Objectives

- Understand the importance of home health STAR ratings
- Identify outcome and process measures used for STAR rating calculation
- State assessment techniques or guidelines for OASIS items used in process measure calculation
- Identify best practices for improving process measures for timely initiation of care, influenza vaccine received and education on medications

Introduction to STAR Measures
## Why does Home Health need Star Ratings?

- **Home Health Compare** information overwhelming to consumers
- 27 outcome and process measures provide information on quality performance to allow informed choice of a home health agency
- Consumers are accustomed to using a “star” rating system to compare and choose products and services
- Home Health Star Ratings offer a simple tool to aid consumers’ healthcare decision making

## Types of Star Ratings

### Quality of Patient Care Star Ratings

- Formerly called the “Home Health Compare STAR ratings”
- Posted on Home Health Compare website since July 2015
- Based on OASIS data submitted by agencies for outcome and process measures, and claims data for acute care hospitalization

### Patient Survey Star Rating Measures

- **Care of Patients**
  Questions: Q9, Q16, Q19, Q24
- **Communication between Agencies and Patients**
  Questions: Q2, Q15, Q17, Q18, Q22, Q23
- **Specific Care Issues**
  Questions: Q3, Q4, Q5, Q10, Q12, Q13, Q14
- **Overall Rating of Care provided by the agency**
  Question: Q20
Quality of Patient Care Star Rating Measures

### Outcome Measures
- Improvement in Ambulation
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Pain Interfering with Activity
- Improvement in Shortness of Breath
- Acute Care Hospitalization

### Process Measures
- Timely Initiation of Care
- Drug Education on all Medications Provided to Patient/Caregiver
- Influenza Immunization Received for Current Flu Season

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Criteria for Measure Selection

- Measure applies to a substantial portion of home health patients and has sufficient data to report for a majority of home health agencies.
- Measure should show some variation between agencies, and agencies should be able to show improvement in performance for the measure.
- Measure should be clinically relevant.
- Measure should be relatively stable and should not show substantial random variation over time.

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Home Health Star Rating: Agency Eligibility

- All Medicare-certified agencies are eligible to receive a Star Rating.
  - Must have at least 20 completed quality episodes for data on a measure to be reported on HHCompare.
  - Must have reported data for 5 of the 9 quality and process measures.
- Eligible agencies must have data for 40 or more patient surveys in the reporting period.
- Eligible episodes must have a discharge date within the 12-month reporting period.
Home Health Star Rating: Calculation

- Each measure is rated and assigned a decile rating. Adjusted ratings are averaged across the 9 measures, and rounded to the nearest 0.5
- Each of the 9 measures carry the same importance in the Star Rating
- Overall Star Ratings range from 1.0 to 5.0, reported in half-star increments, with 3.0 stars as the middle category
- Updated quarterly in January, April, July and October

OASIS-Based ACH Rate Calculation

- Percentage of home health episodes of care that ended with the patient being admitted to the hospital
- Based on OASIS Transfer to Inpatient Facility with or without Discharge (RFA 6 or 7)
- OASIS items:
  - M0100 – Reason for Assessment
  - M2410 – Inpatient Facility Admission
  - M2430 – Reason for Hospitalization

Claims-Based ACH Rate Calculation

- Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.
- Based on Medicare FFS claims data
- The ACH rate publically reported on HHCompare and used for HH STAR measure calculation is the Claims-based ACH rate, not the OASIS-based ACH rate.

So why does the OASIS-based ACH rate matter?

- Submitting a Transfer OASIS then requires a new ROC OASIS assessment when the patient returns home.
- Each ROC OASIS starts a new quality episode – what’s the impact of that on end-result outcome measures? On process measures?
- Make sure transfer criteria are met BEFORE completing transfer OASIS
  - Admission to acute inpatient facility
  - For 24 hours or longer
  - For reasons other than just diagnostic testing
Why should I care about Star ratings?

- Referrals
  - Used by customers, referral sources and payers to choose homecare providers
- Mergers and Acquisitions
  - Used by large agencies to influence decisions on mergers and acquisitions
- Value-Based Purchasing
  - VBP pilot project active in nine states now
  - Uses ongoing performance on outcome and process measures to impact payment for pilot states up to 5% (up or down) in 2018

How can Star Ratings improve?

- Focus on OASIS accuracy at all assessment time points
  - Discharge and transfer as important as SOC!
- When choosing a QAPI project, target a measure that impacts your Star Rating if possible
- Just telling your staff to “Do it better” is not a quality or performance improvement plan!
Process Measures

- Purpose of Process Measures
  - Whose score is it?
  - Why do we need a process?

Timely Initiation of Care Process Measure

- Conditions of Participation require the initial assessment to determine the patient’s eligibility for home care services and immediate care needs; and must be conducted either:
  - Within 48 hours of the date of referral OR
  - Within 48 hours of return home from inpatient facility OR
  - On the physician-ordered SOC date

- Initial assessment vs. SOC visit dates

Timely Initiation of Care Process Measure

- OASIS items used for measurement:
  - M0102 – Date of physician-ordered Start of Care (Resumption of Care)
  - M0104 – Date of Referral
  - M1005 – Inpatient Discharge Date (most recent)

M0102 Date of Physician-ordered SOC/ROC

- Time points: SOC, ROC
- Specifies date HH services are ordered to begin IF the date was specified by the physician
- Mark **NA** if the physician orders do not specify a SOC date
M0102 Date of Physician-ordered SOC (or ROC)

- Must be a single specific date to initiate care, not a range of dates.
- If the originally ordered SOC date is delayed due to patient condition or physician request (example: extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician-ordered start of care.
- Because the State Operations Manual requires a visit for resumption of care within 48 hours following hospitalization, mark NA if the physician orders a ROC date that extends beyond 2 calendar days of the inpatient facility discharge date.

M0104 Date of Referral

- Time points: SOC, ROC
- Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was received by the home health agency.

M0104 Date of Referral

- If SOC is delayed due to the patient's condition or physician request, then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral.
- This does not include calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- The date authorization was received from the patient's payer is NOT the date of referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).
M0104 Date of Referral

- In the example of a hospitalist who will not be providing an ongoing plan of care for the patient, the HHA must contact an alternate, or attending physician, and upon agreement from this following physician, for referral and/or further orders, the HHA will note this as the referral date in M0104 (unless referral details are later updated or revised).
- If a general order to “Evaluate for Home Care services” (no discipline(s) specified) is received from a physician who will be following the patient, this constitutes a valid order, and per CoP §484.55 the RN must conduct the initial assessment visit to determine immediate care and support needs and eligibility for the Home Health benefit for Medicare patients.

3rd Q 2014

M1005 Inpatient Discharge Date (most recent)

- Time points: SOC, ROC
- Identifies the date of the most recent discharge from an inpatient facility (within past 14 days)

M0102 and M0104 for late F2F – Jan. 2016 Q&A #2

- When a new Start of Care date is established based on the completion of a late face-to-face encounter for Medicare eligibility, report M0102 – Date of Physician-ordered SOC as NA and report M0104 – Date of Referral as the day prior to the new Start of Care date.

Example 1

- HH Agency gets a referral from the hospital on Mr. Smith on Jan. 1, with an anticipated DC date of Jan. 3.
- Agency checks hospital census report daily and sees Mr. Smith is still in the hospital end of day on Jan. 3 and there’s no answer at his home number. Contact with hospital: patient has a UTI and they are keeping him another day or two to make sure he responds to antibiotic.
- Patient is discharged from hospital to home on Jan. 7.
- Agency does initial assessment and SOC visit on Jan. 8.
  - M0102 – NA
  - M0104 – Jan. 3 (updated info)
  - M1005 – Jan. 7
**Example 2: Patient Requests Delay**

<table>
<thead>
<tr>
<th>Physician Not Informed</th>
<th>Physician Informed &amp; New SOC Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0030: Jan. 4</td>
<td>M0030: Jan. 4</td>
</tr>
<tr>
<td>M0102: NA</td>
<td>M0102: Jan. 4</td>
</tr>
<tr>
<td>M0104: Jan. 1</td>
<td>M0104: skipped if date entered in</td>
</tr>
<tr>
<td>M1005: skipped, no inpatient discharge in past 14 days</td>
<td>M1005: skipped</td>
</tr>
</tbody>
</table>

**Best Practices for Timely Initiation of Care**

- **Office staff practices:**
  - Record date on all valid referrals.
  - Monitor inpatient census daily to avoid missing discharges.
  - Update referral date on all patients with delayed discharge or change in discharge plan.
  - If patient/family refuses (or staffing issues prevent) the initial visit within 2 days of inpatient discharge, notify the referring physician and obtain order for a new SOC date. Document this communication and either add to the referral information or retain as a separate order.
  - Track all referrals, discharge dates, and communication from field staff if patients are not available for admission visit.

**Field staff practices:**

- Educate patient/family to contact agency for all inpatient admissions.
- For hospitalized patients, inform office so patient is tracked on daily census check.
- When clinician is assigned a SOC/ROC, have a process to make sure there is acknowledgment that clinician has received referral info.
- Clinician contact patient/family the night before to arrange time for initial/SOC visit. Document any problems with visit scheduling and communicate to office staff.
- If unable to make the initial/SOC visit, communicate with office staff or physician to identify reason and obtain order to move SOC visit date.

**Field staff practices (cont’d):**

- When completing the SOC or ROC OASIS items:
  - Check the referral: was there a specific date for SOC? **M0102**
  - Check the referral: what is the referral date? **M0104**
  - Is the date in M0104 more than two days ago? If it is >2 days ago, investigate if there was updated/revised information from the referral source about a delay or change in plan that didn’t get documented on the referral? Does the physician need to be contacted to inform him/her of the circumstances of the delayed SOC?
- Document all communication regarding delays in SOC or ROC visits.
- Remember: the ROC visit cannot be delayed past 48 hours after the inpatient discharge or you are out of compliance with CoPs!
Best Practices for Timely Initiation of Care

- **Quality Assurance staff:**
  - Review all SOC and ROC assessments for compliance with the 48 hour requirement.
  - For all assessments with >2 days before the SOC or ROC date, investigate circumstances and obtain any omitted documentation from office or clinical field staff.
  - If the initial/SOC visit was delayed beyond the required time period identify the case for focus auditing.
  - Focus audit: on all cases where the initial SOC/ROC visit was not made within the 2 day time period, determine if best practices were followed; identify if this is a trend. Is this a process problem or a problem with individual staff member performance? Revise or remediate.

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Influenza Vaccine Received

- Benefits of vaccination
- Challenges to improving vaccination rates

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Process Measure

- **Influenza Vaccine Received**
  - Influenza Immunization is tracked by all healthcare provider settings
  - Ask for influenza vaccination history and information at time of referral
  - Document at SOC and/or ROC visit
    - Where? Responsibility?
M1041 Influenza Vaccine

An “episode of care” includes both SOC/ROC and Transfer/DC
If no part of the care episode (from SOC/ROC to Transfer or Discharge) occurred during the time period from October 1 and March 31, mark “No.”
Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 - March 31).

M1046 Influenza Vaccine Received

- For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why.
- Response 1 - your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge).
- Response 2 - your agency provided the flu vaccine for this year's flu season prior to this home health episode.
- Response 2 - a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year’s flu season.
- Response 3 - patient or caregiver reports (or there is documentation in the clinical record) that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic, a pharmacy, or health fair providing influenza vaccines, etc.
- Responses 1 or 2 or 3 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (that is, flu vaccine was made available early).
- Response 4 - patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.

Note: It is not required that the agency offered the vaccine. Select Response 4 only if the patient was offered the vaccine by any provider and he/she refused.
**M1046 Influenza Vaccine Received**

- **Response 5** - influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months, or other physician medical restriction.
- **Response 6** - age/condition guidelines indicate influenza vaccine is not indicated for this patient.
- **Response 7** - only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- **Response 8** - only if the patient did not receive the vaccine due to a reason other than Responses 4-7.

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**Example**

- Patient admitted to HH on Sept 13 and given the vaccine on September 17. You are now discharging from HH on December 10.
- How would you answer M1041 at Discharge? M1046?

Example

- Patient admitted to home care on January 2. The flu season is bad this year and is lingering on. He is given the flu vaccine on April 2. You are discharging from HH in July.
- How would you answer M1041 at DC? M1046?

Example

- Flu vaccine given on Sept. 15th and there was a Transfer date (M0906) of Sept. 30th, but the date the Transfer OASIS was completed (M0090) was Oct. 2nd.
- How would you answer M1041 at Transfer? M1046?
More than one flu season in the episode

- If a patient's quality episode overlaps more than one influenza season, M1046 should be answered based on whether or not the agency gave the influenza vaccine for the current flu season.

<table>
<thead>
<tr>
<th>Admit</th>
<th>Flu shot</th>
<th>DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1</td>
<td>Jan 5</td>
<td>Oct 10</td>
</tr>
</tbody>
</table>

Best Practices to Improve Influenza Vaccination Rate

- The AFIX Approach from CDC:
  - Assessment of the immunization status of HH patients
  - Feedback of diagnostic information to improve service delivery of vaccinations
  - Incentives to motivate providers to change immunization practices
  - eXchange of information among providers

Best Practices to Improve Influenza Vaccination Rate

- Assessment and Tracking
  - Request influenza immunization information from referral source
  - If admitting patient to HH October through March, ask at SOC visit: has the patient had a flu vaccine for the current flu season?
  - For patients currently on service as of October 1, ask patient and family members if they have had flu vaccine yet?
  - Document immunization status in medical record
  - Flag patients that have not had a flu vaccine and are candidates under CDC guidelines
  - Follow up re-evaluation of unvaccinated patients
  - Increases clinician awareness of need for immunization

Best Practices to Improve Influenza Vaccination Rate

- Immunization education
  - Standardized educational materials for clinicians to use for patient education on need for flu vaccination
  - Identify patients at high risk for influenza, or adverse events from influenza infection, and prioritize for education
  - Re-educate at periodic intervals for patients that have not been vaccinated
  - Provide educational inservice for clinical staff on flu vaccination benefits, available tools and resources, current CDC recommendations for flu vaccination, criteria for vaccination and medical restrictions (changes each year)
Best Practices to Improve Influenza Vaccination Rate

- Keep up to date on CDC current information: [http://www.cdc.gov/flu/index.htm](http://www.cdc.gov/flu/index.htm)
- Coordination with other providers
  - Contact physician to verify patient meets criteria for flu vaccination and has no medical restrictions
  - Request order to administer flu vaccine to patient
  - Obtain supply of vaccination for agency administration
  - Encourage patient families and caregivers to receive flu vaccine from their physician or community resources

Best Practices to Improve Influenza Vaccination Rate

- Reduction of barriers to immunization
  - Raise patient and family/caregiver awareness of benefits of flu vaccination and risks of not receiving vaccine.
  - In September, remind patients that influenza immunizations are due soon and make plan to receive
  - Address concerns related to vaccine side effects, cost, complications or vaccine safety concerns
  - Agency provide vaccine administration for patients in their home, with protocols and equipment as required
  - End of November, notify all patients that have not received vaccine that flu vaccine is past due

Education on Medications

- Purpose of Process Measures
- Education on all Medications
  - Impact of medication errors
  - Challenges to medication education
**Assessment: Intake / Referral**

- **Medication Education**
  - Obtain home medication list
  - Identify new or changed medications
  - Ask what brought patient into hospital – was medication mis-management a factor?

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**M2015 Patient/Caregiver Drug Education Intervention**

(M2015) Patient/Caregiver Drug Education Intervention: At the time of or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- [ ] 0 - No
- [ ] 1 - Yes
- [ ] NA - Patient not taking any drugs

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**M2015 Drug Education Intervention**

- Identify if clinicians instructed the patient and/or caregiver(s) on ALL medications
  - ALF staff are considered caregivers 4b-Q162.3, 162.4
  - Education can occur over the phone 4b-Q161.4

- How to manage meds effectively and safely through knowledge of:
  - Medication effectiveness
  - Potential side effects
  - Drug interactions or adverse effects
  - When to contact the appropriate care provider

- No--
  - Interventions are not completed as outlined in this item
  - Care provider should document rationale in the clinical record

- Yes—
  - Includes education by any agency staff
  - Has to be all 4 components

- NA—
  - Patient takes no prescription or OTC medications
M2015 Patient/Caregiver Drug Education Intervention

- If assessment of the patient/caregiver's baseline knowledge reveals the patient received the education from the pharmacist, you can include this education in M2015.
  - This would require that the pharmacist educated the patient/caregiver to monitor the effectiveness of all drug therapy (prescribed, as well as all OTC), drug reactions, and side effects, and how and when to report problems that may occur to the appropriate care provider.
  - Note that just including written materials in the bag with the medications at the time the medication is dispensed may not provide the specified education. The education of the patient may also be a collaborative effort, in which the pharmacist may provide part of the education, with other healthcare providers. 4b-Q162.

M2015 Example

Mr. Walt’s ROC was completed November 8. The SN documented education on all of the patient’s meds (high risk and non-high risk) was completed at that time.

Mr. Walt is transferred to the hospital on November 10. How will you complete M2015?

- NO?
- YES?

M2015 Example

- M2015 would be “Yes” if, at the time of or since the previous OASIS assessment, the patient and/or caregivers were educated regarding ALL their medications (not just the high risk medications), including how and when to report problems that may occur. If this specified education was accomplished for all medications at the time of the previous OASIS assessment, the appropriate response for M2015 would be “Yes.”
- If review of the documentation on the ROC visit showed the clinician taught only some of the medications, or taught only some of the information on medication effectiveness, potential side effects, adverse drug reactions, and who and what to report about problems, then the appropriate response for M2015 would be “No.”

M2015 Q&A

- Mrs. Washington was opened to home care on Jan. 1, and agency staff provided complete education on all medications during the first certification period. Mrs. Washington was recertified for home care services with a follow-up for recert on Feb. 26. At the recert visit, documentation of the Drug Regimen Review stated the patient had no new medications.
- At the discharge assessment visit on March 28, look-back at visit documentation showed there was no education in the second certification period because the patient had no new medications and there was no need to re-teach on all medications. Do you have to answer “No” for M2015 at Discharge?
M2015 Q&A

- The Condition of Participation 484.55 requires a Drug Regimen Review (DRR) at every comprehensive assessment time point. **When performing the DRR at the Recertification, if the assessing clinician evaluated the patient’s retention of prior teaching and determined and documented that the patient possessed all the required knowledge related to all medications, then M2015 would be answered "Yes" at Transfer/Discharge.**

- If the assessing clinician had not re-assessed the patient's medication knowledge and found the patient to be fully knowledgeable or not provided drug education related to all medications at the time of or since the previous OASIS assessment, the M2015 response would be "No" at Transfer/Discharge.

Medication Knowledge: Assess – Teach – Evaluate

- Comprehensive assessment at all OASIS time points includes learning assessment as well as assessment of current knowledge and ability to take meds
- Identify barriers to learning
- Teach with goal to improve overall medication knowledge, if realistic; if not, determine appropriate goal
- Evaluate and document patient and/or caregiver’s response to teaching

Teaching Points for Medications

- Visual recognition of drug
- Purpose of drug
- Name (generic and brand names)
- Dose (mg, number of pills)
- Administration relative to meals, sleep, other meds
- Expected duration of medication therapy
- What to do if a dose is missed
- How to tell if condition treated becomes/remains a problem (medication ineffective), monitoring plan
- Potential side effects and s/sx to watch for
- Potential drug reactions or adverse effects
- If problems identified, who to call and how to report problems

Med Teaching Tips

- Assess current knowledge and identify knowledge deficit
- Identify the primary learner
- Include family or caregivers when appropriate
- Start med education at SOC visit, provide med review and/or education at every visit
- Always provide written drug information to pt/caregiver
- Utilize standardized medication teaching tools
- Always ask for return demo or “teach back”
- On-going evaluation of understanding of meds
- Pharmacy consult for med simplification
- ID patients at risk for non-compliance/adherence with med regimen
Best Practices to Improve Medication Education

- Obtain current medication list at referral
- Perform drug regimen review and medication reconciliation to resolve any issues identified
- Develop a medication teaching protocol for clinicians to follow: assess-teach-evaluate
- Address “Teaching Points for Medications”
- Utilize “Medication Teaching Tips”
- Document all medication teaching in designated location in patient record
- Assess medication knowledge at DC visit, provide education on any meds patient does not know

Patient Empowerment

- Comprehensive patient education
  - Benefits of influenza immunization
  - Medication administration: drug, dose, frequency
  - Medication purpose, s/sx of ineffective therapy
  - Medication potential side effects, adverse reactions
  - When, how, who to report problems to

Patient Empowerment

- Patient self-management
  - Personal Health Record includes current medication list
  - Personal Health Record lists all vaccinations, including influenza

What questions do you have?

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- Selman-Holman & Associates, LLC
  - Home Health Insight
  - CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
  - CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice