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Comment On: CMS-2008-0141-0001
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Document: CMS-2008-0141-0120
OR

Submitter Information

Address:
OR, 97213

General Comment

See attached comments

Attachments

CMS-2008-0141-0120.1: OR
CMS-2008-0141-0120.2: OR
CMS-2008-0141-0120.3: OR
CMS-2008-0141-0120.4: OR
CMS-2008-0141-0120.5: OR
CMS-2008-0141-0120.6: OR
CMS-2008-0141-0120.7: OR
CMS-2008-0141-0120.8: OR
CMS-2008-0141-0120.9: OR
CMS-2008-0141-0120.10: OR
CMS-2008-0141-0120.11: OR
CMS-2008-0141-0120.12: OR
CMS-2008-0141-0120.13: OR
CMS-2008-0141-0120.14: OR
CMS-2008-0141-0120.15: OR

#120

OASIS COMMENTS

By Donna Luoma, RN

Providence Home Services

Portland, OR

Thank you for this opportunity to address the proposed changes to the oasis documentation. There are many wonderful changes and additions that will improve patient outcome and monitor statistics. While change will be challenging, I welcome the new questions as I can see a definite clarity and patient-centered focus that will only help me better serve patients in the home setting.

I have taken the time to address items that concern me. As I am not familiar with the reporting/measurement of patient outcome on a Quality Control basis, I have made the best educated guess as to the efficacy of the question related to patient outcome.

START OF CARE

(M0102) Date of Referral: Indicate the date the physician made the referral for this home health Start of Care.

CONCERN

Date of referral is ambiguous. There is no way to consistently convey accurate referral dates the way this is worded. Is the date when SOC fax received? Is the date what date is put down with the MD signature? Is it the date when SOC orders inputted into the system?

I'm wondering if this information is to better track the time from receiving the information for the referral to when SOC is actually performed. Certainly, admitting the patient within a reasonable period of time will assist with better patient outcome, however, the wording of this question will not convey accuracy for audits.

RECOMMENDATION

Clarify the date to be used.

EXAMPLES OF REWORDING THE QUESTION

(M0102): Indicate the date home health received written orders for Start of Care.

This change would allow for more consistent and accurate reporting of SOC time. Auditors focusing on patient outcome would have consistent and accurate timetable.

//

(M01038) Does the physician-ordered plan of care establish parameters (limits) for physician notification of changes in vital signs or other clinical findings?

As medical clinicians, RN and PT are required under our standards of practice to notify the MD of vital sign changes that indicate worsening patient condition. "Other clinical findings" is ambiguous with no consistent interpretation by clinicians. This question, in its entirety, does not provide valuable information that would enhance patient outcome.

RECOMMENDATION

Eliminate this question from Oasis. It is unnecessary.

//

(M1242) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

CONCERN

Answering this question will be redundant. Answering the (M01240) Frequency of Pain question answers this question. Clinicians always assess pain using a standardized pain assessment tool that is appropriate for the patient's ability to communicate. (From 1-10 scale, to faces, to facial grimaces and guarding, to elevation of VS, to data from caregivers) in order to answer (M01240). This is an unnecessary extra question for clinicians to do.

RECOMMENDATION

Eliminate this question from Oasis. It is unnecessary.

//

(M1244) Planned Pain Intervention: Does the current physician-ordered plan of care include interventions(s) to monitor and mitigate pain?

CONCERN

As this reads, clinicians will not interpret the language consistently.

1. The way I interpret this question is that the data to answer this question would be found in the SOC orders faxed to our company. This would be where the most current physician orders are to be found.

2. However, the other interpretation is that the "current physician-ordered plan of care" means the POC that is created from the collaboration of home health staff and the MD. These orders would not be considered current at the time of oasis data gathering because clinicians must call the MD with POC recommendations and get their verbal orders (or agreements to the POC).

RECOMMENDATIONS

Decide which data the board wants to gather and reword the question.

EXAMPLES OF REWORDING THE QUESTION

1. **(M1244) Planned Pain Intervention:** Does the initial physician-ordered plan of care (received from the referring physician before start of care) include intervention(s) to monitor and mitigate pain?

2. **(M1244) Planned Pain Intervention:** Will the requested plan of care (after initial assessment) include intervention(s) to monitor and mitigate pain?

By clarifying where the data is to be gathered (before the initial assessment or after the initial assessment) the quality of data will be accurate and allow the measurement of POC interventions to be better focused on specific clinical sources.

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(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers?**

CONCERN

Oasis already includes a standardized tool for assessing pressure ulcer risk. This is an unnecessary question as completing the included oasis standardized tool (which is done with the current oasis questionnaire) and answering (M1302) will convey the same data.

RECOMMENDATION

Eliminate this question from oasis. It is unnecessary.

//

(M1304) Planned Pressure Ulcer Prevention: Does the current physician-ordered plan of care include intervention(s) to prevent pressure ulcers.

CONCERN

Unlikely clinicians will interpret the language consistently as explained above on (M1244).

RECOMMENDATIONS

Decide which source of data the oasis board would like to gather – referring physician initial orders, or the collaborative POC after oasis information has been gathered and patient assessment completed by home health staff. Reword the question.

EXAMPLE OF REWORDING THE QUESTION

(M1304) Planned Pressure Ulcer Prevention: Does the initial physician-ordered plan of care (received from the referring physician before start of care) include intervention(s) to prevent pressure ulcers?

(M1304) Planned Pressure Ulcer Prevention: Will the requested plan of care (after initial assessment) include intervention(s) to prevent pressure ulcers?

By clarifying where the data is to be gathered (before the initial assessment or after the initial assessment) the quality of data will be accurate and allow the measurement of POC interventions to be better focused on specific clinical sources.

//

(M1326) Pressure Ulcer Intervention: Are moisture retentive dressings specified on the physician-ordered plan of care?

CONCERN

Unlikely clinicians will interpret the language consistently as explained above on (M1244).

RECOMMENDATIONS

Decide which source of data the oasis board would like to gather – referring physician initial orders, or the collaborative POC after oasis information has been gathered and patient assessment completed by home health staff. Reword the question.

EXAMPLES OF REWORDING THE QUESTION

(M1326) Pressure Ulcer Intervention: Does the initial physician-ordered plan of care (received from the referring physician before start of care) specify the use of moisture retentive dressings?

(M1326) Pressure Ulcer Intervention: Will the requested plan of care (after initial assessment) include the request-of-orders to use moisture retentive dressings?

By clarifying where the data is to be gathered (before the initial assessment or after the initial assessment) the quality of data will be accurate and allow the measurement of POC interventions to be better focused on specific clinical sources.

//

(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?

CONCERN

There are two concerns regarding this question Unlikely clinicians will interpret the language consistently as explained above on (M1244) related to the source of data (orders before SOC or the collaborative orders for POC).

Secondly there is not enough information regarding the choice of questions "yes" or "no" specifically related to diabetic care interventions and reference for the answer selected.

RECOMMENDATION

This important disease process and potential for poor patient outcome should be divided into two different questions.

EXAMPLE OF REWORDING THE QUESTION

(M1360) Diabetic Foot Care Plan: Does the initial physician-ordered plan of care (received from the referring physician before start of care) include regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care?

0 – No

1 - Yes

(M1360a) Diabetic Foot Care Plan: Will the requested plan of care (after initial assessment) include a request for orders for patient education on proper foot care and regular monitoring for skin lesions on the lower extremities?

0 – No (Patient/CG knowledgeable regarding diabetic foot care and able to regularly monitor lower extremities for skin lesions and notify PCP)

1 – Yes

NA – Bilateral amputee OR Patient does not have diagnosis of diabetes

Will the requested plan of care (after initial assessment) include a request for orders for By adding additional information, the answers give a much clearer picture of clinician's reason for their particular choice thereby not requiring further explanation in a clinical note.

//

(M1940) Fall Risk Intervention: Does the current physician-ordered plan of care include intervention(s) to mitigate the risk of falls?

CONCERN

Unlikely clinicians will interpret the language consistently as explained above on (M1244) related to the source of the data (before the initial assessment or after the initial assessment)

RECOMMENDATION

This important disease process and potential for poor patient outcome should be divided into two different questions.

EXAMPLE OF REWORDING THE QUESTION

(M1360) Diabetic Foot Care Plan: Does the initial physician-ordered plan of care (received from the referring physician before start of care) include regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care?

0 – No

1 - Yes

(M1360a) Diabetic Foot Care Plan: Will the requested plan of care (after initial assessment) include a request for orders for patient education on proper foot care and regular monitoring for skin lesions on the lower extremities?

0 – No (Patient/CG knowledgeable regarding diabetic foot care and able to regularly monitor lower extremities for skin lesions and notify PCP)

1 – Yes

NA – Bilateral amputee OR Patient does not have diagnosis of diabetes

Will the requested plan of care (after initial assessment) include a request for orders for By adding additional information, the answers give a much clearer picture of clinician's reason for their particular choice thereby not requiring further explanation in a clinical note.

//

(M1940) Fall Risk Intervention: Does the current physician-ordered plan of care include intervention(s) to mitigate the risk of falls?

CONCERN

Unlikely clinicians will interpret the language consistently as explained above on (M1244) related to the source of the data (before the initial assessment or after the initial assessment)

RECOMMENDATIONS

Decide which source of data the oasis board would like to gather - referring physician initial orders, or the collaborative POC after oasis information has been gathered and patient assessment completed by home health staff. Reword the question.

EXAMPLE OF REWORDING THE QUESTION

(M1940) Fall Risk Intervention: Does the initial physician-ordered plan of care (received from the referring physician before start of care) include intervention(s) to mitigate the risk of falls?

(M1940) Fall Risk Intervention: Will the requested plan of care (after initial assessment) include a request for orders for intervention(s) to mitigate the risk of falls?

By clarifying where the data is to be gathered (before the initial assessment or after the initial assessment) the quality of data will be accurate and allow the measurement of POC interventions to be better focused on specific clinical sources.

//

(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?

CONCERN

This has ambiguous language of "potential clinically significant adverse effects or drug reactions". Home Health agencies do not use the same pharmacological reference source, nor does each clinician assess in the same manner and use the same criteria for "potential adverse effects", "clinically significant adverse effects", or "potential clinically significant adverse effects or drug reactions". There is no way to standardize the reference source so that any nurse, presented with the exact same situation and symptoms, can routinely have the same outcome.

There would be a significant implementation issue as there are so many different variables related to medications. Our Scope of Practice compels a clinician to take immediate action for patient safety. But even then it is a subjective assessment based on clinician experience and licensure. There is no way a simple "No problems" found or "Problems found" will present auditors with enough data to track medication errors in the home setting. This is not an objective question.

For example, I have seen many, many post-op patients who have elevated BP and are on BP meds. According to the current question the current BP med would be considered ineffective drug therapy. However, usually, after a week or so, the BP begins to normalize. Certainly by two weeks, if the BP remains elevated, I would call the MD – but certainly not within one day. There is also the question of how high the BP reads, are there any symptoms associated with it, what is the pain control situation, etc. etc.

RECOMMENDATIONS

Eliminate this question. There is no way to simplify assessing potential adverse effects/reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance to a single question – nor will the data gathered have enough objectivity to allow for a structured outcome value.

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THERAPY NEED

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated)**

CONCERN

Firstly, there is no way to accurately assess the number of therapy visits. If a nurse is completing the oasis, she/he is not specialized in physical, occupational, and speech-language therapies. A nurse can observe overt signs of need for these therapies; however, it is the disciplines themselves who are educated and experienced to assess subtle nuances requiring a high number of therapy visits. This number is a guess at best and not an educated one should a nurse be completing it.

Secondly, the patient variables can and do affect the number of visits more or less. The information collected from this question just cannot be valuable or valid as it is just a guess at best.

I have been filling out this question for years and every time I place a number in the box, unless it is 000, I know that it is highly likely the information is totally inaccurate.

RECOMMENDATION

Reword the question. The numbers may be a little off on the example, but I hope it will give you an idea of what I am thinking.

EXAMPLE OF REWORDING THE QUESTION

Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, estimate therapy visits (total of reasonable and necessary physical occupational, and speech-language pathology visits combined).

1. No PT,OT, ST Therapy needed
2. Possible total visits 1-5
3. Possible total visits 6-12
4. Possible total visits 13 and above

By giving a window for the clinician to chose from and stating a "possibility" there is more ability to provide accurate case mix groups.

//

DC OASIS-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:

CONCERN

This question would pose an undue burden upon the clinician. So many of our patients are forgetful or have dementia and cannot answer when they got a vaccine or if they even got one, much less where and who might have given it to them. In order to answer this question as it stands, the clinician would have to contact the MD – wait for a call back, which could take 1-3 days, not at all, OR we would have to search our own database, which wouldn't necessarily be easy to do if on a computer system – it would be very time consuming to review previous admissions. If an agency is still on a paper system, the task would nearly be impossible due to filing system storage. How would a clinician even know that the patient was on service the previous year?

EXAMPLE OF REWORDING THE QUESTION

Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, estimate therapy visits (total of reasonable and necessary physical occupational, and speech-language pathology visits combined).

1. No PT,OT, ST Therapy needed
2. Possible total visits 1-5
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4. Possible total visits 13 and above

By giving a window for the clinician to chose from and stating a "possibility" there is more ability to provide accurate case mix groups.

//

DC OASIS-C

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CONCERN

This question would pose an undue burden upon the clinician. So many of our patients are forgetful or have dementia and cannot answer when they got a vaccine or if they even got one, much less where and who might have given it to them. In order to answer this question as it stands, the clinician would have to contact the MD -- wait for a call back, which could take 1-3 days, not at all, OR we would have to search our own database, which wouldn't necessarily be easy to do if on a computer system – it would be very time consuming to review previous admissions. If an agency is still on a paper system, the task would nearly be impossible due to filing system storage. How would a clinician even know that the patient was on service the previous year?

RECOMMENDATION

Reword the question if this information is absolutely necessary to gather. If you want to keep the question, I would recommend adding a question to the SOC oasis .

EXAMPLE OF REWORDING THE QUESTION for DC oasis

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, does the patient have the cognitive ability to accurately answer this question OR is the caregiver able to provide you with an accurate answer?

1 -Yes (go to the next question)

2 - No (skip the next question

Next question – if answered yes on (M1045)

1 – Received from another health care provider (e.g., physician)

2 – Received from your agency previously during this year's flu season

3 – Offered and declined

4- Agency did not receive orders from physician to give injection due to medical contraindication(s)

5 – Not indicated; patient does no meet age/condition guidelines for influenza vaccine

6 – Inability to obtain vaccine due to declared shortage

EXAMPLE OF QUESTION TO ADD TO SOC OASIS

Influenza vaccine: Did the patient receive the influenza vaccine within the past or current influenza season (Oct1 through March 31)?

0 – yes (skip the next question)

1 – No

2 – Unknown

Influenza vaccine question B: If answered no or unknown does patient want an influenza vaccine during this admission (if admission during Oct 1 through March 31)?

1. No
2. Yes

NA – does not apply as admission not in flu season

By adding to the original question and including addressing it in the SOC, it will be easier for the clinician to obtain a correct answer and implement interventions.

//

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

CONCERN

Same concern of undue burden as noted for the influenza vaccine.

Also I think the latter part of the question should be changed to reflect the episode of care to read from SOC to Discharge) ROC and Transfer are inclusive in the episode of home health.

EXAMPLE OF REWORDING THE QUESTION

I am not going to give an example of rewording the question as I would word it exactly like the influenza vaccine question(s).

//

(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?

CONCERN

This would place an undue burden upon the discharging clinician to review every single clinical note to answer this question accurately. There are many times where a nurse, who is not familiar with a patient, is assigned for the agency discharge. If this is a long complicated admission there will be a large amount of clinical notes to review. Also, if the agency does not have computerized charting, the clinical will not be able to answer this question at all, unless they go to the office and read the entire chart. Again, this places an undue burden on the discharging clinician.

RECOMMENDATIONS

Eliminate this question as it poses an undue burden upon the discharging clinician. I'm not sure what the data would be useful for in measuring patient outcomes on a regular basis. We are required by our nursing practice act to act in the best interest of our patients. That would include notifying MD of significant medication issues or reconciliation.

//

In conclusion, I would like to state that many of the changes will be an asset for improving patient outcome. Looking at the oasis from a field nurse point-of-view, I hope I was able to adequately express my concerns, suggest changes, or elimination of the question – and give a valid explanation for my reasons.

Regards,

Donna Luoma, RN

M1870 Feeding or Eating

The concern: These 2 areas are radically different and should be split into: feeding (the process of getting food into the mouth) vs. swallowing (getting food/liquid from the mouth to the stomach). Putting them together makes implementation difficult. It says "refers (only) to the process of eating, chewing, and swallowing, not preparing...
However none the items below it largely reference feeding rather than swallowing. Many people who can feed themselves cannot swallow everything safely and vice versa. It often does not give an accurate picture at intake and often does not allow clinicians to demonstrate progress. Also, it is crucial to split foods from liquids, this may seem odd, but there are many people who can eat a tough steak, but have great difficulty swallowing liquid (especially if unaltered by thickener) and others who can drink thin liquid but can't manage any food more advanced than puree. It is very difficult to give an accurate picture on admit or document progress when these are lumped together.

I would suggest something of the following nature:

M1870 Current ability to feed self meals and snacks adequately/safely. Note: this refers only to the process of physically managing food using appropriate utensils, not preparing the food

0 - Able to independently feed self
1 Able to independently feed self but requires set up
2 Able to independently feed self but requires specialized utensils, cups, plates
3 Unable to feed self and must be assisted or supervised throughout the meal/snack
4 No PO feeding, as is tube fed

M1875 Current ability to swallow foods. Note: this refers only to the process of chewing and swallowing, not preparing the food
0 - Able to eat regular texture foods
1 - Able to eat minimally texturally altered foods (soft)
2- Able to eat chopped or ground moistened foods (mechanical soft)
3- Able to eat only pureed or liquid diet
4 Able to take in nutrients orally but receives supplemental nutrients via nasogastirc tube or gastrostomy
5 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy
6 Unable to take in nutrients orally or by tube feeding

M1876 Current ability to swallow liquids.
0 - Able to drink texturally unaltered liquids (thin)
1 - Able to drink minimally thickened liquids (nectar thick)
2- Able to drink moderately thickened liquids (honey thick)
3- Able to drink maximally thickened liquids (pudding thick)
4- Unable to take any liquids orally and hydration is received by nasogastic tube or gastrostomy
5- Unable to take in any liquids orally or by tube feeding

NOTE: the terms in parentheses are technical terms in fairly common usage, but may not be the exact same throughout the country, so the descriptions that precede them might be sufficient.

Thank you for your attention to and consideration of these potential changes. I assure you that home health speech pathologists and other admitting and d/c'ing clinicians will be grateful for these changes. Please feel free to call me at 503-215-0101 or e-mail me at ruth.jenkins@providence.org for further clarification.

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CT

Submitter Information

Name: Kimberly Skehan
Address:
Wallingford, CT, 06492
Organization: Connecticut Association for Home Care & Hospice

General Comment

Please see attached comments.Please contact me at skehan@cahch.org or 203-265-9931 with any questions or concerns.

Thank you

Attachments

CMS-2008-0141-0121.1: CT

Connecticut Association for
HOME CARE
& HOSPICE

#21

January 13, 2009

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Document Identifiers: CMS-R-245; OMB# 0938-0760; OASIS-C Comments

Dear Centers for Medicare & Medicaid Services:

On behalf of home care and hospice providers serving over 100,000 elderly and disabled patients annually, the Connecticut Association for Home Care & Hospice (CAHCH) is pleased to submit the following comments on the "Agency Information Collection Activities: Proposed Collection; Comment Request for Medicare and Medicaid Programs OASIS Collection Requirements," which was published for proposed collection in the *Federal Register* on November 14, 2008.

CAHCH has identified several concerns with the proposed content and implementation of the OASIS-C document. Our specific concerns include the following:

Agency Burden

CAHCH feels that CMS has significantly underestimated the burden and cost for agencies to implement the OASIS revisions. Regarding the actual implementation of these OASIS revisions, CAHCH disagrees with CMS's assertion that the OASIS revisions pose a minimal burden for agencies because certain OASIS items do not need to be completed with each assessment. Based on review of the proposed revisions, the overall assessment increases the total OASIS assessment to 129 items. Many of the items (for example Influenza) require completion, if only to indicate that the OASIS start-of-care (SOC) falls outside of flu season.

In addition, the changes are significant for agencies utilizing an electronic documentation system as well as those using manual data collection. Necessary operational and clinical documentation system changes and proper staff training will take a significant amount of time and resources to implement. Some of the process measures have already been implemented in agency clinical documentation and these agency-specific measures will need to be modified to reflect the new OASIS items so that agencies can avoid duplication in documentation.

The new OASIS questions, the renumbering of existing questions and the documentation changes agencies must face will require substantially more time for staff education than has been estimated. Based on the experience of educating home health staff regarding

OASIS since 2000, it is apparent that agencies invest significant time and resource in both initial and ongoing training regarding accurate completion of OASIS assessment items, since these assessments are vitally important to quality reporting and payment for each agency. **The estimate of four hours of initial training time and eight hours of annual education is grossly inadequate.**

There are also concerns regarding the staff time needed to complete the OASIS due to the implementation of several process measures that request information, which must be obtained from review of the clinical record (i.e. M1246 Pain Intervention; M1306 Pressure Ulcer Prevention). The completion of these items will require a retrospective review of the record by the clinician completing the OASIS, which may not be operationally possible at the time of the assessment and will add considerable time to the actual OASIS assessment at all time points. In addition, if a different clinician completes subsequent OASIS assessments for the same patient, the retrospective review will take even more time.

In some cases, clinicians completing the OASIS (such as therapists) may not feel that they are qualified to accurately assess many of these new items at any point. This will require a change in agency practice if nurses do not routinely complete all OASIS assessments. There is also the issue of the responsibility of physicians and other health care providers to do their part in assisting the agency with compliance in these areas, since some of the OASIS items require specific information to be obtained from the physician (i.e. M0104 Date of Physician-Ordered Start of Care; M1038 Guidelines for Physician Notification; M2004 Medication Intervention).

In Connecticut, agencies must also complete an OASIS assessment for all patients receiving skilled care under Medicaid Waiver programs. Increasing the visit time and documentation burden in these cases is fiscally imprudent, since our Medicaid rates are approximately 30% below the actual costs of care for the median agency.

For the reasons stated above, CAHCH feels strongly that the new or revised OASIS measures will create additional burden for the agencies, despite the deletion of several OASIS items and that for this reason, implementation should be delayed or reconsidered altogether.

Timing of OASIS Revisions and CARE Instrument Testing

CAHCH is concerned about the timing of testing and the Medicare Continuity Assessment Record and Evaluation (CARE) instrument and the proposed implementation of the OASIS-C revisions. If the plan is to include the CARE instrument measures in the OASIS assessment in the future, CAHCH strongly recommends that CMS postpone implementation of the OASIS Assessment revisions until the CARE instrument is finalized. These changes can then be incorporated into the revised OASIS instrument.

Specific Comments regarding OASIS Revisions

The proposed changes to the OASIS assessment reflect comments that have been provided by MedPAC, industry professionals and through the pilot testing process. Ultimately, it may be worthwhile and necessary to incorporate some of these changes into

the OASIS assessment, in order to improve the accuracy of OASIS data collection and to include items associated with evidence-based practice. Based on the review of the draft revisions, CAHCH recommends clarification of the following specific OASIS-C items:

- Medications (M2000-M2004): Recommend clarification of the definition of some terms (i.e. "potentially significant adverse reactions," "clinically significant issues") as these may lead to inconsistencies in practice and survey issues. In addition, there are significant concerns regarding the timeframe of one calendar day for medication follow up with the physician (M2002) since most of the issues surrounding this are related to delays in response from the physician office or reluctance from the primary care physician to reconcile mediations with the agency when the patient is discharged from the hospital.
- Transferring (M1850): Recommend clarification of assessment item to "Current ability to move safely between bed and chair..." to capture transfer both ways.
- Pressure Ulcers (M1312; 1314): Recommend that measurement requirements also include depth, and add a definition of width/length for consistency among clinicians.
- Pain Assessment (M1240-M1244): Recommend a skip pattern for patient who scores "0" for M1240; another option may be to add a response to M1242 such as "Standardized assessment conducted and indicates no pain" and to M1244 such as "N/A patient has no pain."
- Type and Sources of Assistance (M2110): Recommend clarification of proper completion of this item when there are multiple caregivers at different levels of ability.
- Skin Lesions (M1365): Recommend addition of other ostomies (i.e. urostomy, jejunostomy).

Summary of Comments

CAHCH feels strongly that the new or revised OASIS measures will create additional burden for the agencies and that the implementation should be delayed or reconsidered altogether. In addition, CAHCH recommends a re-calculation of the burden estimate on agencies to provide education and to implement OASIS changes and clinician completion of the OASIS assessment. The added burden of including a large number of process measure items outweighs any relief afforded by removal of the original OASIS items.

Thank you for consideration of these comments. Please contact me at 203-265-9931 or skehan@cahch.org if you have any questions or concerns.

Sincerely,

Kimberly Skehan, RN, MSN
Vice President for Clinical & Regulatory Services
Connecticut Association for Home Care & Hospice

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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-2008-0141-0122
TX

Submitter Information

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General Comment

Our comments are attached.

Attachments

CMS-2008-0141-0122.1: TX

#122

Home Care: Keeping Texans Proud and Independent

Date: January 13, 2009

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development,
Attention: Document Identifier/OMB
Control Number--------, Room C4-26-05, 7500 Security Boulevard,
Baltimore, Maryland 21244-1850

To Whom It May Concern:

The Texas Association for Home Care is a nonprofit trade association that represents more than 1,200 licensed home and community support services agencies in Texas that provide home health and hospice to Medicare beneficiaries. We appreciate the opportunity to provide comments on the proposed OASIS-C assessment form published in the November 14th, Federal Register.

Overall the assessment appears to be more comprehensive in nature and provide better detail for outcomes analysis. It will however; take more time to complete and seems to duplicate policies already outlined in existing policy and professional practice acts. Please see detailed comments below related to the specific OASIS items.

M0102 & M0104 – both of these questions are dictated by current CMS policy and are not necessary in the OASIS. What outcome measure is affected by this question?

M01032 Frailty indicators – what are unstable vital signs? Vital signs and the stability of the vital sign data are specific to the patient. Each agency may set their own perimeters based on the assessment and coordination with the individual's physician. How do you assess on only one visit? Is one vital sign out of perimeters "unstable"? Does debilitating pain mean intractable? Overall – need definition to the first 4 responses.

M1034 Stability prognosis – creates more areas of interpretation than previous question.

M1040 – Does this question indicate that agencies now will be responsible to give vaccines as practice? Will there be a negative impact if an agency does not provide the vaccine?

M1045 – There needs to be another response to indicate the patient has not received but has been referred to another provider for administration. – Maybe response 1 – Received/referred to another provider.

M1055 – there will be some patients that do not recall this information.

M1242 – is there a standardized tool that should be used? With the variability in choice of pain assessment tools what is the value in the question? What if the tool indicates moderate pain and not

severe pain as indicated in the responses? Is the presence of moderate pain not valuable information as individual's thresholds for pain are different and can affect the individual's ability to move or participate in activities differently? Using a standard pain assessment tool, what is the frequency?

M1244/1246 – what if pain is not the focus of the plan of care, but the patient has lower level of pain? Will it lead to survey deficiencies if pain interventions are not indicated?

M1312 – the way the current question is worded; there is some subjectivity and no standardized way of defining length. Should use standard def with measuring of wounds and standardized tool relate to measuring (i.e. clock face). Longest length in any direction may contradict some of this guidance.

M1334 - Wound questions – What document determines the definitions of re-epithelialized or healed; WOCN or National Pressure Ulcer Advisory Panel?

M1326/1328 – what defines a moisture retentive dressing? Does barrier cream qualify? Does it have to be defined as a moisture retentive dressing on the POC?

M1350– What indicates assessment? Given the question as worded every leision or wound would receive an assessment. Is the intent to require active observation and assessment each visit even if no intervention is required on the POC? Are other ostomy's excluded? What about IV's? Does it include breakdown around ostomy's other than bowel?

M1360 – Most likely therapy only admissions with diabetes co-morbidity will have an answer of no – how will that impact and what are you trying to measure?

M1500– What is the definition of heart failure? Does it have to be physician documented? What if the client displays examples given in question but has no formal diagnosis? The answers between M1500 and M1510 could look inconsistent. In therapy only cases level of understanding will be different. When would you not assess symptoms of overload?

M1510 – No action – need definition or option for no action necessary if symptoms are minor and action is not indicated yet.

M1730 - what are the implications related to need for psychiatric nurses. If the screening tool indicates depression must psychiatric nursing be recommended? Recommend using the two PHQ-2 questions from the CARE tool (F2a, F2c). If not, who decides the standard tool used? The screening results would not seem consistent otherwise. What if the screening tool used does not have a 14 day threshold? This could lead to perceived inconsistency between M1730 and M1732.

M1734 – define interventions. Define referral? What if physician does not approve recommendations for home care but feels physician care is the only thing indicated? The answers do not seem to support this scenario.

M1880/1890 – questions worded vaguely and makes it difficult to measure outcomes with these two questions. Does not take into account if someone has been in a SNF for a long time or rehab or had significant changes in last week or two weeks.

M1940 – Should answer this on the SOC initial visit only? Not all interventions require a physician's order (like moving throw rugs, de-cluttering the individual's home. If these things are done but not on the POC it would look like and individual who was assessed as a fall risk in M1930 had no intervention.

M2000 – not assessed / reviewed – you would never not assess this. The first answer seems inappropriate.

M2002/2004 – when does "contacting" count? What if the physician does not call you back? Is the one day from when the medication issue was identified? What about weekend starts when dealing with on – call physicians? What is clinically significant?

M2010 – This is the focus of many plans of care and is given over the course of an episode. Change wording to "does the care plan include". This may not be the most appropriate thing do to on the first visit.

M2040 – change in medication management – how can we assess if better or worse before we admitted them? Patient may have been using medications incorrectly and didn't know it when hospitalized.

M2110 – caregiver assistance – what is the difference between caregiver not likely to provide and unclear if caregivers will provide; seems to be the same question. Add column for home health agency to provide.

Thank you again for the opportunity to comment. You may contact Rachel Hammon at 512-338-9293 or Rachel@tahc.org for any questions.

Respectfully submitted,

Rachel Hammon RN

Rachel Hammon, BSN, RN
Director of Clinical Practice and Regulatory Affairs

PUBLIC SUBMISSION

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Comment On: CMS-2008-0141-0001
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Document: CMS-2008-0141-0123
MN

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General Comment

Guardian Angels □□□ Elim Home Care
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Mary Steinbeck RN
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Attention Document Identifier: CMS-R-245 (OMB#0938-0760)

While we support the use of OASIS data to supplement a comprehensive assessment for home care and using the data as a tool to measure quality indicators, we do have concerns about some of the proposed changes in OASIS-C.

When clients enter the home care arena, they typically have recently discharged from an acute care facility. This change in location is usually exhausting in itself for the client. The information a home care nurse needs to acquire is substantial along with the paperwork and documents required (despite any so called paperwork reduction acts) at admission to home care which already makes for an exhausting effort by the client, caregiver, and nurse. Specifying what assessments may need to be addressed discredits nursing judgment for what is appropriate for that client. Many of the current questions would be not applicable in a large number of clients.

Nurses go into nursing to take care of people. Home care already has a disproportionate of data collection required by nurses compared to hospital nursing and is the most frequent complaint of nurses in the home care arena. How are home care agencies supposed to recruit and retain nurses, which already are in short supply and will get worse, when we already have the challenges of much lower wages that we can offer. I have had excellent nurses who could not succeed in home care ONLY because of the paperwork burden. The burden has increased substantially in my 15 years of home care.

Two problems with indicating requirement to perform specific assessments at the start of care are:

1. Lack of accurate information revealed or present on the initial assessment date(s). It is not unusual for a client to receive support the first few days or week after returning home and doing well, and then start to encounter more problems as the family and support system are reduced. Thus the process measurement of these areas would not be accurate.
2. Lack of a specified assessment tool designated when questions indicate if a screening or assessment has been done. How can this indicate accurate data for comparison if agencies are all using the tools of their choice? This leads to variable data which is not helpful and also increases the likelihood of subjective data being reported.
3. Assessments & Plans to consider regarding the above comments:
a. Pain Assessment
b. Pressure Ulcer Assessment
c. Diabetic Foot Care Plan
d. Heart Failure Follow up
e. Depression Screening
f. Fall Risk

Some of the positive changes proposed for OASIS-C are:
1. Elimination of prior data (14 days) which was not helpful at all, and prone to misinformation
2. M1210 & M1220, Hearing and Understanding: This is more clearly defined and helpful.
3. M1240 Pain: This is more clearly defined and helpful.
4. M1515 – Urinary incontinence: New answers are more appropriate.
5. M1840, M1845 – Toileting: New answers make a lot more sense.
6. M1860 – Ambulation: Better reflects the progress someone would make from a walker to a cane during an episode.
7. M2300 – Emergent Care: This is a more helpful and cost reflective of health care data piece than the current OASIS-B interpretation.

Additional things to consider revising
1. M0102 and M0104: These dates are not helpful as referrals come from different sources. Hospital or SNF discharge date are more concrete and helpful dates as they indicate how long the client had to wait for home care after being discharged. Often hospitals call with "referrals" when a patient is admitted to the hospital as a part of their discharge process.
2. M1010 & M1012: The inpatient diagnosis and procedure information is often not available at the admission date. Hospital discharge summaries need to be dictated and transcribed, and then we need to get the information from their medical records department. This information would be difficult to get on a consistent and reliable basis, and would favor home care agencies that are a part of a hospital system and share software. This would further limit the patient's right to choose an agency of their choice. This is not supposed to happen now but it does.
3. M1032 Frailty: This is likely to be subjective in nature and then subject to unreliable data. How would these be defined more concretely? These are also duplicated in other OASIS assessment areas. Please ask information once.
4. M1034 Stability: Home care providers are supposed to accurately determine this in the first 5 days of meeting a client? This again is too subjective.
5. M1038: Parameters are most appropriately determined after assessing a client for a period of time. Clients rarely come out of a hospital with parameters defined. This would provide excessive paperwork and burden. Physicians would not be happy to define this.
6. M1040, M1045, M1050, M1055: While we support collecting information as to whether or not a client has been given the flu vaccine, it should also allow for an unknown answer on M1040. Elderly clients often have memory issues and may be unreliable historians. If they received their flu vaccine at a flu clinic, the clinic may not have a record of this. Also, it should be clear that home care providers are not mandated to provide the vaccines and incur an additional burden. We try to offer the flu vaccine every year, but please don't create a situation that may lead to mandating providing vaccines. There are other means of promoting vaccinations within a community.
7. M1100 Living Arrangements: Assisted living and foster home situations – specify if assistance in available directly in client's home at the times indicated, or available in the building.
8. M1242, M1244, M1246 – Pain: This is not really helpful at the start of care as it takes time to gather this information. If it is implemented, recommend a standardized assessment tool that each and every agency will use. If that is done, how do you cleanly and simply define those who are able to communicate and those who are not? This again could be too subjective.
9. M1300, M1302, M1304, M1306, M1308, M1310, M1312, M1314, M1320, M1326, M1328 Pressure Ulcer, etc.: Need to specify one assessment tool, not a choice. What if a tool and other clinical factors are both considered? The physician ordered plan of care is not established at the time nurses need to

answer these questions. Stage III & IV are not longer recognized if they have healed, yet these would be more likely to break down again. Pressure ulcer length and width measurements are not helpful. Please follow WOCN guidelines.
10. M1350: Clarify that only bowel ostomies or all ostomies are to be excluded. Not logical to exclude ostomies from skin lesion question. Try to have OASIS response be logical. Current CMS interpretations of skin questions are not logical.
11. M1360 & 1365 - Diabetic Foot Plan: Physician ordered plan of care is not complete at the start of care when these questions would need to be answered. What would be a consistent format for determining if there would be changes since a previous assessment vs. status at the time of the assessment? Again, this could be open to subjective interpretation.
12. M1500, M1510 – Heart Failure: This information should be present in visit notes on a client, not all clients have heart failure. Although I strongly think heart failure is a significant issue in home care, I question this method of tracking with having easy and all access to this information.
13. M1730, M1734, M1736 – Depression: A standardized tool should be specified if this will be required. Typically clients need time to trust their nurse or clinician to reliably answer screening tool questions, so this would not be helpful and reliable to implement at the start of care. Clients often have more support from family immediately upon returning home, and depression may not be evident until later in the episode. Will need to be very clear and careful so it is not subjective and thus less reliable.
14. M1880, M1890 – Changes in Mobility & Self Care: This is too subjective and thus will be unreliable. How do you consider if there is improviement in ambulation but not transferring or vice versa? Clients would typically be worse entering home care than they were prior to the onset of illness so how is this helpful information?
15. M1940 & M1945 – Fall Risk: Standardized screening tool would be needed to be objective and accurate. Physician ordered plan of care is not in place at the time of the assessment.
16. M2000, M2002, M2004, M2010, M2015 – Medication: Drug Regimen Review is already in the Conditions of Participation. Medication follow up needs to be clarified – weekend, format (fax, phone); contacting physician within 1 day may often be unrealistic – they have days off, too. A covering physician often will not address this. Clients in assisted living typically are unable to manage their medication regimen which is often a major reason they have moved to an assisted living.
17. M2040 – Medication Ability: You have the opportunity to make this question say what you mean. ALL medications mean all medications, not 50%. ALL prescribed means all prescribed, not prescribed and over the counter. CMS's current interpretation of ALL is not even close to what ALL means in English.

Thank you for the opportunity to comment on the proposed OASIS-C changes. Please consider this a response from all of my nursing staff (12) as these are the summary of comments and concerns that I have heard working with them

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