PUBLIC SUBMISSION

As of: January 16, 2009
Received: January 12, 2009
Status: Posted
Posted: January 14, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081b946
Comments Due: January 13, 2009
Submission Type: Web

Docket: CMS-2008-0141
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Comment On: CMS-2008-0141-0001
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Document: CMS-2008-0141-0061
MN

Submitter Information

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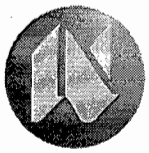
General Comment

Please view attachment below.

Attachments

CMS-2008-0141-0061.1: MN



North Memorial
Medical Center

#61

January 12, 2009

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulation Development
Attention: Document Identifier/OMB Control Number 0938-0760
Room CA-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

I am writing to comment on the proposed changes to the Outcome and Assessment Information Set, referred to as OASIS-C, noticed in the November 14, 2008 Federal Register. Document Identifier: CMS–R–245 (OMB# 0938–0760)

I support the use of OASIS as a comprehensive assessment tool and the OASIS reports as an effective measure to improve quality care to patients. However, I have the following comments regarding the OASIS-C changes.

Concern: **M0102** Date of Referral
***Suggestion for Change*:** Define the date of referral. Suggestions include altering item to read "Indicate the ordered date the agency is to initiate homecare." Differentiate between an inquiry about services and an actual referral for services. Not all referrals come from a physician so eliminate the word physician.
Rationale: .Clarification is necessary for consistent practice among agencies. Starting the services is not always within the home care provider's control. For example, providers may be waiting for authorization from Medicare Advantage programs which may delay the start of care; sometimes referrals are made while the patient is still hospitalized and home care is not able to start care for an extended period of time; and sometimes patients make the request not be seen on a certain day, also delaying the start of services. Provide direction for how agencies are to answer this question when the initial physician's order start of care is delayed. Does the date an agency updates the physician on the patient's availability for start of care become the referral date?

Concern: **MO104** Date of Physician-ordered start of care
Suggestion for change: eliminate this item. It is already recorded on the 485.
Rationale: If MO102 and MO104 are not within the 48 hour time frame, it would set an agency up for an audit without any further documentation that would support going beyond the initial 48 hours as indicated above. Back office operations should not be integrated into patient care.

Concern: **M1010 & 1012** Inpatient Diagnosis and ICD Code

Suggestion for Change: Eliminate this requirement. If CMS needs the data it is available from the hospitals.
Rationale: Not all institutions make this information available in a timely manner. Home health providers do not have access to this information without the timely cooperation of the institution from which the patient is discharged. This is an undue burden and unrealistic expectation because final hospital coding often does not occur until the hospital generates the bill. It is not realistic for home care clinicians to have knowledge of the coding requirements for inpatient facilities; requiring them to enter this information with insufficient or completed data from referrals sources will result in errors in a patient's medical record.

Concern: **M1014** Medical or Treatment Regimen Change
Suggestion for Change: Eliminate this item
Rationale: This information is collected in other M0 items

Concern: **M1032** Frailty Indicators
Suggestion for Change: Define unstable vital signs and clarify what is debilitating pain, recent mental health change and what constitutes a decline in functional status. Include items identified from home health agencies' work with the QIOs as included on the Hospitalization Risk Assessment Form at www.homehealthquality.org web site. The presence of high risk chronic diagnoses place a patient at risk for rehospitalization and speak to the fraility of their overall status. These include the diagnoses of CHF, diabetes, COPD, and chronic ulcers. Antibiotic resistant infections are an increasing challenge and should be included in this category. Environmental conditions or personal attributes such as low socioeconomic status, low literacy, inadequate support network, poor prognosis, shortened life expectancy, inability to manage own medications are all common in the home care population and are contributing factors to the frailty of the patients served. Eliminate this item from SOC
Rationale: At providers will not have historical data on vitals signs and it is unlikely that vital signs are monitored and recorded by patients/families. This makes it difficult to determine whether or not the vital signs are stable or unstable. What is stable for one patient may not be for another. Additionally, for consistent practice within the industry, it is imperative to have concise definitions for stable vital signs, debilitating pain, mental health changes and functional decline. Unclear instructions and definitions will result in unreliable data. Of concern also is that the frailty indicators are not measurable and "other" data would be clinically significant to the patient's home care episode but would not be retrievable from a text field.

Concern: **M1034** Stability Prognosis
Suggestion for Change: Eliminate.
Rationale: This language is similar to M0280 except that the predicted death time has changed. Providers should not have to guess at time of death. This leaves too much room for individual interpretations so data would not be useful.

Concern: **M1038** Guidelines for Physician Notification
Suggestion for Change: Delete this item

Rationale: Physicians already report excessive paperwork from the home care industry. Parameters will likely be different for each patient, depending on history and current health status. Physicians most likely will hesitate to provide this for individual patients. This seems excessively burdensome for providers and physicians. Additionally, surveyors are likely to use this as a reason for survey citation if it is not available on all patients. Ultimately, deciding parameters for individual patients is a physician responsibility and therefore not controllable by a provider. Eliminate the need for parameters for each patient. Home care clinicians are already required to notify a physician about changes in patient conditions that may impact the plan of care. There is no regulatory requirement for parameters. Not every patient requires parameters, and, if they are necessary, it can take time to establish them making it unrealistic to establish them at the start of care.

Concern: **M1040 through M1055** Vaccinations
Suggestion for Change: Clarify through CMS instructions that providers will not be mandated to provide vaccinations without payment for such. Eliminate "from your agency" verbiage and remove #1 and 2 in M1045.
Rationale: It is important to verify vaccination. However, providers should not have to assume the financial and resource burden of vaccination administration. There are more efficient ways to ensure vaccinations. Health Maintenance should be between the patient and physician, Home Health should not be used to drive physician behaviors.

Concern: **M1242** Formal Pain Assessment
Suggestion for Change: Make suggestions and list appropriate standardized assessment tools for pain. Eliminate this question on SOC.
Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care. Additionally, the use of one or two standardized assessment tools will help decrease data variance that is collected by providers. This question is about an agency process and comprehensive assessment tools, not about the patient plan of care. If a standardized pain assessment should be used, it should just be mandated to be done using a particular tool and not asked on every SOC assessment

Concern: **M1300 - M1306** - Pressure Ulcer Assessment
Suggestion for Change: Extend the SOC OASIS assessment time frame from 5 days to 7 days to allow collaboration between disciplines and to determine ability and availability of caregivers as well as the most effective wound care regimen.
Rationale: What if PT or a weekend person is admitting – does the assessment need to be done right away at SOC? It is unrealistic to get all of this done in the 5-day time frame. Consultation with staff outside the home care agency, for example a wound healing clinic, is often necessary to gather all pertinent clinical information. Again, this question is about an agency process and comprehensive assessment tools, not about the patient plan of care. If a standardized pressure ulcer assessment should be used, it should be mandated to be done using a particular tool and not asked on every SOC assessment.

Concern: **M1312 - M1314** Pressure Ulcer Length & Width
Suggestion for Change: Eliminate both items
Rationale: Requiring length and width of the wound does not meet the guidelines for measurement and assessment as established by the Wound, Ostomy and Continence Nurses Society (WOCN). This question does not ask for the components of a complete wound assessment; therefore clinicians will be required to complete redundant documentation in order to accurately document the wound condition. Providing only a length and width of a wound does not provide an accurate accounting of a wound status and is not best clinical practice. WOCN guidelines for wound measurement include a length that is measured at 12 o'clock to 6 o'clock with 12 o'clock always being toward the patient's head. Width is measured side to side from 3 o'clock to 9 o' clock. Simply asking for length and width does not support the guidelines.

Concern: **M1320** Status of Most Problematic Pressure Ulcer
Suggestion for Change: Clarify that this pertains only to stages 3 and 4
Rationale: A healed stage 1 or 2 would no longer be considered a pressure ulcer.

Concern: **M1326** Pressure Ulcer Intervention
Suggestion for Change: Eliminate this item.
Rationale: Moisture retentive dressings are noted on the 485 as supplies. It is in the home care clinician's area of expertise to recommend a wound treatment; however, the physician makes the final determination regarding orders for moisture retentive dressings. Physicians need be responsible for ordering such dressings.

Concern: **M1328** Pressure Ulcer Intervention
Suggestion for Change: Eliminate this item
Rationale: Moisture retentive dressings are noted on the 485 as supplies. It is in the home care clinician's area of expertise to recommend a wound treatment; however, the physician makes the final determination regarding orders for moisture retentive dressings. Physicians need be responsible for ordering such dressings. It is not the home care clinician's area of expertise or scope of practice to determine the use of moisture retentive dressings. Physicians need be responsible for ordering such dressings.

Concern: **M1360** Diabetic Foot Care Plan
Suggestion for Change: Do not collect this at start of care.
Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care.

Concern: **M1500** Symptoms of Heart Failure
Suggestion for Change: Eliminate this item.
Rationale: What if a therapist is doing an assessment and the patient has this diagnosis, even if it is not the primary or secondary diagnosis, how would you expect a therapist to have enough knowledge to answer this question, or if the nurse has been discontinued, to

have knowledge of what transpired during that episode of care without doing a chart review.

Concern: **M1730** Depression Screening
Suggestion for Change: Offer suggestions for specific screening tools
Rationale: Clinicians need to use a standardized screening tool in order to collect and report on standardize data. Comparison across patients will be less accurate if individual providers are using a wide variety of screening tools.

Concern: **M1734** Depression Intervention Plan
Suggestion for Change: Eliminate this from SOC.
Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care.

Concern: **M1880** Change in Mobility
Suggestion for Change: Eliminate this item
Rationale: What if the patient is better at transferring but not at ambulation – how should the question be answered? This is a very subjective assessment. Patients most likely will be worse than prior level of functioning if they are in need of home care services. What if they are worse as a result of surgery – is that considered an injury or illness onset? Various aspects of this item are unclear and likely will result in confusion and inaccurate answers.

Concern: **M1890** Change in Self-care Ability
Suggestion for Change: Eliminate this item
Rationale: What if the patient is better at dressing but not at bathing – how should the question be answered? This is a very subjective assessment. Patients most likely will be worse than prior level of functioning if they are in need of home care services. Various aspects of this item are unclear and likely will result in confusion and inaccurate answers

Concern: **M1910** Ability to use Telephone
Suggestion for Change: Eliminate this item
Rationale: This assessment is covered in an emergency plan and safety assessment.

Concern: **M1920** Change in Ability to Perform Household Tasks
Suggestion for Change: Eliminate this item
Rationale: What if the patient is better at meal preparation but not at laundry – how should the question be answered? This is a very subjective assessment. Patients most likely will be worse than prior level of functioning if they are in need of home care services. The question is too broad to achieve consistent and meaningful data.

Concern: **M1930** Has patient had multi-factor Falls Risk Assessment
Suggestion for Change: Recommend a standardized falls risk assessment.
Rationale: In order to have consistent data collection and comparison across patients and agencies, it is important for clinicians to collect data in a consistent manner.

Concern: **M1940** Falls Risk Assessment Intervention
Suggestion for Change: Do not require this at SOC
Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care.

Concern: **M2002** Medication Follow-up
Suggestion for Change: Eliminate the need to contact the physician within one day and clarify what is considered "contacted" – does that mean a message has been left via phone, a fax has been sent, the home care clinician contacted the physician's nurse or other staff? Define clinically significant. Does "contacted within one calendar day to resolve clinically significant medication issues" imply that both contact *and* resolution is expected in one day, or is the intent of the question to show contact within one day?
Rationale: What if the person completing the OASIS assessment isn't the same person doing the follow-up – does this result in 2 clinicians completing the OASIS assessment? What if the physician is contacted but nothing is resolved – what is the CMS expectation? Consider the discharge disposition for patients in assisted living facilities. The risk adjustment is inadequate. Patients move to assisted living BECAUSE they can't manage their medications and/or ADLs. It is unlikely they will recover the abilities and show improvement during a Medicare episode. This is especially problematic if the Assisted Living facility has a policy requiring the AL staff to administer all medications. This skews outcomes for this population. Is a pharmacist considered a primary care practitioner? What about weekend admissions – it is unlikely that the issue would be resolved in one day. Ability to "resolve" is dependent upon willingness and availability of practitioners outside of the home care provider's control. Providers should not be expected to resolve something that is outside of the scope of practice (ordering medications).

Concern: **M2004** Medication Interventions
Suggestion for Change: Eliminate this item
Rationale: It is unrealistic to expect the discharging or transferring clinician to know all of this without reviewing the entire medical record including looking at previous OASIS assessments. This is burdensome and time consuming to have to review an entire episode to make this determination. Additionally, previous instructions did not allow a "look-back" on OASIS – are those instructions no longer valid?

Concern: **M2020** Management of Oral Medications
Suggestion for Change: Go back to the question asking only about <u>prescription</u> medications (not <u>all</u> medications) and eliminate previous instructions to mark the patient as independent if taking the majority of medications. Further clarify how to answer the item choices – what if both 1 and 2 pertain – how should the question be answered?
Rationale: The actual medication has an impact on the patient's health status. For example, if a patient is taking Colace and a vitamin and remembers to take them but is also taking Digoxin but forgets to take it, the current assessment instructions would be to mark the patient as independent. In general, compliance with and ability to take

prescription medications impacts the outcome far greater than over-the-counter medications. Additionally, M2040 refers to all prescribed medications (including oral) when assessing a change in the management of medications. The difference in M02020 and M02040 is confusing and inconsistent.

Concern: **M2110** Types and Sources of Assistance Matrix
Suggestion for Change: Clarify how to answer this question. For example, in item a, what if the patient can do some of the tasks and not others? If they need help, does frequency impact the patient?
Rationale: Lack of direction will result in inconsistent and unreliable data.

Other general comments and concerns:
I am concerned that there were only 11 pilot agencies. This is not statistically significant. There are over 9,000 Medicare-certified providers. I suggest pilot studies on a much larger scale in order determine the feasibility and usefulness of the proposed OASIS changes.

Please also clarify what previous instructions still apply or no longer apply (i.e.: majority of the time, day of assessment etc.)

Expand the time frame for OASIS assessment completion to 7 days. Completion of OASIS assessment is burdensome for the patient in its current form and will become increasingly exhausting for the patient as all of the other assessments are added. Additionally, allow the recertification to be completed within the last 2 weeks of the certification period. This is less intrusive for the patient and more realistic for the provider. Excessive unbillable visits are being made in order to complete the assessment within the last five days of the certification period. The five-day completion requirement is burdensome to the provider in this time of worker shortages.

It will take considerable time and resources, initially and long-term, to implement these changes. With all of the other home care changes, this change will be overwhelming to clinicians. Already we are seeing clinicians leaving home care due to excessive paperwork. Adding length and completion time to an already cumbersome document is not acceptable. Any future changes to the OASIS assessment should be done in a more comprehensive manner, across care settings, and in conjunction with CMS implementation of the tool and process for the Post Acute Care Assessment.

Instead of asking if standardized assessment tools have been completed to assess pain and risks for skin breakdown, add a tool into the assessment that is approved by nationally recognized experts. This will prevent the need to duplicate documentation in more than one area of the clinical record since many agencies already have tools like the Braden scale and pain assessment scales as requirements in their documentation. This would also be beneficial for national benchmarking.

Please carefully consider our concerns before proceeding with the plan to change the OASIS as proposed.

Sincerely,

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PUBLIC SUBMISSION

As of: January 16, 2009
Received: January 12, 2009
Status: Posted
Posted: January 14, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081b988
Comments Due: January 13, 2009
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Docket: CMS-2008-0141
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Comment On: CMS-2008-0141-0001
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Document: CMS-2008-0141-0062
KS

Submitter Information

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WIchita, KS, 67206
Organization: Serenity Home Health

General Comment

see attachment

Attachments

CMS-2008-0141-0062.1: KS

Serenity
HOME HEALTH

#62

Monday, January 12, 2009

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulation Development
Attention: Document Identifier/OMB Control Number 0938-0760
Room CA-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

We are writing to comment on the proposed changes to the Outcome and Assessment Information Set, referred to as OASIS-C, noticed in the November 14, 2008 Federal Register. Document Identifier: CMS–R–245 (OMB# 0938–0760)

We support the use of OASIS as a comprehensive assessment tool and the OASIS reports as an effective measure to improve quality care to patients. However, we have the following comments regarding the OASIS-C changes and feel updates/changes are necessary to continue improving the effectiveness for its intended use. Input from the clinicians who utilize the tool is vital to enhance usability, compliance and effectiveness.

Concern: **M0102** Date of Referral

***Suggestion for Change*:** Define the date of referral. Suggestions include altering item to read "Indicate the ordered date the agency is to initiate homecare." Differentiate between an inquiry about services and an actual referral for services. Not all referrals come from a physician so eliminate the word physician. Consider making this item N/A for follow up, transfer and discharge.

Rationale: .Clarification is necessary for consistent practice among agencies. Starting the services is not always within the home care provider's control. For example, providers

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may be waiting for authorization from Medicare Advantage programs which may delay the start of care; sometimes referrals are made while the patient is still hospitalized and home care is not able to start care for an extended period of time; and sometimes patients make the request not be seen on a certain day, also delaying the start of services. Provide direction for how agencies are to answer this question when the initial physician's order start of care is delayed. Does the date an agency updates the physician on the patient's availability for start of care become the referral date?

Concern: **M1010 & 1012** Inpatient Diagnosis and ICD Code

Suggestion for Change: Eliminate this requirement. If CMS needs the data it is available from the hospitals.

Rationale: Not all institutions make this information available in a timely manner. Home health providers do not have access to this information without the timely cooperation of the institution from which the patient is discharged. This is an undue burden and unrealistic expectation because final hospital coding often does not occur until the hospital generates the bill. It is not realistic for home care clinicians to have knowledge of the coding requirements for inpatient facilities; requiring them to enter this information with insufficient or completed data from referrals sources will result in errors in a patient's medical record.

Concern: **M1014** Medical or Treatment Regimen Change

Suggestion for Change: Eliminate this item

Rationale: This information is collected in other M0 items

Concern: **M1032** Frailty Indicators

Suggestion for Change: Define unstable vital signs and clarify what is debilitating pain, recent mental health change and what constitutes a decline in functional status. Include items identified from home health agencies' work with the QIOs as included on the

Hospitalization Risk Assessment Form at www.homehealthquality.org web site. The presence of high risk, chronic diagnoses, places a patient at risk for rehospitalization and speak to the frailty of their overall status. These include the diagnoses of CHF, diabetes, COPD, and chronic ulcers. Antibiotic resistant infections are an increasing challenge and should be included in this category. Environmental conditions or personal attributes such as low socioeconomic status, low literacy, inadequate support network, poor prognosis, shortened life expectancy, inability to manage own medications are all common in the home care population and are contributing factors to the frailty of the patients served. Eliminate this item from SOC

Rationale: At providers will not have historical data on vitals signs and it is unlikely that vital signs are monitored and recorded by patients/families. Consider changing option 1 to abnormal vital signs at SOC. This makes it difficult to determine whether or not the vital signs are stable or unstable. Additionally, for consistent practice within the industry, it is imperative to have concise definitions for stable vital signs, debilitating pain, mental health changes and functional decline. Unclear instructions and definitions will result in unreliable data. Of concern also is that the frailty indicators are not measureable and "other" data would be clinically significant to the patient's home care episode but would not be retrievable from a text field.

Concern: **M1034** Stability Prognosis

Suggestion for Change: Eliminate # 3 - The patient has serious progressive conditions' that could lead to death within a year.

Rationale: This language is similar to M0280 except that the predicted death time has changed. Providers should not have to guess at time of death. It is not a question that reflects the actual and clinically substantiated status of the patient. Clinicians will have much difficulty differentiating between number 2 and number 3 in this item. Defining "serious complications" and "high health risks" by various clinicians will result in useless data. With one visit to obtain this data, and as subjective as the assessment is and with the

variables which occur day to day with patients, this data may not be helpful in predicting future risk.

Concern: **M1038** Guidelines for Physician Notification

Suggestion for Change: Delete this item

Rationale: Physicians already report excessive paperwork from the home care industry. Parameters will likely be different for each patient, depending on history and current health status. Physicians most likely will hesitate to provide this for individual patients. This seems excessively burdensome for providers and physicians. Additionally, surveyors are likely to use this as a reason for survey citation if it is not available on all patients. Ultimately, deciding parameters for individual patients is a physician responsibility and therefore not controllable by a provider. Eliminate the need for parameters for each patient. Home care clinicians are already required to notify a physician about changes in patient conditions that may impact the plan of care. There is no regulatory requirement for parameters. Not every patient requires parameters, and, if they are necessary, it can take time to establish them making it unrealistic to establish them at the start of care.

Concern: **M1040 through M1055** Vaccinations

Suggestion for Change: Clarify through CMS instructions that providers will not be mandated to provide vaccinations without payment for such. Eliminate "from your agency" verbiage.

Rationale: It is important to verify vaccination. However, providers should not have to assume the financial and resource burden of vaccination administration. There are more efficient ways to ensure vaccinations.

Concern: **M1100** Patient Living Situation

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Suggestion for Change: Consider using current item answers. Some options will be answered incorrectly secondary to confusion. If a patient lives alone, how would they be living alone only at nighttime? People do not live in assisted living during the daytime only (#12). A person can live alone around the clock, yet have short term assistance (# 04). Consistency from agency to agency will not likely occur without giving clear instruction (with examples). Consider revising this question altogether to avoid misinformation or useless information.

Concern: **M1242** Formal Pain Assessment

Suggestion for Change: Make suggestions and list appropriate standardized assessment tools for pain. Eliminate this question on SOC.

Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care. Additionally, the use of one or two standardized assessment tools will help decrease data variance that is collected by providers.

Concern: **M1300 - M1306** - Pressure Ulcer Assessment

Suggestion for Change: Extend the SOC OASIS assessment time frame from 5 days to 7 days to allow collaboration between disciplines and to determine ability and availability of caregivers as well as the most effective wound care regimen.

Rationale: What if PT or a weekend person is admitting – does the assessment need to be done right away at SOC? It is unrealistic to get all of this done in the 5-day time frame. Consultation with staff outside the home care agency, for example a wound healing clinic, is often necessary to gather all pertinent clinical information. Also M1304 is asking about the POC which has not been developed at the initial visit, extending the assessment time frame may help. Consider changing the word "does" to "will" when referencing the physician ordered plan of care, as it is in the developing stages at initial

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visit; another option would be to say: Agency requesting interventions to prevent pressure ulcers in the plan of care.

Concern: **M1312 - M1314** Pressure Ulcer Length & Width

Suggestion for Change: Eliminate both items

Rationale: Requiring length and width of the wound does not meet the guidelines for measurement and assessment as established by the Wound, Ostomy and Continence Nurses Society (WOCN). This question does not ask for the components of a complete wound assessment; therefore clinicians will be required to complete redundant documentation in order to accurately document the wound condition. Providing only a length and width of a wound does not provide an accurate accounting of a wound status and is not best clinical practice. WOCN guidelines for wound measurement include a length that is measured at 12 o'clock to 6 o'clock with 12 o'clock always being toward the patient's head. Width is measured side to side from 3 o'clock to 9 o' clock. Simply asking for length and width does not support the guidelines.

Concern: **M1320** Status of Most Problematic Pressure Ulcer

Suggestion for Change: Clarify that this pertains only to stages 3 and 4

Rationale: A healed stage 1 or 2 would no longer be considered a pressure ulcer.

Concern: **M1326** Pressure Ulcer Intervention

Suggestion for Change: Eliminate this item.

Rationale: Moisture retentive dressings are noted on the 485 as supplies. It is in the home care clinician's area of expertise to recommend a wound treatment; however, the physician makes the final determination regarding orders for moisture retentive dressings. Physicians need be responsible for ordering such dressings.

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Serenity
HOME HEALTH

Concern: **M1328** Pressure Ulcer Intervention

Suggestion for Change: Eliminate this item

Rationale: Moisture retentive dressings are noted on the 485 as supplies. It is in the home care clinician's area of expertise to recommend a wound treatment; however, the physician makes the final determination regarding orders for moisture retentive dressings. Physicians need be responsible for ordering such dressings. It is not the home care clinician's area of expertise or scope of practice to determine the use of moisture retentive dressings. Physicians need be responsible for ordering such dressings.

Concern: **M1360** Diabetic Foot Care Plan

Suggestion for Change: Do not collect this at start of care.

Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care.

Concern: **M1500** Symptoms of Heart Failure

Suggestion for Change: Clarify what heart failure guidelines include, one symptom or combination of all symptoms referred to in question? Omit the statement "since last oasis assessment". Consider rewording with a time frame instead, such as: In the last 3 months, has the patient exhibited symptoms of heart failure according to clinical heart failure guidelines. *Recommend referencing where these clinical guidelines are found.*

Rationale: Improve data collection by having all clinicians doing the same type of assessment and utilizing the same clinical guidelines.

Concern: **M1730** Depression Screening

Suggestion for Change: Offer suggestions for specific screening tools

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Rationale: Clinicians need to use a standardized screening tool in order to collect and report on standardize data. Comparison across patients will be less accurate if individual providers are using a wide variety of screening tools.

Concern: **M1734** Depression Intervention Plan

Suggestion for Change: Eliminate this from SOC.

Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care. Medications for depression could be noted in this question, but referrals and/or monitoring will be decided or discovered after the initial visit.

Concern: **M1880** Change in Mobility

Suggestion for Change: Eliminate this item

Rationale: What if the patient is better at transferring but not at ambulation – how should the question be answered? This is a very subjective assessment. Patients most likely will be worse than prior level of functioning if they are in need of home care services. What if they are worse as a result of surgery – is that considered an injury or illness onset? Various aspects of this item are unclear and likely will result in confusion and inaccurate answers.

Concern: **M1890** Change in Self-care Ability

Suggestion for Change: Eliminate this item or consider adding the phrase "per patient/caregiver report"

Rationale: What if the patient is better at dressing but not at bathing – how should the question be answered? This is a very subjective assessment and/or takes a complete physical and occupational therapy evaluation to get the most accurate answer. Patients most likely will be worse than prior level of functioning if they are in need of home care

services. Various aspects of this item are unclear and likely will result in confusion and inaccurate answers

Concern: **M1920** Change in Ability to Perform Household Tasks
Suggestion for Change: Eliminate this item or consider adding "per patient and/or caregiver report".
Rationale: What if the patient is better at meal preparation but not at laundry – how should the question be answered? This is a very subjective assessment. Patients most likely will be worse than prior level of functioning if they are in need of home care services. The question is too broad to achieve consistent and meaningful data.

Concern: **M1930** Has patient had multi-factor Falls Risk Assessment
Suggestion for Change: Recommend one or two standardized falls risk assessments.
Rationale: In order to have consistent data collection and comparison across patients and agencies, it is important for clinicians to collect data in a consistent manner.

Concern: **M1940** Falls Risk Assessment Intervention
Suggestion for Change: Do not require this at SOC
Rationale: The physician-ordered plan of care is not yet established at the time of SOC OASIS assessment since this time is actually a data-gathering time on which the clinician bases the plan of care.

Concern: **M1945 Falls Risk Intervention**
Suggestion for Change: Add NA or skip at SOC. This will not be applicable or known if SOC or agency has changed.

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Serenity
HOME HEALTH

Concern: **M2002** Medication Follow-up

Suggestion for Change: Eliminate the need to contact the physician within one day and clarify what is considered "contacted" – does that mean a message has been left via phone, a fax has been sent, the home care clinician contacted the physician's nurse or other staff? Define clinically significant. Does "contacted within one calendar day to resolve clinically significant medication issues" imply that both contact *and* resolution is expected in one day, or is the intent of the question to show contact within one day?

Rationale: What if the person completing the OASIS assessment isn't the same person doing the follow-up – does this result in 2 clinicians completing the OASIS assessment? What if the physician is contacted but nothing is resolved – what is the CMS expectation? Consider the discharge disposition for patients in assisted living facilities. The risk adjustment is inadequate. Patients move to assisted living BECAUSE they can't manage their medications and/or ADLs. It is unlikely they will recover the abilities and show improvement during a Medicare episode. This is especially problematic if the Assisted Living facility has a policy requiring the AL staff to administer all medications. This skews outcomes for this population. Is a pharmacist considered a primary care practitioner? What about weekend admissions – it is unlikely that the issue would be resolved in one day. Ability to "resolve" is dependent upon willingness and availability of practitioners outside of the home care provider's control. Providers should not be expected to resolve something that is outside of the scope of practice (ordering medications).

Concern: **M2004** Medication Interventions

Suggestion for Change: Eliminate this item

Rationale: It is unrealistic to expect the discharging or transferring clinician to know all of this without reviewing the entire medical record including looking at previous OASIS assessments. This is burdensome and time consuming to have to review an entire episode

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to make this determination. Additionally, previous instructions did not allow a "look-back" on OASIS – are those instructions no longer valid?

Concern: **2015 Patient/Caregiver Drug Education Intervention**

Suggestion for Change: This will be NA at SOC or unknown if previous episode was with another HHA.

Concern: **M2020** Management of Oral Medications

Suggestion for Change: Go back to the question asking only about prescription medications (not all medications) and eliminate previous instructions to mark the patient as independent if taking the majority of medications. Further clarify how to answer the item choices – what if both 1 and 2 pertain – how should the question be answered?

Rationale: The actual medication has an impact on the patient's health status. For example, if a patient is taking Colace and a vitamin and remembers to take them but is also taking Digoxin but forgets to take it, the current assessment instructions would be to mark the patient as independent. In general, compliance with and ability to take prescription medications impacts the outcome far greater than over-the-counter medications. Additionally, M2040 refers to all prescribed medications (including oral) when assessing a change in the management of medications. The difference in M02020 and M02040 is confusing and inconsistent. Also consider the population served in home health often will never improve from 1 to 0 and we would not want many of them to. An example is when the patient/caregiver is using a medication planner; it is often the safest way to manage the medications and why would our preferred status be a 1 over 0? This has never been a good example of documenting improvement in outcomes.

Concern: **M2110** Types and Sources of Assistance Matrix

Suggestion for Change: Clarify how to answer this question. For example, in item a, what if the patient can do some of the tasks and not others? If they need help, does frequency impact the patient?

Rationale: Lack of direction will result in inconsistent and unreliable data.

Other general comments and concerns:

We are concerned that there were only 11 pilot agencies. This is not statistically significant. There are over 9,000 Medicare-certified providers. We suggest pilot studies on a much larger scale in order determine the feasibility and usefulness of the proposed OASIS changes.

Please also clarify what previous instructions still apply or no longer apply (i.e.: majority of the time, day of assessment etc.)

Expand the time frame for OASIS assessment completion to 7 days. Completion of OASIS assessment is burdensome for the patient in its current form and will become increasingly exhausting for the patient as all of the other assessments are added. Additionally, allow the recertification to be completed within the last 2 weeks of the certification period. This is less intrusive for the patient and more realistic for the provider. Excessive unbillable visits are being made in order to complete the assessment within the last five days of the certification period. The five-day completion requirement is burdensome to the provider in this time of worker shortages.

It will take considerable time and resources, initially and long-term, to implement these changes. With all of the other home care changes, this change will be overwhelming to clinicians. Already we are seeing clinicians leaving home care due to excessive paperwork. Adding length and completion time to an already cumbersome document is not acceptable. Any future changes to the OASIS assessment should be done in a more comprehensive manner, across care settings, and in conjunction with CMS implementation of the tool and process for the Post Acute Care Assessment.

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Instead of asking if standardized assessment tools have been completed to assess pain and risks for skin breakdown, add a tool into the assessment that is approved by nationally recognized experts. This will prevent the need to duplicate documentation in more than one area of the clinical record since many agencies already have tools like the Braden scale and pain assessment scales as requirements in their documentation. This would also be beneficial for national benchmarking.

Please carefully consider our concerns before proceeding with the plan to change the OASIS as proposed.

Sincerely,

Martha L. Slack, R.N., HCS-D
Vice President – Patient Care
Serenity Home Health, LLC

PUBLIC SUBMISSION

As of: January 16, 2009
Received: January 12, 2009
Status: Posted
Posted: January 14, 2009
Category: Health Care Professional/Association - Nurse
Tracking No. 8081b9c6
Comments Due: January 13, 2009
Submission Type: Web

Docket: CMS-2008-0141
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Comment On: CMS-2008-0141-0001
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Document: CMS-2008-0141-0063
CA

Submitter Information

Name: Carolann Cody
Address:
North Hills, CA, 91343

General Comment

Please see attached letter

Attachments

CMS-2008-0141-0063.1: CA

#63

January 9, 2009

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulation Development
Attention: Document Identifier/OMB Control Number 0938-0760
Room CA-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

To Whom It May Concern:

I am writing to comment on the proposed changes to the Outcome and Assessment Information Set, referred to as OASIS-C, noticed in the November 14, 2008 Federal Register.

The proposed document represents a significant increase in paperwork burden and process problems. The data set questions mix process items with assessment. Notifying the physician of abnormal findings and obtaining orders for interventions are what home care practitioners do as a standard of practice. Asking data set questions regarding the plan of treatment and doctor's orders as part of an assessment does not make sense. These items are covered on the 485. Questions on each assessment regarding pain, pressure ulcer risk utilizing a standardized tool are also redundant. Utilizing standardized tools for assessment are process issues for agencies, not specific to patients or clinicians. I understand the desire to improve care and outcomes, but attempting to do so via a standardized collection tool does not seem the appropriate method to achieve those goals.

The cost to agencies to incorporate the changes, documents, data entry, staff training are significant. Further implications may include the need to increase non-billable Registered Nurse visits to perform the admissions. In the current environment with a shortage of nursing staff, this is not good utilization of their knowledge or skill.

Further field testing and evaluation of the cost/benefit of the proposed OASIS-C tool should be performed before its implementation.

Sincerely,

Carolann Cody MSN, RN
Director of Patient Care Services/Branch Manager

PUBLIC SUBMISSION

As of: January 16, 2009
Received: January 12, 2009
Status: Posted
Posted: January 14, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081ba16
Comments Due: January 13, 2009
Submission Type: Web

Docket: CMS-2008-0141
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Comment On: CMS-2008-0141-0001
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Document: CMS-2008-0141-0064
WI

Submitter Information

Name: Karen Jeffrey
Address:
Milwaukee, WI, 53227
Organization: Aurora Visiting Nurse Association

General Comment

Please see Attached

Attachments

CMS-2008-0141-0064.1: WI

OASIS – C Question

- M0140

#69

Reason for Comment

- Race/Ethnicity list is not all inclusive

Alternatives/Recommendations

- Add selection #7 - Other

Improvement of clarity, usefulness, or quality of data

- As a patient's race is what they define it to be, the additional option is needed.
- A patient who states their race is "Middle Eastern" does not fall into the listed choices.

Enhancement to reporting/measurement of patient outcomes

- Allows health care providers to answer the question more accurately thus increasing the reliability of the data collected.

Proposed Question(s)

M0140 Race/Ethnicity: (Mark all that apply)

1. – American Indian or Alaska Native
2. – Asian
3. – Black or African-American
4. – Hispanic or Latino
5. – Native Hawaiian or Pacific Islander
6. – White
7. – Other

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1032

Reason for Comment

- Clarity of answers
- Increase inter rater reliability

Alternatives/Recommendations

- Add, "outside of individual patient parameters" to answer 1
- Add, "per patient report if verbal or non-verbal pain scale rating if non-verbal" to answer 2
- Add, "unplanned hospitalizations" to answer 5

Improvement of clarity, usefulness, or quality of data

- Unstable vital signs is an ambiguous statement and open to large interpretation, adding the statement, "outside of individual patient parameters" gives direct, clear guidance
- Debilitating pain can be overlooked by clinicians if not asked of patient or assessed via non-verbal pain rating
- Planned hospitalizations should not be included because some patient's are hospitalized for planned interventions that are not indicators of frailty

Enhancement to reporting/measurement of patient outcomes

- Increased inter rater reliability
- Increased validity of data

Proposed Question(s)

M1032: Frailty Indicators: Which of the following signs or symptoms characterize this patient as at risk for major decline or hospitalization? (Mark all that apply)

1. Unstable vital signs (outside of individual patient parameters)
2. Debilitating pain (per patient report if verbal or non-verbal pain scale rating if non-verbal)
3. Recent decline in mental status
4. Recent functional decline
5. Multiple unplanned hospitalizations (>1) in the past 12 months
6. History of falls (2 or more falls – or any fall with an injury in the past 12 months)
7. Other
8. None of the Above

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1034

Reason for Comment

- Patient may be at high risk for serious complications but not death

Alternatives/Recommendations

- Change "and death" to "or death" in answer 2

Improvement of clarity, usefulness, or quality of data

- Allows clinicians to demonstrate patient's fragile status
- Offers a choice for the patient who is a serious high risk but death is not imminent

Enhancement to reporting/measurement of patient outcomes

- Increases validity of final data

Proposed Question(s)

M1034: Stability Prognosis: Which description best fits the patient's overall status? (Check one)

0. The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age)
1. The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age)
2. The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications or death.
3. The patient has serious progressive conditions that could lead to death within a year.

UK – The patient's condition is unknown or unclear

OASIS – C Question

- M1036

Reason for Comment

- Clarification of Obesity

Alternatives/Recommendations

- Add BMI parameter to Obesity

Improvement of clarity, usefulness, or quality of data

- Answer will only be selected if patient is truly obese leading to more valid data

Enhancement to reporting/measurement of patient outcomes

- Increased inter rater reliability

Proposed Question(s)

M1036: Risk Factors characterizing this patient (Mark all that apply)

1. Smoking
2. Obesity (BMI $\geq$ 30)
3. Alcohol dependency
4. Drug dependency
5. None of the above

UK - Unknown

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1038

Reason for Comment

- The topic of this question is an individual agency policy issue and is not required to be physician ordered for all circumstances.

Alternatives/Recommendations

- Remove question

OASIS – C Question

- M1240

Reason for Comment

- If patient reporting no pain, no need to continue with following questions

Alternatives/Recommendations

- Add "Go to M1300" to answer 0

Improvement of clarity, usefulness, or quality of data

- Allows for maneuvering through documentation in logical manner

Enhancement to reporting/measurement of patient outcomes

- M1242, M1244, and M1246 will only be answered if patient is having pain. This will increase the validity of data regarding management of pain.

Proposed Question(s)

M1240: Frequency of Pain interfering with patient's activity or movement:

0. Patient has no pain [Go to 1300]
1. Patient has pain that does not interfere with activity or movement
2. Less often than daily
3. Daily, but not constantly
4. All of the time

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1300

Reason for Comment

- Examples listed in answer 2 are the same items utilized by the standardized tools
- In addition to standardized tools age and nutrition play a factor in risk of pressure ulcers

Alternatives/Recommendations

- Change question to eliminate choice 1 as this is repetitive
- Add question to data set listing risk factors

Improvement of clarity, usefulness, or quality of data

- Will increase the usefulness of the tool by separating the patient's problems allowing the clinicians to create more patient specific care plans
- Will allow tracking within geographic locations to analyze data regarding potential trends

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Increases data gathered
- Allows specific problems to be monitored for outcomes

Proposed Question(s)

M1300: Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

0. No assessment conducted [Go to M1308]
1. Yes

M1301: Pressure Ulcer Risk Factors present for this patient (Mark all that apply)

1. Age 75 and older
2. Nutrition
3. Sensory perception
4. Moisture
5. Activity
6. Mobility
7. Friction/Shear

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1312
- M1314

Reason for Comment

- Research states measurements using longest length and widest width perpendicular to this length may not always be measured in the same spot consistently. "This inconsistency augments the error inherent in the calculation of the size based on length x width. Such error may result in an over-optimistic assessment of the wound and delay in the re-evaluation of the treatment plan and implementation of beneficial treatment. To mitigate this problem, the head to foot and perpendicular measurements should be used."[1]

Alternatives/Recommendations

- Change length measurement to: Head to Toe
- Change width measurement to: Side to Side (at widest point)

Improvement of clarity, usefulness, or quality of data

- Wounds will be measured consistently every time regardless of clinician

Enhancement to reporting/measurement of patient outcomes

- This methodology will provide clarity in determining whether or not wound is healing.

Proposed Question(s)

M1312: Pressure Ulcer Length: Measure Head to Toe - |__|__| . |__| (cm)

M1314: Pressure Ulcer Width: Width of same pressure ulcer, greatest width measured at right angles to length |__|__| . |__| (cm)

1 –*The Prevention and Treatment of Pressure Ulcers*. (2001). In M. Morison (Ed.). *Assessing a patient with a pressure ulcer* (p.). London: Harcourt Publishers Limited.

OASIS – C Question

- M1400

Reason for Comment

- There is a large energy consumption difference between walking 20 feet and climbing a flight of stairs

Alternatives/Recommendations

- Separate answer 1 into two answers

Improvement of clarity, usefulness, or quality of data

- Allows clinicians to answer question in more detail

Enhancement to reporting/measurement of patient outcomes

- Allows improvements made during the course of treatment to be measured in greater detail

Proposed Question(s)

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

0. Patient is not short of breath
1. When climbing flight of stairs or walking more than 100 feet
2. When walking 20 feet to 100 feet
3. With moderate exertion (e.g. while dressing, using commode or bedpan, walking distances less than 20 feet)
4. With minimal exertion (e.g. while eating, talking, or performing other ADLs) or with agitation
5. At rest (during day or night)

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1410

Reason for Comment

- Nebulizers and Bi-PAP are respiratory treatments seen often in home care and involve more education than some of the other choices in this answer

Alternatives/Recommendations

- Add Nebulizer and Bi-PAP as choices for answering this question

Improvement of clarity, usefulness, or quality of data

- Adds to the helpfulness of the OASIS to care planning
- Adds to the monitoring of patient needs

Enhancement to reporting/measurement of patient outcomes

- Adds tracking information regarding important Respiratory Treatments
- Allows for measurement of additional equipment use in the home

Proposed Question(s)

M1410: Respiratory Treatments utilized at home: (Mark all that apply)

1. Oxygen (intermittent or continuous)
2. Ventilator (continually or at night)
3. Continuous positive airway pressure
4. Bi-PAP
5. Nebulizer
6. None of the Above

OASIS – C Question

- M1500

Reason for Comment

- If patient does not have diagnosis of heart failure, no need to answer M1510

Alternatives/Recommendations

- Add, "Go to M1736 at TRN; Go to M1600 at DC" to answer NA

Improvement of clarity, usefulness, or quality of data

- Allows for maneuvering through documentation in logical manner

Enhancement to reporting/measurement of patient outcomes

- M1510 will only be answered for patients who have a diagnosis of Heart Failure

Proposed Question(s)

M1500: Symptoms of Heart Failure: Since the previous OASIS assessment, did the patient exhibit symptoms of heart failure indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point?

0. No {Go to M1736 at TRN; Go to M1600 at DC]
1. Yes
2. Not assessed [Go to M1736 at TRN; Go to M1600 at DC]

NA – Patient does not have diagnosis of heart failure [Go to M1736 at TRN; Go to M1600 at DC]

OASIS – C Question

- M1510

Reason for Comment

- Proposed change to M1500 dictates a change to this OASIS item
- Other actions can be taken for Heart Failure as this is not an all inclusive list
- There is no time that no action would be taken if a patient is experiencing symptoms of heart failure
- Interventions provided regarding heart failure do not have to be physician ordered

Alternatives/Recommendations

- Change answer NA to answer 6 – Other
- Remove answer 0
- Remove "Physician-ordered" from answer 3

Improvement of clarity, usefulness, or quality of data

- Adds an additional choice when the intervention is not listed
- Follows proper sequencing if proposed change to M1500 is made
- Allows documentation of nursing interventions

Enhancement to reporting/measurement of patient outcomes

- Allows more complete reporting of data with the addition of Other
- Inclusion of any intervention applied, not just physician ordered

Proposed Question(s)

M1510: Heart Failure Follow-up: Since the previous OASIS assessment, what action(s) has (have) been taken to respond to each instance of heart failure? (Mark all that apply)

1. Patient's physician (or other primary care practitioner) contacted the same day
2. Patient advised to get emergency treatment (e.g. call 911 or go to the emergency room)
3. Implement patient-specific established parameters for treatment
4. Patient education about symptoms and management
5. Obtained change in care plan orders (e.g. increased monitoring by agency, change in visit frequency, telehealth, etc.)
6. Other

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1610

Reason for Comment

- Clinicians have inadvertently chosen answer 0 when patients have a urinary catheter.
- Answer as written can be confusing…No incontinence or catheter (includes anuria or ostomy for urinary drainage.)
- In their mind, clinician adding 'has a catheter'

Alternatives/Recommendations

- Replace the words 'or catheter' with the words AND NO CATHETER.

Improvement of clarity, usefulness, or quality of data

- Improved clarity of answer will improve clinicians ability to choose correct response

Enhancement to reporting/measurement of patient outcomes

- Accurate depiction of urinary status allows clinician to create individualized care plan accordingly.

Proposed Question(s)

M1610: Urinary Incontinence or Urinary Catheter Presece:
0 – No incontinence and no urinary catheter (includes anuria or ostomy for urinary drainage) **(Go to M1620)**
1 - Patient is incontinent
2 - Patient requires a urinary catheter (i.e.,external, indwelling, intermittent, suprapubic) **(Go to M 1620)**

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1740

Reason for Comment

- Self-neglect is a demonstrated behavior that can lead to serious or fatal consequences.

Alternatives/Recommendations

- Add Self-neglect to list of choices.

Improvement of clarity, usefulness, or quality of data

- Assists with care planning
- Assists with determining needed resources

Enhancement to reporting/measurement of patient outcomes

- Identifies high risk patient and can determine if successful interventions were used during course of patient's care

Proposed Question(s)

M1740: Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)

1. Memory deficit:
2. Impaired decision making:
3. Self neglect: failure to take medications as prescribed, perform self cares or have another perform self cares, etc.
4. Verbal disruption:
5. Physical aggression
6. Disruptive, infantile, or socially inappropriate behavior
7. Delusional, hallucinatory, or paranoid behavior
8. None of the above behaviors demonstrated

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1745

Reason for Comment

- With the examples listed in the question, the reader does not know that the items from M1740 apply to the frequency questioned

Alternatives/Recommendations

- Add "Items in M1740 and/or" to the examples listed in the question.

Improvement of clarity, usefulness, or quality of data

- Provides clarity to the clinician knowing what behavior problem frequency to report

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Increases reliability of the data

Proposed Question(s)

M1745: Frequency of Behavior Problems (Reported or Observed) (e.g., Items in M1740 and/or wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1840

Reason for Comment

- There is a vast difference between using a bedpan and using a urinal
- Interest in detailed information gathering through OASIS

Alternatives/Recommendations

- Separate bedpan and urinal use into two separate questions

Improvement of clarity, usefulness, or quality of data

- Increases ability to show patient's true status

Enhancement to reporting/measurement of patient outcomes

- Provides additional information to be used in demonstrating patient outcomes

Proposed Question(s)

M1840: Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

0. Able to get to and from the toilet and transfer independently with or without a device.
1. When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer.
2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
3. Unable to get to and from the toilet or bedside commode but is able to use a urinal independently.
4. Unable to get to and from the toilet or bedside commode but is able to use a bedpan independently.
5. Is totally dependent in toileting.

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1850

Reason for Comment

- Provide guidelines for transfer assistance within the question

Alternatives/Recommendations

- Add examples of minimal human assistance to answer #1
- Add hoyer lift as an example to answer #3

Improvement of clarity, usefulness, or quality of data

- Provides clear guidelines regarding selection of answer

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Accuracy of outcome data will be increased

Proposed Question(s)

M1850: Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bed fast.

0. Able to independently transfer
1. Able to transfer with minimal human assistance (stand by assist, verbal cues, touch assistance) or with the use of an assistive device.
2. Unable to transfer self but is able to bear weight and pivot during the transfer process.
3. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. (e.g. hoyer lift, etc.)
4. Bedfast, unable to transfer but is able to turn and position self in bed
5. Bedfast, unable to transfer and is unable to turn and position self

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1880

Reason for Comment

- Each provider will determine time frame for prior differently.
- Transfers may have improved and Ambulation may have declined – if so, it is unclear how to answer this question.

Alternatives/Recommendations

- Add "exacerbation" to question following "onset," "onset/exacerbation (whichever is more recent)"
- Separate Transfer and Ambulation into two questions

Improvement of clarity, usefulness, or quality of data

- Consistent answers will be obtained based on specific timeframes
- Specific type of functioning will be addressed

Enhancement to reporting/measurement of patient outcomes

- It increases inter rater reliability
- It allows for reporting and measurement of the two functionalities to be obtained independently of one another.
- It allows for the clinicians to tailor care plans meeting the patient's specific needs.

Proposed Question(s)

M1880: Change in Ambulation: Is the patient's ability to ambulate safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to ambulate is <u>better or the same</u> now than the prior level of functioning.
1 - Ability to ambulate is <u>worse</u> now than prior level of functioning
UK – Unknown

M1885: Change in Transfers: Is the patient's ability to transfer safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to transfer is better or the same now than the prior level of functioning.
1 - Ability to transfer is worse now than prior level of functioning
UK – Unknown

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M1890

Reason for Comment

- Each provider will determine time frame differently.
- Grooming may have improved while Dressing and Bathing abilities have declined – if so, it is unclear how to answer this question.

Alternatives/Recommendations

- Add "exacerbation" to question following "onset," "onset/exacerbation (whichever is more recent)"
- Separate Grooming, Dressing, and Bathing into three questions.

Improvement of clarity, usefulness, or quality of data

- Consistent answers will be obtained based on specific timeframes
- Specific type of functioning will be addressed

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Allows for reporting and measurement of the three functionalities to be obtained independently of one another.
- Allows the clinician to tailor care plans meeting the patient's specific needs

Proposed Question(s)

M1890: Change in ability to Groom self: Is the patient's ability to groom self safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to groom self is <u>better or the same</u> now than the prior level of functioning.
1 - Ability to groom is <u>worse</u> now than prior level of functioning
UK – Unknown

M1891: Change in ability to dress self: Is the patient's ability to dress self safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to dress self is <u>better or the same</u> now than the prior level of functioning.
1 - Ability to dress is <u>worse</u> now than prior level of functioning
UK – Unknown

Follows format provided by OCCB "How to Craft a Comment" Worksheet

M1892: Change in ability to bathe self: Is the patient's ability to bathe safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to bathe is <u>better or the same</u> now than the prior level of functioning.

1 - Ability to bathe is <u>worse</u> now than prior level of functioning

UK – Unknown

OASIS – C Question

- M1920

Reason for Comment

- Each provider will determine time frame differently.
- Light meal preparation may have improved while laundry abilities have declined – if so, it is unclear how to answer this question.
- Shopping is not a Household task as this takes place outside of and away from the home.

Alternatives/Recommendations

- Add "exacerbation" to question following "onset," "onset/exacerbation (whichever is more recent)"
- Separate Light meal preparation, Laundry, and Shopping into three questions.

Improvement of clarity, usefulness, or quality of data

- Consistent answers will be obtained based on specific timeframes
- Specific type of functioning will be addressed

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Allows for reporting and measurement of the three functionalities to be obtained independently of one another.
- Allows the clinician to tailor care plans meeting the patient's specific needs

Proposed Question(s)

M1920: Change in ability to prepare light meals: Is the patient's ability to prepare light meals safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to prepare light meals is <u>better or the same</u> now than the prior level of functioning.

1 - Ability to prepare light meals is <u>worse</u> now than prior level of functioning

UK – Unknown

M1921: Change in ability to perform laundry tasks: Is the patient's ability to perform laundry tasks safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to perform laundry tasks is <u>better or the same</u> now than the prior level of functioning.

1 - Ability to perform laundry tasks is <u>worse</u> now than prior level of functioning

Follows format provided by OCCB "How to Craft a Comment" Worksheet

UK – Unknown

Please see Comment M1925 regarding Shopping portion of comment.

OASIS – C Question

- M1925

Reason for Comment

- Shopping is not a Household task as this takes place outside of and away from the home.
- It involves dealing with one or more *other* persons who are not family members or persons living with patient. Laundry and household tasks can be done alone and does not involve having to converse, discuss, negotiate items for purchase, it does not involve counting money or understanding what your financial situation is, nor does it deal in having to navigate an environment outside of the home.
- A patient's inability to shop or otherwise procure food or medicine would indicate the need for an intervention, particularly a social worker to locate resources/help in order for the patient to be able to safely stay in the home.

Alternatives/Recommendations

- A separate Shopping question

Improvement of clarity, usefulness, or quality of data

- Assesses if the patient is *able to plan for, select, and purchase items* from the store in person or over the phone? (can they write a check, use a credit card, or count out the cash?) All of these are very complex and sophisticated mental skills being used. They vary greatly from those of being able to make a light meal or do laundry. It also assesses how the patient is able to navigate/negotiate outside of the home to meet their basic needs.
- It utilizes the observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining if patient is able to provide for themselves or if they are in need of assistance in order to remain in their home safely.
- It alerts the clinician to *quickly recognize* the need for assistance if there is an inability for the procurement of food and medicine.

Enhancement to reporting/measurement of patient outcomes

- Ability to remain in the home
- Ability to remain in the community after discharge

Proposed Question(s)

(M1925) Change in Ability to Perform Shopping Tasks: Is the patient's ability to perform shopping tasks (plan for, select and purchase items from a store and to carry them home or arrange delivery) better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)?

☐ 0 – Ability to perform shopping tasks is better or the same now than the prior level of functioning.

Follows format provided by OCCB "How to Craft a Comment" Worksheet

☐ 1 – Ability to perform shopping household tasks is worse now than the prior level of functioning.

☐ UK – Unknown

OASIS – C Question

- M2000

Reason for Comment

- Following the Conditions of Participation medication lists must be reviewed for potential adverse effects/reactions
- No choice exists for the patients that have no medications
- Physical Therapists can admit patients and they cannot practice beyond their Scope of Practice

Alternatives/Recommendations

- Change answer 0 to read: No medications
- Change the question wording to follow the Conditions of Participation closely

Improvement of clarity, usefulness, or quality of data

- Provides a choice for patients with no medications
- Provides a question that allows all practitioners to work within their scope of practice

Enhancement to reporting/measurement of patient outcomes

- Provides a tracking question to assess the number of patients on homecare services that have no medications

Proposed Question(s)

M2000: Potential Adverse Effects/Reaction: Does a complete drug regimen review indicate potential clinically significant adverse effects or drug reactions?

0. No medications
1. No problems found during review
2. Problems found during review

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2002- **Medication Follow-up**

Reason for Comment

- Question that should be answered is: Have clinically significant medication issues been resolved?

Alternatives/Recommendations

- Rephrase the question to assess whether issues have been resolved.

Improvement of clarity, usefulness, or quality of data

- Question answers whether issues have been resolved. If answer is yes to current question, the physician may have been contacted, but whether or not the issues have been resolved is not answered.

Enhancement to reporting/measurement of patient outcomes

- Enhances inter rater reliability.
- Safety
- Allows clinicians to improve care plans meeting patient needs.

Proposed Question(s)

M2002 Medication Follow-up: Were clinically significant medication issues resolved? for ex.: drug reactions, side effects, duplicate therapy, ineffective drug therapy, omissions, dosage errors, noncompliance, etc., including reconciliation.

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2004

Reason for Comment

- This question does not provide any information to be used for outcome data, payment, or tracking purposes
- Purpose of question is unclear

Alternatives/Recommendations

- Remove question from OASIS - C

OASIS – C Question

- M2010

Reason for Comment

- "High-Risk Medications" needs clarification
- Question needs to fall within Physical, Occupational, and Speech Therapists' scope of practice

Alternatives/Recommendations

- Determine if specific drug classes should be addressed
- Provide an answer that states "Physician office monitoring high-risk medications – Therapy use only"

Improvement of clarity, usefulness, or quality of data

- Maintains practices within scope of practice
- Provides clear guidelines for drugs to be considered high risk

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Increases accuracy of final data

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2015

Reason for Comment

- Question needs to fall within Physical, Occupational, and Speech Therapists' scope of practice

Alternatives/Recommendations

- Provide two additional answers:
  - "Received education from Physician's office or hospital and state understanding – Therapy use only"
  - "Received education from Physician's office or hospital and state further teaching required – Therapy use only"

Improvement of clarity, usefulness, or quality of data

- Maintains practices within scope of practice

Enhancement to reporting/measurement of patient outcomes

- Increases accuracy of final data

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2020 & M2030

Reason for Comment

- No assessment for management of Inhalant Medications

Alternatives/Recommendations

- Recommend adding M2025 Management of Inhalant Medications

Improvement of clarity, usefulness, or quality of data

- Provides additional information regarding patients ability to care for self

Enhancement to reporting/measurement of patient outcomes

- Allows measurement of the three popular medication routes

Proposed Question(s)

M2025 Management of Inhalant Medications: Patient's current ability to prepare and take all prescribed inhalant medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. (e.g. inhalers, oxygen, etc.) (Note: This refers to ability, not compliance or willingness)

0. Able to independently take the correct medication and proper dosage at the correct times.
1. Able to take inhalant medication at the correct times if: given reminders based on the frequency of administration.
2. Unable to take inhalant medications unless administered by someone else.

NA – No inhalant medications prescribed

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2040

Reason for Comment

- Each provider will determine time frame differently.
- Management of oral medications may have improved while management of inhalant medication abilities have declined – if so, it is unclear how to answer this question.

Alternatives/Recommendations

- Add "exacerbation" to question following "onset," "onset/exacerbation (whichever is more recent)"
- Separate Oral, Inhalant, and Injectable Medications into three questions.

Improvement of clarity, usefulness, or quality of data

- Consistent answers will be obtained based on specific timeframes
- Specific type of functioning will be addressed

Enhancement to reporting/measurement of patient outcomes

- Increases inter rater reliability
- Allows for reporting and measurement of the three functionalities to be obtained independently of one another.
- Allows the clinician to tailor care plans meeting the patient's specific needs

Proposed Question(s)

M2040: Change in ability to Manage Oral Medications: Is the patient's ability to manage oral medications safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to manage oral medications is <u>better or the same</u> now than the prior level of functioning.

1 - Ability to manage oral medications is <u>worse</u> now than prior level of functioning

NA – No Oral medications prescribed

UK – Unknown

Follows format provided by OCCB "How to Craft a Comment" Worksheet

M2041: Change in ability to Manage Inhalant Medications: Is the patient's ability to manage inhalant medications safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to manage inhalant medications is better or the same now than the prior level of functioning.

1 - Ability to manage inhalant medications is worse now than prior level of functioning

NA – No Inhalant medications prescribed

UK – Unknown

M2042: Change in ability to Manage Injectable Medications: Is the patient's ability to manage injectable medications safely better, the same, or worse than prior functioning? (i.e. before the onset/exacerbation - whichever is more recent – of the illness or injury that initiated this episode of care)

0 - Ability to manage injectable medications is better or the same now than the prior level of functioning.

1 - Ability to manage injectable medications is worse now than prior level of functioning

NA – No Injectable medications prescribed

OASIS – C Question

- M2110 & M2120

Reason for Comment

- Flow of information would be more congruent

Alternatives/Recommendations

- Move M2110 & M2120 to follow after M1100

Improvement of clarity, usefulness, or quality of data

- Living arrangements and assistance provided in the home are like items and listing the questions together will flow in the practioner's assessment of the patient

Enhancement to reporting/measurement of patient outcomes

- Increased consistency of data reported when assessment flows from one item to the next

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question

- M2300

Reason for Comment

- When completing this question as part of a Transfer OASIS, it does not indicate that it is also referring to current transfer circumstances

Alternatives/Recommendations

- Add "includes current hospitalization, if applicable"

Improvement of clarity, usefulness, or quality of data

- Promotes understanding that question applies to current circumstances as well as any hospitalization or emergency department visit since last OASIS completion

Enhancement to reporting/measurement of patient outcomes

- Increases validity of data
- Increases inter rater reliability

Proposed Question(s)

M2300: Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation with or without hospital admission and includes current hospitalization, if applicable)?

0. No [Go to M2400]
1. Yes

UK – Unknown [Go to M2400]

OASIS – C Item

- Physician ordered plan of care

Reason for Comment

- Some states allow Clinical Nurse Specialists in Home Care to write orders
- Intact skin can be treated by Registered Nurses without physician orders

Alternatives/Recommendations

- Remove "physician ordered plan of care" from all questions with this wording, replace with "ordered plan of care."

Improvement of clarity, usefulness, or quality of data

- This would allow the questions to apply to all patients regardless of who is writing orders

Enhancement to reporting/measurement of patient outcomes

- Increases data base

Follows format provided by OCCB "How to Craft a Comment" Worksheet

OASIS – C Question Set

- Surgical Wounds

Reason for Comment

- As with Pressure Ulcer assessment, additional items are required to fully assess and monitor Surgical Wounds

Alternatives/Recommendations

- Addition of three questions to OASIS – C (please see below for suggestions)

Improvement of clarity, usefulness, or quality of data

- Improves usefulness of OASIS data in creating patient centered care plans
- Increases quality of care provided to patients through more complete assessment

Enhancement to reporting/measurement of patient outcomes

- Allows for monitoring of patient's healing status

Proposed Question(s)

M1344: Surgical Wound Intervention: Is the appropriate wound care using advanced wound care protocols?

0. No
1. Yes
2. Order requested from physician

NA – Wound healing by primary intention

M1346: Surgical Wound Intervention: Are moisture retentive dressings being used to treat this surgical wound?

0. No
1. Yes
2. Order requested from physician

NA – Wound healing by primary intention

M1348: Surgical Wound Intervention: Is the patient receiving required nutrition to heal wounds?

0. No
1. Yes

Follows format provided by OCCB "How to Craft a Comment" Worksheet

PUBLIC SUBMISSION

As of: January 16, 2009
Received: January 12, 2009
Status: Posted
Posted: January 14, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081ba21
Comments Due: January 13, 2009
Submission Type: Web

Docket: CMS-2008-0141
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Comment On: CMS-2008-0141-0001
Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations in 42 CFR, Sections 484.55, 484.205, 484.245, 484.250 (CMS-R-245)

Document: CMS-2008-0141-0065
VT

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General Comment

1/12/09 OASIS C COMMENTS

The following is an overview of some of our concerns re the draft Oasis C:
General:
- it increases the paperwork burden by 20 plus data elements which is highly burdensome and costly
- it increases the cost and time-demands for ongoing Oasis intensive education due to the ever changing subtleties and complexities of definitions and interpretations
- it demoralizes clinical staff who feel over-burdened and micro-managed by Oasis documentation requirements with little time left over to build effective rapport with patients and families, and use creative means to teach and assess.
- Oasis C threatens our recruitment and retention efforts. It poses a recruitment issue because word is on the street that Home Health documentation requirements are mammoth, unrealistic, and stressful. Oasis C will clearly increase the burden. It poses a retention issue because Oasis documentation and assessment requirements have become job dissatisfiers. Nurses and therapists leave home health due to the documentation burden and the constant dread that they will leave something undone.
- We have to say that some of the changes represented in Oasis C feel like traps being laid for grist for future denials. If documentation is in the POC re specific parameters and these aren't followed to a T even with good reason, clinicians feel they will be criticized. Nurses want to feel there is room for clinical judgment and doctors want nurses to use this judgment. Doctors don't want nurses calling their offices every single time a parameter is exceeded. Rather they want nurses to attend to the issues and notify them when changes may be needed, say after several times of exceeding. An example: if blood glucose is up and it's clear why, then it should be in the nurse's purview to discuss reasons with the pt without notifying the MD every time. When the 60-day summary to the MD is written, these instances will be reviewed and communicated which is the purpose of the summary. If in the nurse's clinical judgment there is risk, the MD will be contacted for strategizing, for med changes, as always. It just can't be so black and white.
- Why should many items have to answered in the Oasis (increasing the documentation burden and involving duplicate documenting), when these items are apparent when reading the POC. CMS should just reference the POC and the visit

notes if they are concerned with practice rather than require double documenting by overworked clinicians.
- Additional data elements proposed in Oasis C increase the difficulties faced by therapists whose education is focused on functional issues, rather than medical/ clinical ones. Medications, heart failure, depression etc are very challenging and uncomfortable for therapists who have limited training, if any, in these areas. It appears that the end result of these new MO items will be to require that RNs complete the Oasis C in therapy-only cases, thereby increasing our costs and the overall costs to the health care system. Does this make sense?
- Why not consider truly decreasing the stress and cost of Oasis (pretty much an unfunded mandate) by reducing the number of clinical outcomes and then rotating, say 10 or 12 outcomes every few years. This would allow agencies to focus on one or two outcomes intensely rather than be overwhelmed or demoralized or distracted by such a large number of measurements. We need Oasis to be a workable, helpful system. We hope it is not developing into a micro-management tool that stresses clinicians and managers, and serves to decrease reimbursement to agencies and decrease needed services to patients. CONTINUED...

Specifics:
-
- MO140 – Clients have the right NOT to identify their race or ethnicity and UNK was removed in Oasis C
- M1032 – Frailty Indicators as written are subjective and need to be well-defined. In addition, what does "other" mean?
- M1055 – The clinician should be able to indicate that patient does not know and cannot reconstruct the information for us. We can't be a detective agency as it again increases our costs, and burdens our slim resources.
- M1304 – Planned Pressure Ulcer Prevention is routine Nursing 101, not necessary to be on the plan of care. Look in the documentation for instruction.
- M1312 and 14 – Pr Ulcer Measurements are contrary to WOCN guidelines.
- M1500 – Sx of Ht Failure – At times, clients may have sx of heart failure without a diagnosis from MD. There are times when doctors don't want to give a ht failure dx and we can't control this.
- M1510 – Clients don't have instances of ht failure. They HAVE heart failure as a constant, and they have exacerbations. Please reword this. Patients live with the disease.
- Answers to the following items and like items can be found in the Plan of Care and do NOT need to be duplicated in the Oasis C, again due to time and expense and clinician dissatisfaction:
o M1038
o M1244
o M1304
o M1360
o M1365
o M1734
o M1940
o M1326

- M2000 – PT, OT, and ST are not capable of this level of complex drug regimen review. This is not realistic and again increases costs and nursing burden in an environment of nursing shortages.
- M2002 – This practice is routine (that med concerns are reported timely). We don't need this extra documentation item. The visit notes will show the contact. This is double documentation and contrary to the Paperwork Reduction Act.
- M2004 – It is not always possible to have the Case Manager complete the discharge, as much as we'd like to have it go this way. Asking if tasks have been completed and making a nurse who may be unfamiliar with the patient's course, audit the chart is time-consuming and unnecessary. The information can be found in clinical notes on med review. You are tasking nurses to do audits when we have a nursing shortage and need our nurses for direct patient care.

We appreciate the questions that have been condensed into one data element in Oasis C. We appreciate the recognition of heart failure as a significant risk factor but the questions need work. Adding toileting hygiene is helpful. Expanding the answers available for M1860 is helpful. Being able to show that ulcers and surgical wounds have re-epithelialized is valuable.

Thank you for the chance to have input and we hope you will make significant revisions with the overall aim to clarify, simplify, reduce. Connie Colman, RN, MEd, QI Director
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