



Home Care

OUTCOMES

OASIS • Quality Improvement • Coding • Competencies

QIOs begin ‘care transition’ project with home health, other providers

Home health was practically left out of the quality improvement organizations’ (QIO) current 3-year contract, *except* in 14 states, where HHAs have started working with their QIOs on “care transitions.”

The only place in the current QIO contract, which began Aug. 1, 2008, that mentions home health is in the “care transition” theme. It says QIOs will work in 14 states to coordinate care and reduce unnecessary rehospitalizations by improving transitions across settings, including from hospital to home [HCO, 3/08].

The 14 states are Alabama, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, Texas and Washington.

Home health agencies that are working on the transitions theme are at varying stages of the project. Some HHAs have just started meeting with other providers to discuss the challenges of care transitions, while other agencies already are collecting data and applying care transition best practices.

continued on page 2

Medication management becomes a critical requirement in OASIS-C

Ensure your clinicians, including therapists, review and reconcile patients’ medications – this information will be officially captured when OASIS-C is implemented next year.

Medication assessment has been greatly expanded in OASIS-C to include five new questions.

These five questions require the assessing clinicians to document they’ve conducted a thorough medication review, including assessing potential adverse effects (M2000), contacted the physician within one day to reconcile any medication issues (M2002), implemented interventions to resolve any medication issues (M2004) and provided patient and caregiver drug education (M2010, M2015), according to the proposed OASIS-C. [For an update on OASIS-C, see p. 8].

This type of extensive medication assessment is a good nursing practice, but in OASIS-C it will become a requirement that is recorded, says Ann Rambusch, director of home health education and training for DecisionHealth, Gaithersburg, Md.

continued on page 5

**April 2009
Volume 5, Issue 4**

IN THIS ISSUE

- * **Implement a transitions coach, reduce hospital readmissions** 3
- * **Get outcome improvement & OASIS-C assistance** 4
- * **OASIS-C medication items** 5
- * *OASIS Tip of the Month:*
How to handle medication review in ‘therapy only’ cases 6
- * *Coding Corner:*
Diagnoses codes and plan of care should match up 7
- * **Latest Attachment D corrections** 8
- * **CMS revises OASIS-C, will post final version March 13** 8
- * *Tool of the Month:*
Medication review protocol ...Extra

QIOs begin 'care transition' work

...continued from page 1

HHAs actively involved in transitions project

Alacare Home Health and Hospice is among the HHAs working with Alabama's QIO on "patient care transitions," says Tina Reed, director of clinical support services for the Birmingham, Ala.-based company. Alacare worked closely with its QIO during the last contract, so when this project came up, the QIO invited the agency to participate.

The agency thus far has participated in one large meeting with all provider types and attended two one-on-one meetings with its QIO on the topic, says Reed. Her sense is that medication reconciliation is going to be a major focus of the care transitions project.

During those meetings, Reed has provided her thoughts and ideas on how to make transitions across settings successful, she says. For example, from home health's perspective, it finds that patients sometimes misrepresent their living arrangements to hospital discharge planners, so when patients get home they aren't able to manage. Reed told the group it would be

helpful if the home health agency could participate in patients' hospital discharge planning.

Although Reed is unsure of what her agency's role will be in this new contract, "this QIO assistance will be much different than in the last scope of work," she says. There probably won't be as much of the one-one-one assistance the QIO provided in the last contract, but it's still too early to tell, she says.

Other states are further along. Pennsylvania's QIO, for example, has identified the providers it will be working with – 10 HHAs, five hospitals and 18 nursing homes in the western part of the state. These providers have admission and discharge streams to each other, says Naomi Hauser, director of Quality Insights of Pennsylvania's care transitions project.

These particular providers were chosen after the QIO's analysis revealed that their area of the state had the highest hospital readmission rates, Hauser says.

So far, the participating providers have conducted an audit to identify the cause of their rehospitalizations and are in the process of selecting interventions they will use to reduce their acute care hospitalization rate by at least 2%, which is the goal, Hauser says.

Home Care Outcomes Subscriber Services

EDITORIAL STAFF:

Vice President: **Corinne Denlinger**, 301/287-2363
cdenlinger@decisionhealth.com

Editor: **Maria Tsigas**, 301/287-2305
mtsigas@decisionhealth.com

Marketing Manager: **Kim Castaneda**, 301/287-2451
jscott@decisionhealth.com

HAVE AN IDEA FOR A STORY OR A COMMENT ON AN ARTICLE WE'VE PUBLISHED? Send your e-mail to: mtsigas@decisionhealth.com

SUBSCRIPTIONS: Direct questions about newsletter delivery and account status, toll free, to 877-602-3835 or e-mail to: customer@decisionhealth.com.

FREE INTERNET FORUM: To join OASIS-L, our free Internet forum for clinical supervisors and quality managers, go to www.homehealthinteractive.com.

CONFERENCES: *Home Care Outcomes* holds seminars to help you improve the quality of care you provide to patients. For program schedules, e-mail: conference@decisionhealth.com or go to www.homehealthinteractive.com.

ADVERTISING: To inquire about advertising in *HCO*, call Isaac Castro, 301/287-2624.

OUR EDITORIAL PROMISE: We want to provide you with the most accurate, fair and balanced information available anywhere. If you ever feel we're not living up to this standard, we want to know about it. Please call Vice President Corinne Denlinger directly at 301/287-2363.

REPRINTS: To request permission to make photocopy reprints of *Home Care Outcomes* articles, call Peggy Hall, site license account manager, toll-free: 301/287-2453 or e-mail phall@decisionhealth.com. Also ask about our **multiple copy and site license programs**.

COPYRIGHT ENFORCEMENT: Copyright violations will be prosecuted. *Home Care Outcomes* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations contact: Roger Klein, Esq., Howrey & Simon, 1299 Pennsylvania Ave., N.W., Washington, DC 20004-2402. Confidential line: 202/383-6846; e-mail: KleinR@howrey.com.

Home Care Outcomes is published monthly by DecisionHealth, 9737 Washingtonian Blvd., Gaithersburg, MD 20878-7364. Price: \$397/year. Copyright 2007. DecisionHealth is a registered trademark of UCG.



Every provider will submit its hospital readmission rates to the QIO monthly, she adds.

The QIO is developing a transfer form to be used across all settings and also has developed a tool kit for providers, but they can use any interventions they've developed and/or have used in the past, Hauser says. [The tool kit will be posted on the QIO's Web site – www.qipa.org – in the near future.]

"Home health is ahead of the game ... they already have a lot of interventions in place," she says. Home health has been focused on reducing hospitalizations for a long time, long before any other provider.

One HHA ready to implement interventions

Consider A-Touch Home Health Care in Edinburg, Texas, which started meeting with representatives from Texas' QIO, TMF Health Quality Institute, in November 2008 to lay the ground work for the care transitions project, says Katherine Leidner, the agency's director of nursing.

The agency already developed a pilot project, which was implemented in one of its smaller branch offices to "test" the best practice interventions the agency has decided to use, she says. Now the agency is ready to implement those interventions in the rest of its branch offices. One of those interventions includes a hospital risk assessment completed by the nurse at the start of care and at recertification.

The agency also is focusing on improving its medication management best practices, including developing a medication booklet, Leidner says. The booklet contains the patient's medications and serves as a guide for how patients should be taking their medications. The nurse fills out the booklet on admission and updates it accordingly. The booklet can easily be taken along to physician visits and contains the agency's name and contact information so patients can identify which agency is caring for them.

The agency chose most of its materials from the Texas QIO's Web site. These forms are available on TMF's Web site at <http://caretransitions.tmf.org/>.

We need to see the big picture

When it first became clear that the QIOs were leaving home health, "it really bothered me ... I was so used to having this contact all the time," says Sarah Claycomb, owner and administrator of Specialty Home Health Care in Evansville, Ind. Her agency was very involved with its QIO in the last contract.

But now she's realizing that "we need to see the

Implement a transitions coach, reduce hospital readmissions

Use a "transitions coach" to reach across all provider settings and fill in the gaps during patient transitions, and you could improve your acute care hospitalization rate.

This is one of the interventions the Quality Insights of Pennsylvania is implementing in its care transitions project, says Naomi Hauser, director of the QIO's care transitions project.

This strategy doesn't only have to be implemented in the QIO care transitions project, consider implementing some form of this strategy at your home health agency.

A transitions coach is an extension of discharge planning and case management, Hauser says. In reality, many health care providers already are offering this type of service, but not calling it a coach.

The way a transitions coach would work in the care transitions project is the coach would meet and greet the patient in the hospital and notify the patient that within 24 hours of discharge the coach will make a visit to the home, says Hauser.

Many HHAs involved in the project worried that since they already are visiting patients at home after a hospital discharge, providing a coach would be a duplication of services, Hauser says. But it's not a duplication of services because the transitions coach model serves its own purpose, which consists of one hospital visit, one home visit and three follow-up telephone calls.

The coach is not focusing on disease management, but is teaching patients self-management, medication management, and is empowering patients to know how to pull resources from the community, she says.

The challenge in implementing this strategy is finding a coach, Hauser says. Hospitals can't afford to create this new position and home health agencies can't bill for this extra visit. "So we have to get creative [in finding a coach]," Hauser says.

And they did. The Westmoreland County (Pa.) Area of Aging committed to dedicate 3.5 full-time care managers to serve as coaches in the project. And now other counties' Areas of Aging are bidding to also participate in the project. The goal is to have nine coach positions, Hauser says. – *Maria Tsigas* [mtsigas@decisionhealth.com]

big picture and how things work across the whole care continuum.” The only way to improve some of these outcomes, especially acute care hospitalization, is to work with all providers to find solutions, she says.

Her agency, for example, worked intensely on its acute care hospitalization (ACH) outcome in the last QIO contract, even participating in the 2-year national home care collaborative Reducing Acute Care Hospitalization (ReACH). But the agency’s ACH score “still goes up and down,” Claycomb says. Patients are coming out of the hospital sicker and it’s really hard to be successful in keeping them from going back in.

“Home health agencies can’t do it alone ... we can’t keep patients out of the hospital on our own,” adds John Beard, Alacare’s president.

It’s time to shift the emphasis away from home health and back to hospitals and physicians, he says. Efforts need to be made to lessen the communication gaps that are keeping critical patient information from moving across silos.

4 ways to still get outcome assistance

So what happens if you’re in one of the 36 states that aren’t a part of the “care transitions” project? You’re basically on your own when it comes to improving your publicly-reported outcomes and preparing for P4P, says several HHAs.

Agencies from Maryland to Mississippi to California say that since the new contract started, they haven’t heard from their QIO.

“We have not had any contact from [our QIO] since they started their new scope of work,” says Barb Ovenshire, performance improvement manager at FMH Home Health Services in Frederick, Md.

The exclusion of home health in the current QIO contract “has certainly created a void in the home health community,” agrees Cheryl Pacella, quality improvement manager at Hebrew SeniorLife in Canton, Mass. “It is indeed a loss for home care.”

However, although the QIOs are no longer exclusively in home health anymore, there are resources still available to agencies to help them with their outcome improvement efforts, says Pacella, who previously worked for the Massachusetts QIO, Masspro. Consider the following four tips:

1. Access your “trend analysis” reports and view your agency’s OBQI/OBQM reports regularly. You don’t need your QIO to do this; you can access these reports through CASPER, says Pacella. The graphs will help you track potential problem trending

and provide you with actual and risk-adjusted scores. The tool allows agencies to look at how well they are or are not doing with the risk adjustment, she adds.

2. Contact your QIO anyway. Home health staff still may be employed at your state’s QIO and they may be willing to help with quality-related issues, says Pacella. Some of the former home care staff at her Massachusetts QIO continues to work at the QIO, albeit with other providers. Also, Alabama’s QIO told Alacare that if it needed assistance with its outcomes, the agency still could contact the QIO and it would offer any resources they had, adds Reed.

3. Get in touch with your state’s home care association. Some of the state home care associations are stepping up to provide assistance and support to agencies, says Pacella. She remains active in her state’s home care association and has had discussions with them about hosting an OBQI training workshop.

4. Access the numerous resources available free on the Internet. Consider the following Web sites – recommended by Hauser – that provide care transition tools: The Care Transitions Program at www.caretransitions.org; Project BOOST (better outcomes for older adults through safe transitions) at www.hospitalmedicine.org/ResourceRoomRedesign/R_CareTransitions/CT_Home.cfm; and Project RED (Re-Engineered Discharge) at www.bu.edu/fammed/projectred/index.html. – Maria Tsigas [mtsigas@decisionhealth.com]

Get outcome & OASIS-C training

The **5th Annual National Quality Outcomes & OASIS Conference** will provide the best practices and tools to help you improve patient outcomes. Also, this year we’re focusing more intensely on **OASIS-C**, which is set to take effect January 2010.

New dates: The Conference will take place Sept. 14-16, 2009, Loews Vanderbilt Hotel, Nashville.

Conference highlights:

- **Preconference:** How to create, implement and monitor an outcomes improvement action plan, including strategies on how to interpret your outcome reports and target specific outcomes; investigate your care processes, strengths and weaknesses, and identify best practices; and much more.

- **One-and-a-half days of OASIS-C and outcome improvement.** More specifically, learn how to put the OASIS-C process measure items into practice to improve patient outcomes. Get more details <http://www.homehealthinteractive.com/conferences/outcomes/home.htm>.

OASIS-C medication management

...continued from page 1

Although medication review is a part of the Conditions of Participation, one of the Joint Commission's safety initiatives, and is a standard of nursing care, CMS is proposing this information be captured in OASIS-C to "remind" clinicians of the importance of reviewing patients' medications, Rambusch says.

It seems as if CMS believes HHAs could be doing a better job of capturing this information, she adds.

Medication management and reconciliation is a huge issue in home care – it impacts patient safety, says Mary Nugent, director of home health and hospice at BroMenn Home Health and Hospice in Normal, Ill.

Clinicians – through accurate and ongoing medication assessment, reconciliation and education – can reduce avoidable hospitalizations, Nugent adds.

That's probably why CMS added these questions to OASIS-C, to make sure every agency is capturing this critical information, she speculates.

It's really no surprise that CMS would focus on medication management – it's already an area that surveyors hone in on, adds Rambusch.

Although these new questions will add time to the assessment, there are strategies agencies can implement to make the medication review process efficient so that it doesn't become a burden, she says.

Tip: Fax the patient's current medication list to the physician to reconcile patients' medication use, recommends Rambusch. Include a note on the fax that reads, "If we do not hear from you within 24 hours, we will assume these are the medications you want the patient to be on." This strategy is especially helpful when answering M2002, which requires you to contact the physician within *one day* to reconcile any medication issues.

Rambusch implemented this strategy when she was an administrator at a home health agency in South Carolina, and it worked, she says. Her agency served 400 patients and, on average, doctors returned clinicians' calls only 10% of the time. The fax was a life-saver.

OASIS-C medication questions

(M2000) Potential Adverse Effects/Reaction: Does a complete drug regimen review indicate potential clinically significant adverse effects or drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

0 - Not assessed/reviewed [Go to M2010]

1 - No problems found during review [Go to M2010]

2 - Problems found during review

(M2002) Medication Follow-up: Was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

0 - No

1 - Yes

(M2004) Medication Intervention: Since the previous OASIS assessment, was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

0 - No

1 - Yes

NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2010) Patient/Caregiver Drug Education: Has the patient/caregiver received instruction on high-risk medications (such as hypoglycemics and anticoagulants) including monitoring the effectiveness of drug therapy, potential adverse effects, and how and when to report problems that may occur?

0 - No

1 - Yes

NA - Patient not taking any high risk drugs

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed to monitor the effectiveness of drug therapy and potential adverse effects, and how and when to report problems that may occur?

0 - No

1 - Yes

NA - Patient not taking any drugs

Note: These questions are based on the most recent draft of OASIS-C, released November 2008.

Get medication management strategies

When Rambusch was a home health administrator, her agency developed a policy for medication management. The policy was Joint Commission compliant and followed the standard of care regarding medication management, she says.

Below is a list of strategies gleaned from that policy that you can implement at your agency to ensure this standard of care is being conducted regularly, efficiently and accurately:

Who and What

It is the responsibility of a registered nurse to complete a comprehensive review of prescribed and over-the-counter medications and herbal supplements for each patient admitted to the agency, including:

- Potential adverse drug interactions, side effects, and/or contraindications;
- Drug allergies or sensitivities to medications ordered;
- Duplication or omission of medicines taken by the patient (over the counter or prescribed);
- Noncompliance with drug therapy.

How often

At a minimum, patient medications should be assessed/reviewed:

- At the time of the initial assessment;
- Once a week or at every visit if visit frequency is less than once a week;
- Following a physician appointment or visit to the emergency room;
- After a change in patient condition;
- At the time of re-certification;
- Whenever there is concern about medications the patient may/may not be taking.

Important note: All home health visiting personnel (RNs, PTs, PTAs, STs, OTs, COTAs, MSWs and CNAs) are responsible for routine medication queries. All visiting staff should follow a specific medication review protocol during every visit. [For a copy of this protocol, see the enclosed Tool of the Month.]

Ongoing Assessment

Ongoing assessments are made during visits by the registered nurse and include, but are not limited to:

1. Changes in the patient's medications;
2. Patient's compliance with the medication regimen;

3. Patient's response to medication (efficacy);
4. Side effects experienced by the patient;
5. Laboratory values or other diagnostic reports;
6. Needed refills of medications; and
7. Checks of medication containers on refilled prescriptions.

OASIS Tip of the Month:

How to handle medication review in 'therapy only' cases

In 'therapy only' cases, physical therapists should perform the medication review in collaboration with a nurse, say home health experts.

The issue of who is responsible for conducting the medication review for 'therapy only' cases is addressed in CMS' Q&As posted Jan. 21, on the OASIS Certificate and Competency Board Web site.

No specific discipline is identified as exclusively able to perform the medication assessment, CMS says. Each agency must determine the capabilities of its staff members to perform comprehensive medication assessments, taking into account professional standards or practice acts specific to your state, according to CMS' Answer #6.

When physical therapists admit the patient and complete the initial assessment, most agencies will then have a nurse complete the medication review in collaboration with the therapist, says Ann Rambusch, director of home health education for DecisionHealth.

However, in these cases, therapists should be expected to review the patient's medications and fill out the medication sheet, Rambusch says. The medication sheet should include: name of drug, who ordered the medication, what it's being taken for, dose, route and frequency. Also the therapist should ask if the patient is experiencing any problems or side effects due to the medication. Then, the therapist returns that medication sheet to the office and a nurse can conduct a more comprehensive review, she says.

The VNA of Hudson Valley does 'PT only' cases on a regular basis, says John Mackenzie, COS-C, director of rehabilitation services for the Tarrytown, N.Y.-based agency. In these cases, the therapist records the patient's medications and then a nurse reviews the medications. When teaching is needed, the nurse will see the patient. Every patient has a nurse case manager who follows the patient from admission to discharge, and corresponds with the therapist in the field on a regular basis, he adds. – Maria Tsigas

Address patient/caregiver teaching needs

OASIS-C requires clinicians to document that they've assessed the patients' teaching needs and provided the appropriate medication education (M2010, M2015). In answering these items, consider the following strategies:

Assessment of teaching/learning needs

1. Assess the patient's readiness to learn. Evaluate level of sensory and motor deficits: speech, hearing, reading, manual dexterity and swallowing.
2. Assess patient's willingness and motivation to learn. Look for clues of non-adherence or resistance to taking prescribed medication.
3. Identify religious or cultural beliefs that may affect medication administration.

Patient education

1. Prioritize sessions according to safety in medication management.
2. Provide short teaching sessions according to level of patient retention.
3. Provide emotional support and positive reinforcement as needed.
4. Make necessary accommodations for effective learning: good lighting, distraction-free environment and comfortable seating.
5. Provide clear and concise information to the patient with regard to the following:
 - a. Continuing medication for prescribed duration of treatment;
 - b. Possible drug-drug and drug-food interactions;
 - c. Possible side effects and adverse effects;
 - d. Administration precautions;
 - e. When to call the physician; and
 - f. Storage precautions.
6. Provide information about administration aids as needed (ie: medical alert bracelets, warning labels for Coumadin, community resource information).
7. Have patient demonstrate preparation of medication, if appropriate.
8. Have patient describe when to take medication and how much, if appropriate.

Important note: One of the references used in developing these strategies and a good reference to consult on medication management is "Medication Management & the Elderly," by Carol O. Long. – Maria Tsigas [mtsizas@decisionhealth.com]

Coding Corner

Diagnoses codes and plan of care should match up

Despite CMS' latest Attachment D corrections, clinicians still should be addressing patients' comorbidities on the plan of care, which means they should document that the condition is being evaluated, monitored or treated, according to several home health experts and CMS.

In addition to addressing patients' comorbidities on the plan of care, clinicians should document – in the clinical notes – all interventions implemented and the patient's response to those interventions, says Judy Adams, HCS-D, COS-C, of Adams Home Care Consulting in Chapel Hill, N.C.

The diagnoses listed in the OASIS are to be addressed on the plan of care, according to CMS.

But many agencies want to know what "addressed" on the plan of care really means. "Addressed" on the plan of care can just mean the condition is being monitored or evaluated, says Ann Rambusch, HCS-D, director of home health education for DecisionHealth. As long as the patient's condition is being evaluated, monitored or treated, it is appropriate to include it on the plan of care, and to code it on the OASIS.

"The issue is that you can only list diagnoses that are relevant to the plan of care. To me that means you would still show how the diagnosis impacts the plan of care and you might or might not have an actual goal listed," adds Adams.

For example, consider a patient with dementia who is receiving therapy services, Adams notes. One way to show the impact might be to include a notation on the plan of care (POC) that the therapist will monitor for signs and symptoms of dementia that impact the patient's ability to participate in therapy. Or, note in the POC that the therapist will develop a home exercise program incorporating strategies that take into account the patient's level of dementia, says Adams.

"In reality, if you code something, you should at least be monitoring the patient for it. If it may impact the care, the clinician should be watching out for potential changes," adds Lisa Selman-Holman, technical editor for HCO's sister publication *Diagnosis Coding Pro*.

Therefore, it's still worth adjusting your work processes, specifically how your clinicians and coders communicate, to ensure coding accuracy [HCO, 3/09].

Coders should review the plan of care for congruency with the coded diagnoses, to ensure the

diagnoses are addressed in the plan of care, says Rambusch. What that entails is up to the individual agency but an intervention can be minimal, such as monitoring medications, blood pressure and/or symptoms of a worsening condition.

Reversal of original guidance

When CMS first released Attachment D in late December, the new coding guidance caused panic because it allowed comorbidities to be coded only if they were **being actively treated** and **listed** on the plan of care. This contradicted long-held guidance to the contrary, and meant that agencies could lose vital codes that earn additional case-mix points and dollars.

The Feb. 12 corrections reestablish that comorbidities can be coded as secondary diagnoses even if they are not the focus of home health treatment, so long as they affect the patient's responsiveness to treatment and prognosis. **Note:** These codes still should be included on the plan of care, say coding experts.

This move is crucial because it allows clinicians to include codes for comorbid conditions, even those that do not require specific treatment, but need monitoring by the clinician.

"I still recommend that all diagnoses on the OASIS be addressed in the plan of care," says home health care consultant Sharon Molinari, HCS-D, COS-

C, of Las Vegas. "That's good clinical practice and I would think CMS would expect that."

For example, blood pressure should always be assessed for any patient with hypertension and there should be parameters established as to when it should be reported, Molinari says. If it's determined that the comorbidity may affect the patient's responsiveness to treatment and rehabilitative prognosis and therefore is coded, it makes sense that it should be at least monitored and documented. -- *Special contribution by Sara Jackson [sjackson@decisionhealth.com] and Meg Egan Auderset [mauderset@decisionhealth.com]*

CMS revises OASIS-C, will post final version March 13

CMS posted an "incorrect" final version of OASIS-C Feb. 26. The federal agency is removing that document, which contains several errors, from its Web site and will be posting a revised version to the Federal Register March 13.

The revised OASIS-C that will publish March 13 will contain feedback from the public comment period that ended Jan. 13. The Federal Register posting also will contain an OASIS-C crosswalk and CMS' response to the public comments, says a CMS spokesperson.

The revised OASIS-C will go through the rule-making process this spring with an expected January 2010 implementation.

One of the major issues the home health industry raised in their comments to CMS was that the November OASIS-C draft contains several process item questions that ask agencies to "look back" and document that they've implemented specific interventions "since the previous OASIS assessment."

This type of "look back" question appears in all the process measure items, including in the pain, pressure ulcer, diabetes, cardiac, depression, fall risk and medication management items. The industry's hope is that these items are streamlined in the final version of OASIS-C. – *Maria Tsigas*

Editor's Note: *This edition of HCO published March 12 – the day before the revised OASIS-C was set to be released – but don't worry. We will provide you with all the pertinent details and major changes in the new document in a subsequent email. If we do not have your email on file, please contact our customer care department at 877-602-3835, or email me directly at mtsigas@decisionhealth.com.*

Latest Attachment D corrections

✓ The document incorrectly omits specific secondary diagnosis instruction. The correct wording is the following: "Ensure that the secondary diagnosis under consideration includes not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself," according to the Feb. 12 correction.

✓ The document omits the word "or" before the phrase "affect the treatment or care." The correct wording is the following: "Secondary diagnoses, or other diagnoses, are defined as all conditions that coexisted with the primary diagnosis at the time the plan of care was established, or which developed subsequently, or affect the treatment or care of the patient." [View CMS' Attachment D guidance and corrections at <http://www.cms.hhs.gov/Center/HHA.asp>.]