PUBLIC SUBMISSION

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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-2008-0141-0066
ME

Submitter Information

Name: Vicki Purgavie
Address:
Augusta, ME, 04330
Organization: Home Care & Hopsice Alliance of Maine

General Comment

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

Dear Sirs:

The following comments are being submitted on behalf of the Home Care & Hospice Alliance of Maine. The comments speak to proposed changes to the Outcome and Assessment Information Set (OASIS-C), which appeared on the November 14, 2008 Federal Register.

While the "Supporting Statement for Paperwork Reduction Act Submissions" states otherwise, we believe the OASIS-C proposal will increase the paperwork burden for home health agencies. Of particular concern are the following:

1. The number of items in the OASIS data set is increasing.
The number of OASIS items at the Start of Care is increasing from 76 to 105 (38 percent) and at Resumption of Care from 61 to 90 (48 percent).

2. The number of new items exceeds the number of items eliminated.
The Supporting Statement claims OASIS-C will have "no net burden impact" and yet the data shows otherwise. The 45 items that were added is more than half the number than eliminated.

3. Burden is additionally increased with the process items that were added to an outcomes data set.
The OASIS data set was designed to be home health setting–specific and based on outcomes. It now appears that CMS is moving toward a Post Acute Care data set, which includes process items. The impact is an increased burden of data collection on home health providers.

4. The additional data items will not be used for the Prospective Payment System or the Home Health Compare.
The rationale for collecting and reporting OASIS data is for quality monitoring and reimbursement under the Prospective Payment System (PPS). Of the 130 items in OASIS-C, only about twenty-six items are used for PPS and Home Health Compare. While the current OASIS B1 data set contains many items that are not used for either purpose, the proposed OASIS-C has exacerbated this problem by adding additional elements, most prominently, the process items. It seems unreasonable for CMS to add additional items, particularly items not used for either of the two core purposes.

5. The burden estimate is likely low but even so is very considerable.
The Supporting Statement estimates the total burden for 2009 at 15,590,610 hours and the average salary at $29.47 per clinician. Thus, CMS estimates the annual burden at nearly $460 million. This estimate likely understates the actual burden given:
- The burden estimate is based on the assumption that OASIS-C will not increase the burden.
- As discussed above, this assumption is unsupported.
- The average salary does not reflect agency overhead. The true cost to the agency of a $29.47 hourly rate would be about $44 per hour.
- The training estimate does not account for annual turnover of new staff.
- The burden estimate does not reflect the fact that almost all agencies have clinical staff to over see the OASIS process and clerical staff to assist in the effort.

Before proceeding with implementing OASIS-C, we respectfully request that CMS further field test the proposed instrument and collect accurate data on the burden of the proposed changes.

Thank you in advance for your consideration.

Sincerely,

Vicki Purgavie
Executive Director

PUBLIC SUBMISSION

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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-2008-0141-0067
NC

Submitter Information

Name: Sue Payne
Address:
High Point, NC, 27265

General Comment

Thank you for the opportunity to provide comments about the proposed OASIS-C document. Please see attached our recommendations and thoughts on the changes.

Attachments

CMS-2008-0141-0067.1: NC

ADVANCED HOME CARE

HOME CARE IS OUR BUSINESS...CARING IS OUR SPECIALTY!
4001 Piedmont Parkway
High Point, NC 27265
Phone: 336.878.8950
www.advhomecare.org

#67

Advanced Home Care is home care company that provides home health, home medical equipment, respiratory, and infusion therapy services in NC, VA, and TN. The company has 10 home health agency locations and has 9 provider numbers. Our annualized PPS episodes are 16,000.

COMMENTS FROM ADVANCED HOME CARE-1/12/09

Please note below our comments regarding OASIS-C:

1) MO1012-Addition of inpatient procedures will give a clearer picture of the patient.
2) MO1032/1034-Fraility and Stability Indicators will make it easier for clinicians to actually determine prognosis since the life expectancy question has always been challenging for clinicians to answer.
   One suggestion for revision: use the word 'heightened' instead of high risk for answer 1 and 2; For question 3, use of chronic or degenerative instead of progressive so clinicians will consider all chronic conditions.
3) MO1038-confused by the intent of this question.
4) MO1040/MO150-agencies may be think that the intent of this question is for the agency to provide the vaccine medication and administer it. Needs clarification of wording.
5) MO1045/MO1055-we believe this will be difficult to determine since patient/family are not always good historians.
6) MO1242/1244/1246-we really like the expanded pain questions including pain intervention. We will need a 'standard' definition for severe pain as this could be interpreted differently by clinicians.
7) MO1312/1314-why are you not using the clock system for measurement as we have been taught?
8) MO1328-add request denied by physician since this can be the case.
9) MO1500/MO1510-again this may difficult to ascertain if the period between previous OASIS and current OASIS was a long time and patient/family are not good historians. How will therapy handle?
10) MO1734-add order requested by physician
11) MO1840-our recommendations:
    0-able to get to and from the toilet and transfer independently with or without a device
    1-intermittent assistance able to get to and from and transfer
    2-able but requires presence and assistance of another person throughout to and from and transfer
    3-unable to use toilet but able to use BSC independently
    4-able to use BSC with assistance
    5-able to use BP with intermittent assistance
    6-use bedpan and/or urinal with constant assistance
12) MO1845- this is a good addition

ADVANCED HOME CARE

13) MO1860-reword #2 just like #1 except change 2-handed to 1-handed; Add independent in ambulation with assistive device but needs assistance on stairs or steps.

14) MO2000/2010-very concerned about therapists ability to answer these questions and question if it is in their scope of practice;

15) MO2004-again, this may be difficult to ascertain depending on the length of time between OASIS assessments. The time component of 1 calendar day may be restrictive as well given we are dependent on physician office to answer.

16) Everyone is pleased that 'unknown' has been removed as an answer choice.

17) Multiple questions about physician plan of care are challenging as we are depending on the physician to give these specific orders. Just a reminder that home health orders are more and more challenging to confirm with hospitalists and SNF Medical Directors ordering home health but refusing to sign orders.

18) While we overall like the prevention focus and details of the OASIS-C as it relates to patient clinical care, we are concerned about the additional time this assessment visit will take the clinician and without any mention of additional reimbursement for the OASIS visits.

Advanced Home Care Team Members Involved in Recommendations:

Sue Payne MBA, RN, CHCE
Vice President, Home Health

Laurie McNichol MSN, RN, GNP, CWOCN
Director Clinical Practice/Quality

Joy Moore PT, COS-C
Home Health Educator

Patty Beard MBA, MHA, RN
Home Health Outcomes Specialist

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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-2008-0141-0067
NC

Submitter Information

Name: Sue Payne
Address:
High Point, NC, 27265

General Comment

Thank you for the opportunity to provide comments about the proposed OASIS-C document. Please see attached our recommendations and thoughts on the changes.

Attachments

CMS-2008-0141-0067.1: NC

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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-2008-0141-0068
CA

Submitter Information

Name: Christine Ihn
Address:
Woodland Hills, CA, 91367
Organization: Accredited Home Health Services

General Comment

See attached document.

Attachments

CMS-2008-0141-0068.1: CA

Center for Medicare and Medical Services
Attn: Document Identifier/OMB Control #1111
7500 Security Boulevard
Baltimore, Maryland 21244-1850

#68

Re: Comments OASIS-C Revision 10

To Whom It May Concern:

My name is Christine Ihn, RN, BSN, Vice President of QM for Accredited Home Health Services in Southern California. When I received the revised OASIS-C, copies were given to the field Case Managers, including SN, PT, OT and ST and to all QM staff for their feedback. Please see attached comments from our company. I listed **General Comments** and **Comments by OASIS questions**. If you have any questions please call me at 818-205-0430 or e-mail me at cihn@accreditednursing.com.

General Comments

1. It's too much to do on a daily basis. Somewhat redundant and invasive beyond SN care. It would take a week to get all the information. Would need an ET nurse to evaluate for wound information and Psych experience for depression screening.
2. Can this be compressed to as few pages as possible, so it looks less daunting? Also remember **more paperwork means less nursing care, intervention and education** period! Please limit our paperwork so we can do more nursing care for our pts!
3. **This will take a lot longer than current OASIS. Current SOC takes at least 2hours!**
4. **Too many questions. Added many new questions that are really "prior"questions.** Instead of adding new "prior" questions, just keep current "prior" column.

Comments by OASIS Question

(M0102) Date of Referral and (M0104) Date of Physician-ordered Start of Care (ROC):

a. Field staff usually doesn't know the date of referral.
b. M0102 and M0104 dates are usually the same.

(M01032) Frailty Indicators: This will be difficult to assess so soon on SOC.

(M01034) Stability Prognosis: This will be difficult to assess on SOC. MD should determine this answer. This question has the same problem as MO280. This is not really a SN/PT/OT/ST question.

(M01032 & M01930 & M01940) Fraility Indicators and Fall Risk Assessment:

a. Our company has a more comprehensive risk factor assessment form. If CMS adds these questions but does not include all risk factors, our company will need to complete two risk factor assessments and this would be a duplication of work.

(M01034) Stability Prognosis: Good-but difficult to assess! MD should determine this.

(M01038) Guidelines for Physician Notification:

a. Most MD's do not provide parameters or guidelines. We are using our company's policy and protocol as guide most of the time.

(M01040) Influenza Vaccine:

a. What is the reason for this question? Does it matter where they got the vaccine?

(M01045) Reason for Influenza Vaccine not received:

a. Options for flu vaccine?! Too many choices! Are we going to be giving flu shots?

(M01050 and 1055) Pneumococcal Vaccine:

a. Pt doesn't know what PPV is? Most of the answers for 1055 will be "5 – none of above" because the patient doesn't know the answer.
b. Why do we need M01055 PPV information?
c. Need to add "unknown" option if we are going to keep this question. Most of the time pt doesn't remember or they don't know what PPV means.

(M01100) Patient Living Situation:

a. Go to M02110 and M02120. Similar Questions.
b. Can we combine M01100, M02110 and 2120 in one question or condensed?
c. Living arrangement questions are too confusing.

(M01242) Pain Assessment:

a. Unnecessary if we show the pain level on the scale!

Integumentary Status: Integumentary is huge and compressive already!

(M01326 & 1328) Pressure Ulcer Intervention:

a. This is covered in wound care orders! Redundancy.
b. Usually not! I don't think wound care should be a part of the questionnaire.

c. What does this mean "are moisture retentive dressings specified on the physician ordered plan of care?" This will be confusing to answer. We will need a definition of what is considered a moisture retentive dressing.

(M01350) Skin Lesion or Open Wound: Only excludes bowel ostomy? How about other ostomies, i.e. urostomy, gastrostomy, ileoconduit, nephrostomy? All were previously excluded. How will we classify other ostomies?

(M01500) Symptoms of Heart Failure: 2 – Not assessed. Why wouldn't it be assessed?

(M01730 – M01736) Depression Screening:

This should be done by a mental health professional. Or, agency with a certified psych nurse. Most likely information will not be known by scoring clinician.

(M01745) Frequency of Behavior Problems:

a. This question should **add "including items listed in M01740 above".**

(M01850) Transferring:

2 – Unable to transfer self but is able to bear weight and pivot during the transfer process
What about the clarification we received "transfer with human assistance and device?" We received instruction from CMS that when pt needs both human assistance AND device, we should answer #2. If this is true, please word differently for choice #2. This is confusing.

(M01880, M01890, M01920 and M02040) Change in mobility/in self-care ability/in routine household tasks/in ability to manage oral, inhalant, or injectable medications:

a. CMS stated that they are not going to collect "prior" but it is just re written and makes the OASIS much longer. If CMS wants "prior", we should keep "prior" column. It would be easier since we are familiar with that version.
b. This is prior function bunched together. Just keep "prior" column for these questions.
c. **"better or the same"**: Should have separate questions for "same" and "better".
d. **(M01880) Change in Mobility**: Why did we put transfer, ambulate together? Need to separate these two items.

Medications (M02000 – 2015):

Follow up med problems and asking questions are part of basic nursing care. Why are we being questioned if we've done our job! Adverse Effects/Reaction is usually difficult to assess when patient just comes home with meds. (M02015) answer will always be yes. Not a good questions.

(M02040) Change in ability to manage oral, inhalant, or injectable meds: Should separate "better" or "same". Why is oral, inhalant, and injectable meds all lumped together? How do we answer if oral got better but inhalant stayed same and injectable med got worse? Again, should leave "prior" column, we are more familiar and it would be easier to answer separately. routine household tas

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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-2008-0141-0069
MN

Submitter Information

Name: Sandra Hoffman
Address:
Duluth, MN, 55805

General Comment

See attached comment letter.

Attachments

CMS-2008-0141-0069.1: MN

St. Luke's
Home Health Services
220 North 6th Avenue East
Duluth, Minnesota 55805

#69

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 Boulevard
Baltimore, MD 21244-1850

Attention: Document Identifier: CMS–R–245 (OMB# 0938–0760)

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 in home health 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/concerns 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 homecare 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 homecare is not able to start care for an extended period of time; and sometimes patients make the request to 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, the information should be obtained from the inpatient facility.
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 coding often does not occur until the hospital generates their bill. It is not realistic for

homecare clinicians to have knowledge of the coding requirements for inpatient facilities; requiring them to enter this information with insufficient or incomplete data from referral sources will result in errors in a patient's medical record.

Concern: **M01014 Medical or Treatment Regiment 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 Quality Improvement Organizations (QIOs) as included on the Hospitalization Risk Assessment form at www.homehealthquality.org website. The presence of high risk chronic diagnoses place a patient at high risk for rehospitalization and speaks to the frailty of their overall status. These include the diagnoses of Congestive Heart Failure (CHF), Diabetes, Chronic Obstructive Pulmonary Disease (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 homecare population and are contributing factors to the frailty of the patients served. Eliminate this item from Start of Care assessment (SOC).
Rationale: At SOC, providers will not have historical data on vital 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. 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 homecare 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 valueless data.

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.

Concern: **M1242 Formal Pain Assessment**
***Suggestion for Change*:** Make suggestions and list appropriate standardized assessment tools for pain. Benchmarking will be difficult and inconsistent if agencies use different standardized assessment tools that may vary on what indicates "severe 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, such as 0-10 scale and Wong-Baker Faces pain scale, 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. Please clarify how this question should be answered if I use a standardized tool and an evaluation of clinical factors to assess.
Rationale: What if PT or a weekend person is admitting – does the assessment need to be done right away at SOC? Is it realistic to get all of this done in the 5-day time frame? Consultation with staff outside the homecare agency, for example a wound ostomy clinic, is often necessary to gather all pertinent clinical information.

Concern: **M1312 - M1314 Pressure Ulcer Length & Width**
Suggestion for Change: Eliminate both.
Rationale: Requiring length and width of the ulcer 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 or a wound does not provide an accurate accounting of a wound status and is not best clinical practice. WOCN guidelines for wound measurement include 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 WOCN guidelines.

Concern: **M1320 Status of Most Problematic Pressure Ulcer**
Suggestion for Change: Clarify that this pertains only to stages 3 and 4 pressure ulcers.
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 may be in the homecare 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 to be responsible for ordering such dressings.

***Concern:* M1350 Skin Lesion or Open Wound**
***Suggestion for Change*:** Clarify that Bowel ostomy is the only ostomy that is excluded when answering this question.
Rationale: Previous OASIS instructions were to exclude ALL ostomies, not just bowel ostomy.

M1328 Pressure Ulcer Intervention
***Suggestion for Change*:** Eliminate this item
Rationale: Moisture retentive dressings are noted on the 485 as supplies. It is not the homecare 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?
Rationale: Improve data collection by having all clinicians doing the same type of assessment.

***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 standardized 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 homecare 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 homecare 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, 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 ADLs. It is unlikely they will recover the abilities and show improvement during a Medicare episode. 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. 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 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.

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 comments/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 to 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 in-put assessment is burdensome for the patient as is and will become increasingly exhausting for the patient as all of the other assessments are added. I know of instances where patients have decided that it just wasn't worth having homecare during the initial start of care visit due to the burdensome paperwork involved. 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 changes, this change will be overwhelming to clinicians. Already we are seeing clinicians leaving home care due to excessive paperwork. Several items on the proposed OASIS-C document would require the clinician to review the medical record documentation for the entire previous episode of care, which would be extremely time consuming. 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 expert bodies. This will prevent the need to duplicate documentation in more than one area of the medical 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.

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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-2008-0141-0070
SC

Submitter Information

Address:
SC, 29615

General Comment

We are providing comments on the proposed Medicare and Medicaid Oasis Collection Requirements. Thank you for your consideration.

Attachments

CMS-2008-0141-0070.1: SC

M1032- Frailty Indicators- Please define the term "Recent." This is very subjective and different clinicians give different time frames when asked to define.

M1034-Stability Prognosis- The descriptors are subjective for clinicians. Patients may require rehab therapies or had an acute illness that does not have additional "high health risks." Please define: High health risks."

M1038- Guidelines for MD notification- Entering all possible changes and parameters on the Plan of Care would create an enormous burden for clinicians and agencies. Would this be entered for all current diagnoses, co-morbidities, and all medications? Clinical findings can encompass a vast number of possible parameters; please clarify.

M1100- Combining living arrangements and availability of assistance can be confusing to clinicians. There is a lack of clarity in the choices and creates multiple questions: is regular daytime/nighttime a defined number of hours? What is the definition of occasional or short term assistance?
M2110 - To assist clinicians with accuracy of responses, M1100 and M2110 should be grouped together for reference in answering correctly.

M1242- Pain Assessment - To establish consistency throughout the industry, please define the specific components of a Pain Assessment or provide an approved list of standardized pain assessments.

M1730- Depression Screening- To establish consistency throughout the industry, please provide an approved list of standardized depression screening tools.

M1850 - Transferring -To enhance the quality and accuracy of the responses and outcome, we recommend that the values for reporting transfers be expanded to include the category **"TRANSFERS WITH HUMAN ASSISTANCE AND WITH THE USE OF AN ASSISTIVE DEVICE."** This additional value will provide clarification for clinicians who have difficulty with the current value 2 description that states" unable to transfer, but is able to bear weight and pivot during the transfer process." Patients who require assistance and a device are able to transfer; confusion results from the "unable to transfer" description. Prior CMS instructions support the additional value.

M1860- Ambulation – Many patients are able to safely ambulate without any device on level surfaces, but require minimal human assistance on stairs, steps, uneven surfaces. Please clarify the correct response for the patient who does not require assistance of another person at all times. We appreciate the expanded responses in the question. An additional value will greatly assist staff to respond correctly to this question.

M1880-M1890-M1920-2040- Patient Ability- Please clarify the correct response when a change occurs in only one of the activities. Does the patient have to decline in all activities to respond as worse?

M1930 -M1945

M1930- To establish consistency throughout the industry, please define specifically the components of a Multifactor Falls Risk Assessment or provide an approved list of Fall Risk Assessments.

M1945 - How will outcomes be determined if the patient receives fall prevention education during early episodes of service and then has multiple episodes? Is the expectation that the plan of care will repeatedly include interventions when teaching has been completed?

M2010- Drug education- Please provide a comprehensive list of "high-risk" medications. Agency and staff interpretation of high risk will influence response.

M2300 – Emergent Care- We agree with and support the proposed change that defines emergent care as the patient utilization of a hospital emergency department.

To improve the accuracy of the data and to further define the role and responsibility of the home health agency, the addition of a category to identify physician referrals to the emergency department would develop and enhance the outcomes. HHAs are increasingly receiving MD instructions to have patients go to the ED when the MD office is closed, schedules are full or the primary MD is not available. In many geographical locations, MD offices are closing at noon on Fridays and will not see patients; all calls to these offices result in referrals to the ED.

Many patients are utilizing the emergency departments for non-emergent reasons due to MD referral, patient or family preference or ability to pay for services.

Additional categories recommended:
MD referral to ED,
Patient/Family Choice – Non-Emergent Care
Patient/Family Choice – Urgent/Emergency Care or EMS
Agency Referral – Urgent/Emergency Care

M2310 Reason for Emergent Care and
M2430 Reason for Hospitalization

The expanded reasons for emergent care and hospitalization will assist the HHA to better identify reasons the patient sought emergency services. We also agree with the reasons being the same for hospitalization.

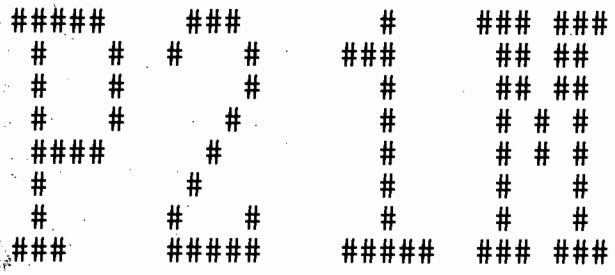
With the expanded reason values for emergent care and hospitalization, we would like to offer the following suggestion:
Number 2 – Injury caused by fall or accident at home is further modified to develop a separate value for FALLS and a separate value for ACCIDENTS.

With the increasing emphasis on falls assessment, frailty indicators, and falls prevention, the HHA will have improved data to accurately identify falls and an increased ability to track the reasons for falls. Having the total number of falls and accidents combined skews the true number of falls per agency. While accidents are a small percentage of the total, smaller agencies are penalized when accidents are incorporated in the falls category. Agencies

... number of fair ... [illegible] ... of the total, smaller agencies are penalized when ... [illegible] ... Agencies ...

M2430 Reason for Hospitalization

We request that patients with a Value Code 19 be exempt from inclusion in the HHA hospitalization rates. The inclusion in the rates for hospitalization is inflated when scheduled treatments or procedures are included in the total agency rate. Providing care to patients with known or scheduled readmissions is an inherent responsibility for the HHA and the agency should not be penalized for providing this invaluable service that allows hospital facilities to send patients home while awaiting additional procedures.



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