



The Importance of Skin Integrity Under the IMPACT Act

Webinar Education Series
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MEDICAL SUPPLIES FOR CARE AT HOME SINCE 1957



IMPORTANCE OF SKIN INTEGRITY UNDER THE IMPACT ACT

Webinar Presented for
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Overview of Impact Act

What is the IMPACT Act

- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 is a Bi-partisan bill introduced in March, U.S. House & Senate; passed on September 18, 2014 and signed into law by President Obama October 6, 2014
 - Implemented between October 2016 - January 2019
- Requires Standardized Patient Assessment Data among skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals and home health agencies to enable:
 - Comparability of assessment data
 - Comparability of quality outcomes
 - Improved care coordination and communication
 - A basis for determining appropriate payment systems

Why PACs Matter

- 32,617 Post-Acute Care Facilities
 - 420 Long-term care Hospitals
 - 1,166 Inpatient Rehabilitation Facilities
 - 12, 311 Home Health Agencies
 - 15,000 Nursing Homes
 - Originally included 3,720 hospices, but hospices were pulled from this initiative since their service line is focused on palliative care during the terminal phase of life rather than curative care.
- 6.8 million Medicare beneficiaries
- \$74 billion in Medicare Spending
- 14.8% of Total Medicare Spending goes to PACs

Requirements for Standardized Assessment Data

- IMPACT Act added new section 1899(B) to Title XVIII of the Social Security Act (SSA)
- Post-Acute Care (PAC) providers must report:
 - Standardized assessment data
 - Data on quality measures
 - Data on resource use and other measures
- The data must be standardized and interoperable to allow for the:
 - Exchange of data using common standards and definitions
 - Facilitation of care coordination
 - Improvement of Medicare beneficiary outcomes
- PAC assessment instruments must be modified to:
 - Enable the submission of standardized data
 - Compare data across all applicable providers

Standardized Patient Assessment Data

- Requirements for reporting assessment data:
 - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
 - The data must be submitted with respect to admission and discharge for each patient, or more frequently as required
- Data categories (implemented between 2016-2019):
 - Functional status (e.g., self care and mobility)
 - Cognitive function and mental status (e.g., express & understand ideas; mental status, such as depression & dementia)
 - Special services, treatments, and interventions (e.g., need for ventilator, dialysis, chemotherapy, And TPN)
 - Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
 - Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
 - Other categories required by the Secretary

Why Standardize Assessment Data

- One in five Medicare fee-for-service Beneficiaries are admitted to an Acute hospital/year.
 - 42% go to at least one PAC setting:
 - Home Health agencies (23%)
 - Skilled nursing facilities (17%)
 - Inpatient rehabilitation hospitals (
 - Long term care hospitals
- A substantial number use 2 or more PAC services During Episode of care.
 - 78% of patients transfer from ACH → SNF → HH

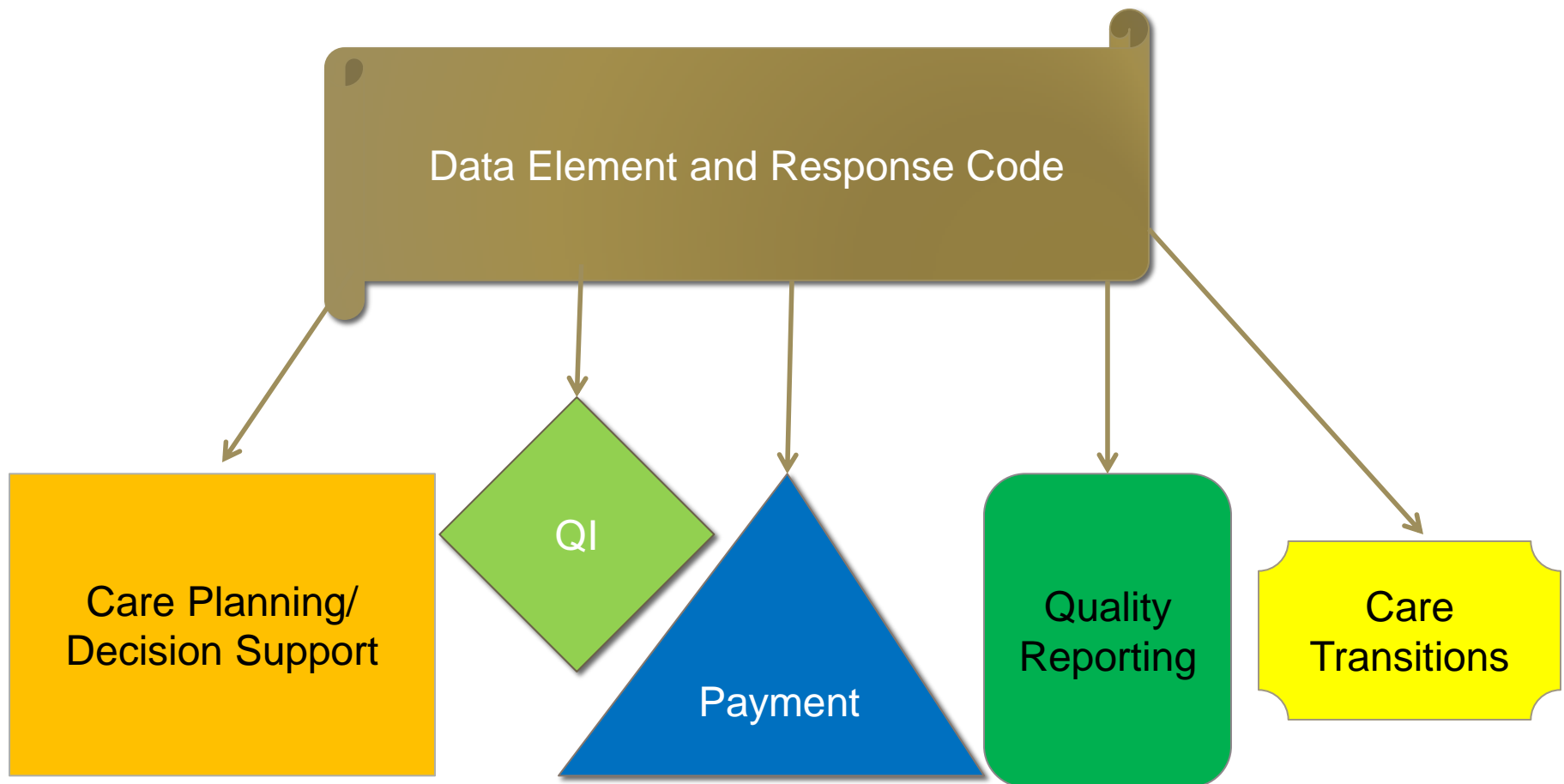
Data Element Standardization

- Achieving standardization (i.e., alignment/harmonization) of clinically relevant data element improves care and communication for individuals across the continuum:
 - Enables shared understanding and use of clinical information.
 - Enables the re-use of data elements for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.
 - Supports the exchange of patient assessment data across providers.
 - Influences and supports CMS and industry efforts to advance interoperable health information exchange and care coordination.
- While data element standardization is required for certain assessment domains in the IMPACT Act, unique data elements specific to PAC settings will also persist.

Interoperability

- Data follows the person.
- IMPACT Act requires CMS to make post-acute care assessment data elements interoperable to allow for exchange of data among PAC providers and other providers, individuals & their families in order to provide access to longitudinal information for providers to facilitate coordinated care and improved Medicare beneficiary outcomes.
- CMS will make available public reports of PAC assessment data elements mapped to health IT standards.
- Use of standardized and interoperable PAC assessment data elements are key enablers to achieving service delivery and payment reform envisioned in the CMS Quality Strategy.

One Response: Many Uses



Keeping in Mind, the Ideal State

- Facilities are able to transmit electronic and interoperable Documents and Data Elements
- **Provides convergence** in language/terminology
- Data Elements used are **clinically relevant**
- Care is coordinated using **meaningful information** that is spoken and **understood by all**
- Measures **can evaluate quality across settings and evaluate intermittent and long term outcomes**
- **Measures and Information can follow the person**
- **Incorporates needs beyond healthcare system**

CMS Quality Strategy

- Triple Aim
 - Better Care – Healthier People – Smarter Spending
- Goals
 - Make care safer
 - Strengthen person and family centered care
 - Promote effective communications and care coordination
 - Promote effective prevention and treatment
 - Promote best practices for healthy living
 - Make care affordable

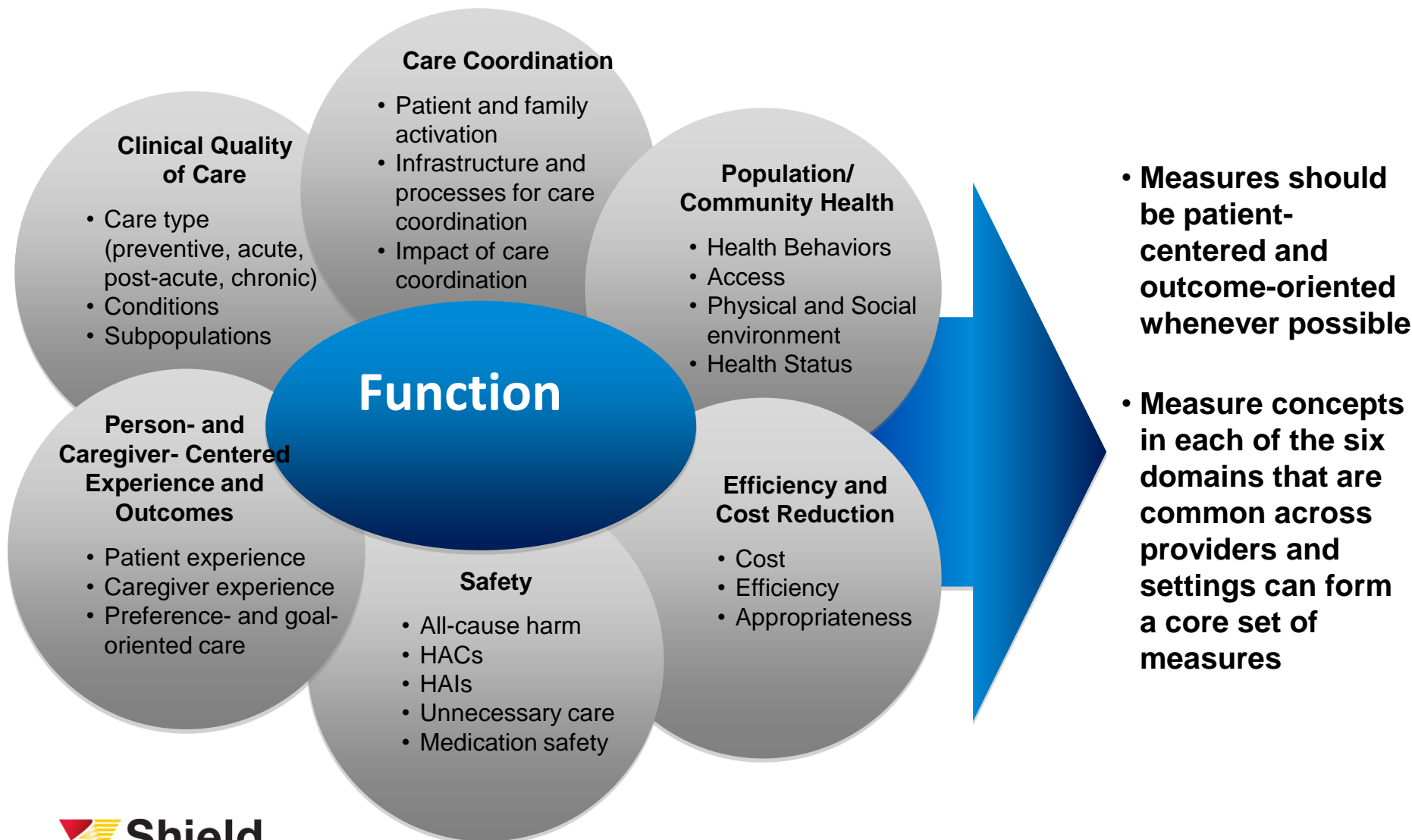
What Outcomes are Expected from the Impact Act?

- Standard terminology to measure patient complexity:
 - At any point in time during the stay or across services
 - Evaluate outcomes: changes between admission and discharge from care
 - Communicate across caregivers (Acute, PAC, social support)
 - Determine Resource needs
 - Measure costs equitably
 - Set payments equitably
 - Improve the Value of Care
 - Are “similar” patients discharged to different types of PAC?
 - Do outcomes for “similar” patients differ by type of PAC used?

Impact Can Help Improve Care Coordination

- Facilitate consistent and reliable definition of patient complexity and needs.
- Improve communication across an episode of care by:
 - Using common language across medical professions to define patient complexity
 - Allowing interoperability of data across organizations involved in episode of care.
 - Preventing potential adverse events
- Improve communication with PAC liaisons about complexity before transfer
- Enable timely transfer of information about patient's:
 - Medical status
 - Functional status
 - Cognitive status
 - Care preferences
- Timely transfer of information to patient's other caregivers, primary care physicians, family members, residential support systems

CMS Framework for Measurement



Impact Act Quality Measures

- Requires CMS to develop/implement quality measures using cross-setting standardized patient assessments from post acute care settings (LTACHs, SNFs, IRFs, and HHAs).
including:
 - Skin integrity
 - Functional status and cognitive function
 - Medication reconciliation
 - Incidence of major falls
 - Medical conditions and co-morbidities
- In addition to clinical quality measures, the Act requires CMS to develop, calculate and enable reporting of measures pertaining to:
 - Resource use, including Medicare spending per beneficiary
 - Hospitalization (re-admission)
 - Discharge to community



HH Outcome Data Collection 2017

Domain	Measure	HH Timeframe
Skin Integrity	% of patients with new or worsening pressure ulcers	OASIS Data collection 2017
Medication Reconciliation	Drug Regimen Review with follow-up for identified issues	OASIS data 2017
Resource Use	Total Medicare estimated spending per Bene (SOC → 30 days after end of treatment period)	Claims based on data January 2017
Resource Use	Discharge to Community With no unplanned re-hospitalization/death X31 days post DC	Claims based on data January 2016 & 2017
Resource Use	Potentially Preventable 30 day Post-discharge readmission	Claims based on data 2015, 2016, & 2017

Future HH Data for Quality Measures

Domain	Measure	HH Timeframe
Functional Status	Defines mobility and impairments in hearing, seeing and/or swallowing; incontinence	OASIS Data collection 2019
Cognitive function	Ability to express & understand ideas Depressions and dementia	OASIS Data Collection 2019
Incidence of Major falls	1-2 falls during an episode	OASIS data 2019
Communicating & transferring health inform. & care preferences.	Communicating the existence of and providing for the transfer of health inform. and care preferences.	January 2019



IMPACT Items Integrated into OASIS for 2017 Focus Primarily on Skin Integrity

Importance of Skin Integrity

- Identifying new and worsening pressure ulcers is one of major outcomes for the first phase of implementing IMPACT in 2017 related to skin integrity.
 - Most changes in the OASIS C2 items were specifically made to capture this information or risk adjust this outcome.
- Home health personnel need to pay particular attention to identifying risk factors for pressure ulcers, ensure they monitor “closed” stage 3 or 4 pressure ulcers for possible breakdown and actively instruct patients and caregivers in pressure ulcer prevention strategies.

Home Health Population Vulnerable to Skin Integrity Issues

- High percentage of elderly patients
- Decline in function, especially mobility and activity limitations
- Presence of bowel and/or bladder incontinence
- Patients live alone
- Caregivers may be unwilling to learn/follow pressure prevention activities
- Lower extremity wounds and ulcerations are common (diabetic ulcers, peripheral vascular disease (venous or arterial), skin tears and open wounds, weeping edema with blisters, abscesses, cellulitis and more.
- Presence of limitations related to vision, sensation, cognition (depression/dementia).
- Nutritional issues
- Multiple co-morbid conditions that increase complexity of care

Let's look at the 2017 Changes to OASIS

M1028 Active Diagnosis of PVD, PAD or DM

**IMPACT**

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)

- **Item Intent:** Identifies whether two specific diagnoses are present and **active**. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcer(s).
- The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment

(M1028) Guidance

- If patient does not have an active diagnosis of PVD, PAD, or diabetes within the assessment timeframe, leave boxes in M1028 unchecked/blank. *(CMS Qtrly Q&A #6-7, 10/16)*
- Use a dash (-) if information not available or could not be assessed. *(CMS Qtrly Q&A #5, 10/16)*
- **information, including past medical and surgical history** obtained from family members and close contacts, must also be documented in the medical record by the physician . . . to ensure validity, follow-up and coordination of care.
- Although open communication regarding diagnostic information between the physician and other clinical staff is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician . . . to ensure follow-up and coordination of care.

(M1028) Guidance

New
Definitions!

- **Active diagnoses**: those that have a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
 - **DO NOT** include diseases or conditions that have been resolved or do not affect the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
- **Nurse monitoring**: includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).
- A diagnosis may not be inferred by association with other conditions (i.e., weight loss inferred to mean "malnutrition").

(M1028) Examples of Active Diagnoses

Example 1: Mr. A is prescribed insulin for diabetes mellitus. He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes mellitus.

- **Response 2:** Diabetes Mellitus would be checked.
- **Rationale:** Diabetes mellitus is considered an active diagnosis because the physician progress note documents the diagnosis and because there is ongoing medication management and glucose monitoring.

(M1028) Examples of Active Diagnoses


- Mrs. B is admitted to home health for physical therapy s/p total hip. The patient also has type 2 diabetes controlled by diet & independently monitors her blood sugars. She is knowledgeable about diabetic foot care & checks her feet daily using a mirror. Because her change in activity could affect her blood sugar levels and because diabetes could affect her ability to heal from her surgery, DM meets the selection criteria for a secondary diagnosis and would be reported in M1023. The PT will be monitoring the patient holistically to identify problems/modify the POC as appropriate with physician collaboration. Orders do not list any active interventions related to her DM.
 - **Response 2:** Diabetes Mellitus would be checked.
 - **Rationale:** The home health provider's monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient. *(CMS Qtrly Q&A #8, 10/16)*

(M1028) Examples of Active Diagnoses

Example 2: Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician's progress note documents peripheral vascular disease and a left below the knee amputation.

- **Response 1:** Peripheral Vascular Disease (PVD) would be checked.
- **Rationale:** Consider PVD an active diagnosis because the physician's note documents with peripheral pulse monitoring and recent below the knee amputation and with dressing changes and wound status monitoring.

M1311 Number of Current Pressure Ulcers

- M1311 contains new/revised terminology and guidance that differs from OASIS-C1.
 - New terminology specifies that “healed” vs. “unhealed” ulcers refers to whether the ulcer is “closed” vs. “open”. 
 - Stage 3 and 4 pressure ulcers that are covered with new epithelial cells (closed) are no longer considered unhealed pressure ulcers for OASIS, but continue to be vulnerable to breakdown in skin integrity.
 - HHAs need to be sure to regularly monitor these areas and all bony prominences for early evidence of developing pressure ulcers and teach all patients and caregivers pressure ulcer prevention techniques. (Consider marking “yes” in M1350 to indicate active treatment to these areas.)

M1311: Current # of Pressure Ulcers

- Line 1 (completed at all time points)

Number of current pressure ulcers at each stage

A1 (Stage 2); B1 (Stage 3); C1 (Stage 4); D1 (Unstageable d/t non-removable dressing; E1 (Unstageable d/t eschar/slough); F1 (Unstageable w/suspected DTI)

- Line 2 (completed at F/U and D/C only)

Number of the current ulcers that were present at most recent SOC/ROC

A2 (Stage 2); B2 (Stage 3); C2 (Stage 4); D2 (Unstageable d/t non-removable dressing; E2 (Unstageable d/t eschar/slough); F2 (Unstageable w/suspected DTI)

(M1311) Guidance

- **Not reported** in M1311:
 - Stage 1 pressure ulcers
 - Pressure ulcers that have healed (closed)
- **Not considered healed:**
 - Stage 1 pressure ulcers, although closed (intact skin)
 - Stage 2 pressure ulcers
 - Suspected Deep Tissue Injury (sDTI), although closed (intact skin)
 - Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough

(M1311) Guidance

- Clinicians should adhere to WOCN Guidelines and definitions in the OASIS Guidance Manual when determining stage of ulcers and category of unstageable pressure ulcers in the OASIS items.
- Surgically debrided pressure ulcers remain pressure ulcers. They are not surgical wounds.
- Pressure ulcers sutured closed are still considered pressure ulcers, not surgical wounds.
- Make and document every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst and report that stage.

(M1311) Guidance (continued)

- A muscle flap, skin advancement flap, or rotational flap graft performed to surgically replace a pressure ulcer is not a pressure ulcer. It is a surgical wound. Do not report the surgical wound in M1311.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound on M1340. (OASIS-C2)

Present on Admission = Present at SOC/ROC

- “Present on Admission” means the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its “Present on Admission” stage should be considered the stage at which it first becomes numerically stageable.
 - If the ulcer subsequently increases in numerical stage, do not report the higher stage ulcer as being “present at SOC/ROC” when completing the Discharge assessment.

Present on Admission = Present at SOC/ROC

- The general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC (5-day/48-hr. window) as possible. *(OASIS-C2)*
 - If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame, the initial stage of the pressure ulcer would be reported in M1311 at the SOC.
 - **For example:** At SOC on 8/1, patient has a Stage 2 pressure ulcer and no other pressure ulcers. At a routine visit on 8/3, the pressure ulcer has worsened to a Stage 3. Report the Stage 2 on M1311, A1.

(M1311) Scenario

- Patient was **admitted with** a Stage 3 pressure ulcer on her right hip at the SOC. She has no other pressure ulcers. **At follow-up**, the patient's ulcer was assessed as unstageable due to eschar and slough. The patient was discharged 3 weeks later because she was moving in with her daughter who lives in another state.
- **At discharge**, the ulcer on the right hip is assessed as a Stage 3. There is a new Stage 2 ulcer on her left hip. How should M1311 be answered at SOC, Follow-up, and Discharge?
 - SOC/M1311: B1 = 1, (stage 3), Line 2 does not apply
 - Follow-up/M1311: B1 = blank, E1 = 1 (unstageable d/t slough)
B2 = blank, E2 = 0 (was not there at SOC)
 - Discharge/M1311: A1 = 1, (stage 2), B1 = 1 (stage 3),
A2 = 0, B2 = 1 (stage 3)

How many pressure ulcers worsened ?

(M1313)

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.

	Enter Number
a. Stage 2	<input type="text"/>
b. Stage 3	<input type="text"/>
c. Stage 4	<input type="text"/>


Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.

	Enter Number
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	<input type="text"/>
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	<input type="text"/>
f. Unstageable – Suspected deep tissue injury in evolution.	<input type="text"/>

M1313 - Continued

- Intent: # of pressure ulcers present at discharge that are new or have worsened (increased in numerical stage) since the most recent SOC/ROC assessment.
- Compare the current stage of each pressure ulcer at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage when compared to the most recent SOC/ROC.
- Count and report the number of pressure ulcers at each stage that are new or have progressed to a deeper level of tissue damage and are therefore staged at a higher number stage (1-4) since the last SOC/ROC was completed.
 - Two step process allows a more accurate assessment than simply comparing total counts at DC and most recent SOC/ROC.
 - If a pressure ulcer increased in numerical stage from SOC/ROC to Discharge, it is considered worsened & included in count of worsened pressure ulcers in M1313 at Discharge.

M1313 - Continued

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
- A dash is a valid response for this item if no information is available or item cannot be assessed. 
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.






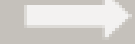


Don't Forget

- Once a pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered healed, and **no longer reported as an unhealed pressure ulcer**.
- A previous Stage 3 or 4 pressure ulcer that breaks down again, should be staged at its worst stage.
- If the pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at DC.

M1313 - Hints to Scoring Correctly

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-up assessment, and by DC the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-up assessment, it should be **considered worsened at DC**
- If the previous stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge compare the stage before and after it was deemed unstageable. **If the stage has increased in numerical staging, report it as worsening.**
- Pressure ulcers that are unstageable at DC due to a dressing/device that cannot be removed to assess the skin, **cannot be reported as new or worsened unless no pressure ulcer existed at the site at the most recent SOC/ROC.**

Use the Algorithm to Score M1313

CURRENT STAGE at Discharge	Look back to most recent SOC/ROC	PRIOR STAGE at most recent SOC/ROC		REPORT AS NEW OR WORSENER?
a. Stage 2 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	<ul style="list-style-type: none"> Not present Stage 1 Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s) 		YES
		<ul style="list-style-type: none"> Stage 2 		NO
		<ul style="list-style-type: none"> Stage 3 Stage 4 		NA (Stage 3 or 4 could not become a Stage 2)
		<ul style="list-style-type: none"> Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge 		NO
b. Stage 3 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	<ul style="list-style-type: none"> Not present Stage 1 Stage 2 Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s) 		YES
		<ul style="list-style-type: none"> Stage 3 		NO
		<ul style="list-style-type: none"> Stage 4 		NA (Stage 4 could not become a Stage 3)
		<ul style="list-style-type: none"> Unstageable until assessed as a Stage 3 at Discharge 		NO

M1311 / M1313 Example (Part 1)

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. How do you complete M1311 at SOC?
 - **M1311:** A1(Stage 2) = 1 (Line 2 does not apply)
- After two weeks in home health, she was transferred to acute care for 3 days due to pneumonia. At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3 and she had a new Stage 1 pressure ulcer on her right hip. Complete M1311 for ROC.
 - **M1311:** B1(Stage 3) = 1
Line 2 completed at F/U and D/C only
Stage 1 pressure ulcers are excluded from M1311

M1311 / M1313 Example (Part 2)

- At Discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated and the Stage 1 pressure on the right hip had evolved to a Stage 2 pressure ulcer. Complete M1311 and M1313
 - **M1311 Line 1:** A1(Stage 2) = 1, B1(Stage 3) = 1
 - **M1311 Line 2:** A2(Stage 2) = 0, B2(Stage 3) = 1
Line 2 is always completed at F/U and D/C
- **M1313:**
 - **M1313a = 1** Stage 2 ulcer worsened
(Stage 1 ulcer at ROC became Stage 2)
 - **M313b = 0** Stage 3 ulcer at ROC remained a Stage 3

(GG0170C Mobility)



- New in OASIS-C2
- **Time Points:** Collected at SOC/ROC only – not at DC
- **Item Intent:** Identify the patient's need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **Rationale:** Risk adjustment for development of pressure ulcers, impact on wound healing.
- **Key words:** Usual performance, lying on back to sitting on side of bed, feet flat on floor, no back support, safe, need for assistance, discharge goal

(GG0170C) Performance Levels

- **06 - Independent** – No human assistance.
- **05 - Set-up/Clean-up Assist** – CG assists prior to or after activity, but not during activity.
- **04 - Supervision or Touching Assist** – CG must provide VERBAL CUES or TOUCHING/STEADYING assist as patient completes activity.
- **03 – Partial/moderate Assist** – CG provides less than half of effort. (Lifts, holds, supports trunk or limbs)
- **02 – Substantial/maximal Assist** - CG provides more than half of effort. (Lifts, holds, supports trunk or limbs)
- **01 - Dependent** – CG must provide ALL effort or 2 or more CGs are required to complete activity.

(GG0170C) Scoring SOC/ROC Performance

- Report patient's usual status at SOC/ROC using 6-point scale (01 – 06) **OR**,
- May use assistive device to be safe to complete task. Use of device should not impact score adversely.
- If performance varies, report patient's usual performance not most independent performance.
- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted with one of the following 3 codes:
 - **07**, Patient refused
 - **09**, Not applicable, patient did not perform this activity prior to the current illness, exacerbation, or injury
 - **88**, Not attempted due to medical or safety concerns
- If no information is available or assessment is not possible for reasons other than above, enter a dash (“–”) for 1-SOC/ROC Performance.

(GG0170C) Scoring Discharge Goal

- Report the Discharge Goal using the 6-point scale. Do not use 07, 09, or 88 to report D/C Goal.
- Assessing clinician, in conjunction with patient and family input, can establish the discharge goal.
- For example:
 - Patient expected to make progress, D/G would be higher than SOC/ROC response.
 - Patient not expected to make progress but would be expected to maintain SOC functional level, D/C Goal would be same as SOC score.
 - Patient expected to decline rapidly but skilled therapy services may slow decline of function, D/C Goal would be lower than SOC score.

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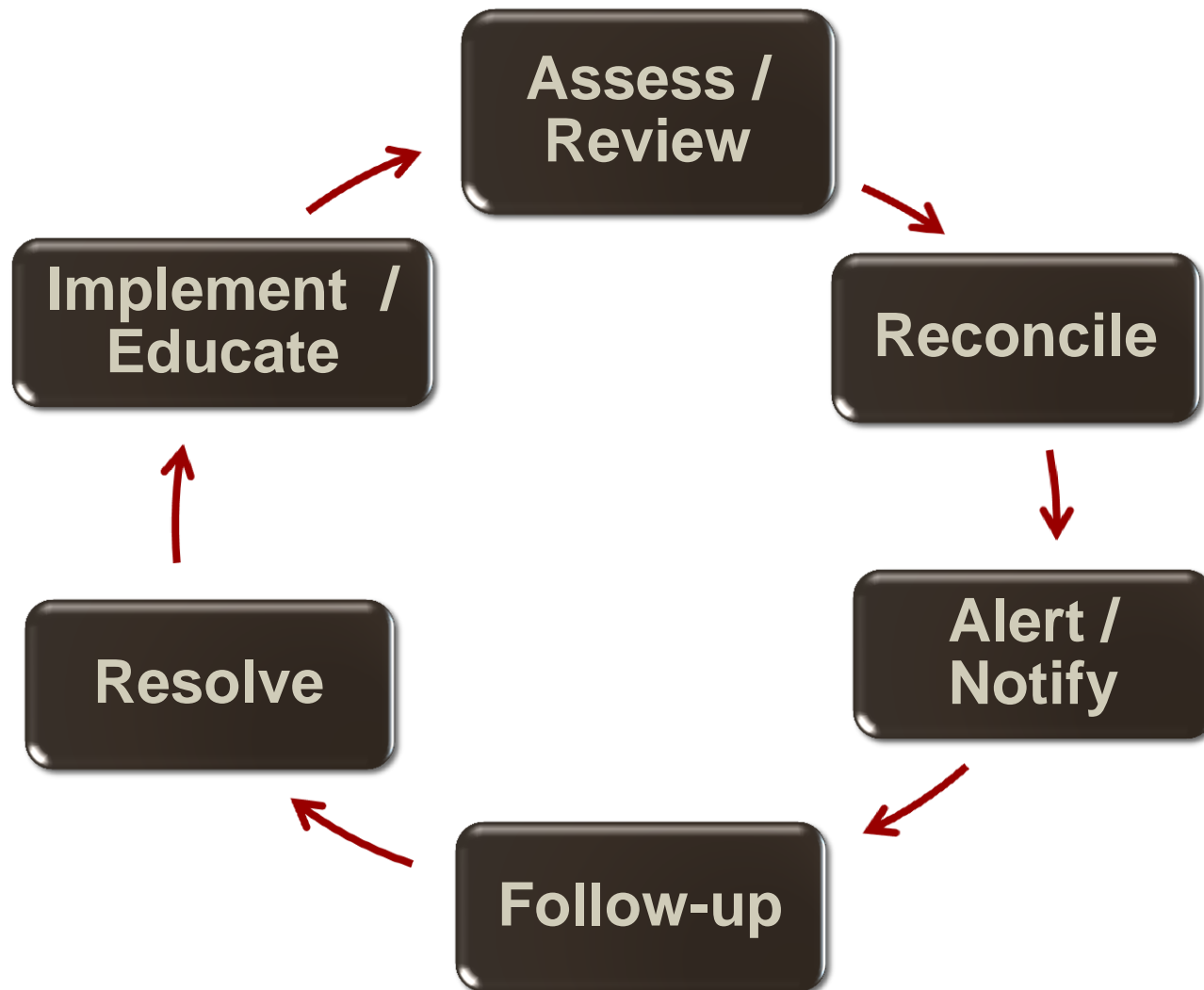
(GG0170C) Scoring Example

- The patient states he wishes he could get out of bed himself rather than depending on his wife to help. At the SOC the patient requires his wife to do most of the effort (more than 50%).
- Based on the patient's prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.
 - **SOC/ROC Performance = 02, Substantial/maximal assistance**
 - **Discharge Goal = 03 Partial/moderate assistance**

Drug Regimen Review and Reconciliation

- IMPACT actually looks at three OASIS items to obtain the Outcome: Drug Regimen Review with Follow Up of Medication Issues
 - M2001, Drug Regimen Review
 - M2003, Medication follow-up at SOC/ROC
 - M2005, Medication Intervention each time there is a potentially clinically significant issue ***at the time of or since*** the most recent SOC/ROC
- Medication related issues is a major problem related to care transitions from hospitalization to PAC and one type of PAC to another.

Drug Regimen Review Process



(M2001) Drug Regimen Review

- *Includes:* **Medication reconciliation**, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- A **potential clinically significant medication** issue is an issue that in the care provider's clinical judgment, requires physician /physician-designee notification by midnight of the next calendar day (at the latest). M2001 includes **existing** clinically significant medication issues as well as new ones.
- To meet this outcome any and all issues must be:
 - identified during the home health episode,
 - communicated to the physician,
 - return communication from the physician, and
 - all orders implemented through the allowable time frame.

M2003 Example

- During the SOC comprehensive assessment visit, the nurse completes a drug review and identifies the patient is taking two antihypertensive meds, one of which was newly prescribed during her recent hospital stay and another that she was taking prior to her hospitalization. During the home visit, the nurse contacts the physician's office, and leaves a message with the office staff providing notification of the potential duplicative drug therapy and a request for clarification. The next day the nurse returns to the home to complete the comprehensive assessment and again contacts the physician from the patient's home. The physician's office nurse reports to the nurse and patient that the physician would like the patient to continue with only the newly prescribed antihypertensive and DC the previous medication.

How would you respond to M2001 and M2003?

M2003 Example

- During the SOC comprehensive assessment visit, the nurse completes a drug review and identifies the patient is taking two antihypertensive meds, one of which was newly prescribed during her recent hospital stay and another that she was taking prior to her hospitalization. ...
- M2001: **Response 1 - Yes, issues found during review**
- **M2003: Response 1 – Yes, the nurse contacted the physician and the issue was resolved by midnight the next calendar day.**

Rationale: Because the issue identified was determined by the clinician to be clinically significant, requiring physician contact by midnight of the next calendar day it meets the criteria for a potential clinically significant medication issue (M2001). As the clinically significant issue was resolved by physician contact and completion of prescribed/recommended actions by midnight of the next calendar day, the criteria for M2003 were met.

M2003/M2005: Physician Contact

- One more time:
- Medication follow-up and reconciliation requires:
 - **2-way communication** with the physician or physician designee regarding the potentially significant medication issue **AND**
 - Completion of the prescribed / recommended actions no later than 12 midnight of the next calendar day
- *Physician notification alone is NOT reconciliation.*



Scoring and Tracking New Data

- Every member of the home health team needs to be involved in identifying and tracking data leading to the new IMPACT outcomes.
 - Nurses, therapists responsible for accurate and thorough scoring on the comprehensive and discipline specific assessments
 - All visiting staff members providing care to patients
 - Documenting changes (positive and negative)
 - Documenting the occurrence of skin changes – when did each ulcer, wound or skin lesion first occur, when did it change and when did it heal
 - Home health aides are often the first to see skin changes and need to report them to clinical supervisor
- The earlier changes are noted and reported to the physician, the earlier treatment can begin and the better odds that complications can be avoided.
- HHAs need to identify standardized methods for documenting presence and changes in individual pressure ulcers.

What Questions do you have?

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Thank you for attending!





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MEDICAL SUPPLIES FOR CARE AT HOME SINCE 1957



Pre-Claim Review: What Home Health Agencies Should Know

The CMS states that pre-claim review does not create new documentation requirements, but instead requires that the same documentation be submitted earlier.

Sarah McIlvaine



CMS Releases MACRA Final Rule for 2017

In October, the Centers for Medicare & Medicaid Services (CMS) announced the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) final rule for 2017

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