PUBLIC SUBMISSION

As of: January 20, 2009
Received: January 13, 2009
Status: Posted
Posted: January 15, 2009
Category: Home Health Facility - HPA25
Tracking No. 8081d6e6
Comments Due: January 13, 2009
Submission Type: Web

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

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

Document: CMS-2008-0141-0115
GA

Submitter Information

Name: Patrick Cunningham
Address:
Atlanta, GA, 30339
Organization: Gentiva health Services

General Comment

To whom it may concern,
Please find attached comments and recommendations regarding the above document.
Sincerely,
Paddy Cunningham RN, BA, MSN
AVP Regulatory Affairs
Gentiva Health Services
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Atlanta, GA 30339
Tel: 770-951-6489
Fax: 913-814-4388

Attachments

CMS-2008-0141-0115.1: GA

#115

GENTIVA®

January 13, 2009

Centers for Medicare & 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, Maryland 21244

Submitted Electronically

RE: CMS-R-245 (OMB Control Number 0938-0760) Medicare and Medicaid Programs OASIS Collection Requirements as Part of the CoPs for HHAs

To Whom It May Concern:
Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) latest revisions to the home health OASIS requirements. In particular, Gentiva is pleased to see the inclusion of process measures that will highlight the critical role home health plays in areas such as Diabetes care, congestive heart failure, falls risk assessment and other areas of critical concern to the Medicare and Medicaid programs and our nation's seniors.

Gentiva Health Services is the nation's largest provider of comprehensive home health and related services, with over 380 service delivery locations in 39 states. Last year, Gentiva provided needed healthcare to over half a million patients comprising all age groups and payer sources.

Our company is known for its dedication to clinical excellence, as evidenced by our desire to work closely with CMS and other organizations to elevate clinical standards and achieve greater efficiency, including our participation in the Alliance for Home Health Quality and Innovation. The new Alliance includes all industry trade associations and a variety of providers seeking to ensure strong clinical outcomes, excellence in care and innovation.

Gentiva is also known for the creation and implementation of unique, specialized services that have thus far addressed the key health needs of many thousands of older Americans. Our published national outcomes have demonstrated the ability of these programs to deliver improved care to Medicare patients with increased efficiency.

Through all of our experience, we believe it is important to continually improve the OASIS Assessment tool to reflect the latest in clinical excellence and innovation within the industry while also being mindful of added burdens to the agencies. A balance between improved quality measures and their increased paperwork burden must be achieved. Having said that, Gentiva believes that the incorporated clinical process measures are vital as the industry treats a sicker, more complex patient population with numerous comorbidities. Home health is and should be relied upon more within our healthcare delivery system as we treat acute, rehabilitative and chronic populations in a less costly-setting. Even more importantly, our patients prefer to have their healthcare needs met in the comfort of their own homes.

Please see below Gentiva's recommendations for potential enhancements to the currently proposed OASIS-C Assessment document. Prior to outlining those recommendations, we would like to briefly mention publicly reported quality measures. It is important to communicate to our patients and the public about the quality of care provided through the various home health agencies. Gentiva obviously supports the patients' right to choose their provider based on quality of care. We would, however, urge CMS to ensure that the quality measures used for public reporting have been fully validated prior to their public release. While all measures can be constantly improved, it is vital that agencies be judged on the best and most accurate indicators.

As CMS is slated to include a patient satisfaction survey with the OASIS-C beginning in January 1, 2010, Gentiva would like to express our concerns that the patient satisfaction survey has yet to be piloted by home health agencies. We would appreciate a pilot with appropriate validation prior to using the patient satisfaction survey for public release. Thank you for ensuring accurate and validated publicly reported quality measures and indicators.

Thank you again for the opportunity to provide comments on this important initiative. Should you wish to discuss our comments further I am available at the contact numbers below

Sincerely,

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General Comments:
Before we proceed with our comments on specific OASIS-C questions we would like to make some general comments related to this assessment instrument.

The first pertains to the inclusion in the instrument of questions that ask "Does the physician-ordered plan of care include interventions to..." e.g. M1244, M1304 and M1360. We would like to point out that under the Conditions of Participation: Home Health Agencies, 42 CFR 484.18, Home Health Agencies are required to establish a written plan of care for every patient. This plan of care must be developed in collaboration with agency staff, address all the patients' problems as identified on the initial assessment and must be authorized in writing by a physician (see below)

484.18 Condition of participation: Acceptance of patients, plan of care, and medical supervision. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.
(a) Standard: Plan of care:
The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of care.

Given this mandate we wonder why it is necessary to include such questions on the OASIS assessment instrument. We further believe that in many instances the issues addressed using these questions may not pertain to every patient and wonder what the impact on the agency will be at time of survey if this question is answered "No". M1304 has a 'skip pattern' that resolves this but the pain and diabetic foot care plan do not.

Questions such as this limit the scope of the home care clinician to use their clinical judgment when assessing their patients and tend to lead the assessment in a direction that it does not necessarily have to go. We suggest that questions such as these be deleted from the instrument.

The second comment we would like to make relates to the large and increasing volume of information that homecare clinicians are mandated to impart and homecare patients are expected to absorb, assimilate and utilize at the various OASIS time points. As we all recognize patients admitted to homecare today are elderly, frail, suffer from multiple medical morbidities, ingest multiple medications that effect more than one bodily system or sensory organ and at a minimum are subject to the normal cognitive decline related to advancing years. At any OASIS time point the homecare clinician is expected to provide information and teaching on the patients diagnoses, medications, treatments, safety issues, physician appointments, homecare clinician schedules and

more. It is expected that the patient manage all this information in addition to attending to their other anxieties that they have related to living in today's society e.g. the cost of food, medications, and fuel, the welfare of a spouse or other sick relative and facing a shortening and increasingly pessimistic future.

Homecare clinicians are perfectly situated in the healthcare continuum to impart all of this necessary information. These clinicians have demonstrated that they are willing and capable healthcare coaches to this fragile, complex and diverse population. In the future our clinicians will be relied upon even more to act in their capacity as healthcare coaches and conduits to patients' healthcare self-management and independence. Given this increasing burden on both the patient and the clinician we suggest that more emphasis be placed on education across the whole homecare episode rather than on narrow time points.

In order for a clinician to ascertain that a patient can absorb, remember and act upon the information imparted to them, a concise and focused evaluation of the patients' mental status, cognitive ability and capacity to learn must be undertaken. One of the most fundamental and glaring omissions from the OASIS assessments to date is that of an appropriate mental status/cognitive assessment. An assessment that addresses the patients' memory, recall, attention, concentration, mood, and thinking amongst others is essential to this process. With this in mind we suggest that **(M1700-M1750) – NEURO/EMOTIONAL/BEHAVIORAL STATUS** be completely eliminated from the OASIS-C and be replaced by Part IV. Cognitive Status, Mood & Pain section of the proposed Home Health CARE Admission Tool.

As a means of reducing the burden of information on both patients and clinicians at specific time points we suggest that questions be introduced that recognize the continuum of the homecare episode, lead the clinician to prioritize teaching/education that is delivered at these time points in order to achieve maximum impact, and also recognize the need for continuous education by incorporating teaching into the ongoing plan of care.

An example might be in question M2010 replace the words "Has the patient/caregiver received instruction…" with the words "Does the <u>care plan include</u> instruction on high-risk..."
And as option #2 to this question (as often may be the case too) "Patient/caregiver is fully knowledgeable of current high risk medication he/she is taking".

At a minimum we recommend that the OASIS-C address the problem of depression amongst our elderly patients. We are informed by recent studies in this area that:

- Depression is twice as common in the home health population as in the primary care population (Bruce et al, 2002).
- Home health care clinicians have difficulty making accurate assessments of depression among older home care patients (Brown et al, 2003).
- One month following admission to homecare up to 42% of patients continue to meet criteria for major depressive disorder (MDD), and a further 27% achieve only partial remission (Raue et al, 2003).
- Patients' low perceived social support is significantly related to suicidal ideation (Rowe et al, 2006).

Depression affects the patients' memory, concentration, attention, energy, motivation, nutrition, mobility, sleep, pain, organization and very importantly their ability to engage in the treatment and education regimens they receive. We suggest and strongly recommend that screening for depression be included in the OASIS-C assessment instrument. To achieve this objective we recommend that the questions relating to depression in the proposed OASIS-C be replaced by the Patient Health Questionnaire (PHQ-2) i.e. Sections F2 and F3 of Part IV. Cognitive Status, Mood & Pain section of the proposed Home Health CARE Admission Tool.

The major caveat here is that many clinicians practicing homecare today have limited experience in mental status/cognitive assessment and an initiative such as this will require much education before it can be implemented whether that is this year or in any future year. This overall information/education issue is also a major reason that the public reporting of questions relating to pain and medications on the Home Health CAHPS should be postponed until home health agencies have had the opportunity to respond and adjust to this situation.

Comments on Specific OASIS-C Items:

(M1032) – Frailty Indicators:
There are a number of concerns and questions with regard to some of the choices in this question.

- We have a concern as to how vital signs are to be judged as "unstable" based on a single recording. The measurement of vital signs at the point of admission to home healthcare is a one-time measurement that does not have an available data set for comparison or trending that allows the clinician to make the judgment of "unstable". We recommend that this item be removed.
- We recommend that in order to preserve consistency with current definitions that in this instance the word "Debilitating" be replaced with the phrase "Pain Interfering with Activity, Movement or Sleep"
- Given the high incidence of polypharmacy and the inherent risks of this to the patients who receive homecare services we suggest that this be considered an indicator of frailty also?
- In choices 3 and 4 of this question the word "Recent" is used. We feel that this is an ambiguous term that does not have consistent meaning across all raters. We suggest that this term be defined in any instruction set that will follow.

(M1038) – Guidelines for Physician Notification:
We ask that this question be clarified in the updated OASIS Chapter 8. Clarification that would be helpful would be guidance on number and type of parameters to be sought from the physician and if one errant finding within a range of all physiological measurements recorded on a patient at these time points qualifies as a "Yes" response on this question.

(M1040)-(M1055) – Questions concerning Vaccinations:
These questions raise a number of concerns for us.

- Do these questions indicate that home health agencies (HHA) will now be responsible for the providing and administering the vaccines in question?

- If this is the case than a number of prevailing condition must be addressed:
    - Current pharmacy conditions make it difficult for HHA's to administer these vaccines
    - State specific regulations with regard to the administration of these vaccines are not consistent from state to state
    - The CDC currently recommends that the Influenza Vaccine not be administered unless the clinician has access to an Epi-pen in case of sudden severe reaction to the vaccine
    - With regard to M1050 there will be many elderly patients who will not remember this information. Many may receive the PPV while in hospital or as a result of a visit to a practitioner other that their primary care physician and the information might not be available in their medical records.

(M1100) – Patient Living Situation:

- We suggest that there be further clarification to the term "congregate living" provided in the new chapter 8
- We also request that the term "availability of assistance" be clarified. Does this question refer to persons who are merely present in the patients place of residence or to people who are present, willing and able to be of assistance to the patient?

(M1210) and (M1220)

We feel that the differentiation between "Ability to Hear" and "Understanding of Verbal Content" in these questions is a positive development

(M1220) - Understanding of Verbal Content:

We would like to see response #1 better differentiated; we suggest:
O – Understands: clear comprehension without cues or repetitions
1 - Understands ordinary conversation but needs extra time or repetition
2: Comprehends only basic conversation/simple greetings and/or short comments
3 – Rarely/Never Understands
UK

(M1240)-(M1246) – Questions regarding Pain:

It is felt that questions M1240 and M1242 can possibly lead to some confusion amongst clinicians. Firstly, the presence, frequency and duration of pain cannot be established without a formal pain assessment. Secondly the characteristics of pain referred to in question M1240 should be part of the formal pain assessment. We suggest:

- that the sequence of these questions be reversed so that the presence of pain is established before the clinician is requested to document some of the content of their formal pain assessment
- that the word :severe be deleted from Options 1 and 2 in question M1242
- pain that is interfering with the patients activity or movement is also likely to interfere with the patients sleep and rest which can also have an impact on the patients overall well-being and ability to function. We suggest that the words "sleep and rest" be added to the heading of question 1240 so that it reads "Frequency of Pain interfering with patient's activity, movement, sleep or rest"

- In M1240 we suggest that the question be changed to "Frequency of Pain interfering with patient's activity, movement, or sleep" The impact of pain on the patients ability to rest and sleep is pervasive and this further adds to the patients experience of fatigue, mood, motivation etc. We also note that this issue has been recognized in the inclusion of pain and sleep in the proposed Home Health Admission CARE Tool.

With regard to questions M1244 and M1246 it is felt that there will be many instances where patients experience low to moderate pain, have exhausted all available remedies and whose pain will not be a focal part of the plan of care. In instances like this will a "No" response to these questions lead to survey deficiencies?

(M1300)- (M1365) – Integumentary Status:
This is another area that has been the focus of much debate. We feel that there are a number of areas that need to be addressed.

- With regard to questions M1312 and M1314 it is felt that these measurements are subjective and confusing, there is no evidence that consistent and accurate measurements will be obtained across all clinicians and on their own are of little value to the clinician. For this reason we suggest that questions M1312 and M1314 be deleted from the instrument
- With regard to question M1326 we would like further clarification on what defines a moisture retentive dressing. For example does a barrier cream meet this definition?
- In question M1350 we would like clarification of the wording "assessment and/or intervention".
- In question M1350 does the term "bowel ostomy" include a small but significant amount of urinary diversion stoma's that we often encounter and is breakdown around the ostomy included in this under the definitions of "Skin Lesion" and "Open Wound"
- With regard to question M1360 a number of issues have been brought to the fore:
    - In the case of patients with well controlled and understood diabetes this will not necessarily be a component of their care plan. What will the implications be of answering "No" to this question
    - Many therapy only admissions e.g. joint-replacement patients will present with well a controlled and understood diabetic condition.
    - We suggest that the scope of this question be limited to primary diagnoses and first secondary diagnoses only.
- Finally with regard to M1310 – third column – number of pressure ulcers present at admission – is this answered on all time points? Can we have our system default based on the SOC assessment?

(M1600) – Treatment for UTI
Our question here is: How do we address the situation when the patient was on prophylactic treatment but developed a UTI anyway? Is it mark all that apply? If not how would you answer this question?

(M1700-M1750) – NEURO/EMOTIONAL/BEHAVIORAL STATUS:
See comments above.

(M1860) – Ambulation/Locomotion
Comments:
1) Clarify "climb stairs" – does this mean "ascend" only? Recommend: "negotiate" stairs or use the terms: ascend/descend.
2) Do not combine even and uneven surfaces with stairs: there is a big difference between ability on even/uneven surfaces and curbs/stairs, especially for Orthopedic patients. It is more meaningful to determine ability on at least a curb.
3) Recommend clarifying a minimum number of steps for stairs (at least 3 steps would differentiate stairs from a curb)

Suggested alternative rating

0 Able to walk Independently on even and uneven surfaces, including up/down a curb and negotiation of stairs with our without railing for at least 3 steps – without human assistance or device
1 Able to independently walk on even and uneven surfaces, no human assistance or device; requires device for curbs or steps (device can be single or two handed such as a cane, crutches, or walker for curbs or steps)
2 With use of one-handed device, able to walk independently on even and uneven surfaces; requires human assistance/supervision to negotiate curbs and steps
3 Use the OASIS C item # 2
4 Use the OASIS C item # 3
5 Use the OASIS C item #4
6 Use the OASIS C item # 5
7 Use the OASIS C item #6

(M1870) – Feeding or Eating
With regard to Option #5 in this question we would ask for clarification in the new Chapter 8 or would suggest a change in wording to: "Unable to take nutrition via Gastrointestinal Tract; patient receiving parenteral nutrition"

(M1945) – Fall Risk Intervention:
We suggest that if (M1940) is response 0 (no) then M1945 should be skipped.

(M2002) and (M2004) – Medications
We suggest that in the new Chapter 8 that the term "clinically significant" be clearly defined

(M2110) – Types and Sources of Assistance
We request that the headings of each column be clearly defined in the new Chapter 8.

References:

Bruce, .L.B., McAvay, G.J., Raue, P.J., Brown, E.L., Barnett, S.M., Keohane, D.J., Jagoda, D.R., Weber, C. (2002). Major depression in elderly home health care patients. *American Journal of Psychiatry, 159* (8), 1367-1374.

Brown, E.L., McAvay, G, Raue, P.J., Moses, S, Bruce, M.L. (2003). Recognition of depression among elderly recipients of home care services. *Psychiatric Services, 54* (2), 208-213.

Raue, P.J., Barnett, S.M., McAvay, G.J., Brown, E.L., Keohane, D., Bruce, M.L. (2003). One-month stability of depression among elderly home-care patients. *American Journal of Geriatric Psychiatry, 11* (5), 543-550.

Rowe, J.L., Yeates, C., Schulberg, H.C., Bruce, M.L. (2006). Social support and suicidal ideation in older adults using home healthcare services. *American Journal of Geriatric Psychiatry, 14* (9), 758-766.

PUBLIC SUBMISSION

As of: January 20, 2009
Received: January 13, 2009
Status: Posted
Posted: January 15, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081d72c
Comments Due: January 13, 2009
Submission Type: Web

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

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

Document: CMS-2008-0141-0116
OH

Submitter Information

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Organization: University Hospitals Home Care Services

General Comment

M0102 Date of Referral - Comment – Question rationale for this question. If this is to track physician referral date compared to SOC, what if the physician specifically requests SOC date beyond the usual 24-48 hour window for SOC?

M0104 Date of Physician ordered SOC/ROC – Comment – if the SOC/ROC is date ranged, what date do we put in the answer?

M1310 Current Number if Unhealed Pressure Ulcers – Comment – add a numbered corresponding body diagram for all wounds

M1320 Status of Most Problematic Pressure Ulcer – Comment -If wound is healed, why would it be problematic and listed here?

M2000 –M2040 MEDICATION – Comment - If the patient is admitted by a PT or SLP, how should this be addressed?

M2110 Types and Sources of Assistance – Comment – Clarify "supportive services to provide assistance"

Additional Comments:

Look at expanding the SOC assessment window to 7 days and also widening recert window to the last 7 days of the certification period. This would allow for better scheduling of patients and allow flexibility based on patient needs and

clinician scheduling.

PUBLIC SUBMISSION

As of: January 20, 2009
Received: January 13, 2009
Status: Posted
Posted: January 15, 2009
Category: Health Care Provider/Association - Home Health Facility
Tracking No. 8081d747
Comments Due: January 13, 2009
Submission Type: Web

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

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

Document: CMS-2008-0141-0117
CO

Submitter Information

Name: Cheryl Lawson
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Denver, CO, 80204
Organization: Centura Health at Home

General Comment

Although there are definately important benefits to the proposed changes to Oasis with Oasis C, we have some very serious concerns about the impact to our agency related to some of those changes.
We feel that this is going to create problems for our agency because of the increased time and cost to collect and document the new Oasis items as well as the the cost and time of educating all of our staff. We also believe that we will need to improve some of our assessment and care tools--ie depression, etc.
We have a great deal of concern about being required to notify the MD within one calendar day about medication issues or discrepencies especially with our therapy only cases. The expectation that we track and provide/administer flu vaccine and pneumonia vaccine for our patients is also very concerning .
Since we do not have an electronic medical record, some of the proposed Oasis C changes will be very difficult for us.

It seems that phasing in some of these changes would be more realistic than doing everything at once. We really do like how some of the questions have been reworded and modified and deleted and believe that those would impact us positively, but we would really appreciate some further consideration around those concerns I have discussed above. Thanks for allowing us to comment.

PUBLIC SUBMISSION

As of: January 20, 2009
Received: January 13, 2009
Status: Posted
Posted: January 15, 2009
Category: Home Health Facility - HPA25
Tracking No. 8081d7bf
Comments Due: January 13, 2009
Submission Type: Web

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

Comment On: CMS-2008-0141-0001
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Document: CMS-2008-0141-0118
WA

Submitter Information

Name: Karen Fernandez
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Organization: Evergreen Healthcare

General Comment

OASIS C
Feedback on proposed changes:

M1032: We were wondering about how to define some of these choices. For unstable vital signs, debilitating pain and recent decline we were wondering what time frame would be considered. Would there need to be an Unknown choice as well, if we are unable to determine prior status to know if there is a decline?

M1036: Are you looking for current or historical data, or both?

M1038: Will there be clarification as to when the physician would or wouldn't need notification?

M1040 and M1050: Do you want to know if the patient received the vaccine in the home, or just if they received the vaccine? For example, if the patient received the vaccine from the MD, do you want to capture that info as well?

M1210 and M1220: Thank you for separating hearing and understanding! That is very helpful from a functional standpoint.

M1242: How will we define severe pain?

M1244, M1304, M1326: As the plan of care is usually in development at the time of SOC ROC completion, do you want to change the wording to say, "Will the current . . ." instead of "Does the current . . ."?

M1350: Thank you for adding "receiving assessment and/or intervention." This makes this much more helpful information.

M1510: We are concerned that this will be difficult to track by multiple disciplines. It is also not capturing whether or not the patient's cardiac status has improved or declined, so we're not seeing how this will be helpful to determining outcomes or plan of care compliance.

M1615: Thank you for adding "occasional stress incontinence."

M1730: Is it up to agency discretion as to what depression screening tool we use?

ADL/IADL questions: Thank you for eliminating the Prior column!

M1830: Thank you for adding choice 4, it makes it much easier to gather a good functional picture of the patient.

M1845: Thank you for separating the toilet transfer from toilet hygiene. Again, we can gather a much better picture of the patient's functional status.

M1860: The addition of choices 1 and 2 is possibly our favorite change! Thank you; it will help us track patient improvement more accurately.

M2000: Will each agency develop their definition of "potential clinically significant adverse effects or drug reactions," or will that be defined by the oasis?

M2004: As in M1510, this will be difficult to track in a multidiscipline system. We would also appreciate clarification on what it means to contact the physician, in case a physician has not responded to our calls.

M2010: Will each agency develop their definition of high risk medications, or will that be defined by the oasis?

M2110: Letter f, supervision and safety, seem to us to be part of ADL and IADL management, thus somewhat redundant.

PUBLIC SUBMISSION

As of: January 20, 2009
Received: January 13, 2009
Status: Posted
Posted: January 15, 2009
Category: Health Care Professional/Association - Nurse
Tracking No. 8081d80e
Comments Due: January 13, 2009
Submission Type: Web

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

Comment On: CMS-2008-0141-0001
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Document: CMS-2008-0141-0119
CO

Submitter Information

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Golden, CO, 80403
Organization: Bayada Nurses, Inc.

General Comment

The following comments represent the combined responses of staff who wish to provide feedback to CMS regarding the proposed OASIS-C. Employees providing these responses are currently employed by this long standing national home health agency and actively work with OASIS as clinicians, managers, information systems staff and/or quality review staff.

1. We support the elimination of all items that have been recommended to be deleted.
2. Eliminating the response "Unknown" for M0140 Race/Ethnicity promotes inaccuracy in data collection. Eliminating the unknown response forces the home care provider into making his/her best guess when the correct answer is not available. This promotes inaccurate data and is a concern for clinicians who are forced to document a potentially inappropriate response. This information should be optional and not a requirement for completing the assessment
3. The use and therefore the purpose of MO102 Date of Referral and MO104 Date of Physician-ordered Start of Care are unclear. The purpose of these should be clearly defined so that it can be determined if the additional time for collection and entry are warranted.
4. MO110 Episode Timing should be deleted. Dates and sequence of episodes can be used to determine whether an episode is early or late. The time required for clinician education and data collection is not justified when an alternative method of determination is possible.
5. MO1010 Inpatient Diagnosis should be deleted. Hospital claims data is available to CMS and would be more accurate. Although clinicians must be aware of medical history and treatments, the time for data collection, coding, and entry are not warranted when the information is available from other sources.
6. Although M1032 Frailty Indicator and M1034 Stability Prognosis provide alternatives for MO260 Overall Prognosis, MO270 Rehabilitative Prognosis and MO280 Life Expectancy, responses to the Frailty Indicator are duplicative and/or inferred with other OASIS items and the Stability Prognosis is not clearly defined.
7. Many OASIS-C items ask how current status compares to the status of the client at the time of the previous OASIS assessment. When the same

nurse or therapist is completing the OASIS assessments for each time period, this is a logical question. However, when two different caregivers are completing the OASIS assessment, these questions would be difficult to answer. A response of "Unknown" is available. Historically a response of unknown has been discouraged and at times eliminated. An unknown response is needed and should not negatively impact an agency's outcome results.
8. Change in response options for M1860 Ambulation/Locomotion should better reflect the more subtle changes that can occur during an episode of care.
9. Although the administration of influenza vaccine and polysaccharide vaccine should be promoted, administration in the home should be an exception held for only those clients unable to obtain it in other settings. The issues related to the administration of these vaccines in the home include:
The risk of a severe reaction to these vaccines is low, however, a reaction including anaphylaxis can occur.
Many clients are poor historians. They may not identify allergies to eggs, thermisol, or other allergies that increase the risk of a reaction.
Many clients are poor historians. The primary physician should be responsible for tracking whether either vaccine has been administered and if any contraindications to receiving it exist.
Storage and transport of the vaccines must be closely monitored. It is more likely to be exposed to unacceptable temperature ranges when transported from office to home. If pre-drawn into the syringe, the vaccine may be wasted if unable to administer it upon reaching the home.
Will Medicare pay for duplicate administrations of these vaccines when the client is unable to remember whether or not it has been administered?
Will vaccine administration be tracked in some way by CMS?
It is understood that these vaccines can be administered in the home, but due to the additional risks other options should be explored before resorting to home administration.
10. M1244 Planned Pain Intervention asks if the physician ordered plan of care includes interventions to monitor and/or mitigate pain. M1246 Pain Intervention then asks if pain management steps in the physician ordered plan of care have been implemented to monitor and mitigate pain. M1304 and M1306 ask similar questions regarding prevention of pressure ulcers. M1360 and M1365 ask similar questions regarding diabetic foot care. M1734 and M1736 ask similar questions regarding depression. M1940 and M1945 ask similar questions regarding fall prevention. The purpose and therefore
the usefulness for all of these have not been defined. The additional time for data collection and entry is not justified at this time. What justifies a yes response versus a no response is unclear when multiple interventions may be involved to respond to each problem area. The responses may be inaccurate depending on which clinician remains involved in providing care. Problems addressed by different clinicians and/or different disciplines my not be evident to the clinician completing the discharge. These items should be deleted unless all of the above issues can be resolved and usefulness is clearly established.
11. M1880 Grooming, M1890 Change in Self-care Ability and M2110 Types and Sources of Assistance duplicate information. Information should be assessed and documented only one time to prevent unnecessary clinician and data entry time.
12. M1860 Ambulation/Locomotion, M1880Change in Mobility, and M2110 duplicate information. Information should be assessed and documented only one time to prevent unnecessary clinician and data entry time.
13. Most state practice acts limit physical therapists' role with medications. Therefore, medication issues are generally addressed by nurses and/or physicians. M2000Potential Adverse Effects/Reaction, M2002 Medication Follow-Up, M2004 Medication Intervention, M2010 Patient/Caregiver Drug Education, and M2015 Patient/Caregiver Drug Education Intervention may be areas managed by someone other than the clinician completing the OASIS and may be items better answered by someone else. Only one clinician is to complete the OASIS according to current regulations. These items create unnecessary data collection issues. These items relate to agency processes that are evaluated within state certification surveys and do not warrant assessment for each individual patient.
14. M1500 Symptoms of Heart Failure includes a response of not assessed. The implications, if any, for choosing this response should be defined.

Thank you for considering these comments.

Attachments

CMS-2008-0141-0119.1: CO

#119

The following comments represent the combined responses of staff who wish to provide feedback to CMS regarding the proposed OASIS-C. Employees providing these responses are currently employed by this long standing national home health agency and actively work with OASIS as clinicians, managers, information systems staff and/or quality review staff.

1. **We support the elimination of all items that have been recommended to be deleted.**
2. **Eliminating the response "Unknown" for M0140 Race/Ethnicity promotes inaccuracy in data collection. Eliminating the unknown response forces the home care provider into making his/her best guess when the correct answer is not available. This promotes inaccurate data and is a concern for clinicians who are forced to document a potentially inappropriate response. This information should be optional and not a requirement for completing the assessment**
3. **The use and therefore the purpose of MO102 Date of Referral and MO104 Date of Physician-ordered Start of Care are unclear. The purpose of these should be clearly defined so that it can be determined if the additional time for collection and entry are warranted.**
4. **MO110 Episode Timing should be deleted. Dates and sequence of episodes can be used to determine whether an episode is early or late. The time required for clinician education and data collection is not justified when an alternative method of determination is possible.**
5. **MO1010 Inpatient Diagnosis should be deleted. Hospital claims data is available to CMS and would be more accurate. Although clinicians must be aware of medical history and treatments, the time for data collection, coding, and entry are not warranted when the information is available from other sources.**
6. **Although M1032 Frailty Indicator and M1034 Stability Prognosis provide alternatives for MO260 Overall Prognosis, MO270 Rehabilitative Prognosis and MO280 Life Expectancy, responses to the Frailty Indicator are duplicative and/or inferred with other OASIS items and the Stability Prognosis is not clearly defined.**
7. **Many OASIS-C items ask how current status compares to the status of the client at the time of the previous OASIS assessment. When the same nurse or therapist is completing the OASIS assessments for each time period, this is a logical question. However, when two different caregivers are completing the OASIS assessment, these questions would be difficult to answer. A response of "Unknown" is available. Historically a response of unknown has been discouraged and at times eliminated. An unknown response is needed and should not negatively impact an agency's outcome results.**
8. **Change in response options for M1860 Ambulation/Locomotion should better reflect the more subtle changes that can occur during an episode of care.**
9. **Although the administration of influenza vaccine and polysaccharide vaccine should be promoted, administration in the home should be an exception held**

for only those clients unable to obtain it in other settings. The issues related to the administration of these vaccines in the home include:
The risk of a severe reaction to these vaccines is low, however, a reaction including anaphylaxis can occur.
Many clients are poor historians. They may not identify allergies to eggs, thermisol, or other allergies that increase the risk of a reaction.
Many clients are poor historians. The primary physician should be responsible for tracking whether either vaccine has been administered and if any contraindications to receiving it exist.
Storage and transport of the vaccines must be closely monitored. It is more likely to be exposed to unacceptable temperature ranges when transported from office to home. If pre-drawn into the syringe, the vaccine may be wasted if unable to administer it upon reaching the home.
Will Medicare pay for duplicate administrations of these vaccines when the client is unable to remember whether or not it has been administered? Will vaccine administration be tracked in some way by CMS?
It is understood that these vaccines can be administered in the home, but due to the additional risks other options should be explored before resorting to home administration.

10. M1244 Planned Pain Intervention asks if the physician ordered plan of care includes interventions to monitor and/or mitigate pain. M1246 Pain Intervention then asks if pain management steps in the physician ordered plan of care have been implemented to monitor and mitigate pain. M1304 and M1306 ask similar questions regarding prevention of pressure ulcers. M1360 and M1365 ask similar questions regarding diabetic foot care. M1734 and M1736 ask similar questions regarding depression. M1940 and M1945 ask similar questions regarding fall prevention. The purpose and therefore the usefulness for all of these have not been defined. The additional time for data collection and entry is not justified at this time. What justifies a yes response versus a no response is unclear when multiple interventions may be involved to respond to each problem area. The responses may be inaccurate depending on which clinician remains involved in providing care. Problems addressed by different clinicians and/or different disciplines my not be evident to the clinician completing the discharge. These items should be deleted unless all of the above issues can be resolved and usefulness is clearly established.
11. M1880 Grooming, M1890 Change in Self-care Ability and M2110 Types and Sources of Assistance duplicate information. Information should be assessed and documented only one time to prevent unnecessary clinician and data entry time.
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Follow-Up, M2004 Medication Intervention, M2010 Patient/Caregiver Drug Education, and M2015 Patient/Caregiver Drug Education Intervention may be areas managed by someone other than the clinician completing the OASIS and may be items better answered by someone else. Only one clinician is to complete the OASIS according to current regulations. These items create unnecessary data collection issues. These items relate to agency processes that are evaluated within state certification surveys and do not warrant assessment each for individual patient.

14. **M1500 Symptoms of Heart Failure includes a response of not assessed. The implications, if any, for choosing this response should be defined.**