OASIS Process Measures

BEST PRACTICE for
BEST OUTCOMES

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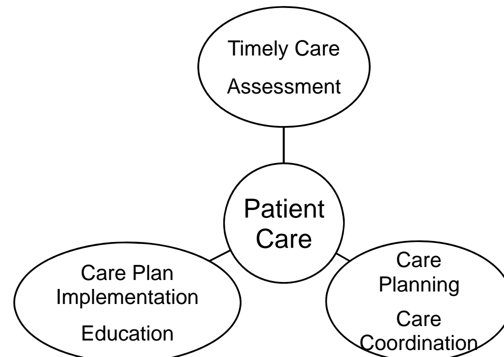
CMS Manuals

1. Process-Based Quality Improvement Manual
   - To assist agencies in collection and use of OASIS data for quality/performance improvement.
2. The Outcome and Assessment Information Set (OASIS-C) Guidance Manual
   - To introduce agencies to OASIS and collection of uniform health status data
3. The Outcome-Based Quality Improvement (OBQI)
   - Focuses on OBQI Outcome Report
4. The Outcome-Based Quality Monitoring (OBQM)
   - Focuses on quality monitoring using Agency Patient-Related Characteristics (case mix) and Potentially Avoidable Event (adverse event outcome) Reports

General Considerations

- Measures elements of care under agency control
- Not Mandated
- Not Necessary for All Clients
- Designed to Improve Patient Care Across Settings
- Forty-seven process measures on agency reports
- Thirteen process measures reported on the Home Health Compare website
- After the first reporting period, a comparison of adherence rate to the previous reporting period also reported

Process Measure Domains



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"Timely Care" Process Measure
Reported on HH Compare

Measure Title	Measure Description	OASIS C Item(s) Used
Timely Initiation of Care	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date whichever is later.	**SOC/ROC:** **(M0102) Date of Physician-ordered Start of Care** **(M0104) Date of Referral** **(M0030) Start of Care Date** **(M0032) Resumption of Care Date** **(M0100) Reason for Assessment** **(M1000) Inpatient Facility Discharge** **(M1005) Inpatient Discharge Date**

Key Considerations

(M0102) Date of Physician-ordered Start of Care

1. Specifies ordered SOC date, which is the most recent date that verbal, written, or electronic authorization to begin home care **was received by the home health agency**
2. Requires specific date from physician to start care

(M0104) Date of Referral

1. Does not refer to calls or documentation from others such as assisted living facility staff or family
2. Does not refer to authorization date from payer
3. If a provider is sent a referral via fax after business hours but no one is there to pick up the fax until Monday, the referral date is still Friday

(M1005) Inpatient Discharge Date

1. Cop Compliance - discharge date compared to SOC visit within 48 hours of the patient's return home

Best Practice for Best Outcomes

- Revise referral form to include specific dates
- Consider policy related to faxing referrals after business hours
- Establish practice to ensure home visit within 48 hours of inpatient discharge
  - Including PT only clients

HANDOUT: Intake Form

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"Care Coordination" Process Measure

Measure Title	Measure Description	OASIS C Item(s) Used
Physician Notification Guidelines Established	**Percentage of home health episodes of care in which the physician-ordered plan of care establishes parameters (limits) for notifying the physician of changes in patient status**	**SOC/ROC:** **(M2250) a. Patient-specific parameters for notifying physician plan of care**

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Key Considerations

(M2250) a. Patient-specific parameters for notifying physician plan of care

1. Specific parameters must be included on the Plan of Care
2. Do not simply reference "agency's patient clinical parameter guidelines" (Q 22 July, 2010)

(M2250) 2250 - Plan of Care Synopsis

1. When completing at ROC may use initial orders received for fall risk, pressure ulcers, etc. if orders received at SOC remain as current orders (can be reported in M2250) (Q 21 July 2010)

"Assessment" Process Measures

- Total of 4 assessment measures
- Report whether specific assessments were conducted at start of episode (SOC/ROC)
- All 4 will appear on Home Health Compare and CASPER/OBQI reports

"Assessment" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Depression Assessment Conducted	Percentage of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start or resumption of care.	**SOC/ROC:** **(M1730) Depression Screening** **(M1710) When Confused** **(M1720) When Anxious**

"Assessment" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Multifactor Fall Risk Assessment Conducted For Patients 65 & Over	**Percentage of home health episodes of care in which patients 65 and older had a multi-factor fall risk assessment at the start of care/resumption of care**	**SOC/ROC:** **(M1910) Multi-factor Fall Risk Assessment** **(M0066) Birth Date** **(M0030) Start of Care Date** **(M0032) Resumption of Care Date**

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"Assessment" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Pain Assessment Conducted	**Percentage of home health episodes of care during which the patient was assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care**	**SOC/ROC: (M1240) Pain Assessment using a standardized pain assessment tool**

"Assessment" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Pressure Ulcer Risk Assessment Conducted	**Percentage of home Health episodes of care in which the patient was assessed for risk of developing pressure ulcers at start of care/resumption of care**	**SOC/ROC: (M1300) Pressure Ulcer Assessment**

Key Considerations

(M1730) Depression Screening

1. If scores three points or more on the PHQ-2©, further depression screening is indicated
2. Identify the tool used

(M1910) Multi-factor Fall Risk Assessment

1. Must be completed by the home health agency
2. During specified time frames for completion of comprehensive assessment (5 days for SOC; 48 hours following inpatient facility discharge, or knowledge of patient's return home for ROC)
3. By clinician completing SOC or ROC OASIS

(M1240) Pain Assessment

1. Defines severe pain
2. Severe pain defined by tool's scoring system

Best Practice for Best Outcomes: General

- Find appropriate assessment tools
- Train all staff on use of assessment tools
- Document findings BEFORE interventions
- Audit for use of assessment tools
- Create policy related to which clients will be assessed
- Annual review of clinician assessment skills
- Co-visits for assessments
- Use client handouts/information
- Engage appropriate staff (nursing, therapy, aide)

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Best Practice for Best Outcomes: Depression

- Use age-appropriate screening tool
- Little interest or pleasure in doing things that were formally enjoyable
- Feeling down, depressed, or hopeless
- Feeling tired or having little energy on more than an occasional basis
- Poor appetite or overeating
- Poor self-esteem – feeling that you are a failure or have let yourself or your family down

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Best Practice for Best Outcomes: Depression

- Trouble concentrating on things, such as completing necessary tasks, reading the newspaper or watching television
- Moving or speaking so slowly that other people notice
  - Or the opposite – fidgety/restless - move around a lot more than usual
- Thoughts that you would be better off dead, or of hurting yourself in some way

Adapted from: Mental Health America

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Best Practice for Best Outcomes: Fall Prevention

- Complete home safety check
- Is the client on multiple medications?
- What is the mental health status?
- Assess toileting frequency & incontinence
- What is the patient's functional vision?
- Blood pressure check

Best Practice for Best Outcomes: Fall Prevention

- What is general mobility/ability?
  - Gait, balance, muscle coordination
- Are there environmental hazards (clutter/pets/footwear)?
- Does the client have predisposing conditions (hypotension, vertigo, CVA, Parkinson's disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures)
- Would client benefit from referral to PT/OT/SN

Best Practice for Best Outcomes: Fall Prevention Resources

www.healthinaging.org - Patient Handouts

1. Improve Your Balance in 10 Minutes a Day
2. Avoiding Falls: Tips for Patients with Low Vision

http://www.health.vic.gov.au/agedcare

1. *Falls Risk Assessment Tool* (FRAT) Tool: includes risk assessment, risk factors, action plan

http://www.bhps.org.uk/falls/documents/TinettiBalanceAssessment.pdf

1. TINETTI BALANCE ASSESSMENT TOOL

HANDOUTS: Checklist for Seniors
Risk Assessment Decision Tree

General Guide for Assessment Tools

Tools	Nursing	PT	OT	Social Worker
Home Safety Check	X	X	X	X
Berg		X		
Beers	X			
Dynamic Gait Index		X		
Mini Mental	X	X	X	X
Depression Scale	X		X	X
Time Up & Go	X	X	X	X
Functional Reach	X	X	X	
Tinetti		X		
Get Up & Go	X	X	X	

Best Practice for Best Outcomes: Pain

- Use tool appropriate to individual client
  - Wong-Baker FACES Pain Rating Scale, numerical scales, Memorial Pain Assessment Card
- Observe facial expressions
- Observe mobility/movement
- Monitor heart rate, respiratory rate, perspiration, pallor, pupil size, irritability at rest and with activity
- Review pain intensity & patterns

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Best Practice for Best Outcomes: Pain

- Screen for pain prior to intervention(s)
- Screen for psychosocial issues, including substance abuse
- Devise overall treatment plan if needed
- Ask client:
  - If you didn't have pain, what other activities would you do?
  - Is the pain relieved with medication?
  - What current & past treatments have you used?

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Best Practice for Best Outcomes: Pain

FOUR "A's" OF PAIN TREATMENT OUTCOMES

1. **Analgesia** – Is the pain relief clinically significant? Is there a reduction in the pain score (0-10)?
2. **Activity levels** – What is the patient's level of physical and psychosocial functioning? Has treatment made an improvement?
3. **Adverse effects** – Is the patient experiencing side effects from pain relievers? If so, are they tolerable?
4. **Aberrant drug-taking behaviors** – Does the patient show signs of addiction? Are there any behaviors that are worrisome such as early refills or lost medication? What is your plan of action?

Source: Passik & Weinreb, 1998; Passik & Portenoy, 1998

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Best Practice for Best Outcomes: Pressure Ulcers

- At least annual training on wounds, including

  Principles of Moist Wound Healing
- Every clinician gets copy of WOCN guidelines
- Review all areas of skin
- Consider all bed or chair-bound persons, or those whose ability to reposition is impaired, to be at risk for pressure ulcers

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Best Practice for Best Outcomes: Pressure Ulcers

- Select and use a method of risk assessment that ensures systematic evaluation of individual risk
  - Norton Scale or the Braden Scale
- Assess at admission to & regular intervals thereafter
- Identify all individual risk factors (decreased mental status, moisture, incontinence, nutritional deficits) to direct specific preventive treatments
- Modify care according to the individual factors

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Best Practice for Best Outcomes: Pressure Ulcers

- If client at risk – are pressure relieving devices available?
- What is client's hydration and nutrition level?
- Look for warning signs - skin stays red longer than thirty minutes, feels warm or firm to the touch and/or is blistered or broken
- Watch client movement for friction - pulls or drags across sheets or pushes or pulls with
- Watch for repetitive movements, such as scratching foot on the sheet

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Moist Wound Healing

- Shift in wound care management favors moist healing
  - For chronic wounds: venous leg ulcers, pressure ulcers and diabetic foot ulcers
- Promotes body's natural process of healing and tissue growth
- Maintains an isolated moist wound environment
- Includes foams, alginates, hydrocolloids, hydrogels, and transparent films

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Moist Wound Healing

- Product depends on the wound's characteristics
  - Amount of drainage, size of the wound
  - Presence/absence of infection, characteristics of surrounding skin.
- Moisture-retentive dressings should be selected for wounds with light to moderate drainage
- Absorbent dressings should be selected for wounds with moderate to heavy exudate
- New technologies = new wave
  - Skin substitutes
  - Growth factors
  - Gene therapy

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"Care Planning" Process Measure

- All on CASPER/OBQI reports
- Pressure Ulcer Prevention on Home Health Compare
- Total of 6 care planning measures
- Derived from M2250 - Plan of Care Synopsis

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"Care Planning" Process Measure

Measure Title	Measure Description	OASIS C Item(s) Used
Diabetic Foot Care <u>and</u> Patient Education In Plan of Care	**Percentage of home health episodes of care in which the patient is diabetic and the physician-ordered plan of care includes regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care**	**SOC/ROC: (M2250) b. Diabetic foot care in plan of care**

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Best Practice for Best Outcomes:
Diabetic Foot Care

- Is the client experiencing pain, heat, or cold in the legs and feet?
- Examine feet at every visit – inspect between the toes and from toe to heel
  - Are there **cuts, sores, blisters, redness, calluses, or other problems** areas on the feet?
  - Check feet for dryness, cracks or fungus such as **athlete's foot**
  - Look for thin, fragile, shiny, and hairless skin—all signs of decreased vascular supply
  - Feel the feet for excessive warmth and dryness

Best Practice for Best Outcomes:
Diabetic Foot Care

- Remove any nail polish. Inspect nails for thickening, ingrown corners, length, and fungal infection
- Inspect socks or hose for blood or other discharge
- Examine footwear for torn linings, foreign objects, breathable materials, abnormal wear patterns, and proper fit
- If any new foot abnormality is found schedule comprehensive foot examination

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Best Practice for Best Outcomes:
Diabetic Foot Care

- Does the client wear protective shoes?
- What is the client's fluid intake (skin moisture)?
- What type of socks are worn (all cotton)?
- What type of soap is used (mild followed by lotion)?
- Provide pt. education (Guide to Foot Care)

http://www.ndep.nih.gov/media/Feet_HCGuide.pdf

HANDOUTS: Diabetic Footcare Guideline

"Care Planning" Process Measure

Measure Title	Measure Description	OASIS C Item(s) Used
Falls Prevention Steps In Plan Of Care	Percentage of home health episodes of care in which interventions to mitigate the risk of falls were included in the physician-ordered plan of care for patients assessed to be at risk for falls.	**SOC/ROC: (M2250) c. Falls prevention in plan of care**

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"Care Planning" Process Measure

Measure Title	Measure Description	OASIS C Item Used
Depression Interventions In Plan of Care	**Percentage of home health episodes of care in which patients with depression symptoms/diagnosis had a physician-ordered plan of care that includes interventions such as medication, referral for other treatment, or a monitoring plan for current treatment**	**SOC/ROC: (M2250) d. Depression intervention(s) Plan of care** (M1710) When Confused (M1720) When Anxious

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"Care Planning" Process Measure

Measure Title	Measure Description	OASIS C Item(s) Used
Pain Interventions In Plan Of Care	Percentage of home health episodes of care in which intervention(s) to monitor and mitigate pain were included in the physician-ordered plan of care for patients who were identified as having pain.	**SOC/ROC: (M2250) e. Intervention(s) to monitor and mitigate pain in plan of care**

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"Care Planning" Process Measure
Reported on HH Compare

Measure Title	Measure Description	OASIS C Item(s) Used
Pressure Ulcer Prevention In Plan Of Care	Percentage of home health episodes of care in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care for patients assessed to be at risk for pressure ulcers.	**SOC/ROC: (M2250) f. Intervention(s) to prevent pressure ulcers in plan of care**

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"Care Planning" Process Measure

Measure Title	Measure Description	OASIS C Item(s) Used
Pressure Ulcer Treatment Based Principles Of Moist Wound Healing In Plan Of Care	Percentage of home health episodes of care in which pressure ulcer treatment based on principles of moist wound healing was specified in the physician-ordered plan of care (or an order was requested) for patients who have pressure ulcers with need for moist wound healing.	**SOC/ROC: (M2250) g. Pressure ulcer treatment in plan of care**

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Key Considerations

(M2250) Plan of Care Synopsis

1. Identifies if POC incorporates specific best practices
2. Physician ordered plan of care" means patient condition has been discussed and there is agreement
3. Can be answered "Yes" prior to receipt of signed orders if clinical record reflects evidence of communication
4. Date Assessment Completed (M0090) then becomes date of communication

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"Care Plan Implementation" Process Measures

- 5 Implementation Measures (15 total reports for short-term, long-term, all episodes)
- 4 derived from M2400 - Intervention Synopsis
- 1 derived from M1510 - Heart Failure Follow-up

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"Care Plan Implementation" Process Measures

- Based on data collected at Transfer and Discharge
- Report care provided "since the last OASIS assessment"
- Calculated separately for short-term episodes and long-term episodes
  - Only short-term reported on HH Compare
  - Agency will get 3 reports (short-term, long-term and all episodes)

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"Care Plan Implementation" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Diabetic Foot Care And Patient /Caregiver Education Implemented (HHC)	Percentage of home health episodes of care in which diabetic foot care and education were included in the physician-ordered plan of care and implemented for patients with diabetes (since the previous OASIS assessment).	**Transfer /Discharge: (M2400) a. Diabetic foot care Intervention(s)** **(M0100) Reason for Assessment**

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"Care Plan Implementation" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Depression Interventions Implemented	Percentage of home health episodes of care during which the patient has symptoms or diagnosis of depression and depression interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	**Transfer /Discharge:** (M0100) Reason for Assessment (M2400) c. Depression intervention(s) (M1710) When Confused (M1720) When Anxious

"Care Plan Implementation" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Pain Interventions Implemented (HHC)	Percentage of all home health episodes of care during which the patient had pain and pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	**Transfer /Discharge:** (M2400) d. Intervention(s) to monitor and mitigate Pain (M0100) Reason for Assessment

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"Care Plan Implementation" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Treatment of Pressure Ulcers Based On **Principles Of Moist Wound Healing** Implemented	Percentage of home health episodes of care during which pressure ulcer treatment based on principles of moist wound healing was included in the physician-ordered plan of care and implemented for patients with pressure ulcers needing moist healing (since the previous OASIS assessment).	Transfer/Discharge: **(M2400) f. Pressure ulcer treatment based on principles of moist wound Healing** (M0100) Reason for Assessment

"Care Plan Implementation" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Heart Failure Symptoms Addressed (HHC)	Percentage of home health episodes of care during which patients exhibited symptoms of heart failure and appropriate actions were taken (since the previous OASIS assessment).	**Transfer /Discharge:** (M1510) Heart Failure Follow-up (M1500) Symptoms in Heart Failure Patients

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Key Considerations

M2400 - Intervention Synopsis

1. Identifies if specific interventions focused on specific problems were **both** included on the physician-ordered home health plan of care AND implemented as part of care provided during the home health care episode (at the time of the previous OASIS assessment or since that time)

2. The physician-ordered plan of care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.

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Key Considerations

M1510 - Heart Failure Follow-up

1. Response 1 includes: Communication by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status AND physician response to agency with acknowledgment of receipt of information and/or further advice or instructions
2. Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the ***same day***. Same day in this item means by the end of *this* calendar day, and is not the same as "within one calendar day", which is defined in M2002, Medication Follow-up as "until the end of the next calendar day."

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Best Practice for Best Outcomes: Cardiac Symptoms

- Known heart disease?
- Short of breath – at rest? with activity?
- Persistent, excessive coughing?
- Experiencing edema of the extremities or abdomen?
- Experienced unintentional weight gain?
- Experiencing heart palpitations (heartbeat sensations that feel like heart is pounding or racing)
- Experiencing difficulty sleeping, fatigue, faintness, indigestions?
- What is exercise tolerance level?
- Check pulse rate and rhythm, heart sounds

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"Education" Process Measures

- 2 Education Measures
  - Focused on drug education
- (M2010) Patient/Caregiver High Risk Drug Education
- (M2015) Patient/Caregiver Drug Education Intervention
  - Calculated separately for short-term episodes and long-term episodes
  - Only short-term reported on HH Compare
  - Agency will get 3 reports (short-term, long-term and all episodes)

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"Education" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Drug Education On High Risk Medications Provided To Patient /Caregiver At Start Of Episode	Percentage of home health episodes of care in which patients/caregivers were educated about high-risk medications at start/resumption of care including instructions on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.	**SOC/ROC: (M2010) Patient /Caregiver High Risk Drug Education**

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"Education" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Drug Education On All Medications Provided To Patient /Caregiver	Percentage of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (since the previous OASIS assessment).	**Transfer/ Discharge: (M2015) Patient /Caregiver Drug Education Intervention (M0100) Reason for Assessment**

Key Considerations

(M2010) Patient/Caregiver High Risk Drug Education

1. High-risk medications: considerable potential for causing significant harm when used erroneously
2. Select Response 0 – No, if the interventions are not completed

(M2015) Patient/Caregiver Drug Education Intervention

1. At transfer and discharge identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.

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Best Practice for Best Outcomes: Medications

Medication Reconciliation process for home care has three basic steps:

1. **Verify**-Collect an accurate medication list
   - Prescription medications
   - Over-the-counter medications
   - Home remedies
   - Over the counter herbal products
   - Dietary supplements & vitamins
   - Occasional use of other family member's medications
   - Outdated, stashed medications

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Best Practice for Best Outcomes: Medications

2. **Clarify**-Clarify any questions about drug/dose/frequency
   – Consider **Beers Criteria** for Potentially Inappropriate Medication Use in Older Adults
3. **Reconcile**-Communicate with physician about any identified medication questions or concerns

Adapted from the Institute for Healthcare Improvement

Best Practice for Best Outcomes: Medications

- Is the client on high-risk medications?
  – Aware of the risk?
- High-risk medications should be identified based on one or more authoritative sources
  – Institute for Safe Medical Practice (ISMP) High Alert Medication List
  – Beer's Criteria
  – Joint Commission's High Alert Medication lists

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Best Practice for Best Outcomes: Medications

Client ability can be temporarily or permanently limited by:

1. Physical impairments (e.g., limited manual dexterity)
2. Emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
3. Sensory impairments, (e.g., impaired vision, pain)
4. Environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)

"Prevention" Process Measures

- 6 Prevention Measures
- Received influenza immunization appear on Home Health Compare
- CASPER/OBQI: offered and refused or medical contraindication(s)
- Ever received PPV on Home Health Compare
- CASPER/OBQI: offered and refused PPV or medical contraindication(s)
- Pressure Ulcer Prevention short-term episodes on Home Health Compare

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"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Influenza Immunization Received For Current Flu Season	Percentage of home health episodes of care during which patients received influenza immunization for the current flu season, or were offered and refused vaccine, or were determined to have medical contraindication(s)	**Transfer/Discharge: (M1040) Influenza Vaccine** **(M1045) Reason Influenza Vaccine not received** **(M0030)** Start of Care Date **(M0032)** Resumption of Care Date **(M0906)** Discharge/Transfer/ Death Date

"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Pneumococcal Polysaccharide Vaccine Ever Received	Percentage of home health episodes of care during which patients were determined to have ever received PPV, or were offered and refused vaccine, or were determined to have medical contraindication(s)	**Transfer /Discharge: (M1050) Pneumococcal Vaccine** **(M1055) Reason PPV not received**

"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Potential Medication Issues Identified and Timely Physician Contact At Start Of Episode	Percentage of home health episodes of care in which the patient's drug regimen at start/ resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day.	**SOC/ROC: (M2002) Medication Follow-up**

"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Potential Medication Issues Identified & Timely Physician Contact	Percentage of home health episodes of care during which the patient's drug regimen was assessed to pose a risk of significant adverse effects or drug reactions and whose physician was contacted within one calendar day (since the previous OASIS assessment).	**Transfer /Discharge: (M2004) Medication Intervention** **(M0100)** Reason for Assessment

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"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Falls Prevention Steps Implemented	Percentage of home health episodes of care during which interventions to mitigate the risk of falls were included in the physician-ordered plan of care and implemented, for patients at risk of falls (since the previous OASIS assessment).	**Transfer /Discharge: (M2400) b. Falls prevention Interventions** **(M0100) Reason for Assessment**

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"Prevention" Process Measures

Measure Title	Measure Description	OASIS C Item(s) Used
Pressure Ulcer Prevention Implemented	Percentage of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented for patients assessed to be at risk for pressure ulcers (since the previous OASIS assessment).	**Transfer /Discharge: (M2400) e. Intervention(s) to prevent pressure Ulcers** **(M0100)** Reason for Assessment

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Key Considerations

(M1040) Influenza Vaccine; (M1045) Reason Influenza Vaccine not received (M1050) Pneumococcal Vaccine (M1055) Reason PPV not received

1. Designed to encourage immunizations (not expected that all providers will give immunizations

(M2002) Medication Follow-up

1. Clinically significant medication issues are those that pose actual or potential threat to health and safety
2. Select Response 1 – Yes, only if physician responds with acknowledgment of receipt of information and/or further advice or instructions

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Key Considerations

(M2004) Medication Intervention

1. **At transfer & discharge identifies if physician notified within one calendar day of significant medication issues at the time of or any time since the last OASIS assessment**
2. **Within one calendar day = by midnight the next day**

(M2400) b. Falls prevention Interventions & (M2400) e. Intervention(s) to prevent pressure Ulcers

1. **Specific measures must be on POC**

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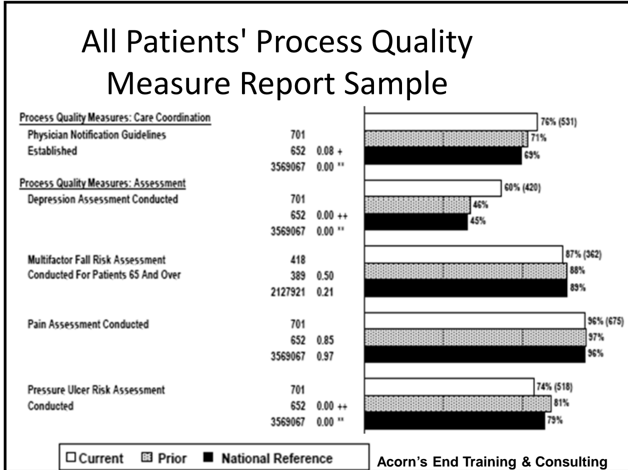

Home Health Compare Process Measures
Collection Period April 2010 to March 2011

Measure	MT	National
Patient was assessed for pain, using a standardized pain assessment tool	94	97
Patient had pain and pain interventions were included during the care plan and implemented	93	96
Patients exhibited symptoms of heart failure for whom appropriate actions were taken	94	97
Patient was assessed for risk of developing pressure ulcers	97	96
Interventions to prevent pressure ulcers were included in the physician-ordered plan of care for patients assessed to be at risk	87	92

Home Health Compare Process Measures
Collection Period April 2010 to March 2011

Measure	MT	National
Interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented	86	90
The start or resumption of care date was either on the physician-specified date or within 2 days of the referral date	83	88
Patient/ caregiver was instructed on how to monitor the effectiveness of drug therapy, recognize potential adverse effects, and how and when to report problems	76	86
Patients 65 and older had a multi-factor fall risk assessment	93	94

Home Health Compare Process Measures
Collection Period April 2010 to March 2011

Measure	MT	National
Patients were screened for depression	92	95
Patients received influenza immunization for the current flu season	73	65
Patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV)	70	61
Diabetic foot care and education specified during the physician-ordered care plan was implemented	78	87

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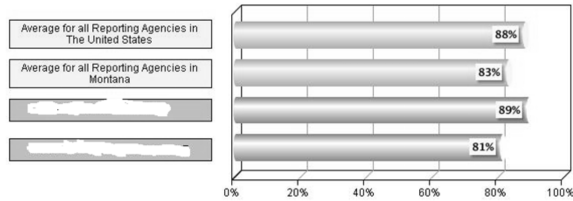
HH Compare Process Measure Graph

How often the home health team began their patients' care in a timely manner.



PBQI Steps

1) Selection of specific care processes
2) Assessment of reasons for low rates of compliance with best practice care processes
3) Development of a plan of action to improve rates of compliance
4) Implementation of a plan of action and monitoring for improvement in rates of compliance

+ Analyze process quality measures in conjunction with relevant outcomes (see Table 3.1 in PBQI Manual for process measures associated with OBQI/OBQM)

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