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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-2008-0141-0101
CA

Submitter Information

Name: Irene Cole
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Sunnyvale, CA, 94085
Organization: Pathways Home Health and Hospice, Inc.

General Comment

Our comments are addressing OASIS-C: the sensitivity of the Transferring measure (current M0690). We gratefully acknowledge the proposed changes: addition of the word SAFELY to the question, and the omission of measurement of transferring on and off the commode/toilet and in/out of shower.

Our concern is that the "1" score verbiage lacks enough detail to measure certain improvements after therapy has completed a plan of care. The possible responses for a bedbound client are more sensitive and wide-ranging than for a mobile client, which are the majority of people in home care. We would like to submit a request for another "able to transfer self" level - for instance, "Transfers with Maximum Human Assistance AND Assistive Device" or "Transfers Self but at Severe Risk for Loss of Balance". The point being that similar to the M0700, Ambulation measure, where you are proposing an increase in sensitivity by separating the types of assistive devices used (for which we are very happy), we need to see this reflected in the related measure of Transferring.

As a matter of example, know that statistically using the CMS Tally Tool for data, we can say that most of our patients who do not improve in transferring come in with a forced score of a "1" and leave as a "1". This is in fact, not the real truth. Improvements have been made by our rehab team, however they cannot be measured by the current scoring of the M0690.

Thank you for the opportunity to comment and request changes on the upcoming OASIS-C. We are very encouraged and excited by the proposed changes!

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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-2008-0141-0102
MN

Submitter Information

Name: DEBBIE STEINBRING
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General Comment

SEE ATTACHED

NO ATTACHMENT

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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-2008-0141-0103
MN

Submitter Information

Name: Jodi Grandprey
Address:
Windom, MN, 56101
Organization: Good Samaritan Society Home Care

General Comment

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

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

Concern: M1010 & 1012 Inpatient Diagnosis and ICD Code
Suggestion for Change: Eliminate this requirement. If CMS needs the data it is available from the hospitals.
Rationale: Not all institutions make this information available in a timely manner. Home health providers do not have access to this information without the timely cooperation of the institution from which the patient is discharged. This is an undue burden and unrealistic expectation because final hospital coding often does not occur until the hospital generates the bill. It is not realistic for home care clinicians to have knowledge of the coding requirements for inpatient facilities; requiring them to enter this information with insufficient or completed data from referrals sources will result in errors in a patient's medical record.

Concern: M1014 Medical or Treatment Regimen Change

Suggestion for Change: Eliminate this item
Rationale: This information is collected in other M0 items

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

Concern: M1034 Stability Prognosis
Suggestion for Change: Eliminate # 3 - The patient has serious progressive conditions that could lead to death within a year.
Rationale: This language is similar to M0280 except that the predicted death time has changed. Providers should not have to guess at time of death. It is not a question that reflects the actual and clinically substantiated status of the patient. Clinicians will have much difficulty differentiating between number 2 and number 3 in this item. Defining "serious complications" and "high health risks" by various clinicians will result in useless data.

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

Concern: M1300 - M1306 - Pressure Ulcer Assessment
Suggestion for Change: Extend the SOC OASIS assessment time frame from 5 days to 7 days to allow collaboration between disciplines and to determine ability and availability of caregivers as well as the most effective wound care regimen.
Rationale: What if PT or a weekend person is admitting – does the assessment need to be done right away at SOC? It is unrealistic to get all of this done in the 5-day time frame. Consultation with staff outside the home care agency, for example a wound healing clinic, is often necessary to gather all pertinent clinical

information.

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

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

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

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

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

Concern: M1500 Symptoms of Heart Failure
Suggestion for Change: 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 standardize data. Comparison across patients will be less accurate if individual providers are using a wide variety of screening tools.

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

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

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

confusion and inaccurate answers

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

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

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

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

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

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

Concern: M2020 Management of Oral Medications
Suggestion for Change: Go back to the question asking only about 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 general comments and concerns:
We are concerned that there were only 11 pilot agencies. This is not statistically significant. There are over 9,000 Medicare-certified providers. We suggest pilot studies on a much larger scale in order determine the feasibility and usefulness of the proposed OASIS changes.

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

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

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

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

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

Sincerely,

Jodi Grandprey RN, Director
Diane Witt RN, Casemanager
Becky Carpenter RN, Casemanager
Billie Halbersman RN, Casemanager
Jennifer Kooiman RN, Casemanager
Jen Boll RN, Casemanager

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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-2008-0141-0104
MN

Submitter Information

Address:
MN, 56220
Organization: Sanford Home Care Canby

General Comment

Please see attachment

Attachments

CMS-2008-0141-0104.1: MN

Sanford
Canby

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Canby MN, 56220
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#104

SANFORD HOME CARE CANBY

1/12/2009

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

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

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

Concern: **M1010 & 1012** Inpatient Diagnosis and ICD Code
Suggestion for Change: Eliminate this requirement. If CMS needs the data it is available from the hospitals.
Rationale: Not all institutions make this information available in a timely manner. Home health providers do not have access to this information without the timely cooperation of the institution from which the patient is discharged. This is an undue burden and unrealistic expectation because final hospital coding often does not occur until the hospital generates the bill. It is not realistic for home care clinicians to have knowledge of the coding requirements for inpatient facilities; requiring them to enter this information with insufficient or completed data from referrals sources will result in errors in a patient's medical record.

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

Concern: **M1032** Frailty Indicators
Suggestion for Change: Define unstable vital signs and clarify what is debilitating pain, recent mental health change and what constitutes a decline in functional status. Include items identified from home health agencies' work with the QIOs as included on the Hospitalization Risk Assessment Form at www.homehealthquality.org web site. The presence of high risk chronic diagnoses place a patient at risk for rehospitalization and speak to the fragility of their overall status. These include the diagnoses of CHF, diabetes, COPD, and chronic ulcers. Antibiotic resistant infections are an increasing challenge and should be included in this category. Environmental conditions or personal attributes such as low socioeconomic status, low literacy, inadequate support network, poor prognosis, shortened life expectancy, inability to manage own medications are all common in the home care population and are contributing factors to the frailty of the patients served. Eliminate this item from SOC

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

Concern: **M1034** Stability Prognosis
Suggestion for Change: Eliminate # 3 - The patient has serious progressive conditions that could lead to death within a year.
Rationale: This language is similar to M0280 except that the predicted death time has changed. Providers should not have to guess at time of death. It is not a question that reflects the actual and clinically substantiated status of the patient. Clinicians will have much difficulty differentiating between number 2 and number 3 in this item. Defining "serious complications" and "high health risks" by various clinicians will result in useless data.

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

Concern: **M1300 - M1306** - Pressure Ulcer Assessment
Suggestion for Change: Extend the SOC OASIS assessment time frame from 5 days to 7 days to allow collaboration between disciplines and to determine ability and availability of caregivers as well as the most effective wound care regimen.
Rationale: What if PT or a weekend person is admitting – does the assessment need to be done right away at SOC? It is unrealistic to get all of this done in the 5-day time frame. Consultation with staff outside the home care agency, for example a wound healing clinic, is often necessary to gather all pertinent clinical information.

Concern: **M1312** - **M1314** Pressure Ulcer Length & Width
Suggestion for Change: Eliminate both items
Rationale: Requiring length and width of the wound does not meet the guidelines for measurement and assessment as established by the Wound, Ostomy and Continence Nurses Society (WOCN). This question does not ask for the components of a complete wound assessment; therefore clinicians will be required to complete redundant documentation

in order to accurately document the wound condition. Providing only a length and width of a wound does not provide an accurate accounting of a wound status and is not best clinical practice. WOCN guidelines for wound measurement include a length that is measured at 12 o'clock to 6 o'clock with 12 o'clock always being toward the patient's head. Width is measured side to side from 3 o'clock to 9 o' clock. Simply asking for length and width does not support the guidelines.

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

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

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

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

Concern: **M1500** Symptoms of Heart Failure
Suggestion for Change: 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 standardize data. Comparison across patients will be less accurate if individual providers are using a wide variety of screening tools.

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

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

Concern: **M1890** Change in Self-care Ability
Suggestion for Change: Eliminate this item

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

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

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

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

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

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

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

Concern: **M2020** Management of Oral Medications
Suggestion for Change: Go back to the question asking only about 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 general comments and concerns:
We are concerned that there were only 11 pilot agencies. This is not statistically significant. There are over 9,000 Medicare-certified providers. We suggest pilot studies on a much larger scale in order determine the feasibility and usefulness of the proposed OASIS changes.

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

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

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

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

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

Sincerely,

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Document: CMS-2008-0141-0105
CT

Submitter Information

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General Comment

Issue: Value vs Burden of Changes
· Thank you for listening to our expressed concerns over the past several years regarding many of these OASIS items. We can see that you have put effort into improving many of them and making them more practical for the home care patient.
· However, the number of questions in two data sets has increased dramatically:
B1 C
SOC/ROC ~81 102
Transfer ~11 27
This increase of the number of questions will cause extended visit time for the assessing clinician—at least an additional 30 to 45 minutes for the SOC visit, which is already 90 to 120 minutes long. Even if you do not consider the extra burden on the home health agency (i.e., the time of the clinician and the extra data entry time), the additional stress to the patient cannot be overlooked. Here is a direct comment from one of our field clinicians: "Patients hate all the questions we ask now, boy they are really going to hate us and not want us." Let's not let our patients get lost in the midst of our trying "help" them so much by gathering all this information. Much of the information on the OASIS is important, but much more of it is just interesting—not necessarily important.
As mentioned, many of these questions are much improved and we can see their value in improving the care provided to the patient. We will comment on several of the questions that we believe increase the burden of the assessment tool without increasing the value to the patient, and should be deleted.
· The process questions related to including interventions on the Plan of Care and verifying that all appropriate interventions have been implemented throughout the episode, although simple in content, are actually quite complex to operationalize. They fall outside of the usual workflow that occurs in a typical home care agency. The assessing clinician may not be the clinician who provides care throughout the episode or who creates the Plan of Care. The clinician who completes the discharge or transfer assessment will be required to conduct a patient chart review in order to be able to answer honestly if all interventions were

appropriately implemented. The clinician who completes the SOC assessment will be required to wait until the Plan of Care is completed (often by someone else) in order to be able to answer honestly if all appropriate interventions are on the Plan of Care.
These particular process questions also require the clinician to work outside of the usual clinical process (i.e., assess, analyze, plan, implement, evaluate). Our clinicians perceive that they are being asked to combine assessing, analyzing and planning in the same step.
We fear that clinicians will become frustrated with the difficulty of collecting the information for these questions and just answer "Yes" to all of them in order to get the assessment completed and off their to-do list. Obviously this approach will not be helpful to the agency, the patient or the healthcare system.
We actually like that these questions are clearly establishing a standard of practice—something that has been lacking in home health—but we believe that the OASIS assessment is not the effective place to try to enforce these standards.
Recommendation: Remove from the OASIS process questions related to the Plan of Care and interventions and use them to establish clear, measurable and objective performance expectations that are used during the survey process.
Issue: OASIS Item (M1034) Stability Prognosis
· This item contains very imprecise and subjective language, such as "heightened" risk, "serious" complications, "high health risk", "likely to return", "typical of the patient's age", "fragile" health, "serious" progressive conditions. Unless these terms are clearly and specifically defined, the variations in interpretation will cross a broad spectrum. Interpretation from one clinician to another will be so inconsistent as to make this question useless.
The term "typical of the patient's age" is actually somewhat offensive as it reinforces stereotypical thinking regarding the elderly. We know and we are constantly reminded (by the U.S. government among others) that each senior is an individual; that there is no such thing as a "typical" 80 year old, for instance.
· The types of conclusions listed as responses in this question go beyond the nurse's or therapist's scope of practice. Their training provides no basis for answering this question.
· This question will cause stress and anxiety among the clinicians responsible for completing OASIS while at the same time it does not contribute to the clinical care that must be planned and provided to the patient.
· Recommendation: remove this question from the OASIS.

Attachments

CMS-2008-0141-0105.1: CT
CMS-2008-0141-0105.2: CT

#105

OASIS – C PROPOSED CHANGES
Interim HealthCare of Hartford, Inc.
Comments

Proposed OASIS Changes	Comments
General M0102 Date of Referral M0104 Date of Physician-ordered Start of Care (Resumption of Care The following are being eliminated and are currently used to support homebound status, a) should they be eliminated, and b) should we keep them if eliminated? (M0730) Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway). (M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.	M0104 will actually make it easier to track the 48 hour rule. But would we need a date for each type of service or just the opening discipline? M0104 – not useful information since many referrals come in well in advance of the SOC date. Not sure how this information would be useful for the agency or CMS. MO730 and MO760 should be eliminated
Pain Management M1242 Has this patient had a formal Pain Assessment using a standardized pain assessment tool (SOC, ROC) M1244 Planned Pain Intervention: Does the current physician-ordered plan of care include interventions to monitor and mitigate pain (SOC, ROC) M1246 Pain Intervention: Since the previous OASIS assessment, have pain management steps in the physician-ordered plan of care been implemented to monitor and mitigate pain? (Transfer, D/C)	**Comments** M1246 -Why would pain mgt be required on a transfer? M1242 is good but the pain scale needs to be standardized for everyone. Otherwise what does formal mean – that is too subjective for accurate data retrieval. M1244 should be a trigger reminder not a question. It is a standard of practice and not about the patient but about clinical practice. Isn't Oasis about data collection – should we be taking precious time from our patient care to ask the clinician if they have followed their standard of practice. I don't see the value in that. Sounds like Oasis is getting into the area of employee supervision. M1246 is a tedious process because to answer it correctly requires a complete chart review. Already overwhelmed with paper demands this question becomes unreliable in its ability to actual capture and record accurate data in a consistent manner? My question is what would the data be used for?

Wound Care	Comments
(M1300) Pressure Ulcer Assessment: Was this patient assessed for risk of developing pressure ulcers? (SOC, ROC) (M1302) Does this patient have a Risk of Developing Pressure Ulcers? (SOC, ROC) (M1304) Planned Pressure Ulcer Prevention: Does the current physician-ordered plan of care include intervention(s) to prevent pressure ulcers? (SOC, ROC) (M1306) Pressure Ulcer Prevention: Since the previous OASIS assessment, were intervention(s) on the current physician-ordered plan of care to prevent pressure ulcers implemented? (Transfer, D/C) (M1312) Pressure Ulcer Length: Longest length in any direction | ___ | ___ | . | ___ | (cm) (SOC, ROC, D/C) (M1314) Pressure Ulcer Width: Width of the same pressure ulcer, greatest width measured at right angles to length | ___ | ___ | . | ___ | (cm) (SOC, ROC, D/C) (continued on next page) Proposed OASIS-C Changes (M1326) Pressure Ulcer Intervention: Are moisture retentive dressings specified on the physician-ordered plan of care? (SOC, ROC) (M1328) Pressure Ulcer Intervention: Since the previous OASIS assessment, were moisture retentive dressings used? (Transfer, DC)	M1300-Again need a standard tool like Braden Scale? The risk assessments need to be uniform or there is no scale for comparison. M1306, 1312, 1314 - Requiring measurements in the written assessment piece is redundant, it is already addressed in the body diagram/wound assessment, which is necessary for a comprehensive clinical assessment. M1326 - Interferes with physician plan of care not all pressure wounds should have a moisture retentive dressing Again needs to be a trigger not a question M1304-Too vague – One agency may have a whole list of interventions, another may have done one intervention? What is the purpose of this question? How would this data be used because it would be tedious to collect? If there is more than one how do we know what ulcer needs to be measured for this answer and we always measure all the ulcers? What is this data for? M1326-Can we assume that this will have a response that says MD refuses to use moisture retentive dressings?
Respiratory Status	**Comments**
(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? (Transfer, D/C) (M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason: (Transfer, D/C) (M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)? (Transfer, D/C) (M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason (Transfer, D/C)	Is not necessary on the OASIS assessment This is great data but shouldn't this be from a patient's physician and not home care? Pt switch agencies and go in and out of facilities. Their record of immunizations remains with their primary care physician not their home care agency. I understand this is important but I think the burden of this tracking shouldn't rely with the home care agency.

Heart Failure (M1500) Symptoms of Heart Failure: Since the previous OASIS assessment, did the patient exhibit symptoms of heart failure indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point? (Transfer, D/C) (M1510) Heart Failure Follow-up: Since the previous OASIS assessment, what action(s) has (have) been taken to respond to each instance of heart failure? (Mark all that apply.) (Transfer, D/C)	**Comments** What is the purpose of addressing that "each"instance is – requires a cumbersome chart review that will add significantly to time of the clinician. M1500 – are you going to produce clinical heart failure guidelines for this question? Many times patients with heart failure have some of these symptoms but we manage to keep them in the community. Also there are times that we report these symptoms to the MD and no changes are made. Then there is the whole area of patient non-compliance. M1510 is a tedious process because to answer it correctly requires a complete chart review. I am not sure how this data would be used. It doesn't seem helpful in aggregate form since each individual case is different. How would it have an impact on quality care or improving outcomes?
Endocrine Status – Diabetes (M1360) Diabetic Foot Care Plan: Does the physician-ordered plan of care include regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care? (SOC, ROC) (M1365) Diabetic Foot Care Plan Follow-up: Since the previous OASIS assessment, was the physician-ordered plan of care regarding patient education and regular monitoring for the presence of lesions on the lower extremities followed? (Transfer, D/C)	**Comments** M1365 not necessary, will be addressed in Interventions and goals Again I think this needs to be a trigger point not a question. Is the point behind it that by asking the question it will be human behavior to put it on the care plan? M1365 is a tedious process because to answer it correctly requires a complete chart review. I am not sure how this data would be used. It doesn't seem helpful in aggregate form since each individual case is different. How would it have an impact on quality care or improving outcomes?

Medications	Comments
(M2000) Potential Adverse Effects/Reaction: Does a complete drug regimen review indicate potential clinically significant adverse effects or drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance? (SOC, ROC) (M2002) Medication Follow-up: Was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? SOC, ROC) (M2004) Medication Intervention: Since the previous OASIS assessment, was the patient's physician (or other primary care practitioner) contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? (Transfer, D/C) (M2010) Patient/Caregiver Drug Education: Has the patient/caregiver received instruction on high-risk medications (such as hypoglycemics and anticoagulants) including monitoring the effectiveness of drug therapy, potential adverse effects, and how and when to report problems that may occur? (SOC, ROC) (M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed to monitor the effectiveness of drug therapy and potential adverse effects, and how and when to report problems that may occur? (Transfer, D/C) (M2040) Change in Ability to Manage Oral, Inhalant, or Injectable Medications: Is the patient's ability to prepare and take all prescribed medications (oral and, if applicable, inhalant or injectable medications) reliably and safely (including administration of the correct dosage at the appropriate times/intervals) better or worse than before the onset of the illness or injury that initiated this episode of care? (SOC, ROC)	Is unrealistic to expect that the physician will be notified within one calender day – does notification indicate a response or just contact with the office? Also, sometimes difficult to get a response on weekends, after hours. M2040 makes no sense, there is no measurement for "better or worse" M2002 Need to define contacted in one calendar day. Many times we call physicians and have to leave messages with their office does that meet the criteria for one calendar day? Define clinically significant med issue? Can you give an example of a med issue that wouldn't be clinically significant? M2004 is a tedious process because to answer it correctly requires a complete chart review. I am not sure how this data would be used. It doesn't seem helpful in aggregate form since each individual case is different. How would it have an impact on quality care or improving outcomes? M0210 are you going to give us a comprehensive list of what are defined as high-risk medications so that everyone can answer this question accurately across the Home Care setting? Would this be within the scope of a physical or speech therapist on a rehab only patient? MO240 is a good question but you need to define better or worse and give us a time frame? Otherwise this is a totally subjective question and the data it collected would be invalid.
Emergent Care Options	**Comments**
(M2310) Reason for Emergent Care: Four response options have been deleted: 2 - Nausea, dehydration, malnutrition, constipation, impaction 4 - Respiratory problems 6 - Cardiac problems 8 - GI bleeding, obstruction 14 response options have been added: 3 - Respiratory infection (e.g. pneumonia, bronchitis) 4 - Other respiratory problem 5 - Heart failure (e.g., fluid overload) 6 - Cardiac dysrhythmia (irregular heartbeat) 7 - Myocardial infarction or chest pain 8 - Other heart disease 9 - Stroke (CVA) or TIA 11 - Upper GI obstruction, constipation, impaction 12 - Dehydration, malnutrition	These are much more specific responses and will be helpful for chart review and aggregate data.

13 - Urinary tract infection 14 - IV catheter-related infection 16 - Uncontrolled pain 17 - Acute mental/behavioral health problem 18 - Deep vein thrombosis, pulmonary embolus	

General comments – Patients will have difficulty tolerating an assessment this lengthy. It is likely that they would refuse home care in the future if they had an experience like this. If the patient is therapy only and / or requires teaching and treatments on the first visit, there will be limited time for this, leading to poor quality of care and poor response to teaching by the exhausted patient.

OASIS – C PROPOSED CHANGES
Interim HealthCare of Hartford, Inc.
Comments

Changes	Comments
General **(M2120) How often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)? (SOC, ROC, D/C)**	**M2120 This question is very burdensome and tedious to complete. These terms regular daytime, occasional, short term etc need to be defined in objective terms for this question to even be answered accurately.** **What is the purpose of this question? How does it contribute to good outcomes? Is it just for risk adjustment and if it is it is too subjective to use as comparison data. If it is just for risk adjustment then how can it contribute to better patient care considering it will add a large time burden to Oasis?**
Musculoskeletal **(M1930) Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? (SOC, ROC, Transfer, D/C)**	**This is good but need a standard fall risk assessment for home care.**

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

(M2110) Types and Sources of Assistance
(Check only **one** box in each row)

Needing assistance = patient needs assistance on any item on the "e.g." list	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	a1. ☐	a2. ☐	a3. ☐	a4. ☐	a5. ☐	a6. ☐
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	b1. ☐	b2. ☐	b3. ☐	b4. ☐	b5. ☐	b6. ☐
c. Medication administration (e.g., oral, inhaled or injectable)	c1. ☐	c2. ☐	c3. ☐	c4. ☐	c5. ☐	c6. ☐
d. Medical procedures/ treatments (e.g., changing wound dressing)	d1. ☐	d2. ☐	d3. ☐	d4. ☐	d5. ☐	d6. ☐
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	e1. ☐	e2. ☐	e3. ☐	e4. ☐	e5. ☐	e6. ☐
f. Supervision and safety	f1. ☐	f2. ☐	f3. ☐	f4. ☐	f5. ☐	f6. ☐
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	g1. ☐	g2. ☐	g3. ☐	g4. ☐	g5. ☐	g6. ☐

Patient is going to be completely exausted after finishing just this part of the assessment

M2110 sounds like judgment calls that will be difficult to make accurately on a new patient. Define Supervision and safety? Define advocacy and facilitation of pt's participation in appropriate medical care? What is the difference between columns 3 and 4?

(M1940) Falls Risk Intervention: Does the current physician-ordered plan of care include intervention(s) to mitigate the risk of falls? (SOC, ROC) **(M1945) Falls Risk Intervention: Since the previous OASIS assessment, have fall prevention steps in the physician-ordered plan of care been implemented? (Transfer, D/C)**	**M1940 sounds like a trigger point not a question. It is a standard of practice and not about the patient but about clinical practice. M1945 is a tedious process because to answer it correctly requires a complete chart review. Many times on a POC we include fall prevention program and not every detailed intervention such as instructing on proper footwear. Those interventions are part of our detailed visit notes. Are you asking us to duplicate on both the POC, Oasis and visit notes about this? That is extra paperwork and documentation that would take away from patient care time.**

Changes	Comments
ADL/IADL (M1880) **Change in Mobility: Is the patient's ability to transfer and/or ambulate safely better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)? (SOC, ROC)** **(M1890) Change in Self-care Ability: Is the patient's ability to perform self-care activities safely (grooming, dressing, and bathing) better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)? (SOC, ROC)** **(M1920) Change in Ability to Perform Routine Household Tasks: Is the patient's ability to perform routine household tasks safely (e.g., light meal preparation, laundry, shopping, etc.) better, the same, or worse than prior level of functioning (i.e., before the onset of the illness or injury that initiated this episode of care)?(SOC, ROC)**	**These are too vague - better, same or worse and contain no time reference. The data collected would be subjective – can you tell us how that would be used to improve patient care?** **No measurement for 'same or worse or better", or prior level of function (what time period would constitute prior?)**
Modified ADL Questions **(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face and hands only):** **<u>Five response options have been modified:</u>** **0 - Able to bathe self in shower or tub independently, <u>including getting in and out of tub/shower.</u>** **1 - With the use of devices, is able to bathe self in shower or tub independently, <u>including getting in and out of the tub/shower.</u>**	**Comments** **M1830 – Improvement, more specific than before.**

4 - Unable to use the shower or tub, but able to bath self independently with or without the use of devices at the sink, in chair, or on commode. 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath. 6 - Unable to participate effectively in bathing and is bathed totally by another person.) (M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode. (M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. deleted from question: *on and off toilet or commode, into and out of tub or shower* (M1860) Ambulation/Locomotion: Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. Response options have been modified: 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings. 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.)	Better M1860 – Typically someone who needs to use a hemiwalker is someone who has so much upper extremity involvement from a CVA that they are not capable of using a walker. It does not seem correct that they would be scored as more functional than someone using a walker.
Severity Index Questions (M1032) Frailty Indicators: Which of the following signs or symptoms characterize this patient as at risk for major decline or hospitalization? (Mark all that apply.) (SOC, ROC, D/C) (M1034) Stability Prognosis: Which description best fits the patient's overall status? (Check one) (SOC, ROC, D/C) (M1038) Guidelines for Physician Notification: Does the physician-ordered plan of care establish parameters (limits) for physician notification of changes in vital signs or other clinical findings? (SOC, ROC)	**Comments** Stability prognosis is a physician question why is home care being asked? M1038 needs to be a trigger not a question. **Frailty question should be answered by MD**
Neurological, Emotional and Behavioral (M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool? (SOC, ROC) (M1734) Depression Intervention Plan: Does the current physician-ordered plan of care include intervention(s) for symptoms of depression, such as medication, referral for other treatment, or a monitoring plan for current treatment? (SOC, ROC)	Comments Will need a standard uniform depression screen for this to be accurate. Would this be an expectation for therapy only cases? M1734 needs to be a trigger not a question. M1736 will require a complete chart review.

(M1736) Depression Intervention Implementation: Since the previous OASIS assessment, were intervention(s) in the physician-ordered plan of care to address depression implemented? (Transfer, D/C)	What is the purpose of this data and is the burden worth the outcome?
Hospitalization Reasons **(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)** **Eight response options have been deleted:** **3 – Respiratory problems (SOB, infection, obstruction)** **4 – Wound or tube site infection, deteriorating wound status, new lesion/ulcer** **6 – GI bleeding, obstruction** **7 – Exacerbation of CHF, fluid overload, heart failure** **8 – Myocardial infarction, stroke** **9 – Chemotherapy** **10 – Scheduled surgical procedure** **15 – Psychotic episode** **14 response options have been added:** **3 - Respiratory infection (e.g. pneumonia, bronchitis)** **3 - Other respiratory problem** **5 - Heart failure (e.g., fluid overload)** **6 - Cardiac dysrhythmia (irregular heartbeat)** **7 - Myocardial infarction or chest pain** **8 - Other heart disease** **9 - Stroke (CVA) or TIA** **11 - Upper GI obstruction, constipation, impaction** **12 - Dehydration, malnutrition** **15 - Wound infection or deterioration** **17 - Acute mental/behavioral health problem** **19 - Scheduled treatment or procedure**	**Better**

Overall my questions would be:

1. Have these questions been field tested for validity and reliability?
2. What is the purpose of the Scope of Practice questions? Can it be explained how that will add value to patient care?
3. Many of the questions are subjective and lend themselves to inaccurate answers. Does CMS have the manpower and the resources in this economy to oversee the integrity and validity of a tool like this?
4. With questions that are this subjective - How can we be assured that everyone will be held to the same rule set and trained in the same fashion?
5. This will add at least 45 minutes to an open, resumption, recertification and follow-up. It will add at least 30 minutes to a discharge and transfer because it incorporates a whole process of chart review. Is the results from the data it produces going to outweigh the additional enormous time burden of paperwork for home care?