Home Health Coding and OASIS Expert

Quality Measures: Gear Up for New Skin Integrity Quality Measure

Now's the time to polish up your pressure ulcer assessment.

The newly-revealed OASIS-C2 makes it clear that the **Centers for Medicare & Medicaid Services** still has its sights set on pressure ulcers. Make certain your OASIS responses and assessment approach don't put your agency in the quality crosshairs.

Background: In late 2015 CMS issued the new OASIS-C2 assessment tool. The form is updated "to comply with requirements for standardized, cross-setting measures for post-acute care under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014," CMS noted on its website.

Among the new items and other changes to the OASIS document are updates to wound items designed to comply with the IMPACT Act, which aims to standardize data collection across the post-acute provider continuum.

"Continuity of care to ensure patient needs are being met across Post Acute Care (PAC) settings has become a priority," says **Sue Kennedy, BS, RN, CWOCN, FACCWS, COS-C,** with **RitKen and Associates**, a nationwide WOC Nurse consulting firm based in Ponchatoula, La. "Additionally, payment reimbursement will be impacted according to reported patient outcomes."

While the OASIS already collects information about patient skin integrity, a new quality measure focusing on this area is behind the OASIS-C2 pressure ulcer item changes. Skin integrity is already a part of the quality measure reporting for Long Term Care Hospitals, Skilled Nursing Facilities and Inpatient Rehab Facilities. Home care providers will join these other post-acute providers with a skin integrity quality measure beginning in 2017.

Know What You Can Do to Prepare

The new quality measure doesn't go into effect until 2017, but there are some steps you can take to improve patient care and prevent any negative impact on your agency. Consider the following tips from Kennedy and **Debbie Ritter, BSN, RN, CWOCN, FACCWS, COS-C,** also with RitKen.

- Ensure clinicians perform a head to toe assessment of the patient's skin integrity. Having a thorough understanding of any existing or developing skin issues will help your staff to take steps to prevent them from worsening.
- Provide education with a focus on OASIS Items M1308 □ Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable (which will become M1311 in OASIS-C2) and M1309 □ Worsening in Pressure Ulcer Status since SOC/ROC (M1313 in OASIS-C2). While the numbers will change, much of the content for these items remains essentially the same.
  Watch for: M1311 will add the prompt "Number of These Stage ___ Pressure Ulcers That Were Present at Most Recent SOC/ROC" for each subitem.
- Offer training that gives clinicians a thorough understanding of pressure ulcer assessment, staging, and accurate documentation. Share the **National Pressure Ulcer Advisory Panel** pressure ulcer staging guidelines (https://www.npuap.org).

Another key to success with the skin integrity quality measure will be making certain clinicians perform a thorough pressure ulcer assessment and implement any appropriate interventions. Give clinicians a refresher to make sure they

know the following, Kennedy and Ritter suggest.

- **Pressure ulcer etiology.** Pressure ulcers develop due to unrelieved pressure related to immobility, or shearing.
- **Pressure ulcer staging.** Pressure ulcers are the only ulcers that require staging in home care.

    - **Stage I** is intact skin with non-blanchable erythema.
    - **Stage II** involves only partial thickness tissue loss.

        A Stage II pressure ulcer will not have slough or granulation.
        Stage II pressure ulcers heal, they most likely will not have a scar.

    - **Stage III and Stage IV** involve full thickness tissue damage.

        Presence of slough or granulation indicate full thickness tissue damage.
        Stage III and Stage IV pressure ulcers do not "heal," they "close."
        A scar will be present when a Stage III or Stage IV pressure ulcer closes.
        A closed Stage III or Stage IV pressure ulcer will break down more quickly with unrelieved pressure since "tensile strength" is less than original skin integrity structures.

    - **Suspected deep tissue injuries.** Intact skin that has a purplish, maroon, or bruised appearance that is located over a bony prominence may be a suspected deep tissue injury. A blood filled blister caused by unrelieved pressure or shear would be considered a deep tissue injury.

Follow these Pressure Ulcer Item Tips

The OASIS pressure ulcer items are some of the trickiest to answer correctly. Although these questions have undergone many changes over the years, they can still give even the most seasoned clinicians some difficulty. Keep the following tips from Kennedy and Ritter in mind as you answer these items that will gather data for the skin integrity quality measure.

M1308 Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:

- Never reverse-stage pressure ulcers.
- You can still stage a wound bed covered with slough if you are able to visualize structures such as muscle, tendon, or bone.
- A Stage II pressure ulcer remains a Stage II until it heals. Once a Stage II pressure ulcer heals, you should no longer count it as pressure ulcer.
- When a Stage III or IV pressure ulcer closes, you should continue to report it at its worst stage.
- When your patient has a closed Stage III or IV pressure ulcer that the patient describes a "bed sore," but the patient or his physician are uncertain as to the stage, report it as a Stage III. The presence of scar tissue supports that this was a full thickness tissue involvement pressure ulcer.
- If your patient has two pressure ulcer openings (for example a Stage III and a Stage IV), and you discover that the two ulcers are connected by a tunnel below the surface, report the open areas as two separate pressure ulcers.
- Pressure ulcers are unstageable if they cannot be visualized due to a cast or a non-removable device or dressing.
- A pressure ulcer treated with a skin graft (not a muscle flap, or skin advancement flap, or rotational flap) is unstageable (M1308 d.1) if the graft edges are not yet healed. Once the graft edges heal, report the closed Stage III or Stage IV ulcer at its worst stage.
- A suspected pressure ulcer may be unobservable due to the presence of a cast, non-removable dressing, or medical device (M1308 d.1).
- Pressure ulcers are unstageable if the presence of slough prohibits the assessment of the amount of tissue layer destruction (M1308 d.2).
- Pressure ulcers are unstageable if a deep tissue injury is in evolution (M1308 d.3).

M1309 Worsening in Pressure Ulcer Status since SOC/ROC:

- For this item, "worsening" refers to the pressure ulcer stage being worse, or to a newly developed pressure ulcer.
- You cannot report pressure ulcers that were "Unstageable" at the most recent SOC/ROC as new or worsened.
- You cannot report pressure ulcers that are "Unstageable" due to presence of dressings or devices that cannot be removed (thus preventing assessment of ulcer) as new or worsened.
- You cannot report suspected deep tissue injury in evolution present at SOC/ROC or discharge as new or worsened.
- Remember: Do not reverse-stage pressure ulcers.

Note: Review the OASIS-C2 on the CMS Home Health Quality Initiative website under the downloads section here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-C2-Item-Set-Effective-1-1-17-.pdf.