CHAPTER 9

PLANNING FOR AGENCYWIDE IMPACTS OF OASIS DATA COLLECTION IMPLEMENTATION

A. INTRODUCTION

This chapter identifies agency systems likely to be impacted by the rules and regulations for the comprehensive assessment, OASIS data collection, and data reporting, including policies and procedures, paper flow processes, record-keeping, and other systems related to the provision of home health care. Many agencies that have implemented OASIS data collection for purposes of performance improvement report that its total impact resembles "the dropping of a stone into a puddle," with resulting agencywide effects. The Prospective Payment System (PPS) for Medicare patients requires close coordination of OASIS data collection and encoding, which places further emphasis on the importance of addressing agency systems and processes. Not all agencies need to modify the totality of policies, systems, and processes included here, but all are encouraged to review these for potential revision.

B. POLICIES AND PROCEDURES IMPACTED BY THE REGULATIONS

The regulations include several attributes of care delivery that are specifically stated and may differ from current agency policy. Because Medicare-certified agencies must comply with both CMS regulations and their own policies, agency staff will desire these to be congruent. It is important to conduct a thorough review of existing agency policies and procedures to determine where changes are needed to existing policies, where new policies and associated procedures are needed, or where current procedures should be modified. It is likely that every agency will need to make some modification to current policies and procedures, if only those pertaining to the timing of assessments and to the correction of patient data. Policies and procedures concerning patient care, clinical records, billing, and personnel responsibilities should be reviewed for potential updating.

As noted in Chapter 6, a subgroup appointed by the Implementation Team can be assigned the responsibility for review and revision of policies and procedures. If all new agency policies are to be reviewed by the professional advisory committee prior to implementation, this subgroup is likely to experience some time constraint in completing their tasks. A well-sequenced plan and clear identification of responsibilities can assist the group to successfully complete their activities.

1. Clinical and Personnel Policies Related to the Comprehensive Assessment

Policies and procedures that relate to the performance of patient assessments at start of care and other times should be reviewed and possibly revised. Historically, the most likely time for an agency clinician to perform an extensive assessment was at admission and possibly when the patient returned to home care from a hospital stay. The requirements for comprehensive assessments to be performed at designated points during the home care episode, plus the specific time intervals associated with these required assessments (e.g., within 48 hours of the patient's return home from an inpatient facility stay, etc.), may require modification of current agency policy. Agencies must learn the details of these required time points and intervals to incorporate them correctly into policy and procedure documents.

Staff of specific disciplines, personnel categories, or competency levels may be designated as able to complete the comprehensive assessments at specific time points. Both clinical and personnel policies can be impacted by these decisions.

The number of visits over which the comprehensive assessment can be conducted (e.g., a single visit, two visits separated by no more than one day and only in extenuating circumstances, etc.) is specified in some agency policy statements. This policy and its associated procedure also may be impacted by the comprehensive assessment or the PPS regulations, particularly those assessments that must be done within specified time intervals.

Policies or procedures regarding follow-up (recertification) reassessments, telephone (i.e., verbal) physician orders, tracking and timeliness of receiving signed physician orders, and billing procedures may be impacted by the timing of the follow-up (recertification) assessment to be conducted in the last five days of the 60-day certification period. These policies, procedures, and any associated processes warrant special attention.

2. Policies and Procedures Associated with Tracking Inpatient Facility Admissions

Chapter 6 included a recommendation that the Implementation Team determine the approach the agency should adopt regarding patients transferred to inpatient facilities, in particular whether these patients should be routinely discharged or not. Depending on this decision, policies and procedures may need minor revisions or a complete rewrite. If the Implementation Team's decision was to consider these patients as being on "hold" status, procedures to track the length of the inpatient stay are needed.

3. Policies and Procedures Related to Clinical Documentation

All agencies have policies and procedures concerning the patient's clinical record. The precise details of these policies and procedures should be reviewed to determine the impact of the data collection/reporting and the PPS regulations. Do these policies or personnel policies state the time expectations for clinicians to submit completed documentation? Where are the statements of clinical data completeness and data accuracy found? What policies and procedures are in place regarding correction of errors in the clinical record?

Several aspects of the OASIS data collection/reporting and PPS regulations must be considered in reviewing clinical record or documentation policies and procedures. If policies or procedures describe the clinical record contents, then OASIS item integration must be mentioned. If clinicians are responsible for correcting omissions or errors in required data, a time frame for such correction should be included that will facilitate agency compliance with CMS' data transmission requirements. Because transmitted data are required to match the actual clinical record maintained in the agency, policy and procedure statements must indicate that clinical record data failing to pass edit checks must be corrected in both the agency clinical record and the data record transmitted to the State agency.

4. Statements of Case Management and Primary Discipline Accountability

Agency clinical procedures are likely to contain statements about case management or oversight in multidiscipline cases (i.e., which discipline is considered "primary" when both nursing and therapy services are provided, etc.). These should be reviewed to determine if the responsibility for completion of the comprehensive assessment is clearly defined, or whether statements of such responsibility should be added.

5. Personnel Expectations

Clinical staff expectations and statements of competency should be reviewed to determine whether the conduct of comprehensive assessments, requirements for complete and accurate data collection, necessity for timely submission of documentation, the scheduling and completion of timely assessment visits, data correction procedures, and care coordination in multidiscipline cases are adequately addressed. The regulations include several expectations of clinical practice within the agency -- the policy and procedure review group should be sure that their agency's clinical staff position descriptions and requirements are clearly delineated.

Contracts for clinical staff also should be reviewed to determine whether the requirements imposed by the regulations are included. While a current contract with general language requiring contract providers to conform to all applicable agency policies may be sufficient for many issues, agencies may wish to add contractual language clarifying the agency's expectations of the contract providers relative to a variety of OASIS-related activities. A listing of issues that may require contract modification or contract provider notification is found in Attachment A to this chapter.

As the agency revises or adds policies, procedures, and staff expectations to meet the OASIS regulation, contract providers should be notified of any changes that affect those duties contractually provided.

C. SYSTEM IMPACTS OF OASIS IMPLEMENTATION

OASIS data collection, data entry, and data transmission are likely to affect many processes or departments in the HHA. Some of these processes or departments are identified below.

The agency should carefully review the current processes for the **intake of a referral**, including all steps from the receipt of a telephone call to the assignment of the referral to a clinician. This review should include referrals that come from all sources: hospitals, nursing homes, physician offices, and the community, as they may each be handled somewhat differently. It is often helpful to make a detailed flow chart of each step in the process.

Intake staff can obtain some OASIS patient identifying (i.e., clinical record) information that can be verified later by the clinician at the home visit. The intake staff thus facilitate the clinician’s OASIS data collection.

Investigate how and when the **ICD coding** is currently done. Some OASIS items require ICD codes. If ICD codes currently are entered just before the plan of care goes to billing, that process must be modified to make the codes available for data entry at the completion of the assessment. If the agency determines that the clinical staff should provide the appropriate ICD codes for their own patient assessments, Attachment D to Chapter 8 provides guidance for diagnosis coding.

HHAs currently have some **mechanism to remind clinicians of due dates** for recertifications or other necessary paperwork to be completed. These tracking and reminder processes assume even greater importance when the assessment time period is tightly defined and significantly impacts billing activities, as occurs with PPS requirements. Agencies are encouraged to review, refine, and if

possible, simplify current reminder and tracking mechanisms. Other tracking issues are discussed in Section D.

The patient Plan of Care (PoC), which may entail **mailing out and receiving signed physician orders** by the agency is monitored by state survey agencies. Oversight is necessary because the PoC impacts both clinical quality and justification for reimbursement.

Determine how **data entry and transmission** of OASIS data can best be added to existing data-related processes. When planning these steps, allow time for the correction of data entry errors and the process of correcting clinical documentation errors. With the implementation of PPS, agencies must plan the coordination of data entry with various billing procedures that require special payment codes. The Implementation Team's decisions about data entry options and staff must also be considered when reviewing these processes.

D. TRACKING ISSUES

Multiple agency processes need to occur smoothly for an effectively integrated data collection and reporting system that will also need to be closely coordinated with billing processes. Tracking of needed assessments, physician orders, data encoding, data transmission, and patient episodes are some of the key processes requiring attention in OASIS implementation. Although a well-designed computerized tracking system is ideal, not all agencies have the resources to create such a system. Tracking can be done efficiently using a manual system which is well thought out. It is advisable to begin developing a tracking system as soon as other OASIS implementation activities begin, to pilot test it, and to revise as necessary until it meets the agency's needs.

The agency currently may track due dates for recertifications in order to notify case managers. The timing of the current notification most likely requires revision because the comprehensive assessment must occur within the last five days of the 60-day certification period (i.e., during days 56 through 60). The documentation must be submitted promptly for data entry, a telephone order for recertification must be obtained from the physician, and the plan of care must be completed and sent to the physician for signature. (The signed orders must be received before final claims can be submitted for the 60-day payment episode.) Tracking the return of the signed plan of care is important to avoid loss of necessary documentation. In addition, a procedure must be set up to coordinate data entry of follow-up assessments done for significant changes in condition with the associated billing procedures.

The agency also may have had a system for tracking inpatient admissions to avoid problems caused by submitting claims for dates covering an inpatient stay under the pre-PPS payment system. The current system should be reviewed with the goal of making it current on a day-by-day basis and thus effective for PPS. If the agency places patients with inpatient facility admissions on "hold" status, the inpatient stay must be tracked to ensure the resumption of care visit occurs promptly (within 48 hours) after the inpatient facility discharge.

Discharges can be reported to clerical staff in the same manner that admissions to inpatient facilities are reported and entered into a tracking system. Documentation submission requirements for discharges should be no different than documentation for other assessments and will need to be tracked in the same way.

Data entry and transmission staff must track compliance with submission of data for all Medicare and Medicaid patients within 30 days of completion of an assessment (i.e., M0090). Additionally, the agency benefits from tracking the submission of appropriate forms at appropriate time points, beginning with receipt of the referral and the expected start of care date. Such a tracking system can include reported inpatient admissions and the receipt of the Transfer to Inpatient Facility form as well as reported deaths and discharges. The tracking system then can identify missing follow-up (recertification) assessments, start of care assessments, or discharges. A report can go to clinical supervisors weekly (or more often) listing missing documents.

Many agencies have found it useful to thoroughly examine their current paper flow system(s) with an eye toward simplifying tracking processes and reducing the number of people who handle any single piece of documentation. An exercise that assists in examining current paper flow process(es) is found in Attachment B to this chapter.

E. DATA CORRECTION IMPACTS

Under the regulations, agencies must enter data, check for errors, correct any errors, and submit the data within 30 days after the date the data are collected (i.e., M0090) for all Medicare and Medicaid patients. To meet this time limit, HHAs will need to plan and monitor several processes concerning data accuracy and data correction.

One key issue to address is determining the time frame in which clinicians must submit documentation following patient assessments. This interval must be long enough for clinicians to adequately follow up on the visit findings, yet short enough to allow time for review and possible data correction. A review of the submitted documentation for timeliness, as well as completeness and appro-

priateness, prior to data entry is an important first step in monitoring data accuracy. This activity is sufficiently important that the agency should plan replacement coverage when there are illnesses, vacations, and other staff "reviewer" absences. Monitoring these steps helps to identify "road blocks" or "traffic jams."

After the data are entered, they will be checked for errors of omission, invalid answers, or logical inconsistencies between items. Some errors are likely to be data entry errors, which can be identified and corrected within minutes by comparing the computer entry with the hard copy from the clinician.

Correction of clinical documentation errors is more time consuming because the documentation must be returned to the clinician with an explanation of the error. The clinician must correct the error promptly and return the record to the data entry staff person. The correction is then entered and the record checked again for errors. In some instances, the correction of one error can cause another error to surface, and the process must be repeated. The agency will benefit from designing a systematic process for correcting clinical documentation errors which functions efficiently despite clinicians' absences or their inability to return to the office. Revising such processes may indicate the need to review and revise the agency policy for correcting clinical records. This process should clearly define each step, identify responsible persons at each step, and estimate the time allowed for each step. If copies of documentation are submitted for data entry, the procedure will need to include steps to ensure the correction is made in the official agency clinical record as well as in the data submitted to the State agency. As with other process changes, once the process is finalized, it must be rigorously enforced. The agency can monitor its own compliance with the 30-day submission requirement by including this component in the tracking system. The correction policy has not changed and corrections can be made following guidance found on the CMS website. Go to the Survey and Certification page at: http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp. In the left column click on Policies and Memos to State and Regions, scroll to: New Correction Policy for HHAs, Memo # 01-12, posted 04/20/01.

Agencies participating in demonstrations and HHAs who audit their data have noted that the upfront review of assessment documentation by a clinician is worth the effort, due to their effectiveness in reducing clinical documentation errors. It is critical for staff to understand how inaccurate data will affect the agency's outcome reports and payment under PPS, as well as the legal clinical record. Staff need initial education about using the OASIS items in assessing patients, followed by frequent reviews and discussions the first few months. It is a good idea to periodically review appropriate documentation and assessment techniques as well as OASIS items from both legal and clinical perspectives.

When clinical documentation errors are noted, either by supervisory review of documentation or by data entry staff, it is advisable for the supervisory staff to track the frequency and type of errors and to provide prompt constructive feedback to the staff. Feedback can be one-on-one for unique errors or done in a group setting for common, frequently occurring errors. It is equally important to give feedback to the staff when the frequency of a specific type of error decreases. Some clinicians may need more assistance than others during start-up; supervisors should recognize these differing staff needs.

Monitoring for data accuracy should begin during the start-up period and then continue as an integral part of the agency's quality improvement program. Additional information on continuous data accuracy monitoring is found in Chapter 12.

F. PILOT TEST, REVIEW, REVISE

As each procedure or string of related processes is designed, it is critical to conduct small-scale pilot tests that involve only a few staff and limited data. (These tests are often called "mini-pilot" tests.) The best system is derived not only from good and thoughtful design but also results from careful testing, reviewing results, making revisions, and retesting. The cycle of testing, review, and revising should be repeated until the agency is satisfied with the result. It is much easier to revise a process involving only a few staff members than with all staff.

When all procedures have been tested, and as staff members are educated about OASIS implementation, the agency should begin wider scale pilot tests. These pilots should include ALL processes: intake and referral, time frames to complete assessments and submit documentation, review of documentation, ICD coding, and, for all Medicare and Medicaid patients, tracking, data entry, error correction, and time frame for transmission of data. Concurrently, related processes which may also have been revised (e.g., plan of care, processing, telephone orders, billing, filing in medical records, etc.) should be tested. Initially, the agency can begin the pilot test with a few staff, perhaps those involved in the mini-pilots. These staff members also are good candidates to assist with staff education.

Staff members who had key roles in planning and designing the implementation activities must be those available to monitor and evaluate the progress of the pilot test. It is vital to frequently review the results of all parts of the pilot testing, including feedback from staff, and to make necessary revisions. Maintaining close communication with staff about successes and necessary revisions

promotes a feeling of partnership for successful implementation of OASIS data collection and reporting requirements.

FREQUENTLY ASKED QUESTIONS

1. Why is there so much emphasis on tracking of patients? Haven't we always had to do this in providing home care?

Home care agencies have tracked patients for a variety of reasons in the past -- primarily dealing with physician orders. Under the current regulations, more attention must be paid to tracking because the comprehensive assessments, the reporting of patient transfers to an inpatient facility, the submission of assessment data for transmission to the State agency, and billing procedures for Medicare and Medicaid patients, all have associated time requirements. (The requirement for current physician orders also remains.) Agencies participating in various OBQI demonstrations have found tracking to be one of their most thorny issues. Agencies are advised to devote sufficient attention to designing or redesigning tracking systems that will meet the requirements of the regulations.

2. What exactly are "logical inconsistencies" between OASIS items? How can I tell if my clinical staff is making such errors?

Logical inconsistencies are the reporting of health status facts that are contradictory in nature, such as the patient having no skin lesions ***and*** *having a surgical wound. These two facts are not perceived to both be true. Another such inconsistency is the patient discharged to both a hospital and to a nursing home (only one of which can be true at the point of discharge). Still other examples are the comatose patient that is fully independent in ambulation, or the patient who has no pain but whose pain interferes with activity or movement all of the time. Such inconsistencies, when data entered for transmission to the State, generate edit check errors. The data can be corrected when these errors are discovered through use of the edit check program. Because these inconsistencies are relatively obvious, an "upfront review" of the clinical documentation prior to data entry also may reveal their existence.*

FREQUENTLY ASKED QUESTIONS

3. What are the differences between data entry errors and clinical documentation errors?

Data entry errors occur when the person doing data entry inadvertently enters a response that is not found on the clinical record. For example, numbers might be transposed in a birth date (e.g., "12" is entered when "21" appears on the clinical record). Some data entry errors can be detected by edit checks, but others may not (the example above is one that might only be found when patient matching procedures fail to locate a matching record due to birth date error). Clinical documentation errors most often are of the "logical inconsistency" type mentioned in Question 2 above. These errors actually exist in the clinical documentation, which is the patient's legal clinical record. Both types of errors are important to minimize in the processes of data collection and data reporting. The easiest ones to discover are those which actually generate edit checks.

4. Why is it more time consuming to correct clinical documentation errors than data entry errors?

Most agencies require clinical documentation errors to be corrected by the clinician because the patient's record is a legal document that the clinician has signed. Therefore, the clinician must be made aware of the error (either by a person doing the upfront review or by the one running the edit check process) and must make arrangements to correct the error in the clinical record, which then must be corrected in the data entered for reporting to the State. Because it is possible for the correction of one error to generate other errors, the edit check procedure must be run again after data are corrected. If additional errors are discovered, the process must be repeated.

On the other hand, if data entry errors are revealed by the edit check process, it is usually possible for the data entry staff member to correct the errors immediately. There is no time delay associated with such error correction.

ATTACHMENT A TO CHAPTER 9

COMMUNICATION POINTS FOR CONTRACT CLINICAL STAFF

Clinical staff providing patient care under contracts with the home health agency must be informed of new regulations, policies, procedures, and expectations. Depending on agency decisions, the following information points should be discussed with contract staff. Attention to these and other pertinent issues will promote a collaborative effort between contract providers and agencies in achieving compliance through clearly defined and communicated expectations.

- **Clinical and Personnel Policies and Expectations Related to the Comprehensive Assessment**

  a) Requirement for a comprehensive patient assessment and standardized data collection using an OASIS-integrated comprehensive assessment tool at specific time points.

  b) Timeliness of visits requiring completion of the comprehensive assessment (i.e., for start of care, resumption of care, and follow-up).

  c) The time period or number of visits allowed for completion of the start of care comprehensive assessment.

  d) The process for updating the comprehensive assessment at specified time points throughout the patient's care and at agency discharge.

  e) The process and responsibility for patient, caregiver, or physician contact to allow required data collection for transfer and death at home time points.

  f) The agency definition describing situations or conditions constituting "a significant change in condition," to identify consistent and appropriate data collection time points.

  g) Revised paper flow processes.

  h) Monitoring, coordination, and evaluation of services related to conducting the comprehensive assessment or collecting and submitting OASIS data.

  i) Personnel and competency requirements for performance of the comprehensive assessment and OASIS data collection.

j) Definition of minimum clinical staff expectations or demonstrated competency measures relative to the comprehensive assessment.

k) Agency-defined care planning or interdisciplinary referral activities based on findings from the comprehensive assessment and OASIS data collection. (Example: An agency developing or utilizing a tool to identify interdisciplinary referrals based on pre-established scoring responses on particular OASIS items or groups of items, should notify the contract provider regarding this tool and process to facilitate care plan development by contract providers consistent with the agency's policies and practices.)

l) Agency-established procedures to ensure the confidentiality of all patient identifiable information contained within the clinical record, including OASIS data.

m) Procedures for payment for services furnished under contract due to PPS regulations necessitating changes in contractual invoicing or payment procedures.

- **Policies and Procedures Associated with Tracking Inpatient Facility Admissions**

a) Policies related to the status of a hospitalized patient (i.e., "hold" vs. discharged) to allow timely completion of the appropriate OASIS items and coordination of related billing procedures.

- **Policies and Procedures Related to Clinical Documentation**

a) Policies related to timeframes and procedures for submitting clinical notes containing assessment data to facilitate compliance with the data transmission requirements.

b) Policies related to clinical data completeness and accuracy, including the timely accessibility of contracted staff for correction of data errors and omissions to maintain agency compliance with data transmission timeframes.

c) Programs and processes the agency will use for evaluating and ensuring OASIS data accuracy. These processes, which may include clinical record review for data consistency, joint visits for evaluation of assessment and data collection skills, or serial data collection visits for internal interrater reliability activities may affect contract provider duties.

- **Statements of Case Management and Primary Discipline Accountability**

  a) Policies related to the identification of the discipline/provider responsible for conducting the comprehensive assessment and OASIS data collection for therapy-only and multidisciplinary cases.

  b) Policies related to the identification of the discipline/provider responsible for completing the OASIS data collection after unexpected situations (i.e., hospitalization, unforeseen home care discharge, etc.)

  c) Agency policies defining the communication process between care providers throughout the delivery of care in a multidisciplinary case, which are critical in facilitating compliance with data collection requirements. (Examples: Expected and unexpected data updates, patients discharged by individual disciplines in multidiscipline cases.)

  d) The scheduling of patient visits to allow compliance with comprehensive assessment time points and appropriate clinical assessors. (Examples: Role of therapy assistant, accessibility of qualified supervising therapist for unexpected data collection updates.)

ATTACHMENT B TO CHAPTER 9

REVIEWING CURRENT AGENCY PAPER FLOW PROCESS(ES)

EXERCISE:

1. Plot current paper flow process.

   - Using “sticky” notes, write the name of each person or department that handles a document on a “sticky” (one name to a single sticky).
   - Place the stickies on a large piece of paper or poster board in the order that the paper currently follows.
   - Draw connecting lines between the stickies.
   - If desired, estimate the time for each line or in each person’s (or department’s) possession.

2. Examine the process.

   - Identify roadblocks or log jams to the flow.
   - Identify circular steps that require paper to return to an office or department from which it already exited.
   - Identify redundancies (i.e., two people, or departments reviewing something when only one is necessary). Remove the sticky with the redundant name (or department).

3. Re-engineer the process.

   - Move the stickies into a simplified process.
   - Draw connecting lines.
   - Revisit the new process a few hours or days later — does it still appear feasible? Can it be further simplified?
   - Share the new process with others for their input.
   - Make any revisions necessary.
   - Pilot test the process.