Home Health Line

Regulatory news, benchmarks and best practices to build profitable home care agencies

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IN THIS ISSUE

2019 Trends Report

Prepare for PDGM

Faster documentation will be crucial to success under PDGM: Prepare now

Make completing documentation in the home a requirement for all clinicians. Doing so will improve coordination of care and speed up the billing process — a key to survival under the Patient-Driven Groupings Model (PDGM).

Picking up the pace on documentation is one strategy experts recommend to help agencies improve operations before PDGM takes effect on or after Jan. 1, 2020.

PDGM is the regulatory change expected to have the biggest impact on agencies' operations and financials in 2019,

*(see **PDGM**, p. 6)*

OASIS-D

OASIS-D among changes expected to have biggest impact on agencies in 2019

Agencies should continue efforts to get clinicians comfortable with OASIS-D as 2019 unfolds.

Focus on doing so will be especially important because OASIS-D is one of the regulatory changes expected to have the biggest impact on home health agencies' operations and financials in 2019, according to 184 respondents to a question on *HHL's* 2019 Trends Survey. *(See benchmark, p. 8.)*

*(see **OASIS-D**, p. 9)*

Key steps to survive OASIS-D

Ensure your agency is fully prepared and poised for success for the upcoming launch of OASIS-D. During a 1 p.m. to 2:30 p.m. EST Jan. 10 replay event — featuring live Q&As with industry expert Arlynn Hansell — receive the latest guidance CMS provided about OASIS-D and learn how to prepare your agency for the revised assessment. Sign up at http://store.decisionhealth.com/final-countdown-to-oasis-d-011019.

Claims reviews

A year's worth of data show agencies fared poorly in targeted probe and educate

Newly released data show a massive percentage of agencies participating in CMS' targeted probe-and-educate review have failed "Probe 1." Industry experts expect agencies to continue struggling with the claims reviews in 2019.

In a year's worth of data for the review, 65.9% of agencies with either Palmetto GBA or CGS as their Medicare Administrative Contractor (MAC) were deemed noncompliant in Probe 1. The data show that 497 of 754 agencies participating in the probe with those MACs failed the probe from Oct. 1, 2017, through Sept. 30, 2018.

Results are far worse when only CGS' data is considered over the same timeframe.

With CGS, 97.5% of agencies (197 of 202) in the probe were deemed noncompliant.

Joe Osentoski, reimbursement recovery and appeals director with Quality in Real Time (QIRT) of Floral Park, N.Y., was disheartened by the data.

"I get that these agencies are targeted for a reason. But wow, that's an astounding noncompliance percentage," he says. "You'd think somebody would just luck into compliance."

Face-to-face issues have been a problem for the industry for years, and they remain a problem.

5FF2F/5TF2F — face-to-face encounter requirements not met — was Palmetto's top denial reason for review participants.

Other top denial reasons, such as issues with physician signatures, also have been a longtime problem.

"The industry is stuck in a pattern," Osentoski says. "Whether it's probe and educate or targeted probe and educate, the same issues come up. I don't see progress in agency compliance, and I don't see progress in the main areas of noncompliance. To me, I don't see that targeted probe and educate has been a success for what it wants to be — that you target specific agencies, you provide education, you see improvement."

Palmetto had 552 home health agencies in Probe 1 of targeted probe and educate from Oct. 1, 2017, through Sept. 30, 2018. Among those agencies, 252 were compliant and 300 were noncompliant.

In other words, 54% of agencies in the probe had an error rate of 21% to 100%.

The vast majority of Palmetto's agencies to participate in Probe 1 thus far were based in Texas. There, 225 of 430 agencies that were in the probe were noncompliant.

How does the probe work?

There are several reasons why agencies may be asked to participate in the targeted probe-and-educate review. Among them: Struggles through two rounds of the prior home health probe-and-educate review, failure to respond

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to additional documentation requests (ADRs) and having "aberrancies" suggesting questionable billing practices.

Many agencies will receive 20 to 40 ADRs during the targeted probe-and-educate review's first round. They'll be part of up to three rounds if they don't achieve success *(HHL 5/28/18)*.

And agencies that show a high percentage error rate and no effort to get payments under control during the reviews could face extrapolation, referral to a Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC), 100% prepay review or referral to the recovery auditor (RAC), according to CMS *(HHL 2/12/18)*.

With such high denial rates in Probe 1 — such as those for CGS agencies — it's likely many providers won't succeed through Probe 1, 2 and 3, industry experts say.

Agencies that fail all three rounds "would then have an asterisk next to their name, as if they have been found to be fraudulent," contends Annette Lee, owner of Provider Insights Inc. in Des Moines, Iowa. "And we all know that there are a few bad apples — but not 97.5%."

Avoid the top denials under the probe

- **Review your processes.** "Agencies need to have a process in place that ensures the physician encounters include assessment information related to primary diagnosis along with the certifying physician acknowledging the encounter date and that he has received a copy," says Diane Link, director of clinical services for BlackTree Healthcare Consulting in Conshohocken, Pa. "Without a process and corresponding internal auditing, agencies will continue to run risk of noncompliance."

- **Ensure you submit adequate documentation of a face-to-face encounter.** "An agency should have a face-to-face-specific review at the time of admission to see if all the requirements are met for it," Osentoski says. "You really can't correct it once you're past 30 days after admission."

- **Make sure there is a physician recertification estimate for episodes prior to Jan. 1, 2019.** Seeking to eliminate what it considers an unnecessary burden, CMS is removing its requirement that certifying physicians must estimate in home health recertifications how much longer skilled services will be necessary *(HHL 7/16/18)*. But that change is only effective beginning Jan. 1, 2019, and beyond.

- **Triple check that signatures are dated.** Undated physician signatures remain a common problem for agencies, Osentoski says.

At Palmetto GBA, the third-most common denial reason in the targeted probe-and-educate review is 5F072/5T072 — no physician's order for services or more than ordered. Palmetto explains that these denials occur because Medicare requires all services (including discipline, duration, frequency, treatment, legible, signed/dated appropriately) be ordered by a physician. — *Josh Poltilove* (*jpoltilove@decisionhealth.com*)

Related links: *View Palmetto's data at https://bit.ly/2QtwXIh and CGS' data at https://bit.ly/2Bp7wgu.*

Regulatory compliance

Experts: Blue wave drowns GOP agenda in Congress for 2019

As you might expect now that Democrats have taken control of the House and Republicans have retained control of the Senate, health policy experts predict gridlock will slow legislative action on national health care policy.

But expect the administration to stay busy — and maybe get busier — in the regulatory arena in ways that will affect you and your patients.

The midterm elections in November 2018 left the House in the hands of Democrats for the first time since 2010. Also notably, 24 health professionals ran for Congress and 18 were elected — including former HHS Secretary Donna Shalala, says Monica Hon, vice president of Mokeno, Ill., health care consultancy The Advis Group.

For the home health industry in 2019, a major effort is underway is to get behavioral assumptions removed from the Patient-Driven Groupings Model (PDGM), which launches on or after Jan. 1, 2020.

While PDGM is budget neutral, CMS assumes agencies will take several steps to adapt including increasing the number of visits they provide in an attempt to avoid a LUPA.

Without behavioral assumptions, CMS estimated the 30-day payment amount needed to achieve budget neutrality under PDGM would be $1,873.91 *(HHL 11/12/18)*. But with assumptions, the 30-day payment amount is estimated to be $1,753.68 (6.42% less).

Legislation to stop behavioral assumptions is "neither terribly partisan nor very expensive," contends attorney

Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman.

But the home health industry in general has difficulty getting legislation through Congress, he notes. And beginning Jan. 1, 2019, Congress likely will become gridlocked.

Removing assumptions "is the sort of legislation that could get bipartisan support, but with the level of partisanship at an all-time high and the likelihood it will increase in January, I fear that even unobjectionable legislation will find it hard to move forward," he says.

In general, Markette doesn't expect Congress to accomplish much in the next few years other than the Senate confirming appointees including judges.

"That would mean we shouldn't expect Congress to do anything to help," he says. "But they will also be prevented from doing much harm."

What about the Affordable Care Act?

In December 2018, a federal judge in Texas struck down the Affordable Care Act (ACA), stating that the individual mandate is unconstitutional and as a result the rest of the ACA can't exist. That ruling is expected to be appealed, and in the meantime the ACA remains in place.

Assuming attempts to strike down the ACA fail in the court system, experts are nearly unanimous that a revival of the Trump administration's efforts to kill the Affordable Care Act (ACA) is off the table until January 2021 at least.

"There is no chance a repeal-and-replace effort would succeed in the House under new leadership," says Hector de la Torre, executive director of the Transamerica Center for Health Studies in Los Angeles.

But some hold out hope for compromise.

Hon is monitoring one bill that would restore some of the recent cuts to Medicare. She also anticipates "additional bills aimed at nullifying other recent cuts to the health care industry."

Rosemarie Day, CEO and founder of Day Health Strategies in Somerville, Mass., points to bipartisan hearings held by Patty Murray, D-Wash., and Lamar Alexander, R-Tenn., last fall to come up with legislation to stabilize the ACA markets that had been destabilized by the actions of the Trump administration.

Though legislation from Murray and Alexander collapsed and was followed by the Republican tax bill that got rid of the ACA's individual mandate, Day and other experts think it may be revived in the next term.

San Francisco-based management consultant Etienne Deffarges notes that the day after the election, Republican Senate Majority Leader Mitch McConnell "suggested that lawmakers should now address the flaws in the ACA, instead of attempting to repeal it, 'on a bipartisan basis.'"

Gavel power

Not all government action depends on compromise between the parties. The Democrats now have more options to squeeze the administration in the court of public opinion.

With the government divided, "we'll see lots of headlines and very little if any [health care] legislation," says John J. Kelliher, managing director of the Berkeley Research Group in Washington, D.C. "Democrats will hold lots of hearings. Many of these will be about [President Donald] Trump's business dealings and Russia, but I expect they'll also have hearings on health care policy issues — such as the exchanges, Medicare for All, drug prices, etc."

Day sees the House leadership conducting oversight hearings and perhaps even introducing budget legislation — because, as Hon points out, Congress "controls the purse strings" — that "could try and undo some of the ACA changes CMS has put in."

HHS still pushing

In the other direction, health care experts see the Trump administration staying very busy on regulations that will conflict with the Democratic agenda.

"HHS works for and is responsive to the executive branch," say Deane Waldman, M.D., director for the Center for Health Care Policy of the Texas Public Policy Foundation.

He points to the administration's recent efforts to encourage states to institute Medicaid work requirements as an example of its "posture of devolving Medicaid control to the state level."

He expects that to continue and further expand.

"The administration will be at least as bold if not more bold than before" in regulation, Kelliher says.

"You've seen their recent rules on home health, SNFs [skilled nursing facilities], 340B drug pricing — these are all bold regulatory moves," Kelliher says. "You'll continue to see them use their regulatory authority in payment

reform at the Innovation Center. … Expect to see more ambitious demonstration models" that promote reforms.

Meanwhile back in the states

But a lot of the post-election action on health reform isn't really coming from Washington D.C., Deffarges says.

Three Republican states — Idaho, Utah and Nebraska — approved referenda on Medicaid expansion under the ACA, and three other states — Kansas, Wisconsin and Maine — elected Democratic governors whose predecessors had blocked Medicaid expansion and who can now be expected to approve it.

Also, Day notes, states such as California are working on their own more localized versions of the ACA, including in-state individual mandates. — *Roy Edroso* (*redroso@decisionhealth.com*) *and Josh Poltilove* (*jpoltilove@decisionhealth.com*)

Mergers & acquisitions

Active year for mergers & acquisitions; small agencies continue to struggle

Merger-and-acquisition activity in the home health market remained hot in 2018, with some of the biggest deals the industry has seen. And experts predict that as more Baby Boomers move into their 70s, the demand for home health and related businesses will continue — but that smaller agencies will continue to struggle and disappear.

As the industry deals with alternative payment models including bundling and value-based purchasing, and with the explosion of Medicare Advantage and now Medicaid Advantage, the home health market will likely see "more energy and urgency" around mergers and acquisitions through 2019, says Mark Kulik, managing director at Pittsburgh-based mergers and acquisitions advisory firm The Braff Group.

According to Kulik, 2018 yielded about the same number of mergers and acquisitions as 2017, which closed out the year with 134 home health, hospice, Medicaid and private duty deals. But the scale of the 2018 deals is even larger.

In fact, 2018 was the busiest year Simione Healthcare Consultants in Hamden, Conn., has ever had when it came to mergers and acquisitions — particularly with the size and scope of the deals expanding, says David Berman, Simione's principal of mergers and acquisitions.

"Where three, four or five years ago we saw the occasional $100 million deal, the deals we're working on now are significantly bigger in size, multi-state, multi-provider and multi-vertical," Berman says.

Some deals were in the billions

The biggest acquisition was the sale of Kindred at Home to Louisville, Ky.-based Humana. The $4.1 billion deal was finalized in July 2018, with Humana taking a 40% stake in Kindred's home care business and two other private equity firms picking up the other 60%.

That acquisition is the first time an insurer has made a solid investment in the home health market, and according to Humana, provides the company with an approximately 65% home health geographical overlap with its Medicare Advantage members.

The same Humana-led group also announced a $1.4 billion deal in April 2018 to acquire hospice operator Curo Health Services of Moorseville, N.C.

Kulik says the Humana acquisition is a game changer in the industry.

"It's the first time we've had a major insurance company buying into home health and hospice," he says. "It certainly points to their strategy that it's important enough to spend money to focus on this particular service area."

Other big deals in 2018 included the March merger between home health giants LHC Group Inc., of Lafayette La., and Louisville, Ky.-based Almost Family, Inc., to create the second-largest in-home health care provider in the U.S.; and the April merger between Great Lakes Caring, National Home Health Care and Jordan Health Services, which together become the fourth-largest home-based care provider in the country with combined revenues of $1 billion.

Expect more big booms

Berman sees the home health industry continuing to boom. Although payment changes are on the horizon with the 2020 implementation of the Patient Driven Groupings Model (PDGM), Berman says PDGM thus far has had little effect on movement in the home health market — unlike CMS' prior proposal for a Home Health Groupings Model (HHGM), which Berman says caused some buyers to hesitate.

PDGM's budget neutrality is creating "a little more comfort for the buyers," he says.

Berman also hasn't seen the revised Home Health Conditions of Participation (CoPs) impact buyer interest in the home health market.

It has, however, made smaller providers consider merging with neighbors or putting themselves on the market.

"The cost for a sole proprietor to keep up with the regulations and state compliance is getting more extensive, and getting harder," Berman says. "That's why we're seeing not only acquisitions growing but the merger market growing as well."

Investors have been highly strategic

Another 2018 trend in the home health marketplace was the highly strategic approach investors have taken.

"Buyers are very disciplined in this market," says Jack Eskenazi Jr., managing partner of Healthcare Advisory Partners, based in Soquel, Calif. "It's not just consolidation to aggregate size; [investors are] considering the needs for a particular service in a particular geographical area."

Another trend that is likely to continue is more private equity companies getting into the game by building pure-play companies — those that focus on just one particular part of home care — into powerhouses that they can then divest to strategic buyers for a higher premium, Eskenazi says.

Eskenazi also believes the regulatory environment favors larger players and is taking a toll on smaller agencies because risk-based compensation requires a certain scale, and with fewer patients referred to smaller agencies through that model, "the pie for smaller providers keeps getting smaller."

Do this to succeed in active market

- **Find a unique aspect of your business that you can bring to referral sources.** For larger agencies looking for a strategic acquisition, seek out agencies that have a marketable specialty that would make a good partner, Kulik advises.
- **Make compliance a top priority, particularly if you're looking to sell.** Kulik is wary of PDGM's implementation and predicts a brief slowing of activity in 2019. He recommends agency owners who are ready to retire or exit to evaluate their compliance and get on the market — or else be prepared to wait five years to get beyond PDGM.
- **Create a solid integration plan.** The biggest mistake in mergers and acquisitions is a lack of a plan to combine all the business aspects of different home health companies, Berman says. He says a plan on how to integrate, with a big focus on employee relations, is crucial.

"Without the staff, you can't provide the care," he says. "Having a solid communication plan with the staff of an acquired entity is key." — *Angela Childers* (*angela.childers@gmail.com*)

PDGM

(continued from p. 1)

according to 184 respondents to a question on *HHL's* 2019 Trends Survey. *(See benchmark, p. 8.)*

To succeed under PDGM, clinicians should complete documentation within 30 minutes of leaving the home, contends Laura Page-Greifinger, president/CEO of Quality In Real Time (QIRT) in Floral Park, N.Y.

While some agencies may see this as an aggressive goal, it is an attainable and important one, Page-Greifinger says.

Lack of complete documentation is one of the biggest delays in billing, according to Todd Montigney, managing principal with BlackTree Healthcare Consulting in Conshohocken, Pa.

These delays will be more keenly felt under PDGM because the new payment model shifts to 30-day payment periods, essentially halving the time agencies have to bill.

Many agencies currently allow clinicians to provide documentation 24 to 48 hours after an initial visit, and some agencies allow three to five days to submit visit notes for regular visits that happen after OASIS completion, Page-Greifinger says.

That lag time between visit and complete documentation slows back office operations, including billing, Montigney says.

These bad practices must end "or you're going to have issues under PDGM, and those are money issues," Page-Greifinger says.

Documentation delays put people at risk

Speeding up the documentation process is also important for reducing errors.

"The longer you go from assessment to charting, the more accuracy you lose," says Kristi Bajer, vice

president of clinical operations with Socorro, N.M.-based OperaCare.

And home health is the only health setting "that allows people to do documentation after the fact," Page-Greifinger says.

Accuracy is a benefit of in-home documentation that April Busbee, owner of Wyoming-based Cowboy Cares, has seen firsthand. The agency has worked to get all clinicians to chart in the home.

"It's stronger documentation because they are doing it when it's fresh in their minds," Busbee says.

Not only does accuracy suffer when clinicians document after the fact, but so does patient care and staff collaboration.

If there are no visit notes or documentation available for the patient days after the start-of-care visit, everyone on the care team is operating blindly, Page-Greifinger says. Lack of documentation also can prevent the completion and implementation of the plan of care, all of which puts the patient at risk.

For some agencies, it can take a full two weeks to get the plan of care together, Bajer says. While she acknowledges this isn't good standard of practice and shouldn't be the case even under the current PPS, "we do have 60 days and can usually turn it around."

But if this kind of delay happens under PDGM, half the payment period would be spent without addressing the plan of care.

"If you have the plan of care locked when you leave [the home] and start interventions, you will have better outcomes," Bajer says.

There's another reason delays could pose an even bigger risk under PDGM, Page-Greifinger says.

PDGM assigns higher case-mix weights to patients admitted from a hospital or other facility and to patients who have serious illnesses, injuries or medical conditions requiring frequent skilled care to bridge the transition from institution to home *(HHL 9/24/18)*. This may motivate agencies to take on more patients in those categories.

"To have no documentation available [for those patients] is really going to cause risk down the line," Page-Greifinger says.

Expedite in-home documentation

- **Update your agency's policy.** Establish when you expect clinicians to have visit documentation complete. The policy also should include what disciplinary actions your agency will take if clinicians don't meet this requirement.
- **Start with a small group.** Reducing the required timeframe for documentation likely will involve a culture shift. Make changes in small increments and start with a few select clinicians before rolling the new expectations out to staff as a whole, Page-Greifinger suggests.

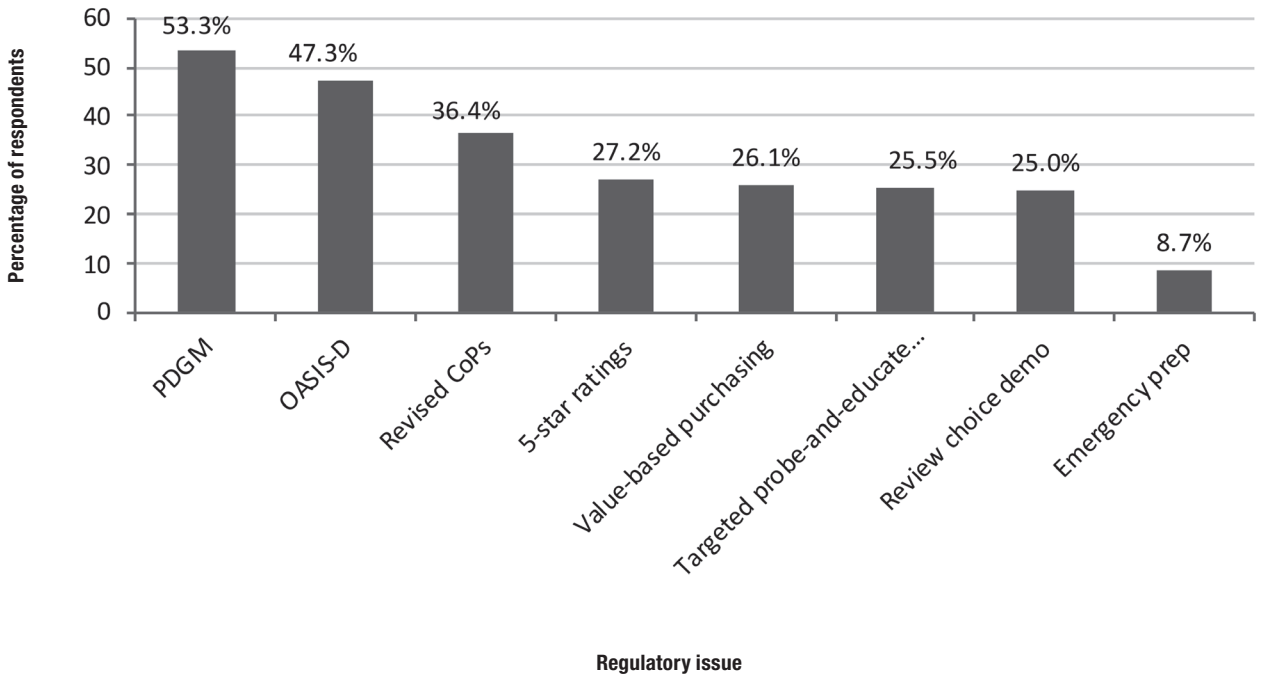
Conduct pre-teaching and supervision for this small team. Let them go through the process. Listen to their feedback.

BENCHMARK of the Week

Regulatory issue that will cause the biggest impact on operations, financials in 2019

About 53% of agencies say the Patient-Driven Groupings Model (PDGM) will be the regulatory issue that causes the biggest impact on agencies' operations and financials in 2019, and about 47% of agencies say OASIS-D will be the issue that causes the biggest impact. That's according to the 184 respondents to a question on *HHL's* 2019 Trends Survey. *(See story, p. 1.)*

Note: Agencies were provided a list of 11 regulatory issues and told to choose their top three.



Source: *CMS*

"As you start off, you need to talk to people almost on a daily basis," Page-Greifinger says.

Acknowledge that it's a change and ask these clinicians how it's going. This demonstrates empathy and facilitates valuable dialogue. You may want to tweak the process based on what you hear.

- **Get staff on board with the change.** Involving clinicians in refining workflow will make them likelier to champion the process to other staff, Page-Greifinger says. Once your small group of clinicians is on board, bring them in to talk to the rest of your staff as part of the overall rollout.

Educate field staff about what happens in the back office when documentation isn't submitted timely, Montigney recommends. This will help them understand how late documentation impacts other people's jobs.

Explain the positive impact for patients and patient outcomes, the potential for better work-life balance and the financial challenges.

"We can't continue to pay our bills if we can't bill," Busbee says. "We can't pay you if we can't get paid ourselves."

Blame the change on regulatory changes, Page-Greifinger suggests. Explain documentation will be needed at a faster pace than ever in order for the agency to survive under PDGM.

Often the biggest factor in getting clinicians on board is the realization that doing documentation in

the home allows them to leave work behind when they finish their visits.

"There's no reason you want to go see patients and then go home and chart for two to three hours after the visit," Busbee says. "That visit needs to include documentation time. We really focused on their quality of life."

- **Set patient expectations around electronic documentation.** Use of a laptop, tablet or phone to document in the home helps speed up the documentation process. One common objection, however, is that it cuts down on patient interaction. Get ahead of this by setting patient expectations around device use early, Page-Greifinger recommends.

Let patients know before the first visit that clinicians will document on devices. Have clinicians explain again during visits that they will have the device open and will work on it throughout the visit.

This was a crucial part of improving in-home documentation at Cowboy Cares. Setting expectations for clinician workflow helps "patients understand [clinicians] really aren't looking at Facebook, they're doing documentation," Busbee says.

- **Ensure accountability.** The requirement must apply to everyone. Allowing a pass for one clinician who doesn't like computers, for instance, undermines the process, Page-Greifinger says.

Establish a way to monitor compliance. This could be done through telephony or by pulling through electronic medical records (EMR) if your agency has such a system. Let staff know their compliance is being tracked.

If clinicians don't submit documentation timely, follow through with disciplinary action, Montigney recommends.

Conduct supervisory visits to review performance and hold a sit-down debrief with clinicians to provide helpful hints, Page-Greifinger recommends. If something isn't right during that supervisory visit, follow up quickly, she adds.

- **Consider using a scribing service.** OperaCare has a program that provides scribing services to home health clinicians — similar to what some doctors' offices use. This approach allows clinicians to interact with patients and dictate notes while they are in the home. — *Kirsten Dize* (*kdize@decisionhealth.com*)

OASIS-D

(continued from p. 1)

The Patient-Driven Groupings Model (PDGM) was the only regulatory change that ranked higher than OASIS-D on the survey question. *(See story, p. 1.)*

As part of the transition, expect declines in clinician productivity, struggles with data accuracy, burden associated with assessing new items and challenges to back office operations. Getting these issues under control could be a slow process for some agencies.

From when OASIS-D launches Jan. 1, 2019, it will take agencies a year to get up to speed, says Jennifer Sandel, co-owner of Home Care Service Solutions LLC in Battle Creek, Mich.

"People are still struggling with OASIS-C2 and it's been a year; now they're changing it again."

Productivity, training among challenges

In the weeks leading up to implementation, many agencies were "panicking," Sandel says. Ongoing challenges with OASIS-C2, a raft of changes coming as part of the revised assessment, the cost of training and a desire for more guidance contributed to the anxiety.

With two weeks left in the year, agencies still awaited a final guidance manual. Lingering questions around new items had not yet been answered.

"I do think people were waiting for that final guidance manual so they could teach right the first time and not go back and correct," Sandel says.

Training overall has been a big challenge for agencies.

"Agencies are cash-strapped. They don't want to hire an outside source to do it, but then the supervisors themselves are struggling," Sandel says. "Some smaller agencies aren't going to train at all. They just don't have the money. January and February are going to be really tough."

Regardless of training, clinician productivity is expected to take a hit in 2019.

About 75% of the respondents to DecisionHealth's OASIS-D Survey believe the revised assessment will take more time overall to complete than OASIS-C2 *(HHL 10/22/18)*.

And agencies and industry experts expect OASIS-D to take more time to complete than CMS estimates.

CMS expects clinicians to spend 47.7 minutes on OASIS-D at start of care (SOC). But 70% of the

270 respondents to a question on DecisionHealth's OASIS-D Survey believe OASIS-D will take 70 minutes to complete at SOC.

New items pose biggest challenge

OASIS-D involves removing 28 items, adding six items and revising seven additional items.

New items capturing information on mobility and self-care are causing agencies the most concern during the transition, says Amanda Gartner, manager of compliance and OASIS education with Overland Park, Kan.-based The Corridor Group.

"The number of elements really scares people at first," Gartner says.

New item GG0170 (Mobility) involves scoring performance and discharge goals for up to 17 activities, plus responding to three additional elements at SOC and resumption of care (ROC).

New item GG0130 (Self-care), meanwhile, involves scoring performance and discharge goals for seven activities at SOC/ROC.

It's going to take time for clinicians to get comfortable with all of the elements in these items, as well as the other changes in OASIS-D.

"I don't think you can expect to all of a sudden teach this to a clinician and expect them to 'get it' all at once," Sandel says.

Consider strategies, tips for new items

- **Assess once, but respond twice.** While there are some differences between new and longstanding ADL items, there is no reason to have a patient do the same activity more than once simply to assess for two different items, Gartner says.

Assess the patient doing the activity, such as eating, then respond to M1870 (Feeding or Eating) and GG0130A (Self-care, eating) based on specifications for each item.

There may be instances when you assess similar activities and gather enough information to respond to other items. For instance, if you learn the patient can't safely ambulate, you likely know the patient won't be independent on bathing, Gartner says.

- **Plan your assessment to make the most of time and patient effort,** Gartner recommends. Don't assess activities piece by piece.

"Start thinking about what type of activity you can get your patient to do and think about all the things you can score when they do that activity," Gartner says.

For example, have the patient go from lying on her back in bed to standing and walking to the room where she keeps her medication. After that single activity, you could respond to M1860 (Ambulation), GG0170C (Mobility, lying to sitting on side of bed), GG0170D (Mobility, sit to stand), GG0170I (Mobility, walk 10 feet) and — if the distance is great enough — GG0170K (Walk 150 feet).

Once in the other room, you can complete medication reconciliation and respond to the medication items.

- **Remember patient and caregiver reports are permitted.** Make use of this feedback when appropriate.

"Getting [patients] up and moving is the ideal, but if that can't happen in a certain scenario, you can consider reports," Gartner says.

- **Equip clinicians to assess distance-based activities.** Provide every clinician with pieces of twine 10 feet long and 50 feet long, Sandel recommends. This can help better assess the GG0170 activities that involve walking specific distances.

"If you pace it off, it's inconsistent," Sandel says.

Before assessing the patient's ability to walk each distance, use the Timed Up and Go (TUG) test to assess the patient's ability, Sandel says. Always consider safety.

- **Exclude incontinence when responding to GG0130C (Self-care, toileting hygiene)** — at least for now, Sandel says. GG0130C and M1845 (Toileting hygiene) assess for similar things, but M1845 specifically includes incontinence products while GG0130C makes no mention of these products.

Some agencies have questioned whether they should assume GG0130C includes these kinds of products, Sandel says. But the draft manual didn't provide clarification, and CMS hasn't offered specific guidance on the issue.

- **Develop scenarios for ongoing training.** Come up with your own scenarios and build interactive training activities around these scenarios. Start the activity by asking clinicians to list the activities they could have the patient do in order to help answer as many items as possible. — *Kirsten Dize* (*kdize@decisionhealth.com*)

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