Home Health and Outcome Based Quality Improvement (OBQI)
By Joyce Sierk Bergen, RD, LD

When I started working part-time as a senior nutritionist in home health, I had little working knowledge of how patients were assessed by nurses or therapists and how data was collected on the patient care provided. In 2003 my agency had an opening for a position to work on assessing and improving patient outcomes and I became the OBQI (Outcome Based Quality Improvement) coordinator. I quickly became familiar with the Centers for Medicare and Medicaid Services (CMS) and its long list of acronyms. I will discuss two of them—OASIS (Outcome and Assessment Information Set) and OBQI—that I use as OBQI Coordinator.

The Conditions of Participation by Medicare state that a skilled nurse or therapist conduct a comprehensive assessment at given time points, such as Start of Care (SOC). For Medicare or Medicaid non-maternity patients 18 years or older, this assessment must include OASIS data. (1)

According to the OASIS-C Guidance Manual, December 2010, OASIS “...is a group of standard data elements developed, tested, and refined over the past two decades...” (2) In January 2010 OASIS-C became the latest data set. A new guidance manual became available in January 2011. Prior to January 2010, OASIS-B data was collected.

OASIS is completed and submitted at given time points throughout the care of the patient—SOC, Resumption of Care (ROC), Recertification, Transfer to Inpatient Facility (TIF), Death in the home, and Discharge. OASIS questions are designed to compare measurement of home health patient outcomes at two points in time. (2)

OASIS data elements are numbered with an “M” or “M0” indicating that data will be collected. For example, Mr. Smith at SOC is unable to take oral medication unless administered by another person. This data is collected in M2020. Home health assists the patient to safely manage medications in his home. At discharge he is able to take medication at the correct times if individual dosages are prepared in advance by another person. M2020 is again completed. By comparing medication management at these two points in care, improvement is noted for Mr. Smith.

CMS states, “In any data-driven system, the quality of the output is only as good as the quality of the data input.” (3) As OBQI coordinator, I work with the staff to use the Item-by-Item Guidance Manual (4) to make sure that the “M” and “M0” questions are answered correctly. I review all OASIS forms for completeness and consistency and assist with diagnosis coding. For example, if M1030 “Therapies the patient receives at home” is marked for enteral nutrition, does the diet include the type of feeding? Is the nutrition supplement listed on the medication list? Is the patient assessed under the review of systems to have dysphagia? Does the patient receive all oral medications via percutaneous endoscopic gastrostomy (PEG) tube? If so, M2020 “Management of Oral Medications” may be marked as NA—no oral medications prescribed. Does M2100e indicate caregiver assistance of equipment? Is there a diagnosis code in M1020 or M1022 for dysphagia and attention to gastrostomy or status of gastrostomy to reflect the plan of care? Such a review makes certain that the OASIS tells the patient’s story.

Completed OASIS are encoded and transmitted to each state for processing. Detailed reports of patient outcomes are available to agencies only; however, comparative measurements of home health care patient outcomes are available to the public through Home Health Compare at
http://www.medicare.gov/homehealthcompare/search.aspx  The website contains detailed information about patient outcomes from OASIS-B and OASIS-C for every Medicare-certified home health agency in the country. Up to three home health agencies can be compared at a time, along with state and national averages, to see patient improvement in managing daily activities, pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned medical care. As OBQI coordinator, I review these quarterly and compare how we rank with other local agencies as well as state and national averages.

Outcome measure reports allow home health agencies (HHAs) to assess and improve quality of care. These reports are the basis for OBQI. ‘Under OBQI, CMS provides HHAs with agency-patient related characteristic (case mix), risk-adjusted outcome, potential avoidable event (adverse event outcome), and patient tally reports for their patients for a 12-month period.”(2) The reports provide HHAs with the prior 12-month period and national reference data as well. The latest OBQI reports include both outcome and process measures. These reports allow HHAs to determine what outcomes or processes need improvement. As OBQI coordinator, I review these reports and work with staff to determine which need improvement and then help develop an improvement plan. Our agency worked to improve oral medication management. In a case such as Mr. Smith, his improved ability to manage his own medications would be pooled with all the other HHA patients and would have helped us raise our “improvement in oral medication management” rate.

At discharge or TIF, particular attention is paid to outcomes that are considered adverse events which appear on adverse event outcome reports (AEOR). The intent of AEOR is for HHA to evaluate all adverse events to determine whether the event was unexpected and whether the agency could have prevented the outcome. Among the 13 adverse events categories are emergent care for injury caused by fall or accident at home; emergent care for wound infections, deteriorating wound status; emergent care for hypo/hyperglycemia; and increase in number of pressure ulcers. As OBQI coordinator, I am responsible for reviewing AEOR, auditing patient charts, and determining if improvement is needed to prevent future adverse events. Reviewing all discharges and TIFs allows me to make sure that documentation is present regarding an adverse event.

In addition to outcome measures, OASIS-C contains questions that allow CMS to compute and report clinical process measures. Medicare’s focus is on “…high-risk, high-volume, problem-prone conditions in home health care…” (5) Measures include pressure ulcer risk assessment, diabetic foot care education, and heart failure symptoms and follow-up. (6) The OASIS-C Guidance Manual, December 2010, states:

> Care processes refer to the use of assessment tools (included in a comprehensive assessment) or the planning and delivery of specific clinical interventions. Several evidence-based screening tools and interventions that can be considered “best practices” in home health care were identified…OASIS-C includes data items to measure the use of these “best practice” care processes. (5)

Prior to 2008, many HHAs worked with Quality Improvement Organizations (QIOs) to improve outcomes. Presently Home Health Quality Improvement (HHQI), a national campaign, provides participating agencies with resources for improving two outcomes: avoidable hospitalization and medication management. Monthly reports are available that include data from the “M” questions related to these outcomes. (7) Our agency improved our acute care hospitalization rate through an improvement plan that included assessment for hospitalization risk at SOC and ROC. This plan also included providing handouts on emergency plans and self-management guides to encourage patients to call our agency first if they have a change in condition.

Can a registered dietitian play a role in improving outcomes? Ask to look at your agency’s reports. Can nutrition intervention improve the outcomes for wound healing, prevent development of pressure ulcers, aid in treatment of pressure ulcers, avoid emergent care for hyper/hypoglycemia, or keep patients with congestive heart failure out of the hospital? As a senior nutritionist and OBQI coordinator, I am aware of our
numbers and available to provide nutrition intervention to help decrease the length of HHA stay and/or help avoid hospitalization or emergent care.

References:

Joyce Sierk Bergen is a registered, licensed dietitian. Joyce holds a BS degree in Dietetics and Community Nutrition from the University of Minnesota in 1973. She has worked as a senior nutritionist at Panhandle Health District’s Home Health Division since 1998, adding OBQI coordinator in 2003. Joyce can be reached at 208-415-5160 or jbergen@phd1.idaho.gov

---

**Enteral Nutrition in Home Care**

**Cindy Thomas, RD**

Patients discharging home on enteral nutrition can experience great success as long as there is good coordination between the hospital, the home care company and the patient and family. The registered dietitian (RD) following the patient in the hospital can coordinate with the home care dietitian and help transition the patient to bolus feedings while he/she is still in the hospital (if possible). Bolus feedings eliminate the need for a pump, better mimic normal feeding times and situations and are easier to administer than pump feedings. Pump feedings can certainly be done if needed, and taught to patient and family.

**Preparation for discharge:** The discharge coordinator of the home care company can gather information from the hospital’s medical record: The nutrition assessment/recommendation of the hospital RD; recent labs, patient’s weights, diagnoses, history and physical and any other pertinent information. Depending on the home care company used, either an RD or a nurse will be the one going to the patient’s home (or coming to the hospital if the patient lives too far out of town) and providing the education. If the patient isn’t able to perform their own tube feeding, or may need help, be sure that that the appropriate family member or care giver is present for this education.

**Education:** The following elements should be included in the enteral education of the patient. There are numerous education aids available, many of which are written by commercial enteral nutrition companies, and can be obtained on their Web sites (see bibliography). A proper enteral education session will last from 45 minutes to over an hour if done thoroughly. Even though you provide written information to the patient, going through that information with them and verbally instructing them will assure that they understand and retain what they need to know to be confident in performing their enteral nutrition tasks. Remind the patient prior to all these tasks to WASH THEIR HANDS, and be sure to wash your hands as an example prior each demonstration.