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Comment On: CMS-2008-0141-0001
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Document: CMS-2008-0141-0083
IL

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General Comment

Please see attached letter

Attachments

CMS-2008-0141-0083.1: IL

#83

January 13, 2009

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number 0938-0760
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sir:

Thank you for this opportunity to comment on the Information Collection Request published in the Federal Register on November 14, 2008 (Vol. 73, No. 221, Page 67519) entitled "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". The Illinois HomeCare Council (IHCC) is a trade association representing approximately 250 home care provider and supplier organizations in Illinois. These comments were developed by IHCC's Regulatory and Reimbursement Committee.

General Comments

While IHCC members welcome many of the changes that are included in the proposed version of OASIS C, they are quite concerned about the added burdens that the proposed version will represent. First, such a significant revision of OASIS will require extensive re-training of home health agency staff across the country. Not only will existing staff have to learn an entirely new numbering system, but many of the definitions we have struggled to pound into people's brains are being abandoned or modified. While many of the changes are appropriate, the training burden remains significant.

IHCC members anticipate that the time required to collect the data will increase, as will the complexity of the data collection process. Much more data must be collected at transfer, an event which happens relatively frequently in home health care. IHCC members also anticipate that the start-of-care, resumption-of-care and discharge time points will require more data collection time, primarily as a

result of the process items that have been added. In addition, the process items that relate to whether or not interventions were ordered in the plan of case since the previous OASIS assessment (for example M1736) will be difficult or impossible for field staff to complete unless they are working in an agency with an electronic clinical record.

Agencies will also have difficulty completing the new process items when they use contract therapists to complete the transfer or discharge OASIS. These clinicians typically do not have access to the entire chart, so much of the data collection will have to be done by agency office or supervisory staff. In fact, in many agencies many of the process items required at transfer and discharge that require review of the clinical record will need to be completed by clinical or supervisory staff in the office in order to insure accuracy.

Agencies will also be faced with having to secure new or updated software that reflects the new items. Training is involved in any software change, adding to the costs. And these demands are coming at a time when CMS is severely limiting the cost-of-living increases that agencies are receiving under the home health prospective payment system. In fact, in Illinois the majority of our agencies have received payment reductions this year as a result of the "coding creep" cuts coupled with reductions in the hospital wage index for approximately half the state, including the Chicago metro area.

So, while IHCC supports many of the proposed changes found in OASIS C, members hope that CMS recognizes that the adoption of a significantly revised OASIS instrument carries with it a considerable financial impact as well at the effects of this ongoing cycle of change that the industry has experienced during the past 10 years. IHCC members worry that the OASIS changes together with the upcoming transition to ICD-10 will drive even more nurses out of home care or out of nursing all together. This would not be a good development for the home care industry or for the Medicare program.

M0080 Discipline of Person Completing Assessment

This item has been problematic for some time. But, given the increased role that supervisory staff and clinicians working in the office will have to take to complete the process items proposed for the transfer and discharge OASIS tools, IHCC finds CMS insistence that a single discipline take responsibility for the OASIS data collection even more unrealistic. Completion of an OASIS data set often cannot and should not be accomplished by a single individual. Collaboration between disciplines is frequently needed to complete the health status items; ICD coding is rarely done in the field; and the new process items will require a review of the clinical record and plan of care at transfer and discharge.

Recommendation: IHCC members believe that CMS should revise M0080 to capture information on all of the individuals and disciplines who contribute to the

collection of information found in each data set. IHCC members think that this information is actually critical to good quality control in OASIS data collection, and would be more meaningful and worthwhile to gather than the current M0080.

M0140 Race/Ethnicity

CMS has proposed eliminating the "unknown" response from this item. IHCC members are concerned that elimination of this option may lead to clinicians drawing race and ethnicity conclusions based on the patient's appearance, particularly in instances where the patient is unwilling to discuss his background. IHCC doubts that this approach is one that CMS wants to encourage.

Recommendation: IHCC recommends that CMS restore the "unknown" response to M0140.

M1010 Inpatient Diagnosis and ICD-9-CM code for conditions treated during inpatient stay within last 14 days

IHCC members find the elimination of the prohibition against including surgical codes to be confusing, particularly in light of the inclusion of M1012 which requires that the agency list each inpatient procedure and associated ICD-9-CM procedure code. It appears to IHCC that surgical codes are procedure codes.

Recommendation: IHCC recommends that CMS clarify whether surgical codes are to be included in M1010 or in M1012.

M1032 Frailty Indicators and M1034 Stability Prognosis

IHCC applauds CMS' replacement of the current prognosis items with M1032 and M1034. IHCC members find the new items to more appropriately reflect the issues faced by home health patients. However, we have two concerns about the proposed items.

First, IHCC members believe that it would be useful for response #7 in M1032 to include an optional opportunity for the agency to identify the "other" reason for finding the patient to be "at risk for major decline or hospitalization." If a patient characteristic is so significant that it can lead to this kind of prognosis then it should be noted in the clinical record. Allowing agencies to note it within the OASIS item seems the most logical place to identify this piece of information.

Regarding M1034, IHCC members object to the inclusion of a one year time frame in response #3. It is difficult enough to identify a patient who is likely to experience death within six months (the current terminal time frame). Predicting death within a year is considerably less certain, and serves no discernable purpose.

Recommendations: IHCC recommends that CMS add an optional line to response #7 in M1032 that will allow agencies to record the reason they consider the patient to be at risk of major decline or hospitalization. IHCC also recommends that CMS either eliminate response 3 from M01034 or replace the one year time frame in the response with a six month time frame.

M1038 Guidelines for Physician Notification

IHCC supports the practice that this item is designed to promote, but is concerned that the item is so broad that it will be meaningless from the standpoint of standardized data collection. Without an extensive set of definitions in the Item-By-Item Tips for this item, agencies will interpret the language so broadly that they will always be able to respond with a positive answer, resulting in useless aggregated information.

Recommendation: IHCC recommends that CMS either focus this item narrowly on vital signs and clinical indicators related to the patient's primary diagnosis or eliminate it.

M1100 Patient Living Situation

IHCC members like the apparent ease the format of this item offers, but anticipate that training staff to use this item will be challenging. The grid is more complex than it appears on first blush, and IHCC members are concerned that the format has the potential for confusion and inaccuracy. Items such as this one that require the clinician to identify what "best describes" the patient's circumstances offer a great potential for inaccuracy—how is a clinician to answer this item if the patient has daytime assistance four days per week? Achieving inter-rater reliability on this item will be difficult.

Recommendation: IHCC recommends that CMS revise the opening sentence of this item to more clearly emphasize that respondents are to report the client's living situation the majority of the time, and include very clear instructions for how to answer this item in the Item-By-Item tips.

M1240 Frequency of Pain

IHCC members applaud CMS' proposed revision of response "0" in M1240. Separating a response of no pain from a response of pain that does not interfere with activity or movement will help to clarify this item for clinicians conducting the comprehensive assessment. IHCC also supports elimination of M0430 as this item has presented significant challenges to inter-rater reliability.

M1300-M1306 Pressure Ulcer Questions

IHCC supports the addition of these questions to the assessment of integumentary status required in OASIS, though we note that M1306 will require additional time and investigation to complete.

M1310 Current Number of Unhealed Pressure Ulcers at Each Stage

IHCC has some significant concerns about the column on the right of this item and whether or not agencies will be able to accurately report this information. First, in order to complete the right-hand column the clinician will have to review the OASIS data that was collected at admission—this places an additional burden on the clinician and the agency to insure that the information is available. At discharge this information will likely be collected in the office based on a clinical record review, particularly if the nursing service has already discharged the patient and only therapy services remain.

Not only is there a significant potential for inaccurate information to be recorded here, but it will be difficult to discern whether the inaccuracy is due to upstaging of ulcers or simply recording an inaccurate count of the number of ulcers at each stage. Simply inaccurate data can easily look like bad outcome data. Given the potential for inaccuracy, it is questionable how useful data from this column of this item will be.

Recommendation: IHCC recommends that CMS delete the right-hand column from M1310 (the column requesting how many pressure ulcers at each stage were present at admission) because of the potential for error in completing this item. CMS can much more accurately, and therefore more meaningfully, generate this information by electronically matching responses to M1310 from the start of care data set with the data collected at discharge.

M1312 Pressure Ulcer Length and M1314 Pressure Ulcer Width

IHCC questions why CMS is requesting these measurements without the measurement of the depth of the pressure ulcer, particularly since these items are restricted to Stage 3 and 4 pressure ulcers. It is arguable, in fact, that depth is the most critical dimension.

Recommendation: IHCC recommends that CMS add an item requiring agencies to record the depth of the pressure ulcer addressed in M1312 and M1314, and that the introduction to this item be revised to require that this data be collected for the pressure ulcer with the greatest depth.

M1320 Status of Most Problematic (Observable) Pressure Ulcer and M1324 Stage of Most Problematic (Observable) Pressure Ulcer

IHCC members applaud CMS' addition of the term "healed" to response "0" in this item. This language will clarify the item significantly. However, IHCC

members question why CMS has reversed the order of the items requesting the status and stage of the patient's most problematic pressure ulcer from the order historically found in OASIS. Reversal of the order of these items serves no apparent purpose but does offer the opportunity for confusion and frustration for clinicians being re-trained in the new OASIS.

Recommendation: IHCC recommends that CMS revise the proposed OASIS C to mirror the historic order of items requesting information on status and stage of the patient's most problematic pressure ulcer. Members believe strongly that we should minimize as much as possible the demands and potential for frustration that the revised OASIS C will place on clinical staff.

M1322 Current Number of Stage I Pressure Ulcers

IHCC members find the location of this item among the flow of pressure ulcer items to be Illogical and disruptive.

Recommendation: IHCC recommends that CMS relocate M1322 to a location between M1306 and M1308 in the proposed version. Relocation would result in a much more logical thought pattern for clinicians completing this sequence of items.

M1330-M1342 Stasis Ulcer and Surgical Wound Questions

IHCC applauds CMS' efforts to improve the clarity and logic of the responses and skip patterns within these two sequences of items. These revisions will make training clinicians to use the data collection tool much easier.

M1350 Skin Lesion or Open Wound

While IHCC members recognize the purpose of M1350 we are concerned that this item will generate confusion, particularly for those clinicians who have been using the historic versions of OASIS. IHCC members also question why any ostomies are excluded from the response to this item, and why only bowel ostomies were excluded. M0440 has historically excluded all ostomies. What is the rationale for CMS proposal for M1350?

Recommendation: IHCC recommends that CMS revise the instructions for M1350 to include all ostomies as skin lesions or open wounds. If the goal of this process item is to evaluate whether or not the agency is addressing issues with the patient's integumentary status beyond pressure ulcers, stasis ulcers and surgical wounds, then it would make sense to open this item up to any issue with integumentary status.

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

IHCC members applaud the revision of response "0" in this item as we believe it will relieve confusion for clinicians.

M1615 When does Urinary Incontinence Occur?

IHCC members also applaud CMS' revisions of the potential responses to this item. Clarity has been needed for some time to insure that the data collected in this item is meaningful and accurate. IHCC believes that CMS has achieved this goal.

M1730 Depression Screening

IHCC members find the language in responses "1" and "2" to be very confusing. Is CMS asking for symptoms displayed on the day of the assessment or during the prior 14 days?

Recommendation: IHCC recommends that CMS clarify the time frame for which data is to be collected in M1730. Perhaps it would be most meaningful to reference the time frame identified in the most common standardized assessment tools.

M1730-M1736 Depression Questions

On one hand IHCC members are very pleased to see increased attention to depression screening and treatment in the proposed version of OASIS C as we believe that this is an under-recognized and under-treated issue in the Medicare population. However, we have some concerns about the volume and scope of the items and the direction they lead agencies to take.

Based on our experiences and the literature, IHCC members recognize that several barriers arise in addressing the under-identification and under-treatment of depression in the elderly. First, many of the anti-depressant medications work differently in the elderly than they do in the remainder of the adult population. They can cause psychosis-like symptoms and behaviors that disappear when the medications are removed, or are simply ineffective. Second, few physicians treating the elderly are well versed in these medications or their potential side-effects. IHCC members are concerned that inclusion of these process items will result in inappropriate treatment of many Medicare beneficiaries, particularly in those agencies that do not offer a psychiatric nursing program.

The sheer number of OASIS items devoted to this issue is a testament to how important CMS believes this issue to be. And, IHCC concurs that it is important. However, we are concerned that attempts to address the issue with flawed medications and a very under-educated physician population may cause more problems than it will solve.

Recommendations: IHCC is uncertain exactly what recommendations to make to CMS in this area, other than to urge CMS to devote some of its resources and influence to addressing the issues raised above.

M1800-M1945 ADL/IADL Items

IHCC members applaud CMS' elimination of the "Prior" column from the ADL and IADL items and the inclusion of M1880, M1890 and M1920 in their place. These items collect the information that clinicians need to have regarding the patient's prior functioning without requiring the type of speculation required by the previous approach. This change will be warmly welcomed by home health clinicians.

IHCC members also welcome the increased emphasis on safety that is represented by the inclusion of the word "safely" in the opening sentences of M1800, M1810 and M1820. However, we wonder if this focus could not be further enhanced by including the word safely in responses "0" and "1" in the majority of the ADL and IADL items.

Recommendations: IHCC recommends that CMS add the word "safely" to responses "0" and "1" in items M1800, M1810, M1820, M1830, M1840, M1845, M1850, M1860, M1870, M1880, M1890, M1900, and M1920.

M1830 Bathing

In light of the other revisions to this item that are clearly designed to separate the issue of transferring out of this item, IHCC is puzzled by the retention of response "2(b)". Getting in and out of the shower is part of transferring, not of bathing.

Recommendation: IHCC recommends that CMS delete option "2(b)" from M1830 in the interests of clarity and consistency with the other revisions made in this item.

M1845 Toileting Hygiene

IHCC applauds CMS inclusion of this item in the OASIS data set as it is clearly relevant to the patient's ability to maintain himself at home. However, IHCC members find some of the language in the introductory sentence to be confusing. First, the phrase "maintain safely perineal hygiene" is awkward and confusing. Also the meaning of the phrase "include cleaning opening but not managing equipment" is not immediately apparent.

Recommendations: IHCC recommends that CMS revise the language in the opening sentence of this item to include the phrase "safely maintain perineal hygiene" and the phrase "include cleaning the ostomy opening but not managing the equipment."

M1860 Ambulation/Locomotion

IHCC applauds the revisions CMS has made in the possible responses to this item, rendering the item much more sensitive to improvement in ambulation by home health patients.

M2000-2015 Medications

While IHCC members understand the reasons for CMS' inclusion of these process items in OASIS C, many find the intensity and detail in these items to be excessive.

M2002 Medication Follow-up

IHCC members believe that the one day time frame required in this item is unrealistic in the home health environment, particularly given the fact that the phrase "clinically significant" is not defined. More time is typically required to secure a response from a physician regarding a medication issue with a home health patient than when a patient is hospitalized. And, home health clinicians frequently must triage or bundle their calls to physicians based on importance so as not to "wear out their welcome." While IHCC members recognize and support the importance of medication reconciliation and of immediately contacting the physician promptly when a medication issue arises that has the potential to cause major or immediate harm to the patient, this item lumps urgent and less-urgent medication problems together into a single process measure in an unrealistic manner.

Recommendation: IHCC recommends that CMS reconsider the language and the link between M2000 and M2002 so that they more realistically reflect the circumstances in which home health services are provided. Perhaps CMS could further define the instances to which the one day time frame applies to situations that present a life-threatening or potentially immediately damaging medication problem, without implying that all medication reconciliation matters must be addressed within that time frame.

M2110 Types and Sources of Assistance

IHCC members find the approach to collecting information about the patient's assistance needs in this revised item to be comprehensive and the format to be attractive. M02110 provides a great model for assessing the patient's needs and available resources, and for planning what will be needed to maximize the patient's caregiving environment. However, we have grave doubts about a clinician's ability to complete this detailed grid accurately and completely within the first one or two visits to the patient upon admission. Accurately discerning the true extent of the patient's needs and available assistance usually takes more

time and familiarity with the patient and his or her caregivers than can be accomplished so early in the relationship. As a result, IHCC members are concerned that clinicians will tend to under-report the assistance available to the patient at start of care in an effort to minimize the impact of reporting greater needs and limitations in the patient's environment which become apparent later.

Recommendation: IHCC recommends that CMS reduce the number of columns currently found in M2110 at least for use during the start of care assessment, recognizing that it may not be possible to accurately assess caregiver abilities in all of these areas within the first five days of the episode of care.

M2310 Reason for Emergent Care and M2430 Reason for Hospitalization

IHCC applauds CMS' expansion of the available responses in both of these items. IHCC believes that CMS should include an optional opportunity for clinicians to identify that "other" condition might have lead to either emergent care or hospitalization. And, IHCC has noted a typo in M2430 resulting in two options identified as #3.

Recommendations: IHCC recommends that CMS include an optional opportunity for the clinician to identify what "other" condition lead to emergent care (M2310 response 19) or hospitalization (M2430 response 20). IHCC also recommends that CMS correct the typo in M2430 noted above.

Thank you for the opportunity to comment on this data collection proposal. Please do not hesitate to contact IHCC's regulatory consultant, Rebecca Friedman Zuber at (312) 787-8017 or rfzuber@cs.com if you have questions or require clarification of any of these comments.

Sincerely,

Mary M. Newberry
IHCC President

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Document: CMS-2008-0141-0084
MN

Submitter Information

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General Comment

See attached comment letter.

Attachments

CMS-2008-0141-0084.1: MN

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#84

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 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.