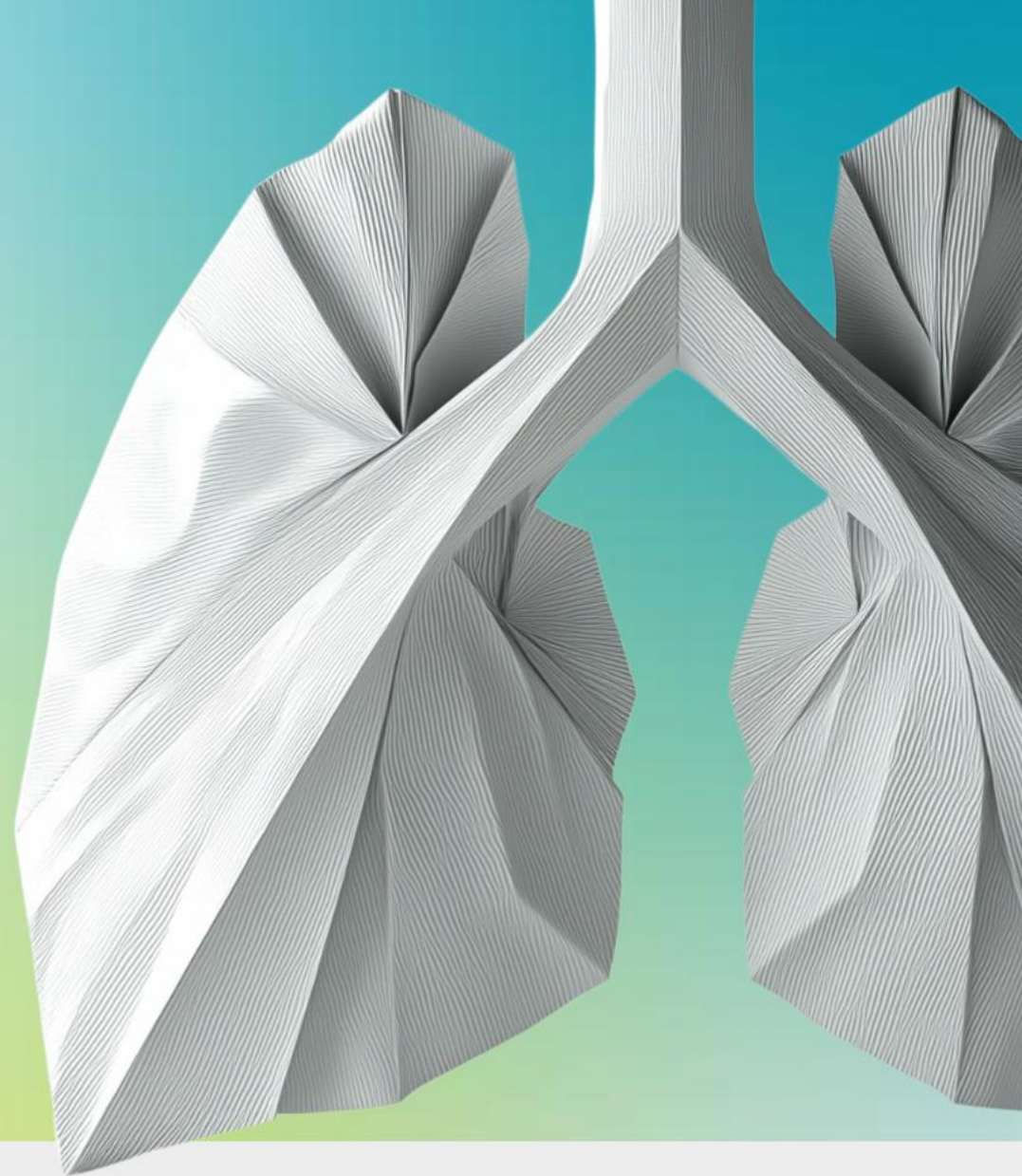


FREE WEBINAR

The Dyspnea Disconnect

Why you're not seeing the M1400 outcomes you expect

THU, JUL 31 | 2 PM CT



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HOME HEALTH

TODAY'S SPEAKERS



LISA

SELMAN-HOLMAN

JD, BSN, RN, HCS-D, COS-C

VP Clinical Services | McBee



MICHELLE

HORNER

BSN, RN, HCS-D, HCS-O, HCS-H, COS-C

Clinical Consulting Manager | McBee

Agenda

- **Explain the role of M1400 Improvement in Dyspnea in HHVBP & Star Ratings**, including differences in calculation & risk adjustment.
- **Identify common documentation & assessment errors** that lead to inaccurate scoring of dyspnea status.
- **Demonstrate strategies to assess dyspnea accurately**, including patient & caregiver interviews, observation & interdisciplinary input.
- **Explore how dyspnea scores should influence care planning** across nursing, therapy & other clinical disciplines.
- **Discuss the importance of team-wide accountability** in driving improvement & supporting accurate, compliant documentation.



POLL | IPR RANKING

What is your percentile ranking on the IPR for Improvement in Dyspnea?

1. <25
2. 25-49
3. 50-74
4. >75
5. I have no idea; I haven't looked at my IPR.

Improvement in Dyspnea

Which OASIS Items?

Star

(Outcome/Process)

- M0102/M0104
- M1860
- M1850
- M1830
- **M1400**
- M2020



PDGM

(Payment)

- M1033
- M1800
- M1810
- M1820
- M1830
- M1840
- M1850
- M1860



VBP

(Outcomes)

- M1800, M1810, M1820, M1830, M1845, M1870
- M1840, M1850, M1860
- **M1400 – 5.83%**
- M2020
- M2420

+/- 5%

2025 VBP

(Outcomes)

- **M1400 – 6%**

- M2020
- GG0130A
- GG0130B
- GG0130C
- GG0170A
- GG0170C
- GG0170D
- GG0170E
- GG0170F
- GG0170I
- GG0170J
- GG0170R



+/- 5%

Improvement in Dyspnea



Measure Description:

Percentage of home health *quality episodes* during which the patient became **less** short of breath or dyspneic.

Numerator:

Home health *quality episodes* where the discharge assessment indicates less dyspnea than at the start (or resumption) of care.

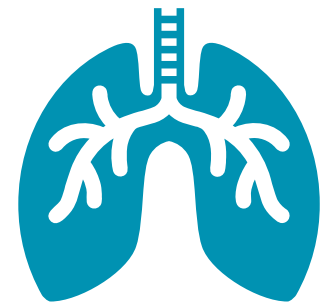
Denominator:

Home health *quality episodes* ending with a discharge (M0100=9) during the reporting period, except those meeting exclusion criteria.

Exclusions: Home health quality episodes for which the patient

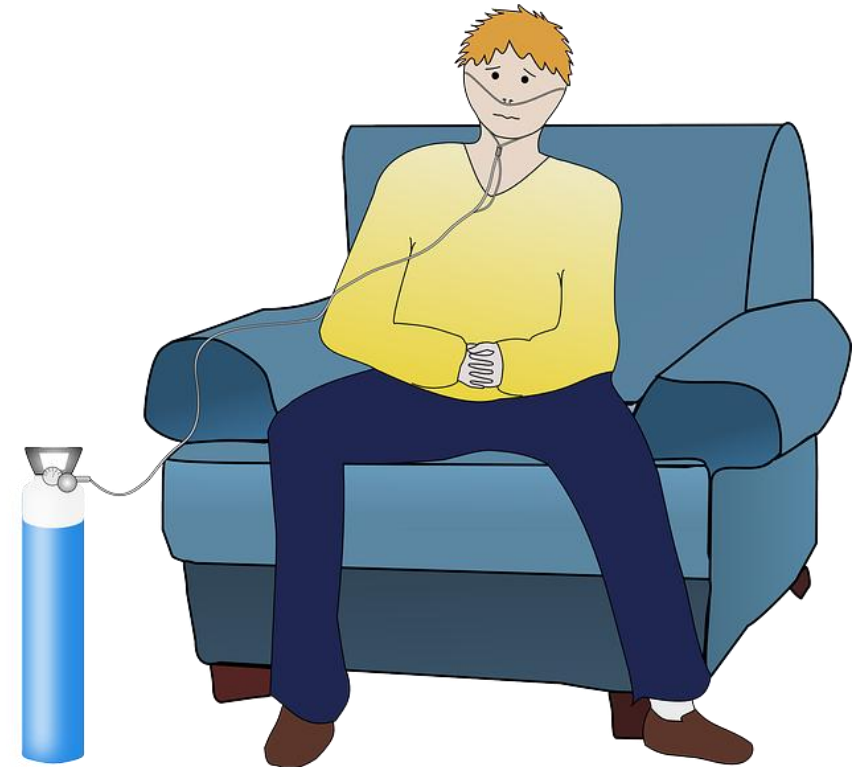
- Scored 0 Never short of breath on M1400 at SOC or ROC
- Episode ending with transfer or death (M0100 = 6, 7, 8)
- Is discharged to a non-institutional hospice (M2420=3)

OASIS item: M0100, M1400, M2420



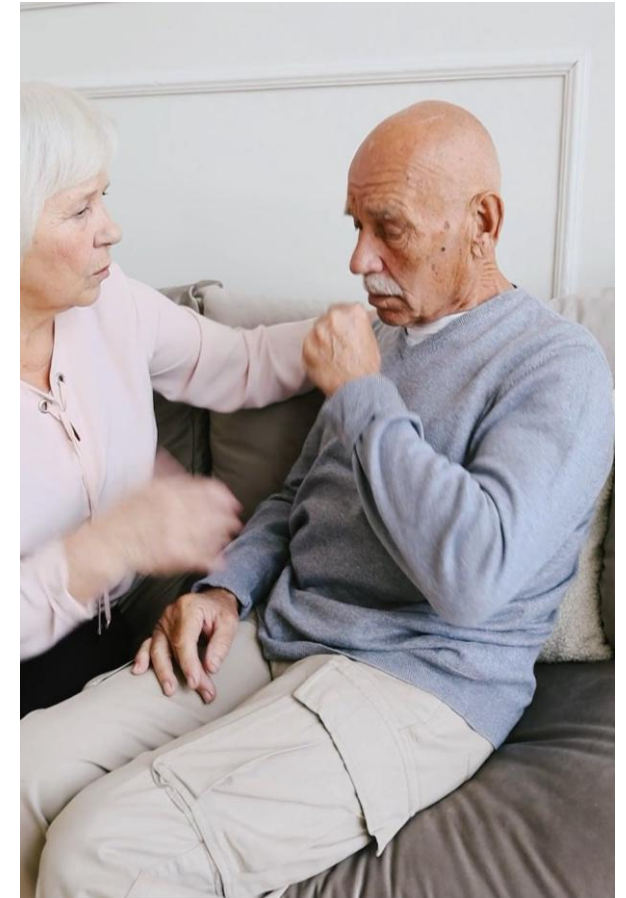
Improvement in Dyspnea in Star and VBP

- Improvement in Dyspnea –really means it takes a higher level of activity to create SOB
 - It can also mean that the patient does not do that activity any longer.
- Not mild, moderate, or severe SOB but what ACTIVITY is causing the SOB
- Scoring is not based on how often the dyspnea occurs; it may only be at night



Causes of Dyspnea... not just COPD

- Pneumonia and other resp infections
- COPD, Asthma, emphysema
- Heart conditions – CHF, cardiomyopathy, Afib
- Any tachycardia → what is cause
- Renal disease → fluid retention
- Liver disease → fluid retention, ascites
- Diabetes - ketoacidosis
- Obesity
- Anemia → low hemoglobin to carry the oxygen
- Neuro issues: Parkinson's, ALS
- Medications → Lopressor
- Deconditioning
- Pain
- Anxiety



Two Issues



Responding to the OASIS
item according to guidance.



Implementing interventions
to improve dyspnea.

Assessing Dyspnea

M1400 Dyspnea - Overview

SOC
ROC
DC

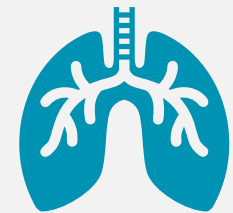
M1400. When is the patient dyspneic or noticeably Short of Breath?

Enter Code

0. **Patient is not short of breath**
1. **When walking more than 20 feet, climbing stairs**
2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) **or with agitation**
4. **At rest** (during day or night)

- Identifies the **level of exertion/activity** that results in a patient's dyspnea or shortness of breath
- Uses Oxygen continuously → assess WITH Oxygen
- Uses Oxygen intermittently → assess WITHOUT Oxygen
- Positional dyspnea at rest = 4

- Day of Assessment
- Baseline **before** interventions
- Observed or Reported
- Collaborate
- Examples are **illustrative**
- In chairbound & bedbound patients evaluate the level of exertion required to produce shortness of breath



Identifying Dyspnea

Dyspnea is a subjective sensation experienced and described differently by different patients

- Shortness of breath
- Trouble catching breath
- Unpleasant Breathing
- Labored, difficult breathing
- Uncomfortable sensation with breathing
- Awareness of breathing
- Winded or short-winded
- Unable to get enough air
- Breathlessness
- Air hunger
- Choking
- Suffocating, smothering
- Heavy breathing
- Plum tuckered out



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Assessing for Dyspnea

- ⦿ **Observation:** Any shallow, rapid or irregular breaths? Chest deformities? Nostrils flaring? Using accessory muscles? Pursed breathing? What is the respiratory rate? (everyone is not 16)
- ⦿ **Listen to the patient's lungs:** Auscultation of the lungs to identify any wheezing, crackles, or other abnormal sounds that may be indicative of a cause of dyspnea.
- ⦿ **Check vital signs:** Dyspnea can cause changes in vital signs, such as an increased heart rate and decreased **oxygen saturation** levels
- ⦿ **Assess** appetite, diet, fluid intake, weight loss/gain
- ⦿ **Look for signs of anxiety:** Dyspnea can cause anxiety and panic in patients. Patient can become agitated, restless, or fearful.

Assessing for Dyspnea

Review Medical Record:

- ⦿ Any underlying acute and/or conditions that could cause dyspnea
- ⦿ Any compliance issues with meds, treatments, appointments
- ⦿ Current smoker? History of?
- ⦿ Oxygen – what is ordered – how are they using it?
- ⦿ What respiratory meds?
- ⦿ What non resp meds? *Some can have side effects that cause dyspnea – like metoprolol*

Assessing for Dyspnea

Day of Assessment: Time spent in the home by the clinician and the preceding 24h

Ask the patient & caregiver:

- When does SOB occur?
- New or old? Is this SOB new or something the patient is used to?
- What seems to make it worse or better?
- How severe do they feel it is?
- When was the onset of the symptoms? Did they develop suddenly or gradually over time?
- Have they identified any triggers or aggravating factors?
- Are they taking meds and using oxygen as ordered? Have them demonstrate.
- Are they sleeping propped up on pillows or in a recliner?

Are you asking the right questions?

Assessing for Dyspnea

Day of Assessment: Time spent in the home by the clinician and the preceding 24h

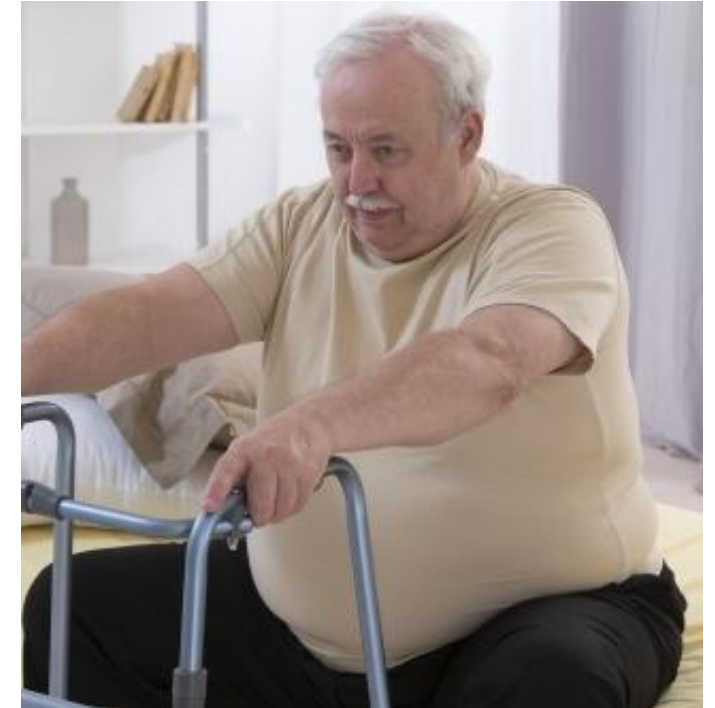
Observe, then ask the patient (caregiver): Do you feel SOB when...

- At rest? When you lay down? When you try to sleep?
- Eating or drinking?
- Talking, laughing?
- Agitated?
- Walking? What distance?
- Doing stairs? How many?
- Transferring
- Bathing?
- Bending over to put on or tie shoes?
- Using the bathroom?
- Getting dressed?
- Washing face?
- Brushing teeth?
- Scooping litter box?
- Letting dog in and out?
- Getting your meds from where they are kept?
- Cooking?
- When you go outside?

Are you asking the right questions?

Assessing for Dyspnea

- ⦿ Ambulate the patient!
- ⦿ Do stairs!
- ⦿ Get in and out of bed!
- ⦿ Get in and out of shower! Mimic washing feet and body!
- ⦿ Get on and off the toilet!
- ⦿ Mimic dressing activities...including shoes
- ⦿ If pt uses O2 intermittently – assess without
- ⦿ If pt uses continuously – assess with the oxygen
- ⦿ Keep in mind that the patient may have already made modifications in activity to avoid dyspnea.



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Are you short of breath?



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POLL | SELF ASSESSMENT

How would you rate your dyspnea right now:

- 0 – no SOB
- 1 – when walking more than 20 ft or climbing stairs
- 2 – with moderate exertions (ex: dressing, toilet, <20ft)
- 3 – with minimal exertion or with agitation
- 4 – at rest

What was the patient doing when Dyspnea occurred?

4 – Was the patient at **rest**? If no, then

3 – Was it with **minimal exertion**? If no, then

2 – Was it with **moderate exertion**? If no, then

1 – Walking more than 20 feet, climbing stairs, If no, then

0 – No shortness of breath



What activity is causing Dyspnea?

4 – At Rest

- During the Day or At Night
- Lying or sitting
- Positional Dyspnea
- Not asking if the dyspnea is severe, moderate or mild!



What activity is causing Dyspnea?

3 – Minimal Exertion or Agitation

- Eating
- Talking/Laughing
- With agitation
- Transferring
- Grooming – hair, teeth, face, etc.
- Other ADLs like tying shoes, or just putting arm in sleeve

Use your Clinical Judgment!



What activity is causing Dyspnea?

2 – Moderate Exertion

- Walking LESS than 20 feet
- Dressing
- Using Commode or bedpan
- Showering or bathing (could be minimal too)

Use your Clinical Judgment!



What activity is causing Dyspnea?

1 – walking more than 20 feet, climbing stairs

- Walking **more** than 20 feet
- Climbing stairs
- Demanding bed mobility or transfer activities

Use your Clinical Judgment!

Are you asking the right questions?



M1400 Dyspnea/Shortness of Breath

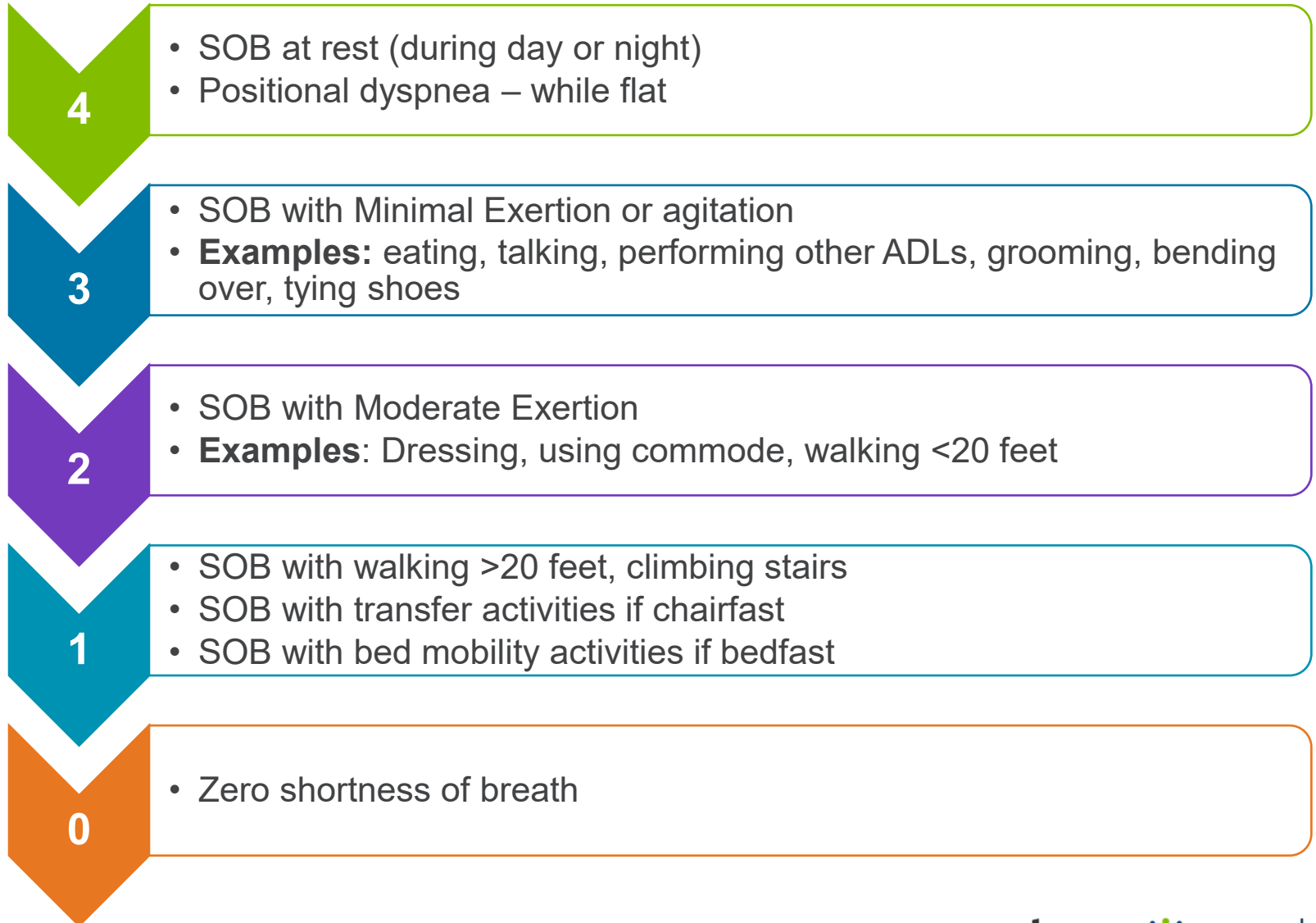
Dyspnea Flowchart

Trigger Words:

- Activity causing?
- Activity avoidance?
- Oxygen use?

**Review Respiratory Assessment*

VBP Item
***Star Item**



How do we improve Dyspnea?

Teamwork and Collaboration

- ⦿ Is everyone assessing for dyspnea?
- ⦿ Is everyone sharing identified dyspnea with the team? (including HHA)
- ⦿ Is improving dyspnea a goal for all team members?
- ⦿ Do all team members have this addressed in their interventions?
- ⦿ Are you discussing progress at interdisciplinary meetings?
- ⦿ DOCUMENT what activities cause dyspnea
- ⦿ Identify causes
- ⦿ Identify opportunities for improvement

Environmental Modifications for Energy Conservation

- Keep things needed for dressing, grooming, cooking, etc., together in easy to reach place
- Simplify routines for cooking, cleaning, chores
- Use a small table or rolling cart to move things around, avoid carrying heavy items, sit
- Do things slowly, pace activities, rest after meals
- Arrange home to avoid climbing stairs often
- Keep home air clean, avoid sprays and fumes
- Wear loose clothes, slip-on shoes
- Avoid going to stores during busy times, crowds
- Avoid very cold, windy or very hot, humid days



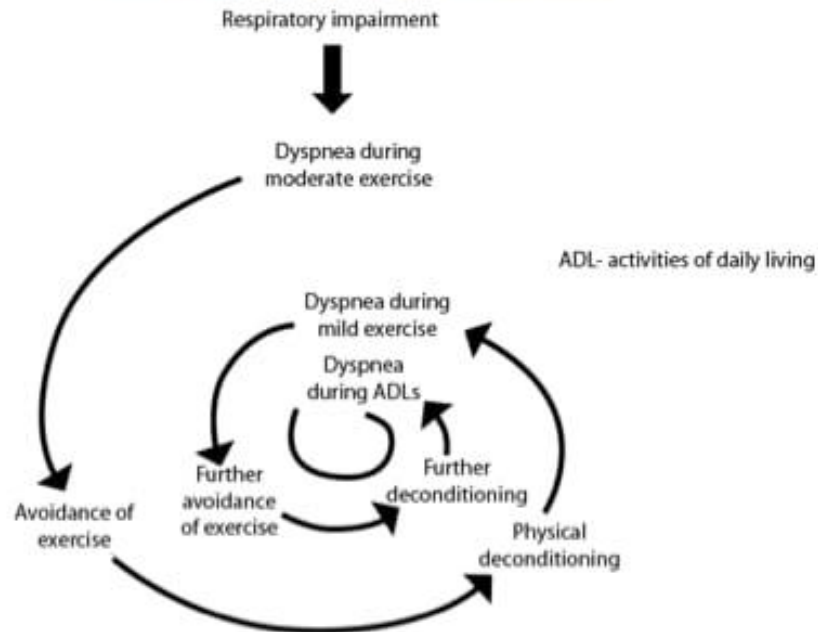
Environmental Modifications

- Patient sleeps with 2 pillows or in recliner and currently not short of breath at rest and otherwise not SOB
- Environmental modifications: If patient restricts an activity to remain free of dyspnea, can be a “0” or improved
- Arrange for mail delivery at door



Physical Therapy

The Dyspnea Spiral

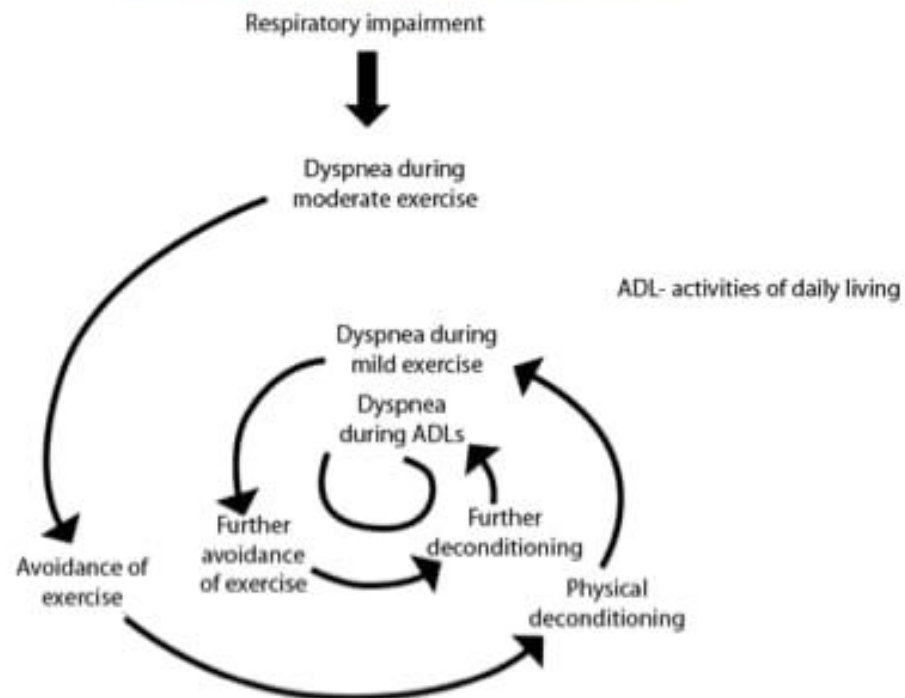


Haas F, et al. In: Casaburi R, Petty TL, eds. *Principles and Practice of Pulmonary Rehabilitation*. Philadelphia, Pa; Saunders; 1993.

- Identify and address difficulties with
 - muscle strength
 - flexibility
 - balance
 - activity intolerance
- Impaired functional mobility
 - Decreased quality of life
 - More hospitalizations
- Increased fall risk—COPD patients have a 55% higher risk of falls than non-COPD patients

Physical Therapy

The Dyspnea Spiral



Haas F, et al. In: Casaburi R, Petty TL, eds. *Principles and Practice of Pulmonary Rehabilitation*. Philadelphia, Pa; Saunders; 1993.

Identify and address difficulties with

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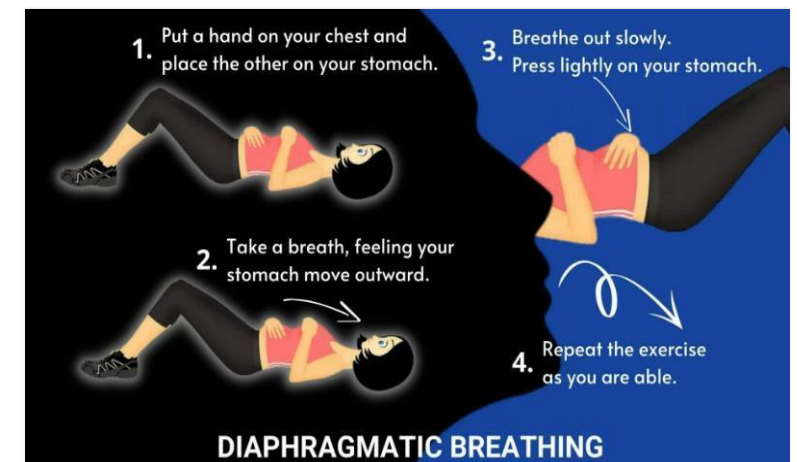
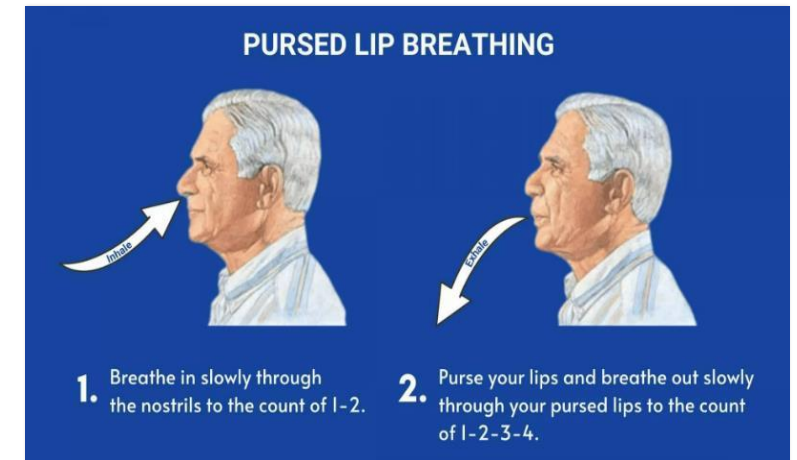
Impaired functional mobility

- Decreased quality of life
- More hospitalizations

Increased fall risk — COPD patients have a 55% higher risk of falls than non-COPD patients

Occupational Therapy

- Identify deficits
- Energy conservation
- Breathing exercises and techniques
- Equipment recommendation
- Environmental modifications
- Simplify activities
- Therapeutic exercises
- Self-monitoring
- Help create habits and routines



Speech Therapy

COPD is linked to dysphagia

- Presents as a cough – can be interpreted as symptom of COPD

Poor respiratory function can

- interrupt swallowing phases
- create inability to clear food
- create a lack of coordination between breathing and swallowing
- create a weakened cough reflex

- Assess for swallow deficits
- Recommend swallow strategies
- Teach on aspiration risks and prevention
- Teach swallowing exercises to improve pharyngeal muscle control
- Teach use of expiratory muscle training devices (EMST)
- Make diet texture/consistency recommendations
- Address cognitive deficits as well

Should we change our assessment?

- Do you feel you have any difficulty swallowing?
- Do you cough or choke when eating?
- Do you often feel like food goes down the wrong way?
- Do you cough or choke after drinking liquids?
- Do you feel like food is getting stuck in your throat?
- Do you experience pain or discomfort while swallowing?
- Are you able to swallow all of your medications?
- Have you had to change your diet due to swallowing difficulties?
- Are there certain types of food or liquids that seem more challenging to swallow?
- Have you noticed any food or liquid coming back up after swallowing?
- Have you noticed any changes in your voice or speech clarity?
- Do you feel like your voice is hoarse after eating or drinking?

Does the patient have any neurological conditions that may have impacted swallowing?

POLL | IMPROVE DYSPNEA

The disciplines that can help improve dyspnea are:

- Nursing
- PT
- OT
- ST
- All of the above

Nutrition

- Is the patient following the ORDERED diet?
- Diet teaching
 - Low sodium – if not followed, causes fluid retention
 - Renal diet – if not followed, causes fluid retention
 - Diabetic diet – if not followed, causes high glucose – can lead to ketoacidosis
 - Modified consistency – thickened liquids, ground meats, etc.
 - Obesity can contribute to dyspnea
- Is patient staying hydrated?
- Do they have access to healthy foods? Maybe SW referral?

Mental Status

- ⦿ Anxiety
- ⦿ Depression
- ⦿ Dementia
- ⦿ Confusion
- ⦿ Are these contributing to dyspnea?
- ⦿ What interventions can assist?
- ⦿ Are they adequately treated?



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Physician Follow-up

- ⦿ At SOC and ROC visit, ask about follow-up appointments with physicians
 - Recommended 7-14 days from hospital DC
- ⦿ Assist with scheduling appointments if needed
 - Communicate with family or caregivers
- ⦿ Identify barriers to keeping appointments
 - Arrange special transportation if needed
 - Therapy or MSW referral
 - Provide reminders to keep appointment
- ⦿ Follow up to make sure appointment kept



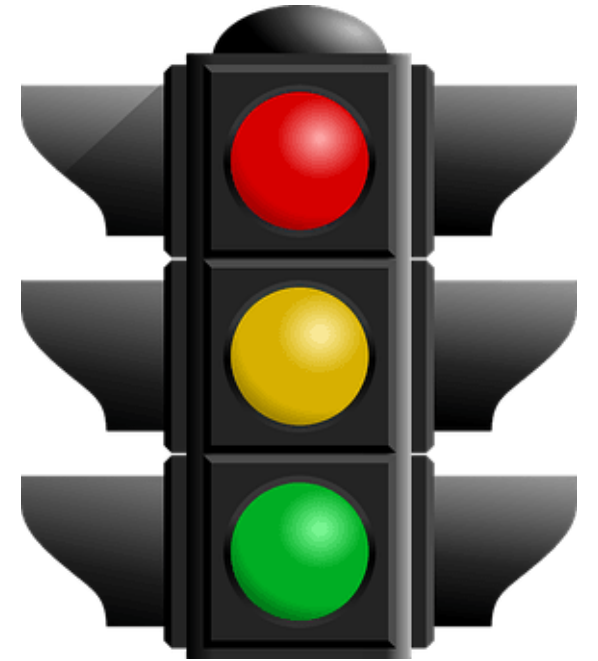
Use of Equipment & Medications

- ⦿ Oxygen use and safety
- ⦿ Clean and working equipment – nebulizers, CPAP, O2
- ⦿ Using nebs correctly?
- ⦿ Using Inhalers correctly?
- ⦿ Do not assume patients are using correctly
- ⦿ Emergency plan? What if power goes out? Do they have back up canister that does not require power?
- ⦿ Do they have all meds?
- ⦿ Plan in place to continue to get meds after discharge? Can they be delivered?

Stop Light Tools

- Identify pts at risk for hospitalization
 - Any hospitalizations related to dyspnea?
- Check with physician for parameters
- Teach Zone (stop light) tools for COPD and Heart Failure
- Discuss practice scenarios to help pt/cg gain confidence in identifying and managing s/sx of COPD or heart failure exacerbation
- Check out the AHA website for free printable tools

<https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources>



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Disease Management

- ① Assess knowledge of s/sx of disease process
 - Create Plan of Care/interventions to address deficits
- ① Set patient-specific goals, patient-centered POC
- ① Use educational materials appropriate for patient/caregiver learning level
- ① Correlate symptoms to adherence with treatment guidelines (meds, exercises, activity, etc.)
 - Teach monitoring of symptoms correlating to weight gain
- ① Practice decision-making skills using scenarios and emergency plan tools with pt and family

Example #1

Mrs. Mintz has had an exacerbation of her emphysema and says she doesn't always use her oxygen even though it is ordered 24/7. She doesn't like to be "tied down" with that tubing. She reports that she will wear it when she gets "winded."

- The last time she wore her oxygen was yesterday when she got too excited watching the Cowboys lose and couldn't catch her breath. She is using pursed breathing as she shows you that she can walk to the bathroom (10 ft) and does get out of breath when showing you how she dresses herself while sitting (all without oxygen). She has a bed set up in the dining room because she cannot make it up the stairs to the bedroom anymore.
- You ask her about her inhaler and she says she doesn't need any help—she's been using one for years. She then shows you how she does it. She doesn't use the spacer. The inhaler doesn't appear clean. She shakes it 2-3 times and then inhales 2 puffs in quick succession, holds her breath for 5 seconds and blows out hard. She says she does the 2 puffs 10-12 times per day. (The directions say no more than 12 puffs per day.)
- She's always running out before the prescription can be filled. She gets agitated about that, and she begins using her accessory muscles to catch her breath. She says it makes her very anxious.
- Her nebulizer doesn't look like it's been cleaned in a while.
- She often chokes on food, but mostly liquids.

Plan

- ⦿ Dyspnea is answered at 3 (day of assessment).
- ⦿ Oxygen use, nebulizer cleansing and use, inhaler correct use.
- ⦿ Decrease anxiety.
- ⦿ OT—Energy Conservation, simplify dressing, bathing
- ⦿ PT—work on deconditioning, equipment
- ⦿ SLP—dysphagia evaluation and modification of diet

At DC, she uses her oxygen 24/7 so dyspnea will be assessed with oxygen on. She uses her respiratory meds correctly. She's not as anxious about running out of her meds and her follow-up appointments with transportation are arranged ahead of time. She has adapted her ADLs and IADLs so that life is simpler. She takes her time eating and uses the swallowing techniques taught to her by SLP. She still has emphysema, still watches those Cowboys, but she is managing it better and dyspnea is scored a 1.

Example #2

Mr. Lorenzo is being admitted after a TKR. The nurse notes that Mr. Lorenzo is healthy—no HF or COPD and asks him about shortness of breath. He says it's not a problem and that before his knee got so bad he walked the mall every morning with a group of friends. His patient centered goal is to be able to do that again.

- Mr. Lorenzo is toe touch on his right with a walker and has an increased respiratory rate and pain when ambulating. It takes him some effort and assistance to get on and off the commode and in and out of the chair. He says he just needs a moment to rest while the pain ebbs.
- The nurse marks him a 0 on M1400 as he doesn't have any respiratory conditions and he stated he is not short of breath.
- Plan: Increased range of motion and strength and endurance.
- Missed opportunity: Mr. Lorenzo should have been marked a 2 because of the SOB in transferring and ambulation.

Summary

- ⦿ Interdisciplinary approach – everyone should have interventions and goals
- ⦿ Improve activity/exercise tolerance, mobility, etc.
- ⦿ Respiratory status addressed at every visit by every discipline
- ⦿ Consider pulmonary rehab program
- ⦿ Consider telehealth
- ⦿ Address environmental barriers
- ⦿ Address dietary/nutrition needs
- ⦿ Address underlying anxiety/depression/cognitive status
- ⦿ Ensure pt has meds and equipment and is compliant
- ⦿ Disease management teaching
- ⦿ Have goals related to activity causing dyspnea
- ⦿ Do not d/c until goals met

Meet with us



We would love to meet with you! Set up a free consultation to learn about...



Lisa Selman-Holman

VP Clinical Services

LisaSelman-Holman@McBeeAssociates.com



Michelle Horner

Clinical Consulting Manager

MichelleHorner@McBeeAssociates.com



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