available in summer 2015 for ACOs that started in the Shared Savings program in 2014 or will start in 2016.

For more information on the ACO Investment Model, visit: *www.innovation.cms.gov/initiatives/ACO-Investment-Model/*.

QAPI

(*continued from p. 1*)

CMS believes that the combined proposed changes would cost agencies more than $148 million overall in the first year and about $142 million in years two and thereafter. The revised CoPs will take agencies nearly 3.8 million hours to collect information, according to the proposed rule.

For the roughly 60% of agencies CMS estimates are not accredited, complying with the new QAPI CoP will require assigning an employee increased quality improvement responsibilities equivalent to hiring another part-time employee, says 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.

It could cost a few thousand dollars in extra work to use an existing employee for the QAPI role. But if an agency determines the role requires a new full-time employee, that position could cost $50,000 to $110,000 per year, depending on the location, she says.

The quality improvement person will track outcomes measured by OASIS assessments, patient characteristics reports within the Certification and Survey Provider Enhanced Reports (CASPER), discharge summaries and potentially avoidable events on a consistent basis, Whitemyer says.

Quality staff will need to drill down into the data to see if a particular clinician, referral source or a diagnosis or combination of diagnoses is causing a problem leading to increased readmissions, advises Barbara Rosenblum, founder and CEO of Strategic Healthcare Programs of Santa Barbara, Calif.

This type of data and the related quality improvement projects can be taken from outcomes reported in Home Health Compare or within agencies' CASPER reports.

They'll then have to propose ways to reverse undesirable outcomes like a high readmission rate, educate clinicians on how to do so and document not just improvements but that an agency sustains such improvements.

When quality improvements aren't realized, agencies will have to show through documentation why this didn't happen and what plan they put in place to remedy the issue, Whitemyer says.

According to the proposed CoPs, CMS expects non-accredited agencies to spend $3,810 during the first year and $3,318 in subsequent years to identify quality measures to improve, train clinicians on the QAPI program and gather and aggregate related data. But Whitemyer believes this likely significantly underestimates what an agency's true cost will be.

Appropriate OASIS training could cost from $9,000 to $30,000, depending on the size and number of branches an agency has, she estimates.

The federal Medicare agency says it will direct surveyors to ensure agencies can demonstrate with objective data from the OASIS data set and other sources that improvements in outcomes, processes of care, patient satisfaction levels and other quality indicators occurred.

CMS plans to leave it up to agencies to decide how to focus their own QAPI programs, which quality measures to track and improve and how many QAPI projects to undertake.

Piece the QAPI puzzle together

Agencies and quality managers developing QAPI programs will need to examine disparate reports like diagnoses related to readmissions, diagnoses by referral source and criteria for determining what constitutes and places patients at high risk for readmission and connect the dots to improve outcomes and follow the QAPI guidelines, Whitemyer says.

For example, in one quarter at a Texas agency Whitemyer consulted for, 34% of patients developed urinary tract infections (UTIs) — an extremely high number, she says.

The agency looked at its OASIS data and patient characteristics report in CASPER and discovered it was admitting twice as many patients who were incontinent and using a catheter at the start of care than the national average, Whitemyer says.

The agency looked at its electronic medical record reports for referral sources and saw one urologist was providing 30% of the agency's referrals during that quarter; moreover, a majority of the patients referred from that doctor were developing the UTIs, she says.

The agency didn't have a protocol in place for evaluating patients with UTIs that were at high risk for rehospitalization, Whitemyer says. It worked with the doctor to develop a high-risk screening for patients admitted to the agency with UTIs, asking patients questions such as if they had a catheter in place, were incontinent or recently had been admitted to the hospital.

If two of those three conditions were met, the agency had a standing order from the doctor to immediately undertake a urinalysis to screen for a UTI.

As a result, the agency saw its census of patients with UTIs drop to 17% in two quarters, she says.

"A true QAPI plan puts the puzzle pieces together like this," Whitemyer says.

Separate clinical/quality manager roles

Agencies will need to separate roles of clinical and quality managers as much as possible, Whitemyer recommends.

The person in charge of QAPI under these new CoPs will have to spend more time focusing on quality and outcomes processes, regulatory changes and surveys, Whitemyer says.

Under the CoPs, agencies will also have to integrate their infection control practices within QAPI.

Develop baseline, goals

Use the following tips to get your agency's QAPI project off the ground:

- **Establish realistic QAPI goals.** After considering which patients are high risk and which diagnoses occur frequently, QAPI staff should start with a baseline to measure improvements and a one-year goal for improvement, Rosenblum says. For example, if your agency's baseline rehospitalization rate is above the national rate (currently 16%, according to Home Health Compare), establish a goal to improve it to the national rate within a year, she says.
- **Develop an internal standard for how often your QAPI staff should check quality data.** If your agency has employees dedicated predominantly to the QAPI project, quality data should be checked daily, Rosenblum says. If your QAPI staff also share clinical and other duties, they should check in on the QAPI project at least weekly.
- **Meet once a month by phone or in person with clinical staff.** At this meeting, review QAPI data and let people know what's working well and what's not so they feel more connected to the QAPI project, she says.

— Nicholas Stern (nstern@decisionhealth.com) & Josh Poltilove (jpoltilove@decisionhealth.com)

Related links: *CMS' Outcome-Based Quality Improvement (QBQI) Manual, the PBQI Manual and the CASPER Reporting Application can be found at www.tinyurl.com/ksgm9bg.*

More QAPI resources can be found at www.homehealthquality.org.

OASIS

(*continued from p. 1*)

This change presents the risk for delay of care and thus an increase in re-hospitalizations, as patients in need of skilled nursing services wait for agencies to secure orders from a primary care physician or other doctor, says Trish Twombly, BSN, RN, HCS-D, HCS-O, COS-C, CHCE, AHIMA approved ICD-10-CM certified trainer, senior director for DecisionHealth.

Visits made before that doctor's referral date aren't billable.

It could be particularly problematic when an agency gets a referral from a hospitalist for a patient discharged over the weekend, a time when a primary care physician is not usually available to give orders and other physicians who might provide orders are not comfortable doing so for patients they don't know, says Michelle Mantel, MSN, GNP-BC, RN, BCHH-C, COS-C, HCS-D, Atlanta-based quality assurance manager at Gentiva Home Health.

An agency could assess a patient and provide whatever care is ordered for a specific visit on a weekend based on the orders of the referring facility, but that visit(s) would not be billable if CMS does not consider the referral date valid because the agency hasn't contacted the patient's doctor, Mantel says.

This is exactly the scenario that could leave a patient waiting at home to be given an IV medication, for example, before the agency has the opportunity to receive orders from a physician following up with the patient, Twombly says.

Not getting a valid referral in place before treatment begins could also subject an agency to surveyor scrutiny, says Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O, AHIMA Approved ICD-10 CM trainer, owner of Transitions Health and Wellness Solutions in Harlingen, Texas.

Be proactive, reach out to docs early

In order to prevent that, agencies should make sure their intake staff asks discharge planners whether the patient's primary care doctor knows the patient is in the hospital and why hospitalization was needed, says Ann Rambusch, MSN, HCS-D, HCS-O, RN, AHIMA approved ICD-10 trainer and president of Rambusch3 Consulting in Georgetown, Texas.

If that is not the case, the intake staff needs to ask the discharge planner for copies of the patient's history and physical examination, as well as the last three progress notes, as soon as possible.

Intake employees can provide this information to the patient's doctor when they call to obtain orders instead of speaking with a doctor about a patient he may have not seen in months, had no idea was in the hospital and may thus be apprehensive about immediately ordering home health for the patient, she says.

Also, make sure your agency has contact information for an on-call nurse at doctors' offices for patients who are discharged from hospital on Friday afternoons or over the weekend. These times can be difficult to contact a primary care doctor to make the required referral, Rambusch says.

Agencies should also establish a network of doctors in their service area who are accepting new patients and are willing to refer to home health, Whitemyer says. When patients with no primary care or other doctor are referred to your agency, your intake staff can suggest they contact one of these doctors. — *Nicholas Stern (nstern@decisionhealth.com)*

2 more changes explained in October OASIS Q&As

- **Error in M1340.** An ileostomy is a bowel elimination ostomy and should not be reported in M1350 (Skin lesion or open wound) in either OASIS-C or OASIS-C1/ICD-9, CMS says in response to question No. 8 of the latest OASIS Q&A, released Oct. 22. That's despite incorrect guidance in both guidance manuals in the ninth bullet of M1340 (Surgical wound) item-specific guidance.
- **Hypergranulating ulcer is "not healing."** Because the growth of granulation tissue above the skin plane causes delayed healing due to obstructed epithelialization, the presence of any hypergranulation in a pressure ulcer should be reported as Response 3 — "Not healing" in M1320 (Status of most problematic pressure ulcer that is observable).

CMS provided this guidance in response to question No. 7 in the Q&As that asked what healing status should be reported for a pressure ulcer presenting with hypergranulation.

Pressure ulcers that are unstageable at the start of care due to the presence of black eschar that later peels off and leaves an area of newly epithelialized tissue should be, without documentation supporting a higher stage, considered Stage III in M1308 (Current number of unhealed pressure ulcers), CMS says in response to question No. 6 about how to stage such an ulcer.

Moreover, Stage 1 and II ulcers do not form eschar or slough, CMS says. This type of situation often occurs in home health in pressure ulcers that form at the heel, says Ann Rambusch, MSN, HCS-D, HCS-O, president of Rambusch3 Consulting in Georgetown, Texas. — *Nicholas Stern (nstern@decisionhealth.com)*

Related link: *Some errors in Chapter 3 of the OASIS-C1/ICD-9 guidance manual have been corrected since its June release. Download the revised form at: tinyurl.com/ldvynwp.*