


OASIS D: WHAT YOU NEED TO KNOW

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LEARNING OBJECTIVES

- At the completion of this educational activity, the learner will be able to:
 - Identify the OASIS items that are scheduled to be removed from the OASIS D data collection tool.
 - Formulate strategies to prepare staff to complete the modified items in OASIS D.
 - Create a plan to address training needs for OASIS items that will be added in 2019.



OASIS D GUIDANCE

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HQIOASISUserManual.html>




OASIS D MODIFICATIONS

- 28 Items Removed
- 14 Items Changed
 - Skip Patterns related to removed items
 - Text of Item
- 41 Items with Guidance Changes
 - Intent
 - Response Specific Instructions
 - Time Points
 - Sources




OASIS D – REMOVED ITEMS

Let the grieving process begin....




REMOVED ITEMS

- M1011 – Inpatient Diagnosis
- M1017 – Medical or Treatment Regimen Change
- M1018 – Conditions Prior
- M1025 – Optional Diagnoses
- M1034 – Overall Status
- M1036 – Risk Factors
- M1210 – Ability to Hear
- M1220 – Understanding of Verbal Content
- M1230 – Speech and Oral Expression
- M1240 – Pain Assessment



REMOVED
ITEMS
CONTINUED

- M1300 – Pressure Ulcer Assessment
- M1302 – Risk of Developing Pressure Ulcers
- M1313 – Worsening in Pressure Ulcer Status
- M1320 – Status of Most Problematic Pressure Ulcer
- M1350 – Skin Lesion
- M1410 – Respiratory Treatments
- M1501 – Symptoms in Heart Failure Patients
- M1511 – Heart Failure Follow Up
- M1615 – When Does Incontinence Occur
- M1750 – Psychiatric Nursing Services




REMOVED
ITEMS
CONTINUED

- M1880 – Light Meal Preparation
- M1890 – Telephone Use
- M1900 – Prior Functioning ADLs/IADLs
- M2040 – Prior Medication Management
- M2110 – ADL or IADL Assistance
- M2250 – Plan of Care Synopsis
- M2430 – Reason for Hospitalization
- M0903 – Date of Last Home Visit





OASIS D – CHANGED ITEMS

Now we get nervous....



CHANGED ITEMS: SKIP PATTERNS

- M1000 – Inpatient Facilities
- M1051 – Pneumococcal Vaccine
- M1311 – Current Number of Unhealed Pressure Ulcers
- M1340 – Surgical Wound
- M1610 – Urinary Incontinence or Urinary Catheter
- M2001 – Drug Regimen Review
- M2410 – Inpatient Facility Admission
- M2420 – Discharge Disposition




CHANGED
ITEMS:
RESPONSE /
TEXT

- M1028 – Active Diagnoses
 - None of Above Added (yay!!)


“injuries”, “ulcers/injuries”

- M1306 – Unhealed Pressure Ulcer Stage 2 or Higher
- M1311 – Current Number Unhealed Pressure Ulcers
- M1322 – Current Number Stage 1
- M1324 – Stage of Most Problematic Pressure Ulcer



CHANGED
ITEMS:
RESPONSE /
TEXT

- M2310 – Reason for Emergent Care
 - Only #1 (medication), #10 (Hypo/hyperglycemia), #19 (Other) and UK (unknown)
- M2102 – Types and Sources of Assistance
 - SOC/ROC:
 - ONLY row f – Supervision and Safety
 - Focus on cognitive behavioral component
 - DC:
 - Row a – ADL Assistance
 - Row c – Medication Administration
 - Row d – Medical Procedures/Treatments
 - Row f – Supervision and Safety



ABILITY AND WILLINGNESS

Select the response that represents the greatest need

Response 0
No assistance needed – patient is independent or does not have needs in this area

Response 1
Non-agency caregiver(s) currently provide assistance


Response 2
Non-agency caregiver(s) need training/ supportive services to provide assistance

Response 3
Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

Response 4
Assistance needed, but no non-agency caregiver(s) available

Indicates that the caregiver(s) has indicated an unwillingness to provide assistance OR That the caregiver(s) is/are physically and/or cognitively unable to provide needed care.

Indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance.



CHANGED ITEMS: GUIDANCE (NOT SUBSTANTIVE)

- M0080 – Person Completing Assessment
- M0090 – Date Assessment Completed
- M0102 – Physician Ordered SOC Date
- M1046 – Influenza Vaccine Received
- M1056 – Reason Pneumococcal Vaccine not Received
- M1610 – Urinary Incontinence or Urinary Catheter
- M2301 – Emergent Care
- M2401 – Intervention Synopsis
 - References to OASIS items as risk tools removed since M1300 and M1240 no longer exist.



(M0090) Date Assessment Completed:

- If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record.
- When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources, and selecting the appropriate item response(s), within the appropriate timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.



(M2401) Intervention Synopsis: (Check only one box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

| Plan / Intervention | No | Yes | Not Applicable |
|--|----------------------------|----------------------------|--|
| a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee). |
| b. Falls prevention interventions | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls. |
| c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used. |



| | | | | |
|--|----------------------------|----------------------------|-----------------------------|---|
| d. Intervention(s) to monitor and mitigate pain | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA | Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain. |
| e. Intervention(s) to prevent pressure ulcers | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA | Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers. |
| f. Pressure ulcer treatment based on principles of moist wound healing | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> NA | Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated. |

Will you still use tools??



CHANGED ITEMS: GUIDANCE (NOT SUBSTANTIVE)

“Ulcer/Injury” and remove “suspected” from DTI

- M1306 – Pressure Ulcer Stage 2 or Higher
- M1307 – Oldest Stage 2 Present at Discharge
- M1322 – Current Number Stage 1 Pressure Ulcers
- M1324 – Stage of Most Problematic Pressure Ulcer

M1332 Dropped from DC / WOCN Resource Reference removed

- M1332 – Current Number Stasis Ulcers
- M1334 – Status of Most Problematic Stasis Ulcer

M1340 Dropped reference to M1350 / WOCN Resource Reference


- M1340 – Surgical Wound
- M1342 – Status of Most Problematic Surgical Wound



CHANGED ITEMS: GUIDANCE
(NOT SUBSTANTIVE)

- M1800 – Grooming
- M1810 – Upper Body Dressing
- M1820 – Lower Body Dressing
- M1830 – Bathing
- M1840 – Toilet Transferring
- M1845 – Toileting Hygiene
- M1850 – Transferring
- M1860 – Ambulation
- M1870 – Feeding or Eating

“When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact.”




CHANGED ITEMS: GUIDANCE
(NOT SUBSTANTIVE)

- M2003 – Medication Follow Up
- M2005 – Medication Intervention
- M2010 – High Risk Drug Education
- M2016 – Drug Education Intervention

How much time do you need to spend on these changes?


Priorities:
M1028
M2102
Injury/Ulcer
Risk Tools
Collaboration



CHANGED ITEMS: GUIDANCE (SUBSTANTIVE)

- M1021 – Primary Diagnosis
- M1023 – Secondary Diagnosis
- M1028 – Active Diagnosis
 - Instructions for “None of the Above”
- M1060 – Height and Weight
 - With “unsuccessful attempts”, agency collected data from a visit within last 30 days can be used. NOT go to method.
- M1311 – Current Number Pressure Ulcers
 - Instructions tweaked....again
- M1730 – Depression Screening
 - Someone else can administer test for assessing clinician to analyze results


References to Columns 3 and 4 removed



(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply. See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- 2 - Diabetes Mellitus (DM)
- 3 – None of the above

- **Step 1 – Identify Diagnosis**
 - *The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.*
- **Step 2 – Determine whether diagnoses are active**
 - *If information regarding active diagnoses is learned after the end of the assessment time frame, the OASIS data set should not be revised to reflect this new information.*
 - *If, however, it comes to light after the data set is submitted that a documented active diagnosis was present but not indicated on the OASIS data set, the Home Health Agency should modify the OASIS data set in accordance with the instructions in the Survey and Certification Memo #15-18-HHA*




(M1060) Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up

inches a. Height (in inches). Record most recent height measure since the most recent SOC/ROC


pounds b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

- Only enter a height that has been directly measured by agency staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.
- Only enter a weight that has been directly measured by agency staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.
- When there is an unsuccessful attempt to measure a patient's height or weight, at SOC/ROC, and there is a documented agency-obtained height or weight from a documented visit conducted within the previous 30-day window may be used to complete M1060 for this SOC/ROC assessment. Whenever possible, a current height and weight should be obtained by the agency as part of the SOC/ROC assessment.




SOC/ROC

| (M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage | Enter Number |
|--|----------------------|
| A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers | <input type="text"/> |
| B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers | <input type="text"/> |
| C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers | <input type="text"/> |
| D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device | <input type="text"/> |
| E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers/injuries due to coverage of wound bed by slough and/or eschar | <input type="text"/> |
| F1. Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury | <input type="text"/> |



DC


| (M1311) Current Number of Unhealed Pressure Ulcers at Each Stage | Enter Number |
|--|--------------------------|
| A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1] | <input type="checkbox"/> |
| A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |
| B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers [If 0 at FU/DC Go to M1311C1] | <input type="checkbox"/> |
| B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |
| C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers [If 0 at FU/DC Go to M1311D1] | <input type="checkbox"/> |
| C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |



DC

| | |
|--|--------------------------|
| D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1] | <input type="checkbox"/> |
| D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |
| E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1] | <input type="checkbox"/> |
| E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |
| F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)] | <input type="checkbox"/> |
| F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | <input type="checkbox"/> |

[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]



CHANGED ITEMS: GUIDANCE (SUBSTANTIVE)


- M1910 – Fall Risk
 - Someone else can administer test for assessing clinician to analyze results
- M2001 – Drug Regimen Review
 - “Issues” list changed

“Day of” and documentation of others can be considered

- M2020 – Oral Medication Management
- M2030 – Injectable Medication Management

Updated due to removed response options

- M2102 – Types and Sources of Assistance
- M2310 – Reason for Emergent Care



(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications.**
(NOTE: This refers to ability, not compliance or willingness.)

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
 - (a) individual dosages are prepared in advance by another person;
 - OR (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

• This item is intended to identify the patient's ability to take all oral (p.o.) medications reliably and safely on the day of assessment. If the patient's ability to manage varies, consider the medication for which the most assistance is needed when selecting a response.

• Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly), open the container, select the pill/tablet or millimeters of liquid and orally ingest at the correct times.

• Enter Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner, were adequate assistance for the patient to take all medications safely.






BRIDGE TO OASIS D




THANK YOU!

ARE YOU CONFIDENT IN THE ACCURACY OF YOUR OASIS DATA COLLECTION? WE CAN HELP!




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Kornetti & Krafft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions to address OASIS and coding needs.





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