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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-2008-0141-0079
LA

Submitter Information

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General Comment

Please find attached a file containing a cover letter and comments prepared and submitted by the OASIS Certificate & Competency Board, Inc. for consideration in finalization of OASIS-C.
Thank you for the opportunity to review and provide comments.
Linda Krulish
President, OCCB
LKrulish@oasiscertificate.org

Attachments

CMS-2008-0141-0079.1: LA

#79

The OASIS Certificate and Competency Board, Inc.
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January 13, 2009

The Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier CMS – R – 245 OMB # 0938-0760
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

Enclosed please find comments addressing various components of the proposed OASIS-C instrument. These comments were compiled by the OASIS Certificate and Competency Board, Inc. (OCCB), including contributions by participants at the OCCB's 2nd Annual Conference.

From November 17-19, 2008, the OCCB conducted its second annual meeting. Over 100 home care clinicians gathered to attend workshops on OASIS data collection and presentations by representatives from CMS and Case Western Reserve University on the OASIS–C pilot project. These clinicians reviewed the latest proposed revision to OASIS–C and worked in small, facilitated groups to draft comments and recommendations related to proposed revisions. These individuals drafted over 50 comments, and the documents were posted in the meeting rooms for the next 2 days. Attendees were given the opportunity to review the comments, prioritize them, and vote for those they felt had the greatest merit. Contributions by these attendees are indicated within the body of the comments by an asterisk, with highest ranking comments offered in BOLD. The OCCB is honored to submit their work for your consideration.

The OCCB is a non-profit organization whose goal is to encourage and promote greater reliability in OASIS data through the consistent application of guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The OCCB offers a voluntary certificate examination that home care clinicians may take in order to demonstrate and establish their expertise and commitment to OASIS data accuracy. Over 5000 clinicians have taken this exam since its inception in 2004. The organization sees support of the comment process as an important part of its mission to promote reliability in data collection.

The comments are presented in a table format, indicating the OASIS item(s) that the comment applies to, the comment with recommendations, and whether the recommendation will likely impact revision of the data set, or supplemental guidance documents. We hope that you find these comments and they way they are presented helpful in your work.

Thank you on behalf of the OCCB and the clinicians who have developed these comments. We hope they are helpful to you in your task of improving the quality of care for our citizens. Please do not hesitate to contact me with questions or for clarification.

Sincerely,

Linda Krulish, PT MHS COS-C
President
LKrulish@oasiscertificate.org

OASIS-C Comments

Prepared by the OASIS Certificate & Competency Board (OCCB)

*Indicates comments contributed by attendees at the OCCB's Annual Conference – Nov 2008

Comments ranked with highest importance by conference attendees are presented in **bold** type

Items	Comment	Item/Response wording impact	Guidance document impact
Recommendation to ADD Item	***Consider adding an item to report the current number of healed stage III and IV pressure ulcers (by stage), to highlight risk for recurrence and impact care planning.**	X	
Recommendation to ADD Item	*Consider adding an item to report if a "never" event occurred during the most recent hospitalization. (yes, no, unknown) and if Yes… what "never" event occurred (list events). This may prevent early hospital discharges due to "never" events.	X	
Planned Intervention items (M1244, M1304, M1360, M1734, M1940)	***The plan of care may not be formulated until after the completion of the assessment, so assessment items that require reporting of details of the "current physician-ordered plan of care" are confusing. Consider keeping consistency between the item title and actual language within item: "Will orders for interventions to monitor and mitigate pain be requested from the physician based on this assessment"**	X	X
Process Measures	"Physician-ordered plan of care". Define clearly. Does the specific intervention have to be on the signed orders? Does the agency have to receive the signed order prior to marking that the intervention is included on the physician-ordered plan of care?		X
Process Measures	"Current physician-ordered plan of care". Define whether you are referring to a 60-payment episode/certification period or a quality outcome episode, meaning just SOC to Transfer or ROC to Discharge? Example: For *Guidelines for Physician Notification;* if the blood sugar parameters were on the SOC POC, do they have to be on the ROC orders to be considered on the current MD-ordered POC?		X
Process Measures	Consider clarifying if process measure tasks must be completed by the home health agency or if the agency can use assessment information (depression screen or fall risk assessment) conducted by the physician or other professional external to the agency.		X
Process Measures	***Consider clarifying if process measure tasks (including development of plan of care and implementing actual clinical interventions like diabetic foot teaching or fall prevention steps) must be completed by the assessing clinician or if care planning and clinical interventions can be provided by another clinician seeing the patient. And if so, would the M0090 Date Assessment Completed need to be delayed until after all assessment, care planning and relevant clinical interventions are implemented?**		X

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Items	Comment	Item/Response wording impact	Guidance document impact
Diagnostic Coding Items	* The items allow 7 spaces and ICD-9 codes have a maximum of 5 digits. If this is intended to prepare for ICD-10, consider changing "ICD-9-CM" to "Diagnostic Code" to allow transition Guidance will be required to instruct how providers should use the 7 spaces prior to ICD-10 implementation (e.g., right justified)	X	X
Change in Status Items	* Need guidance in defining "prior level of functioning/onset of illness injury". What if there are multiple illnesses or events that have resulted in patient's current need? Need to address how to respond when the patient's status changes vary between the tasks listed. Consider adding grid to capture detail:	X	X
All items	Include as much of the CMS Q&A guidance as possible in the new OASIS guidance document, so we can delete as many Q&As as possible.		X
All items	Do all the existing OASIS Rules or Conventions stand? 1. Report what is true on the day of the assessment unless the item includes a different timeframe. 2. The day of assessment is the 24 hours immediately preceding the assessment visit and the time spent in the home. 3. If the patient's ability, circumstance, condition or status varies on the day of the assessment, report what is true greater than 50% of the time. 4. If the patient's ability varies between the various tasks included in a multi-task item, report what is true greater than 50% of the time in the more frequently performed tasks. 5. Only use NA/Unknown when it is truly the only appropriate response 6. Make each OASIS assessment an independent observation of the patient's status and ability without referencing back to prior assessments. 7. Combine observation and interview when performing an assessment but direct observation is the preferred strategy.		X

	Better	Same	Worse
Grooming			
Dressing			
Bathing			

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M1012 Inpatient Procedure Codes	*This will be extremely difficult for HHAs to obtain, especially those that are not affiliated with the referring hospital/system. Consider evaluating the benefit/burden of this data. Recommend Deleting.	X	
M1040 Influenza Vaccine M1045 Reason Influenza Vaccine not received M1050 Pneumococcal Vaccine M1055 Reason PPV not received	Captured on Transfer and Discharge. Will require review of clinical plan/interventions to be able to be completed in 2 calendar days. May require assessing clinician to look back at previous assessment time points, which is in conflict with current guidance. Provide clarification if guidance regarding "look back" is changing. Consider process of post-episode review, separate from the patient assessment (and outside the 2-day assessment time frame) for the assessing clinician or other agency clinician to review the record to identify if relevant interventions were previously implemented.	X	X
M1020/M1022/M1024	*Fourth sentence of this item wording states "V codes… or E codes … may be used. To comply with ICD-9-CM instructions, language should be "V codes… or E codes should be used when appropriate, per ICD-9 coding guidelines."	X	
M1032 Frailty Indicators	Consider adding guidance in Ch 8 regarding the use of clinician judgment in response selection? Consider defining or providing objective parameters for "debilitating pain" Consider defining or providing objective parameters for "Recent functional decline"		X
M1100 Patient Living Situation	Does "available assistance" include assistance available by phone? Lifeline? 911? Nearby? In another state but accessible by phone? Consider objective definitions Existing guidance states if a patient lives in their own room in an ALF, they live alone. Clarification needed to determine if the patient would be "a-Patient lives alone" or "c-Patient lives in congregate situation (e.g., assisted living)"		X
M1240 Frequency of Pain	Skip language is missing. In prior version, skip language was only included on Response "0-Patient has no pain." Suggest considering the skip also be applied to "1-pain does not interfere with activity or movement."	X	
M1244 Planned Pain Intervention	*Concern that an order that is requested but not provided would not be captured. Consider adding response option: "NA – order requested from MD but to date, not received"	X	
M1242 Pain Assessment	*Consider providing parameters to define "severe pain" Consider providing examples of pain assessments.		X

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Item	Comment	Item/Response wording impact	Guidance document impact
M1246 Pain Intervention	Captured on Transfer and Discharge. Will require review of clinical plan/interventions to be able to be completed in 2 calendar days. May require assessing clinician to look back at previous assessment time points, which is in conflict with current guidance. Provide clarification if guidance regarding "look back" is changing. Consider process of post-episode review, separate from the patient assessment (and outside the 2-day assessment time frame) for the assessing clinician or other agency clinician to review the record to identify if relevant interventions were previously implemented. Consider revising the language used to increase comprehension of clinicians (whose primary language is not English, etc.) – consider changing "mitigate" to "decrease"	X	X
M1300 Pressure Ulcer Assessment	*Responses #1 and #2 are not mutually excusive. (Risk could be assessed using both a standardized tool and additional or other clinical factors.) Consider adding guidance to not mark "2" if "1" is chosen, or "Mark all that apply", or combine responses 1 and 2, unless there is value in determining that the risk was evaluated via a standardized tool vs clinical factors.	X	X
M1302 Pressure Ulcer Risk	*Consider defining or providing objective threshold for "RISK". Risk assessment tools typically assign varying levels of risk which may make application subjective and inconsistent.		X
M1304 Planned Pressure Ulcer Prevention M1306 Pressure Ulcer Prevention	* "Physician-ordered plan of care" terminology may not include routine nursing interventions that do not require physician's orders (e.g., turning schedule). Consider adding terminology to include the reporting of routine nursing interventions.	X	X
M1306 Pressure Ulcer Prevention	* Captured on Transfer and Discharge. Will require review of clinical plan/interventions to be able to be completed in 2 calendar days. May require assessing clinician to look back at previous assessment time points, which is in conflict with current guidance. Provide clarification if guidance regarding "look back" is changing. Consider process of post-episode review, separate from the patient assessment (and outside the 2-day assessment time frame) for the assessing clinician or other agency clinician to review the record to identify if relevant interventions were previously implemented.	X	X

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M1310 Current Number of Unhealed Pressure Ulcers at Each Stage	*To report the number of pressure ulcers present on admission will require the assessing clinician to look back at prior assessments, which is in conflict with current guidance. Provide clarification if guidance regarding "look back" is changing. Clarify if, at SOC, the "number present on admission" would always be the same as the "number present".	X	X
M1310 Current Number of Unhealed Pressure Ulcers at Each Stage	Instruction is to enter "4" if "4 or more". This will introduce a situation where the OASIS documentation disagrees with the clinical documentation or misrepresents the true clinical status. Recommend keeping the choices 0, 1, 2, 3, 4 or more, or UK	X	
M1324 Stage of Most Problematic (Observable) Pressure Ulcer	If a pressure ulcer is NA-No observable pressure ulcer, the instruction is to skip the Pressure Ulcer process measures regarding moisture retentive dressings. This means that an ulcer that cannot be staged due to the wound bed being covered with avascular tissue or an ulcer covered with a non-removable dressing will not be addressed in the process measures. Is that intended?	X	
M1326 Pressure Ulcer Intervention M1328 Pressure Ulcer Intervention	Who can determine moisture retentive dressings are not indicated for the patient? Per MD, Per WOCN, per agency protocols? Per clinician's judgment?		X
M1328 Pressure Ulcer Intervention	Captured on Transfer and Discharge. Will require review of clinical plan/interventions to be able to be completed in 2 calendar days. May require assessing clinician to look back at previous assessment time points, which is in conflict with current guidance. Provide clarification if guidance regarding "look back" is changing. Consider process of post-episode review, separate from the patient assessment (and outside the 2-day assessment time frame) for the assessing clinician or other agency clinician to review the record to identify if relevant interventions were previously implemented.	X	X
M1304 Planned Pressure Ulcer Prevention	*Concern that an order that is requested but not provided would not be captured. Consider adding response option: "NA – order requested from MD but to date, not received"	X	
M1322 Current Number of Stage I Pressure Ulcers	*Concerned this item is out of order with surrounding items. Consider reordering so M1322 is after M1304 or M1306, but before M1308.	X	