

INTRODUCTION

ADVERSE EVENT OUTCOME REPORTS BINDER

The *Adverse Event Outcome Report* is a 3 part OASIS derived report produced by the Centers for Medicare & Medicaid Services (CMS) for each Home Health Agency to utilize in their Outcome-Based Quality Monitoring (OBQM) process. The findings reported pertain to your specific agency which are also compared/benchmarked with a reference group. This “reference group” consists of all patients served by all home health agencies who report OASIS data to CMS under the Medicare Conditions of Participation.

The reports which are downloaded from the state OASIS server (see “*Accessing OBQM Reports*” which can be downloaded from the CMS web site: www.hcfa.gov/medicaid/oasis/hhtrain.htm) are downloaded at a frequency determined by the agency. It is recommended that the first report cover a year span so that the agency can establish their annual findings and internal benchmark for the first year (2001). It is further recommended that subsequent reports are retrieved on a quarterly basis.

All *Adverse Event Outcomes* are required to be investigated. It is up to each agency to prioritize the outcomes for review and to establish the time interval to review care provided. The investigation of all 13 *Adverse Events Outcomes* can be phased over several months. The result of care review should be improvement plans in areas for improvement are identified. The ultimate goal is to reduce the incidents of *Adverse Events Outcomes*.

This *Adverse Events Outcome Report (AEOR) Binder* is intended to provide agencies with all the information and tools needed to manage, track, and respond to their *Adverse Event Outcome Reports* in a systematic way. Additionally, it will assist the agency in documenting their Outcome Based Quality Management activities and progress.

The most Frequently Asked Questions surveyors ask will be answered utilizing the tools contained inside this *AEOR Binder*.

1. Who is involved in *Adverse Event Outcome Report* investigation?
2. What *Adverse Event Outcomes* is the agency investigating?
3. When does the agency access and investigate *Adverse Event Outcome Reports*?
4. Where is the agency’s Outcome Based Quality Management activities documented? &
5. How does the agency use the *Adverse Event Outcome Reports*? How did the agency identify and prioritize the adverse event outcomes?

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