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OASIS D Part 1: Are You Ready for the Changes?

Modified and Removed Items

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Chapter One

Overview

OASIS D Guidance Manual

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.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

Chapter Two

Removed Items

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 (cont.)

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

Gone Effective 1/1/19

Removed Items (cont.)

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

Gone Effective 1/1/19

Chapter Three

Changed Items: Minor

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 the above added
"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
M2310	Reason for Emergent Care
M2102	Types and Sources of Assistance

M2310: Reason(s) for Emergent Care (TF/DC)

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out

M2102: Types and Sources of Assistance (SOC/ROC)

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

M2102: Types and Sources of Assistance (DC)

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Ability and Willingness

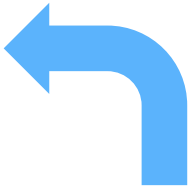
Response 0
No assistance needed: patient is independent or does not have needs in this area

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

Select the response that represents the greatest need

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



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.

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

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

Will you still use tools?

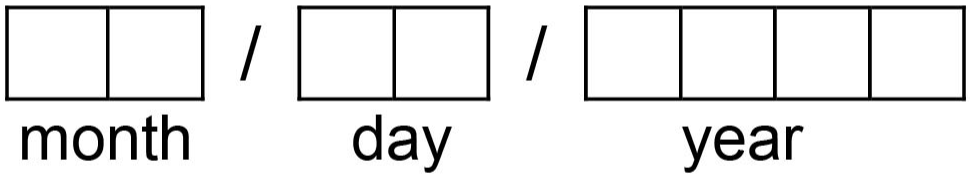
M0080

(M0080)	Discipline of Person Completing Assessment
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

- Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home
- While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, he/she may collaborate to collect data for all OASIS items, if agency policy allows
- According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments

M0090

(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

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
Dropped from DC/WOCN Resource Reference Removed	
M1332	Current Number Stasis Ulcers
M1334	Status of Most Problematic Stasis Ulcer
Dropped Reference to 1350/WOCN Resource Reference Removed	
M1340	Surgical Wound
M1342	Status of Most Problematic Surgical Wound

Changed Items: Guidance (Not Substantive) (cont.)

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) (cont.)

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

Chapter Four

Changed Items: Significant

Changed Items: 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

M1021/M1023: Diagnoses

(M1021) Primary Diagnosis & (M1023) Other Diagnoses	
Column 1	**Column 2**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
(M1023) Other Diagnoses b. _____	**All ICD-10–CM codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

M1028: Active Diagnoses

(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

M1028: Active Diagnoses (cont.)

- Step one: 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 two: 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

Changed Items: 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

M2001: Code 0, No Issues

- Patient's inpatient facility discharge medication list matches medications patient has on hand
- Patient has a plan for taking medications safely at the right time
- Patient is not showing signs/symptoms that could be adverse reactions caused by medications
- The diagnosis/conditions for which the patient is taking the medications appear adequately controlled

M2001: Code One, Issues Found

- Patient's list of medications from the inpatient facility discharge instructions **do not** match the medications the patient shows the clinician at the SOC/ROC assessment visit
- Assessment shows the diagnoses/symptoms for which the patient is taking medications are **not** adequately controlled
- Patient seems confused about when/how to take medications indicating a high risk for medication errors
- Patient has not obtained medications or indicates that he/she will not take prescribed medications because of financial, access, cultural, or other issues with medications
- Patient has signs/symptoms that could be adverse reactions to medications
- Patient takes multiple non-prescriptions medications (OTCs, herbals) that could interact with prescribed medications
- Patient has a complex medication plan with medications prescribed my multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high

M2020: Management of Oral Medication

(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.)**
Enter Code ☐	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.

M2020: Management of Oral Medication (cont.)

- 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 three 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

M2030: Management of Injectable Medication

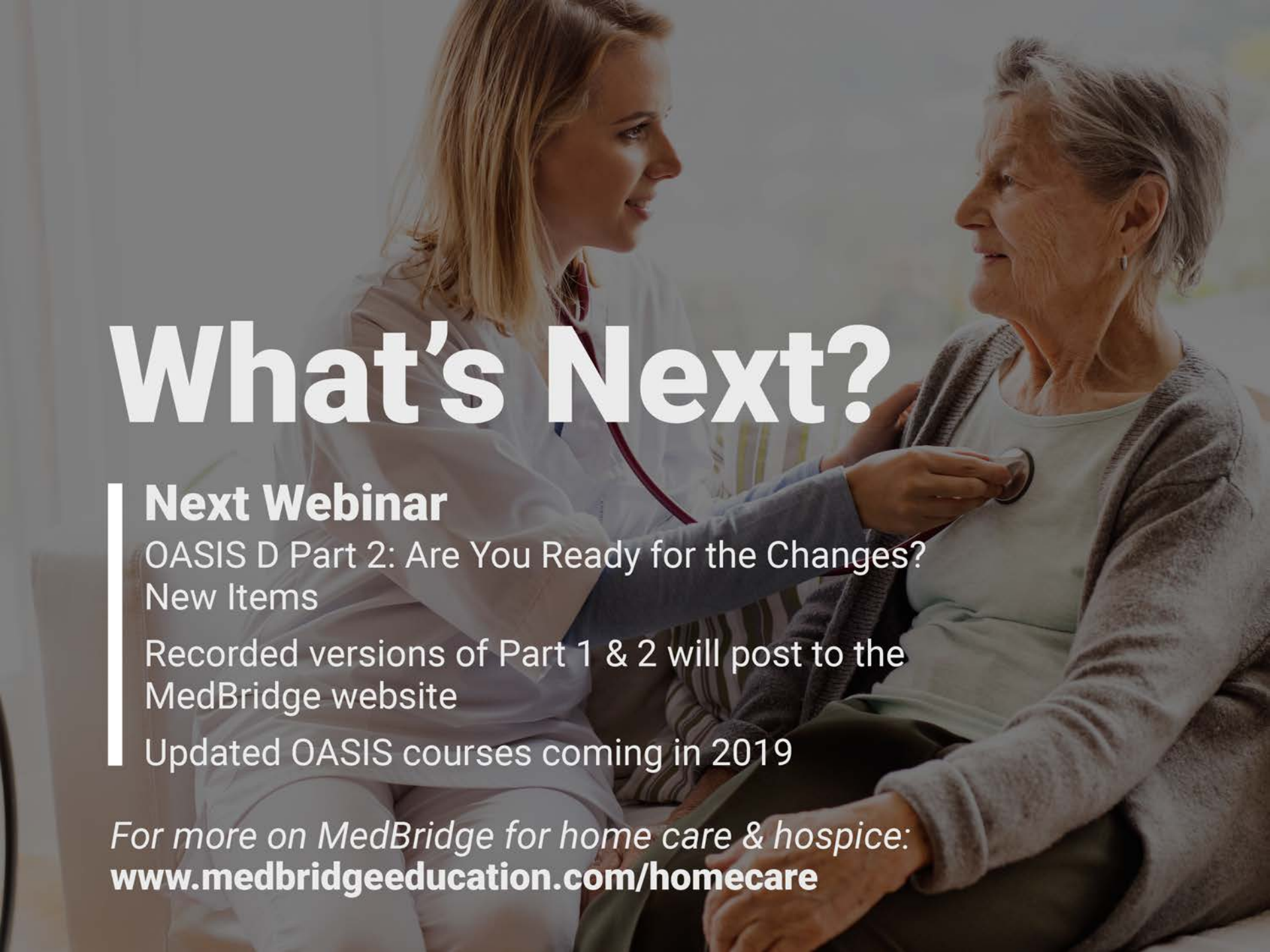
(M2030)	**Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 Able to take injectable medication(s) at the correct times if: (a) individual syringes 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 based on the frequency of the injection 3 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.

M2030: Management of Injectable Medication (cont.)

- Excludes IV medications, infusions (i.e., medications given via a pump), and medications given in the physician's office or other settings outside the home
- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly
- Enter response three if the physician ordered the RN to administer an injection in the home

Strategies for Changed Items

M1060	Use of agency data as an **exception**
M1311	Review again (and again)
M1730/M1910	Tool completed by others
M2001	Revisit “Issues” examples
M2020/M2030	Address new parameters
M1021/M1023/ M1028/M2102/ M2310	Highlight “positive” changes for the clinicians and reinforce need for accuracy



What's Next?

Next Webinar

OASIS D Part 2: Are You Ready for the Changes? New Items

Recorded versions of Part 1 & 2 will post to the MedBridge website

Updated OASIS courses coming in 2019

For more on MedBridge for home care & hospice:
www.medbridgeeducation.com/homecare

Bibliography

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OASIS D Part 1: Are You Ready for the Changes? Modified & Removed Items
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