Home Health Value-Based Purchasing (HHVBP)

OASIS and HHCAHPS: Improvement Strategies for Medication-Related Measures

April 6, 2017

Prepared for CMS by the HHVBP Technical Assistance, contract number HHSM-500-2014-0033I. If you have suggestions for additional topics, please email the helpdesk at HHVBPquestions@cms.hhs.gov.
HHVBP Learning Event Structure

HHVBP Model Curriculum

- Quality Improvement
- HHVBP Model Information
- Measures Improvement Strategies:
  Medication-Related Measures
Agenda

- Discuss the 3 quality measures related to medication management
- Highlight tools and strategies that HHAs can use to improve in these measures
- Provide opportunities to learn new improvement strategies from guest speakers related to:
  - Collaborating with community pharmacies
  - Collaborating with the managed care organizations
  - Highlighting a high performing HHA for insights on their successes on the measures
Handouts & Questions

Handouts

• Presentation slides
• Available via the green “Resources” widget for live presentations and on HHVBP Connect if viewing a recording

Questions

• Questions may be submitted through the Q&A feature on your screen OR HHVBP Help Desk at HHVBPquestions@cms.hhs.gov
Questions to Consider

1. What are your current strategies for improving your medication-related measures?

2. Using the tools, strategies, and guest presenter tips from today’s session, have you identified ways to improve your current strategies for these measures?
1. Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care (OASIS-based)

2. Improvement in Management of Oral Medications (OASIS-based)

3. Specific Care Issues (HHCAHPS-based)
**1. Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care (OASIS-based)**

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Percentage of home health quality episodes during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (at the time of or at any time since the most recent SOC/ROC assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of home health quality episodes during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (at the time of or at any time since the most recent SOC/ROC assessment).</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of home health quality episodes ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusion</td>
</tr>
<tr>
<td>Measure-specific Exclusions</td>
<td>Home health quality episodes for which the patient was not taking any drugs since the last OASIS assessment prior to transfer/discharge, OR the patient died.</td>
</tr>
<tr>
<td><strong>OASIS-C2 Item(s) Used</strong></td>
<td>(M0100) Reason for Assessment (M2016) Patient/Caregiver Drug Education Intervention</td>
</tr>
</tbody>
</table>
## 2. Improvement in Management of Oral Medications (OASIS-based)

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Percentage of home health quality episodes during which the patient improved in ability to take their medicines correctly (by mouth).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at start (or resumption) of care.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.</td>
</tr>
<tr>
<td><strong>Measure-specific Exclusions</strong></td>
<td>Home health quality episodes for which the patient, at start/resumption of care, was able to take oral medications correctly without assistance or supervision, episodes that end with inpatient facility transfer or death, or patient is nonresponsive, or patient has no oral medications prescribed.</td>
</tr>
<tr>
<td><strong>OASIS-C2 Item(s) Used</strong></td>
<td>(M2020) Management of Oral Medications (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious</td>
</tr>
</tbody>
</table>
3. Specific Care Issues (HHCAHPS-based)

Specific Care Issues Composite (“Patients who reported that their home health team discussed medicines, pain and home safety with them.”)

Q3 - When you first started getting home health care from this agency…

Q4 - When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription and over-the-counter medicines you were taking?

Q5 - When you started getting home health care from this agency, did someone from the agency ask to see all the prescription and over-the-counter medicines you were taking?

Q10 - In the last 2 months of care…

Q12 - In the last 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines?

Q13 - In the last 2 months of care, did home health providers from this agency talk with you about when to take these medicines?

Q14 - In the last 2 months of care, did home health providers from this agency talk with you about the side effects of these medicines?
Measure Improvement Strategies
Measure Improvement Strategies

Basic Clinical Education

Tools and Interventions

Collaboration
# Sample Clinical Staff Education Resources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Sample Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Measure Specifics</td>
<td>• <a href="#">CMS Home Health Quality Measures Tables</a></td>
</tr>
<tr>
<td>2. OASIS Data Accuracy</td>
<td>• <a href="#">OASIS-C2 Guidance Manual</a></td>
</tr>
<tr>
<td></td>
<td>• <a href="#">OASIS Q&amp;As</a></td>
</tr>
<tr>
<td>3. Clinical Best Practice Education</td>
<td>• <a href="#">Medication Management Performance Focused Best Practice Intervention Package (BPIP)</a></td>
</tr>
<tr>
<td>4. Teach-Back</td>
<td>• <a href="#">10 Elements of Competency for Using Teach-Back</a></td>
</tr>
</tbody>
</table>
# Medication Non-Adherence – A Staff Education Tool

**Purpose:** To promote a comprehensive and standardized approach to evaluating the presence and possible underlying causes of medication non-adherence. When general assessment findings suggest patient is not taking oral medications as prescribed, assess further.

<table>
<thead>
<tr>
<th>Potential Non-Adherence Issue</th>
<th>Assessment Strategies</th>
<th>Referral Trigger(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Deficit</td>
<td>Is there evidence to support/suggest that patient/caregiver does not understand medication regimen?</td>
<td>RN</td>
</tr>
</tbody>
</table>
|                              | • “I'm not having (symptom) anymore, so I'm not sure whether to keep taking this.”  
• “That makes my stomach upset, so I try not to take it.”  
• “I don't know when to take my meds or what dose to take.” |                     |
| Illiteracy                   | Is there evidence to support/suggest that patient's/caregiver's inability to read is affecting medication compliance? | RN, SLP, OT          |
|                              | • Unable to read medication name, frequency, dose, other instructions |                     |
| Financial Concerns*          | Is there evidence to support/suggest that patient is limiting medication use to save drug (i.e. to save money)? | RN, MSW              |
|                              | • “I take it when I really need it.”  
• “I sometimes only take half the ordered amount.” |                     |
| Fear of Addiction*           | Is there evidence to support/suggest that patient is limiting medication use due to concerns he or she will become addicted? | RN, MSW              |
|                              | • “I want to get off that stuff.”  
• “I only take it when I can't stand it anymore.” |                     |
| Drug Diversion or Over-Medicating* | Is there evidence to support/suggest that patient is taking too much medication? | RN, MSW              |
|                              | • “I need a refill; the bottle spilled in the sink.”  
• “Even doubling the prescribed amount does not touch the pain.” (don't assume intentional over-medicating without evaluating for true ineffectiveness of current meds, need for adjuvant therapy, etc.) |                     |

**Health Belief/Expectations:**

- Is there evidence to support/suggest that the patient’s medication non-compliance may be due to general beliefs or expectations about health and illness?
  - “If he is meant to get better, it will happen.”
  - “If I take the pills, it will show a lack of faith.”

**Memory Deficit:**

- Is there evidence to support/suggest that the patient is forgetting to take medications, or forgetting that medications have already been taken resulting in non-compliance?
  - “I usually take one after lunch, but my daughter called, and I can’t remember if I took it.”
  - Pills found in chair, on table by cup, etc.
  - Incorrect pill counts
  - Signs of ineffective drug therapy

**Functional Deficit:**

- Is there evidence to support/suggest that patient/caregiver non-adherence is due to functional deficits?
  - Fine motor/gross motor/mobility
  - Vision
  - Swallowing

**Disorganization:**

- Is there evidence to support/suggest that the patient’s medication administration methods lack organization?
  - Bottles/pills in multiple locations
  - Unable to locate all medications
  - Reported administration methods vary from day to day (inconsistent)
  - Lack of established or predictable routines (sleep, meals, ADLs, etc.)

*May not affect patient's ability to take medications, therefore may not impact M2000. Referrals should be made based on patient need, state practice acts, and agency policy.  


This material was modified from The Home Care Comprehensive Assessment and Drug Regimen Review: Competency Assessment & Training Program for Home Care Therapists and distributed by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the
10 Elements of Competency for Using Teach-Back Effectively

TIP: Teach-back can improve medication management AND impact your patient recall of the events related to the HHCAHPS measures!

Home Health Quality Improvement National Campaign
Measure Improvement Strategies

- Basic Clinical Education
- Tools and Interventions
- Collaboration
Toolbox: Medication Quality Measure

MEDICATION MANAGEMENT CARE PLANNING TOOL

PATIENT FRIENDLY MEDICATION SCHEDULE (available in multiple languages)

7 STEPS TO MEDICATION SIMPLIFICATION

YOUR MEDICINE: BE SAFE. BE SMART.
**Medication Management Care Planning Tool**

**TIP:** Use with each Start of Care/Resumption of Care to identify patient-specific strategies for improvement!

<table>
<thead>
<tr>
<th>Patient Behavior or Comments</th>
<th>Problem/Barrier</th>
<th>Assess</th>
<th>Strategies/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fills only some prescriptions</td>
<td>Fearful or anxious about addiction or dependence OR Fearful of undisclosed effects of medications</td>
<td>Allow/encourage patient to express, elaborate on concerns, Fear or anxiety is a legitimate emotional inability to take some or all meds</td>
<td>RN referral to address fears, provide education on purpose, effects, and side effects of medication(s)</td>
</tr>
<tr>
<td>Takes only some medications</td>
<td></td>
<td></td>
<td>SW referral for brief counseling related to fears/anxiety</td>
</tr>
<tr>
<td>&quot;I don't want to be on a lot of medications.&quot;</td>
<td></td>
<td></td>
<td>Rule out financial barriers</td>
</tr>
<tr>
<td>&quot;I don't think it's good for me to take medications.&quot;</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Someone I know took pills like those and got worse so I don't want to take them.&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;I have trouble reading all that stuff on the bottles.&quot;</td>
<td>Limited literacy</td>
<td>Ask if patient learns better by hearing, seeing demo or reading</td>
<td>OT referral to address alternate means of information acquisition</td>
</tr>
<tr>
<td>Resists requests to read information on medication labels or other medication information</td>
<td></td>
<td>Assess reading ability to determine literacy (how does patient manage other print information?)</td>
<td>Try visual model of meds/dosages (i.e., picture of meds for times and dosage)</td>
</tr>
<tr>
<td>&quot;I have trouble reading the labels.&quot;</td>
<td>Visual impairment</td>
<td>Does patient have/use corrective lenses? Does patient have/use magnification beyond corrective lenses?</td>
<td>Consult pharmacy re: system to color code or apply large print or high contrast label to containers</td>
</tr>
<tr>
<td>&quot;I can't tell which pill is which, they look alike.&quot;</td>
<td></td>
<td></td>
<td>OT referral for low vision compensation strategies</td>
</tr>
<tr>
<td>Unable to:</td>
<td></td>
<td></td>
<td>Large print/high contrast model (example) for dosing or filling mediplanner</td>
</tr>
<tr>
<td>o read information on container OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o read other instructional material OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o discern shapes/shadings or discriminate between pills</td>
<td></td>
<td></td>
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</tbody>
</table>
Your Medicine: Be Smart. Be Safe.

- Free patient education booklet
- Medication list wallet card
- Can be used for Patient-Staff Education/Discussion
TIP: Effectively implementing this tool may help to improve in management of oral medications for patients who have reading problems or who are not effectively managing their medications.
7 Steps to Medication Simplification

TIP: This simple check can be completed with each medication addition or change to provide interventions for simplifying the patient’s medication regime!
Today’s Discussion

- Basic Clinical Education
- Tools and Interventions
- Collaboration
Duquesne University
School of Pharmacy

Kimberly Grant, Pharm.D.
Shawn Shuman, MSN, RN
Director, Medicare Clinical Programs
Healthy@ Home
Value-Based Purchasing Journey
Who we are:

- 8 Home Care locations
- Serving 20 counties in NC
  - Diverse population consisting of both rural and urban counties
- 1800-2000 Average daily census
- 350 front line clinicians
- Non profit, hospital based, committed to serve all patients regardless of payer
- Owned by and serving The Carolinas Healthcare System
Culture

"Culture does not change because we desire to change it. Culture changes when the organization is transformed; the culture reflects the realities of people working together every day."

— Frances Hesselbein  The Key to Cultural Transformation, Leader to Leader (Spring 1999)

Focus – Our Four “Cs”:

- Creating a sense of urgency
- Connecting accountability to purpose
- Communication is bidirectional
- Change agent VBP strategies and tools
Creating a Sense of Urgency

• VBP leadership team
  » Work plan (A3 format)
• Investment in training – Internal Experts
• Focused education with Branch VBP scorecards
  » Clinical Managers, one-on-one education with their “reality”
• Aligned 2016 and 2017 operational goals
• Began Intentional Conversations - “Value Speak” – in forums, leadership meetings, discipline specific councils/meetings
Connecting Accountability

• Who is touching that VBP Outcome?
  » OASIS assessment practice/scoring – Front Line Clinicians
  » Documentation Review – Process measures – Clinical Services Supervisors
  » The VBP Outcomes aligned with Therapy – PT Team Lead

• Who is leading or supporting the Changes?
  » Senior leaders, local leadership, front line staff, nursing council, therapy leads, preceptors, PI teams and quality staff.
Communication: Show Me the Value!
Change Agent VBP Strategies and Tools:

- Predictive Analytics Tool
- Branch specific Action Plans - “Playing in the Sandbox”
- Identification of 2 key drivers/opportunities for all branches
  - Improvement in Oral Medications
  - Flu Vaccination
- HHCAHPs strategies to address patient engagement
- Fostering professional development and leadership
- Broader utilization of technologies
Medications and Motivation

Engaging the Clinicians

• Utilized the tools mentioned in the HHQI BPIP tool kit
  ➢ Medication Test – what we discovered!
  ➢ Poster boards and post test
• “Check the Bottle” Initiative – Accountability and Visibility
• Medication Management PI Teams
  ➢ Subgroups: Medication reconciliation, Medication adherence, and Medication education
Medications and Motivation

Changing the Communication

• Patient Handbook into a Workbook
  ➢ Open ended questions on their knowledge about meds and rating themselves
  ➢ How important is it to them to have a better understanding?

• PI Team Recommendation:
  ➢ Modify the “Check the Bottle” process
  ➢ Develop a process for patient engagement in maintenance of an accurate medication profile
Is it Worth It?

"Change is hard because people overestimate the value of what they have—and underestimate the value of what they may gain by giving that up."

—James Belasco and Ralph Stayer Flight of the Buffalo (1994)
Discussion!
Resources & Reminders
Mark Your Calendars

All learning events will be held at 2 PM, Eastern Time. Please register via the *HHVBP Connect* Calendar.

<table>
<thead>
<tr>
<th>Upcoming Learning Event Topic</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning from the Literature: Highlights from the Environmental Scan</td>
<td>April 20, 2017</td>
<td>2:00 PM ET</td>
</tr>
<tr>
<td>Journey to Improvement: Trending Your IPR Data to Guide Quality Improvement</td>
<td>May 11, 2017</td>
<td>2:00 PM ET</td>
</tr>
<tr>
<td>Claims-based Measures – Acute Care Hospitalization and ED Use Without Hospitalization</td>
<td>May 18, 2017</td>
<td>2:00 PM ET</td>
</tr>
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</table>
Questions

Do you have questions about the HHVBP Model? Contact the HHVBP Model Help Desk at HHVBPquestions@cms.hhs.gov.

If you are experiencing technical issues with gaining access to the HHVBP Secure Portal or HHVBP Connect, please call: (844) 280-5628.

Stay on the line until your issue is resolved.
HHVBP Connect Chatter

- Join the discussion!
  » Engage with your peers on HHVBP Connect by liking and commenting on their posts

- If you would like to ask a question of your peers:
  » Log into the HHVBP Connect site at https://app.innovation.cms.gov/HHVBPConnect/CommunityLogin
  » On the Chatter page, select “Post” at the top and type in your question and post to the group

- To request access to HHVBP Connect, visit the HHVBP Connect site and select the new user registration link
  » Follow the on-screen instructions
  » The CMMI Help Desk will contact you to complete the registration process
Thank you!

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