Excellence in OASIS-C

COS-C Prep & OASIS Training

Webinar Series - Session 4
March 26, 2014
2:00 – 3:00PM EST

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Session 4 Agenda

- Review of Chapter 3 OASIS M items/Clinical M1030-M1700s (except M1300)
  - Review of Therapies the Patient Receives at Home M1030
  - Living Arrangements M1100
  - Sensory Status M1200-1242
    - Vision, Hearing, Verbal & Pain
  - Respiratory, Cardiac, Elimination M items
  - Review of Neuro, emotional and Behavioral M items

M1030 Therapies the Patient Receives at Home

(Mark all that apply)

- ☐ 1 – Intravenous or infusion therapy (excludes TPN)
- ☐ 2 – Parenteral nutrition (TPN or lipids)
- ☐ 3 – Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 – None of the above
- **Item used for HHRG calculation**

M1030 Therapies the Patient receives in the Home

- IV/Parenteral *ANY* IV therapy received in the home, even if by another company.
  - ☐ Flushing PICCs and Port A Caths count.

  The patient may be receiving both tube and oral feedings.
- *Note: Be sure to answer M1870 (Feeding & Eating), M2100 row e (Management of Equipment) appropriately*

M1030 TIPS

Includes

- Includes hemodialysis or peritoneal dialysis at home
  - Even if flush is just to maintain patency
- Include all infusion, enteral or parenteral therapies the patient is currently receiving regardless of who administers/cares for it.
- Includes: subcutaneous, epidural, intrathecal infusions and insulin pumps.
- Includes: Enteral nutrition.
- Therapy initiated at SOC
- Therapy planned after SOC assessment if MD orders are in place with date.

Excludes

- Hydration alone is not considered nutrition.
- Excludes: Presence of feeding tube if no RX for therapy which provides nutrition
  - Feeding tube for medication only
  - Flushing tube for maintenance or patency
- Excludes: An irrigation or infusion of bladder
  - Flushing of nephrostomy tube
- Excludes: Mammosite (balloon radiation catheter)
- Excludes: Flushing tubes for urine, ascites, other wound drainage
- Order for prn does not count unless administered during SOC visit

Influenza Vaccine (QM) TRN/D/C

- **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine from your agency for this year's influenza season **(October 1 through March 31)** during this episode of care?

☐ 0 - No
☐ 1 - Yes [Go to M1050]
☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

- **(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:

☐ 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 - Assessed and determined to have medical contraindication(s)
☐ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
☐ 6 - Inability to obtain vaccine due to declared shortage
☐ 7 - None of the above

Pneumococcal Vaccine (QM) TRN/D/C

- **(M1050) Pneumococcal Vaccine:** Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care **(SOC/ROC to Transfer/Discharge)**?
  - ☐ 0 - No
  - ☐ 1 - Yes [Go to M1500 at TRN; Go to M1230 at DC]

- **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:
  - ☐ 1 - Patient has received PPV in the past
  - ☐ 2 - Offered and declined
  - ☐ 3 - Assessed and determined to have medical contraindication(s)
  - ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
  - ☐ 5 - None of the above

Vaccines

- Influenza
- M1040 Influenza Vaccine
- Specific timeframe October 1 – March 31
- During this episode of care
- M1045 Reason vaccine not received
- Pneumococcal
- M1050 Pneumococcal Vaccine
- Timeframe - Ever received
- During this episode of care
- M1055 Reason PPV vaccine not received

Test Your Knowledge
M1040 No or Yes

- Patient is admitted on October 5th and receives the influenza vaccine on October 25th
- Patient is admitted on September 7th and receives the influenza vaccine on December 15th
- Patient is admitted on September 7th and receives the influenza vaccine on September 28th

Living Arrangements

M1100

Patient Living Situation M1100 (QM)

Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

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

Living Situation Tips

- Only 1 box should be marked
- 2 parts to answer question
  1. Determine living situation
     - Report usual living situation
     - Lives alone= home, apt, boarding house, live in paid help, caregiver temporarily staying w/patient
  2. Determine availability of assistance
     - Caregivers do not need to live w/patient to be available
     - Do not include telephone assistance
     - Assistance includes ADL's, IADL's, Meal Prep, Med Mgmt
     - If person in home does not provide ANY ADL/IADL assistance select box 10.
- Not considered in this question is the amount or type of assistance the person needs

Test Your Knowledge - What is the answer to M1100 (1-15)?

- Patient lives in own home across street from daughter. She brings mother dinner every night & is available by telephone 24 hours per day.
- Patient lives with her daughter who works during the day but is home every evening and sleeps there every night. A paid aide comes in 3 days a week to assist with ADLs. Daughter has back problems that prevent her from lifting patient, but she assists the patient with dressing every morning and takes the patient to doctor's appointments.
- Patient lives alone in her own apartment. Since her discharge from the hospital, her two daughters alternate staying with her during the day and night so that one of them is always there, except for the times when one goes out to run an errand.

Sensory Status

M1200s

M1200 EYES: Vision with corrective lenses if the patient usually wears them

- 0 – Normal vision – sees adequately in most situations; can see medication labels, newsprint.
- 1 – Partially impaired – cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout, can count fingers at arm's length.
- 2 – Severely impaired – cannot see objects without hearing or touching them or patient non-responsive.
- **Item used for HHRG calculation**

M1200 TIPS

- The clinician is assessing the patient's functional vision
- Physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered.
  - Consider neck injury, limited ROM
  - Consider orbital swelling
- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.
- Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.
- A person is considered:
  - Partially or severely impaired if magnifying glass is used to read small print or med labels.
  - Severely impaired is there is lack of sight or is non-responsive to commands.

Test Your Knowledge

- How do you score a patient who is blind in one eye?
  - *It is possible to score a "0" if with the patient's existing vision, they are able to see adequately in most situations and can see medication labels or newsprint.*
- How do you score a patient with dementia (cognitively impaired) who is unable to answer questions?
  - *It is possible to score a "0" if after observation by the clinician the patient could see the their eating utensils, buttons on blouse etc then patient would be reported as a "0-Normal vision" even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels.*

Sensory Status

- **(M1210) Ability to hear** (with hearing aid or hearing appliance if normally used):
  - ☐ 0 - Adequate: hears normal conversation without difficulty.
  - ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
  - ☐ 2 - Severely Impaired: absence of useful hearing.
  - ☐ UK - Unable to assess hearing.
- **(M1220) Understanding of Verbal Content** in patient's own language (with hearing aid or device if used):
  - ☐ 0 - Understands: clear comprehension without cues or repetitions.
  - ☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
  - ☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
  - ☐ 3 - Rarely/Never Understands.
  - ☐ UK - Unable to assess understanding.

Sensory Status Tips

M1210	M1220
■ Hearing is evaluated with hearing aids or devices if the person usually wears them. □ Be sure devices are in place, turned on and are working ■ Select UK if patient not able to respond. □ e.g. Dementia, schizophrenia, unconscious	■ Assess patient's ability to comprehend in the patient's own language. Use interpreter, as appropriate, if primary language of the patient differs from clinicians. ■ If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf.

M1230 Speech & Oral (Expression) of Language (QM)

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

☐ 5 - Patient nonresponsive or unable to speak.

M1230 TIPS

- In patient's own language
- Augmented Speech is considered verbal expression
  - Trained esophageal speaker
  - Electrolarynx
- Response 5 – Non-Verbal
  - If the patient cannot vocalize sounds and depends entirely on the speech generating device, the appropriate score would be a 5-Patient nonresponsive or unable to speak
  - Dynavox message board that converts text to speech
  - Sign language
  - Writing
- Presence of trach – needs to be assessed further

Pain Assessment/Management (QM)

- **(M1240)** 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)?
- 0 - No standardized assessment conducted
- 1 - Yes, and it does not indicate severe pain
- 2 - Yes, and it indicates severe pain
- *Be sure to answer M2250e, M2400d correctly*

- **M1242 Frequency of Pain** interfering with patient's activity or movement:
- 0 – Patient has no pain
- 1 – Pain does not interfere with activity or movement
- 2 – Less often than daily
- 3 – Daily, but not constantly
- 4 – All of the time
- Item also used for HHRG calculation

M1240-M1242 TIPS

- Identifies frequency of **pain interfering with activities**, with treatment if prescribed.
- If a patient voluntarily restricts their activities to be pain free
  - = Pain interfering with activity
- If pain medication allows patient to be pain free
  - = No restriction on activities
- Severe pain is defined according to scoring system used for standardized assessment.
- If nonverbal, evaluate facial expressions or postures and other responses (e.g. monitoring heart rate, respiratory rate) to pain during activity or movement.
- Responses to **M1800 – M1880 (ADL's) should reflect that pain is interfering with activities.** If all answers are a "0" or "1" then this contradicts the answer to M1242. Also, pain will be down coded if the clinical notes do not support the OASIS.

Test Your Knowledge

- **If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity?**

- If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considered as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M1242.

Assessments

- If a ROC is delayed beyond 48 hours because a patient refused a visit – M1240 is answered as “0 = no” because it was not completed within acceptable time frame.
- Same for all assessments: M1240, M1300, M1730, M1910, M2250
- *Rationale: At the ROC, there is no regulatory language allowing the ROC to be delayed by physician order, greater than 48 hours from the inpatient facility discharge. If the assessment is completed late, the responses to the Process Measure items must be “no” as they were not completed within the timeframe allowable.*

Respiratory Status

M1400s

M1400 When is the patient dyspneic or noticeably short of breath?

- 0 – Patient is not short of breath
- 1 – When walking more than 20 feet, climbing stairs
- 2 – With moderate exertion (e.g. while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 – With minimal exertion (e.g., while eating, talking, or performing other ADL's) or with agitation
- 4 – At rest (during day or night)
- **Item used in HHRG calculation & Home Health Compare (QM)**

M1400 When is the patient dyspneic or noticeably short of breath?

- If the patient regularly uses oxygen, assess patient when oxygen is on.
- If patient occasionally uses oxygen, assess patient when oxygen is off.
- Based on the patient's actual use of O2 not the physician's order.
- The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest or physically demanding transfer activities.
- If demanding bed-mobility activities produces dyspnea in the bedbound patient response 1 is appropriate
- 485 should include O2 orders & box 18A should indicate DOE. If choosing SOB or DOE (box 2-4), the clinical notes must support the assessment finding or M1400 is down coded by the RHHI
- Oxygen Dependence V46.2

Test Your Knowledge

- Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it.
- Answer: 0 – Not short of breath

Cardiac Status

M1500s

Heart Failure Symptoms (TRN/DC)

- **M1500 Symptoms in Heart Failure (QM)**
  Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

☐ 0 - No **[*Go to M2004 at TRN; Go to M1600 at DC*]**
☐ 1 - Yes
☐ 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**
☐ NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

M1510 Heart Failure Follow-up (QM):

Timepoint at TRN/DC

- If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**
- 0 - No action taken
- 1 - Patient's physician (or other primary care practitioner) contacted the same day
- 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
- 3 - Implemented physician-ordered patient-specific established parameters for treatment
- 4 - Patient education or other clinical interventions
- 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Heart Failure Symptom Tips

- Include symptoms of heart failure at any given point since the previous assessment
- Diagnosis of heart failure regardless of whether the diagnosis is documented elsewhere in the OASIS assessment
- Include usage of telehealth
- Include any actions taken at least one time since the last OASIS assessment
- Response 1 is only appropriate if the MD responds to the agency communication
  - This time period means by the end of this calendar day

Elimination Status

M1600s

M1630 Ostomy for Bowel Elimination:

- Does this patient have an ostomy for bowel elimination that (within the last 14days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?
- 0 – Patient does not have an ostomy for bowel elimination
- 1 – Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen
- 2 – The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen
- **Item used for HHRG calculation**

M1630 TIPS

- Identifies if patient has an ostomy for bowel elimination and if so, whether the ostomy was related to an inpatient stay or change in medical treatment plan
- Assess for presence of ostomy
- Determine reason for inpatient stay
  - Example: If pt admitted with diarrhea, mark response 2
- Compare with M1010 Inpatient Stay & M1012 Inpatient Procedure
- If an ostomy has been reversed, do not include

Neuro/Emotional/ Behavioral Status

M1700s

Behavioral Status

- M1700 Cognitive Functioning (QM)
  - Timeframe = day of assessment
  - report the patient's cognitive functioning, as evidenced by their level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands
- M1710 When Confused (QM)
  - Timeframe = within last 14 days
  - identify the time of day or situations when the patient experienced confusion
- M1720 When Anxious (QM)
  - Timeframe = within last 14 days

- If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710.
- If a patient was NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710.
- If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g.; forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.

M1730 Depression Screening (QM)

PHQ-2© scale. Has the patient been screened for depression, using a standardized depression screening tool?

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")
- ☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- ☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

If patient scores 3 or higher, further depression screening is indicated.

Depression Assessment

- CMS does not mandate that clinicians conduct a depression risk screening for all patients, nor is there a mandate for the use of a specific tool
- PHQ-2 ranges from 0-6. If patient scores 3 or higher, further depression screening is indicated

- TIP: Compare with M2250d Plan of Care Synopsis & M2400c Intervention Synopsis

Next Session:

April 2, 2014
2:00 – 3:00PM EST

Some Highlights:

- Chapter 3 OASIS M Integumentary System
- Wounds: surgical, pressure ulcers, stasis ulcers