HCAF - Part 5
VALUE BASED PURCHASING

Improving
Oral Medications
Dyspnea
Pain

Presented by:
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Outcomes

- Improvement in Oral Medication Management (OASIS – M2020)
- Improvement in Pain Interfering with Activity (OASIS – M1242)
- Improvement in Dyspnea (OASIS – M1400)

How to Improve Your Scores? Key areas of focus:

- OASIS – Accuracy and Consistency
- Care Management Model (Case Management)
- CASPER Outcome Reports
- QAPI
- Engaging ALL HHA staff
- Education…..Education…..Education….

Improvement in Oral Medication Management (OASIS – M2020)

M2020- Management of Oral Medications:

CASPER current national - Improvement in Oral Medication Management (OASIS – M2020) – 77.8%

__Patient's current ability__ to **prepare** & take __all__ oral meds __reliably & safely__, including administration of the correct dosage at the appropriate times/intervals.

Excludes injectable & IV meds.

(NOTE: this refers to __ability__, not compliance <adherence> or willingness)

0- Able to independently take correct oral meds & proper doses at correct times

1- Able to take meds at correct times if:

a) individual dosages are prepared in advance by another person; OR

b) another person develops a drug diary or chart

2-Able to take meds at correct times if given reminders by another person at the appropriate times

3- Unable to take meds unless administered by another person.

NA- no oral meds prescribed

M2020- Management of Oral Medications:

- Items addresses the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment.
- The patient must be viewed from a holistic perspective in assessing ability to perform medication management.
- Ability can be temporarily or permanently limited by:
  - *physical impairments (for example, limited manual dexterity);*
  - *emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);*
  - *sensory impairments (for example, impaired vision, pain);*
  - *environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).*

M2020- Management of Oral Medications:

- If the patient already sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this, enter Response 0.
- Includes assessment of the patient’s ability:
  - *to obtain the medication from where it is routinely stored*
  - *to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications),*
  - *open the container,*
  - *select the pill/tablet or milliliters of liquid and*
  - *orally ingest it at the correct times.*

M2020- Management of Oral Medications:

Enter Response 2-Able to take meds at correct times if given reminders by another person at the appropriate times IF:

- Daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a “pill planner”)
- A medication is ordered PRN and the medication is needed by the patient on the day of assessment—and the patient needed a reminder to take this PRN medication on the day of assessment

M2020- Management of Oral Medications:

Enter Response 3- Unable to take meds unless administered by another person IF:

- The patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful.
  - *The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely!*

M2020- Management of Oral Medications:

- For a patient residing in an assisted living facility where the facility holds and administers medications:
- M2020 should continue to report the **patient's ability** to take the correct oral medication(s) and proper dosage(s) at the correct times.
- Report ability based on assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, despite the facility's requirement.

How Can We Improve Medications?

- Request patient to gather all drugs, Prescription and OTC, at SOC. This allows assessment of physical ability and safety to get to meds.
- Ask patients to Read the Medication bottles or list – can assess the importance of vision and cognitive state.
- Assess if patient knows what the drugs are for and what to report.
- Ensure all high-risk meds are taught at SOC/ROC visits. Document these drugs by name in clinical note.
- If med planner present, check that is accurately filled for times meds are due.

How Can We Improve Medications?

- Always compare to discharge med list and call on any medication issues at SOC. This includes duplicate drugs and medication interactions. Ensure patient understands the ramifications of duplicate drugs.
- Have every discipline (SN, PT, OT) ask if any med changes at each visit and document if any changes.
- If medication education is documented as needed, requested by physician, or reflected in M2102 c. (checked 2 for medication education needed), then ensure ability to take meds on M2020 & M2030 show the need for education.
- If YOU, the Clinician, makes changes on the SOC visit to improve meds, DO NOT count what you did! The way the patient was when you walked in the home is scored. Then you improved it for the next OASIS timepoint.

Performance Improvement Project (PIP): Medication Management
Example from HHQI

Problem(s):

- Low number of patients improving in management of oral medications, which is impacting patient recovery, outcome reports, Quality of Patient Care Star Ratings and Patient Survey Star Rating (from HHCAHPS)
- Lower medication independence may be leading to higher hospitalization rates.
- Questioning patients' understanding of clinical medication education

Performance Improvement Project (PIP): Medication Management
Example from HHQI

Expected Outcome:

- Increase number of patients who improved the management of their oral medications to **60%** as of [date] (e.g., 4 months post-implementation) as evidenced by

Interventions:

- Educate all clinicians on the use of teach-back with medication education.
- Designated documentation location for using teach-back techniques and patient/caregiver response

Performance Improvement Project (PIP): Medication Management

Example from HHQI

Barriers:

- Clinicians feel rushed to complete requirements during visits.
- Therapists feel uncomfortable with medication education.
- Inconsistencies in clinician's assessments
- Inconsistencies for patient education
- Weak documentation

STAGE	ACTIONS
PLAN:	· Plan clinician education on teach-back with medication education during upcoming team meetings. ○ Provide "10 Elements of Competence for Using Teach-Back Effectively" sheet. ○ Show a short video from YouTube. ○ Designate location in medical record to document teach-back and response.
DO:	• Select a small team including clinician champions to test the education plan with 5 patients. o Provide education session including YouTube video. o Use the HHQI Teach-Back Role Play exercise with education. ○ Ask for initial feedback about teach-back and which patients were tested. ○ Ask staff to try teach-back with one patient each day for the next week and report back any feedback (positive or negative).
CHECK:	· Review documentation in the charts where teach-back was utilized. · Review comments and create talking points to address all feedback and share successes (de-identified patient information) during roll-out.
ACT:	· Modify instructions for documenting teach-back. · Ask the same clinician team to again use teach-back on 8 patients for the next week and provide feedback.

Performance Improvement Project (PIP): Medication Management

Example from HHQI

- Roll-out with small, receptive nursing team to gather constructive feedback.
  - *Create talking points for managers to provide to staff for negative feedback during roll-out.*
  - *After two weeks of testing with the first team, expand to a second nursing team, and continue to roll-out to all teams within the next 30 days.*
- Create a short e-news article about medication "teach-back" at your HHA to go out every two weeks initially for first two months and then monthly for four months.
  - *The article's purpose will be to: communicate consistent messaging about importance of medication teach-back from administration; highlight individual clinicians; how to address barriers encounter with more complex patients; and provide other teach-back resources (e.g., short video clips, short articles).*

Improving Medications - Aides

- Help nurses evaluate med compliance for patients . Be alert for anything a patient or caregiver may say that sounds inconsistent with what is on med list
  - *Example: patient takes pill at times different from med list, report to the nurse or therapist.*
- Let nurse know if you find pills in bed sheets, under bed, etc. when helping patient bathe and dress.
- If pill boxes are in use, scan for any unopened slots and update the patient's nurse
- Patient may feel more comfortable with aide than nurse or therapist about concerns re meds such as side effects.
- DO NOT ASSUME the nurse or therapist is aware of these issues!
- As a member of the interdisciplinary team your role in reporting issues about meds is vital!

Improving Medications - Aides

- Ask patient if they have all their medications and is there anything you need to tell the nurse about the medications?
- Report other factors that you may have noticed when caring for the patient that could impact the ability to safely take medications
  - *Problems with vision (needs new glasses, blurry vision)*
  - *Problems with physical ability (weakness in hands, lacking coordination)*
  - *Difficulty swallowing (chewing, coughing or "spitting up" after taking medications)*
  - *Confusion*
  - *Financial problems (either stated or evident by not enough food or other necessities)*
  - *Patient stating the medication makes them sick*
  - *Patient/caregiver stating fear that the medication may cause addiction*

Improving Frequency of Pain Interfering with Patient's Activity or Movement

M1242- Improvement in Pain Interfering with Activity– CASPER current national - 77.8%

- To improve Pain in your patients, the entire interdisciplinary team caring for the patient must be working together!
- Best Practice: Choose Pain as a team outcome at start of care, have all members focus on this on visits, document, and report to all team members.
- This WILL increase your Pain Outcomes! And have a happier patient, therefore CAHPS will be higher as well!!!

Pain Assessment

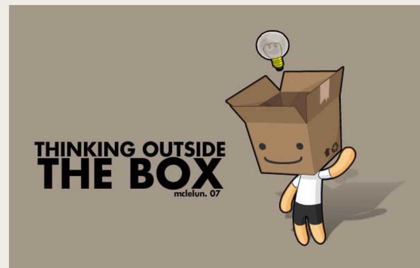
All team members MUST BE thorough in the pain assessments!

- Does the patient take their pain meds? What is the pain then? Etc.
- If pain is not relieved by meds, contact MD

Severe Pain:

- Severe pain is defined according to the scoring system for the tool being used. CMS does not endorse a specific tool.
- Agency must inform staff what rating on scale is Severe! Be consistent !
- 7 is what most use for severe pain.

Interventions for Pain Management



- **Duke University's Pain management in Homecare:**
- **Along with medications, the home health team also gives the patient education to manage the pain at every visit and ways to manage pain without drugs called a "Getaway in a Bag."**
- **The Bag includes opportunities for relaxation, aroma and guided imagery therapies, as well as a squeeze ball and cuddly item for general comfort"**
- **This helps the patient and caregiver to also Think Outside the Box in dealing with pain & gets the patient more connected to the mind/body/spirit!**

M1242 ($) Frequency of Pain interfering with Patient's Activity or Movement

- Intent indicates that Interference in activities does not just include ADL's,
  - e.g. sleeping, watching TV, recreational activities
- Look at the frequency with which pain interferes with patient's activities, with treatments,
- Pain interferes with activity when pain results in
  - *activity being performed less often than otherwise desired,*
  - *required the patient to have additional assistance in performing the activity,*
  - *or causes the activity to take longer to complete.*

Pain Management ZONES [Insert Agency Logo]

References: Lewis, Dirksen, Heitkemper, & Bucher, (2014) *Medical-Surgical Nursing: Assessment and Management of Clinical Problems*, 9th Edition; WebMD, 2014; CHAMP-Advancing Home Health Care Excellence for Older People, 2009

Zone		
GREEN ZONE	**ALL CLEAR (GOAL)** • Your comfort level is _____ (0 - 10 scale where 0 = no pain and 10 = worse pain ever had) • You are able to do basic activities and rest comfortably • You do not have any new pain • If you're taking opioid pain medication, your bowels are moving at least every 2 - 3 days	**Doing Great!** • You are managing your pain at an acceptable level for you • Actions: ○ Continue your medicines as ordered ○ Continue ____________(ice, heat, therapy, etc.) along with your medicines ○ Keep all doctor visits ○ Continue regular exercise as prescribed
YELLOW ZONE	**CAUTION (WARNING)** **If you have any of the following:** • Pain that is not at your comfort level with your usual treatments • You are not able to do basic activities or rest comfortably • New pain you have never had before • If you are taking opioid medication, your bowels have not moved in 2 - 3 days • You are sleeping more than usual • You feel sick at your stomach • You cannot take your medicine	**Act Today!** • Your pain control plan may need to be changed • Actions: ○ Call **your home health nurse** ____________________ *(agency's phone number)* ○ Or call **your doctor** ____________________ *(doctor's phone number)*
RED ZONE	**EMERGENCY** • You cannot get any relief from your usual treatments • You have new, severe pain • If you are taking opioid pain medication, your bowels have not moved for more than 3 days • You are extremely sleepy • You are throwing up • You are confused	**Act NOW!** • You or your family need to call your nurse or doctor right away • Actions: ○ **Call your home health nurse** ____________________ *(agency's phone number)* ○ **OR call your doctor right away** ____________________ *(doctor's phone number)*

HHQI

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Pain – QAPI Indicator

- Review 20% (or higher if your outcome in pain is lower than national) clinical records quarterly to ascertain if pain improved, stayed the same or declined
- For all that declined, do detailed audit to be able to drill down! Need to see if your agency could have done more to improve the patients pain.
  - *For those that stayed the same, may have a streamlined audit.*
- Look at visit notes to identify if all clinicians are completing a thorough pain assessment every visit and WHAT they are doing if patient's pain is not improving!

Pain – QAPI Indicator

- Share results with all field staff
- Choose a Pain task force of various disciplines
- Brainstorm to think outside the box generally and patient specific
- Identify if :
  - *Therapy is not sufficiently utilized*
  - *Team is not reporting signs/symptoms of pain and/or ineffectiveness of pain meds*
  - *Early intervention is utilized by team*
  - *Physician is contacted when pain is not improving*
  - *Sufficient education is performed*

Improving Dyspnea

M1400- When is the Patient Dyspneic or Noticeably Short of Breath?
CASPER current national - Improvement in Dyspnea– 77.9%

- **Timing – 24 hours preceding assessment and during the assessment**
- Use clinical judgment to determine the level of effort required to complete a task. Particularly distinguishing between minimal and moderate for eating, talking, etc. consider the effort required.
- If patient is on O2, if continuous assess patient while using O2, if O2 is intermittent, assess patient without O2
- TUG can be used to assess walking 20 feet or more
- Also use ADLs to assess dyspnea
- If patient is only SOB when supine, pick response 4- at rest
- If patient modifies environment and is not dyspneic because of this for more than 24 hour period, then pick 0

Pulmonary Rehabilitation

An evidence based intervention done over the years in health care and homecare

- Multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased ADL's
- Integrated into the individualized treatment of the patient, pulmonary rehabilitation is designed to reduce symptoms, optimize functional status, increase patient participation, and reduce healthcare costs through stabilizing or reversing manifestations of the disease." American Thoracic Society (ATS) Statement on Pulmonary Rehabilitation
- Has been shown to significantly reduce hospital admissions, ED use, and unscheduled MD visits

Pulmonary Rehab Programs can Include:

- Exercise training- Patients at all stages of disease benefit from exercise training programs, with improvements in exercise tolerance and symptoms of dyspnea and fatigue.
- Individually tailored and supervised walking & arm exercise program for homebound elderly
- Home based PR program can include stationery bike, upper extremity exercise and stretching, along with education
- 6 minute walk test

Education

- PR programs use a combination of teaching, counseling, and behavior modification techniques to promote self care management skills

Expected Outcomes

- Improved exercise tolerance as measured by increased distance walked during a 6 minute time period from baseline to discharge.
- Improved knowledge of disease and management strategies
- Improved score on OASIS ADL's and IADL's
- Improvement in Dyspnea in M1400

Clinical Interventions – Nursing
Comprehensive Assessment Includes:

- Current knowledge of disease
- Medical diagnoses associated with dyspnea- Ex: COPD, asthma, pneumonia, heart failure, TB, pulmonary embolism, panic attacks
- Recent surgical history contributing to dyspnea- Ex: cardiothoracic or other major surgeries
- Past patterns of health care use- Ex: frequent ER visits
- Patient perception of exacerbations and contributing factors
- Nutritional status: Meal pattern, weight history (recent loss/gain), use of vitamins/nutritional supplements
  - *Avoid activity that requires energy for 1 hour after eating*
- Medications- knowledge/adherence including use of oxygen and inhaled medications (frequency, effectiveness)

Detailed Respiratory Assessment

- Respiratory rate, rhythm, depth - Observe for chest symmetry, use of accessory muscles, nasal flaring; Observe for cough, sputum production
- Use of breathing techniques such as pursed lip or diaphragmatic breathing
- Breath sounds -Presence of crackles, wheezes (inspiratory, expiratory), rhonchi, pleural rub
- Tenor of voice, skin color, Nail color, Capillary refill time, clubbing
- History/impact of environmental factors- Ex: mold, mildew, dust, temperature extremes, occupational, industrial exposures
  - *Current environmental factors evident in home or reported by patient*
- Smoking history- # cigarettes/cigars per day; history of smoking cessation attempts/successes

Comprehensive Assessment Visit

- To the extent possible, the clinician will encourage performance of tasks necessary to enhance patient assessment and scoring of dyspnea
- Each time the patient becomes dyspneic, the clinician will note the activity or situation occurring with the dyspneic episode, and document so the team can develop goals and outcomes.
- At the end of the assessment, the clinician will review the activities or situations which resulted in dyspnea, and get the most accurate score.

Clinical Interventions Physical Therapist

Comprehensive Assessment includes:

- 6 minute walk test – first and last visit
- Patient understanding of the role of exercise in decreasing shortness of breath, strengthening LE and increasing endurance
- Use of primary vs accessory muscles in breathing level of dyspnea
- Development and implementation of home exercise program focusing on LE strengthening

Clinical Interventions Occupational Therapist

- Assessment
- Patient understanding & use of energy conservation and work simplification techniques
- Teaching of energy conservation techniques
- Level of ADL/IADL independence projection
- Level of dyspnea improvement projection
- Development and implementation of home exercise program focusing on UE

Case Management for Respiratory Management and Improved Outcomes

- SN, PT, OT visits on alternate days- Be each other's Eyes & Ears!
- Educate Aide to call RN for sign/symptoms individualized for this patient
- Telephone calls on days without visits AND/OR at different time of visit –
  - *Example: PT visit at 9am – patient potentially slightly worsening signs- RN call at 2 pm, then make visit and/or notify physician*
- MUST stay on Top of Respiratory patients to keep them out of the ER and to improve their dyspnea!

Teaching Topics

- Breathing retraining strategies
- Pathophysiology- Disease Self-care Management
- Proper use of medications
- Benefits of exercise
- Energy conservation
- Secretion clearance strategies
- Smoking cessation: *the single most effective intervention in reducing risk of development/progression of COPD*
- Eating right
- Avoidance of respiratory irritants
- Relaxation techniques
- Prevention/treatment of exacerbations (Action Plan)
- When to call the home care agency, MD, 911 - early symptom recognition & actions to take

What to tell the patient they can expect:

- Improve your ability to exercise
- Decrease shortness of breath with activity
- Improve your understanding of shortness of breath and disease and how to manage it better
- Give you a Better Quality of Life so you can do more of what you want to do"

EXACERBATION PREVENTION STRATEGIES

- *Primary causes of exacerbation include tracheobronchial infection and environmental factors but in about 1/3 of cases, the cause is unknown.*
- Annual flu vaccine: *flu vaccines can reduce serious illness and death in COPD by about 50%*
- Pnemococcal vaccine at least once
- Reduce risk of infection
  - *Wash hands frequently*
  - *Avoid crowds– especially during season of increased prevalence of cold and upper respiratory infections*
  - *Reduce exposure to irritants- Monitor air quality alerts; stay indoors if air quality poor*
  - *Avoid extreme temperatures*
  - *Avoid tobacco smoke exposure*
- Eat a balanced diet, adequate sleep, ↑ activity/exercise

Energy Conservation: Purpose- To provide techniques to maximize patient function while minimizing limiting dyspnea and/or fatigue

Patient whose ADLs are limited by dyspnea will be provided energy conservation instruction to improve comfort and maximize functional status.

STRATEGIES:

- **Ambulation:** Walk slowly; Have chairs placed throughout home to allow rest stops; Use a rolling cart to transport items, instead of carrying
- **Bathing:** bath bench, handheld shower head, and adaptive equipment like long-handled sponges or brushes. Consider sponge bathing. Use a terrycloth robe to help dry off after bathing
- **Dressing:** Use slip on shoes, shoes with elastic laces; Dressing aids (sock aid, shoe horn, dressing stick, reacher, etc.). Put underwear inside pants or skirt, and pull them on together; Dress seated instead of standing; Avoid clothes that are tight, or have many buttons, etc.
- **Grooming:** grooming tasks seated; low-maintenance hair styles; hair air dry, or use hair dryer cap instead of a blow dryer
- **Toileting:** Avoid waiting to toilet, which might cause rushing & anxiety

Energy Conservation Strategies - General

- Plan Ahead & Get Organized, so you can function in at a slow and comfortable pace
- Organize your daily routines, alternating easy and more demanding activities
- Organize “work centers” so all necessary equipment is readily available
- Simplify tasks as much as possible (i.e. prepare light meals)
- Consider eliminating unnecessary tasks (especially those that stress you out!)
- Prepare for activities by resting and performing breathing exercises
- When possible:
  - *Complete tasks using larger muscle groups (i.e., legs vs. arms)*
  - *Use both hands to complete tasks (i.e., lifting or pushing)*
- Keep room temperature comfortable
- Recognize when you need help, and ask.

Discharge OASIS Assessment

- Take the Time to do the full comprehensive assessment with the patient so that you can "SEE" the patient in Action:
  - *Accurate level of dyspnea*
  - *Pain improvement with activities*
  - *Medication knowledge and ability*
- Remember, outcomes are from SOC to ROC to Transfer or DISCHARGE!
- Work as a Team to increase patient outcomes!

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