

HOME HEALTH QUALITY REPORTING PROGRAM PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 3 AND 4, 2017

Current as of August 2017



PLEASE NOTE: Questions related to topics covered during this webinar that are not included in this document are being reviewed by CMS. This document will be updated at a later time to reflect those responses.

#	Question Category	Question	Proposed Response
1	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	Which item is used in the pressure ulcer measure? M1311 or M1313? What was said today in the Quality Reporting Program (QRP) training was said differently then what has been reported previously.	The item used in the calculation of the quality measure is M1313. We trained on M1311 because understanding how to code M1311 helps to understand how to code new or worsened pressure ulcers at M1313.
2	Data Submission and Reporting	<p>Is there a plan to address all of the statistically “topped out” quality measures that are impacting the star measure ranking of home health agencies (HHAs)?</p> <p>Patients are used to seeing five stars as good (five-star restaurants, hotels, etc.). If the statistical data continues to rise rapidly such as influenza vaccination requiring 100% to achieve a five-star rating, how does a HHA truly report 100%? Is the data being submitted in the QRP truly accurate? Are there other ways to rate HHAs? Potential examples:</p> <ul style="list-style-type: none"> • Include patient satisfaction in just one-star ratings. Is what patients are saying about a HHA more important than data that HHAs submit that could be falsely altered to show better numbers? • Use claim-based information. Is there a way to have a star rating that is more familiar to patients, perhaps something similar to hospitals or skilled nursing facilities? Why is it necessary to use a bell curve? Does it matter that more than 5% of HHAs become five star? 	<p>We evaluate all measures for continued public reporting on Home Health Compare as well as for use in the Quality of Patient Care star ratings. As more measures become available for consideration for use in star ratings, we will evaluate whether replacing them with the existing measures results in a better summary of agency performance.</p> <p>Additional information regarding the Home Health Quality of Patient Care star rating can be accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.</p>
3	Data Submission and Reporting	Can you explain why we see warnings on our validation report showing there was a Health Insurance Prospective Payment System code change from what was originally submitted on the extract file?	This question should be referred to the payment policy staff at HomeHealthPolicy@cms.hhs.gov .

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4	Home Health QRP Requirements, Definitions and Assessments	Is the other follow-up used for risk adjustment?	No, the other follow-up is not used for risk adjustment. Only the SOC and ROC are used for risk adjustment.
5	Home Health QRP Requirements, Definitions and Assessments	What is the best way to be compliant with transfers to an inpatient acute facility when you are unsure if the patient is being held for observation or will be admitted to the inpatient facility?	When a home health patient goes to an inpatient facility, the HHA should make efforts to communicate with the facility to determine the patient status (e.g., whether the patient is admitted as an inpatient or in observation status). Based on information available to the agency at the time of the transfer, a transfer assessment should be completed when the criteria for a qualifying patient admission has been met.
6	Home Health QRP Requirements, Definitions and Assessments	Are star ratings calculated from each quality episode (SOC to ROC and ROC to discharge) or from the time of SOC to the final discharge of the episode?	Star ratings are calculated for all quality episodes: from SOC to transfer, from SOC to discharge, from ROC to transfer, and from ROC to discharge.
7	Other	Can a nurse practitioner following a patient at home sign a clinician's verbal orders, or must a medical doctor cosign it? Can the nurse practitioner order lab tests for patients?	This is a payment policy question that should be referred to HomeHealthPolicy@cms.hhs.gov .
8	Other	When will Interpretive Guidelines be out for the July regulations that are now delayed until January? Having Interpretive Guidelines can assist in policy decisions.	This question is outside the scope of the purpose of this OASIS-C2 training. Please refer your question to Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov .
9	Drug Regimen Review Conducted with Follow-Up for Identified Issues	How should we complete M2003 if the SOC occurs on a Sunday, the registered nurse finds a medication issue, and the physician is unavailable within the 24-hour period?	In completing M2003, select response "1 – Yes" when the two-way communication with the physician or physician designee AND completion of the prescribed/recommended actions have occurred by midnight of the next calendar day after the potential clinically significant medication issues were identified, regardless of the assessment's day of the week or the physician's availability.
10	Drug Regimen Review Conducted with Follow-Up for Identified Issues	During medication reconciliation, how far do we look back when the patient has multiple longstanding medications? What is the CMS regulation on the timeframe?	The Drug Regimen Review should consider all medications that the patient is currently using.

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11	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	<p>Please expand on directing clinicians on using clinical judgement to determine if an issue is clinically significant.</p> <ol style="list-style-type: none"> 1. Our electronic medical record (EMR) has numerous alerts; some are things like “may require dose adjustment.” I would not think that is significant. 2. I would hesitate to recommend clinicians entering all meds into a secondary system or application (increase time, may be more confusing). 3. Physicians are complaining when they are informed about medication combinations the patient has been on for years as an issue. 4. Therapists are especially hesitant not to inform the physician about every alert. 5. Could it be that the physician should be aware of an issue, but may not require the 24-hour timeframe, and therefore is not clinically significant? 	<p>Determination of whether a situation is considered a potential clinically significant medication issue is completely up to the clinical judgement of the assessing clinician. This includes interpreting EMR drug review alerts. It is possible for a clinician to determine the physician should be notified of an issue that does not require the timing of “by midnight of the next calendar day,” and therefore the issue would not meet the definition of a potential clinically significant medication issue as defined for this item.</p>