ALPHABET SOUP:
OASIS-C1/ICD-9 & POC

Rhonda Crawford BSN, RN,CHCE, HCS-D, HCS-O, COS-C
Objectives

1) Describe current guidance and assessment tips to accurately complete challenging OASIS-C1 items
2) Discuss specific strategies to maximize role of OASIS data in care planning

OASIS-C1: Risk for Hospitalization

(M1033) Risk for Hospitalization

• Reasons for change:
  1) Collect data on factors identified in literature as predictive of hospitalization
  2) Provide guidance on time period under consideration for each response
  3) Ordered responses to reflect length of “look-back” period

(M1033) Item Guidance

• (M1033) Risk for Hospitalization
  • Responses are listed in descending order according to the time period under consideration (past 12 months, past 6 months, past 3 months, & current)
  • The similar OASIS-C item had a uniform “look back” of 12 months for all responses
  • This OASIS-C1 item requires a change in assessment strategy to ensure accurate data collection
Risk for Hospitalization

- When compared to the former version of this item, there are new responses and several changes in the “look-back” time frame
- **Requires a CHANGE in assessment strategy**
- Potential impact on care planning: increase focus on acute concerns

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>OASIS-C</th>
<th>OASIS-C1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of falls (2+ or any w/injury)</td>
<td>12 mos</td>
<td>12 mos</td>
</tr>
<tr>
<td>2. Unintentional weight loss (10+ lbs)</td>
<td>12 mos</td>
<td>12 mos</td>
</tr>
<tr>
<td>3. Multiple hospitalizations (2+)</td>
<td>12 mos</td>
<td>6 mos</td>
</tr>
<tr>
<td>4. Multiple emergency department (2+)</td>
<td>NA</td>
<td>6 mos</td>
</tr>
<tr>
<td>5. Decline in mental/emotional/behavior</td>
<td>12 mos</td>
<td>3 mos</td>
</tr>
<tr>
<td>6. Non-compliance w/medical instruction</td>
<td>NA</td>
<td>3 mos</td>
</tr>
<tr>
<td>7. Five or more medications</td>
<td>current</td>
<td>current</td>
</tr>
<tr>
<td>8. Exhaustion</td>
<td>12 mos</td>
<td>current</td>
</tr>
</tbody>
</table>
OASIS-C1: M1308 column 2 removed

- (M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable
  - Identifies the number of Stage II or higher pressure ulcers at each stage **present at the time of assessment**
    - Row a: unhealed Stage II ulcers
    - Row b: Stage III (at any healing status, including closed)
    - Row c: Stage IV (at any healing status, including closed)
    - Row d1: Unobservable due to dressings or devices (for example, casts) that cannot be removed to assess the skin underneath
    - Row d2: Unstageable because no bone, muscle, tendon, or joint capsule (Stage IV structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage IV structures
    - Row d3: Suspected deep tissue injury (DTI) in evolution

OASIS-C1: New Item “Worsening”

- (M1309) Worsening in Pressure Ulcer Status since SOC/ROC
  - Collected only at Discharge (RFA 9)
  - Similar to former OASIS-C M1308, column 2
    - Identifies whether pressure ulcers present at discharge are new or have worsened since SOC/ROC
    - Applies to:
      - Stage II, Stage III, Stage IV pressure ulcers (M1308, rows a, b, c)
      - Pressure ulcers that are Unstageable due to slough/eschar (M1308, row d2)

(M1309) Guidance

- (M1309) Worsening in Pressure Ulcer Status since SOC/ROC
  - Item is collected at discharge
  - Documents the number of pressure ulcers that are new or have “worsened” (increased in numerical stage) since the most recent Start or Resumption of Care assessment
  - Review the history of each current pressure ulcer
    - Specifically, compare the current stage of the pressure ulcer to the stage of that ulcer at the most recent SOC/ROC to determine whether the pressure ulcer currently present is new or worsened when compared to the presence or stage of that pressure ulcer at the most recent SOC/ROC

(M1309) Guidance

- (M1309) Worsening in Pressure Ulcer Status since SOC/ROC, continued
  - Pressure ulcers that were Unstageable for any reason at the most recent SOC/ROC cannot be reported as new or worsened at Discharge

- Reporting Algorithm for M1309
<table>
<thead>
<tr>
<th>CURRENT STAGE at Discharge</th>
<th>Look back to most recent SOC/ROC</th>
<th>PRIOR STAGE at most recent SOC/ROC</th>
<th>REPORT AS NEW OR WORSENGED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II at discharge</td>
<td>If same pressure ulcer at most recent SOC/ROC was:</td>
<td>Not present</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage I</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage II</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage III</td>
<td>NA (reverse staging not allowed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstageable</td>
<td>NO</td>
</tr>
<tr>
<td>b. Stage III at discharge</td>
<td>If same pressure ulcer at most recent SOC/ROC was:</td>
<td>Not present</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage I</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage II</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage III</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage IV</td>
<td>NA (reverse staging not allowed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstageable</td>
<td>NO</td>
</tr>
<tr>
<td>c. Stage IV at discharge</td>
<td>If same pressure ulcer at most recent SOC/ROC was:</td>
<td>Not present</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage II</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage III</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage IV</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstageable</td>
<td></td>
</tr>
<tr>
<td>d. Unstageable due to slough or eschar at discharge</td>
<td>If same pressure ulcer at most recent SOC/ROC was:</td>
<td>Not present</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage I</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stage IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstageable</td>
<td>NO</td>
</tr>
</tbody>
</table>
(M1308) & (M1309)

- Scenario: At SOC, Mr. Black has a suspected DTI on his left heel and an unhealed Stage III pressure ulcer at SOC that closes after 4 weeks. During the episode, the DTI opens to reveal full thickness loss with visible bone. He also develops another Stage III ulcer which is present at discharge, when family members move him to their home in another state.

In OASIS-C1: How will this information be recorded in M1308 at SOC? At Discharge? How will M1309 be recorded at Discharge?
### (M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

<table>
<thead>
<tr>
<th>Stage Descriptions—unhealed pressure ulcers</th>
<th>Number Currently Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage II: 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 serum-filled blister.</td>
<td></td>
</tr>
<tr>
<td>b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</td>
<td></td>
</tr>
<tr>
<td>c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often Includes undermining and tunneling.</td>
<td></td>
</tr>
<tr>
<td>d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device</td>
<td></td>
</tr>
<tr>
<td>d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.</td>
<td></td>
</tr>
<tr>
<td>d.3 Unstageable: Suspected deep tissue injury in evolution.</td>
<td></td>
</tr>
</tbody>
</table>

### (M1308) & (M1309) at Discharge

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:
(Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

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<td></td>
</tr>
<tr>
<td>d.3 Unstageable: Suspected deep tissue injury in evolution.</td>
<td></td>
</tr>
</tbody>
</table>

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:

| Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC |
|                                                                                       | Enter Number |
|                                                                                       | (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC) |
| a. Stage II                                                                          |             |
| b. Stage III                                                                         |             |
| c. Stage IV                                                                          |             |

| Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC |
|                                                                                       | Enter Number |
|                                                                                       | (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC) |
| d. Unstageable due to coverage of wound bed by slough or eschar                       |             |
OASIS-C1: “Status” of “Observable”

• (M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)
  • ONLY those ulcers identified in M1308, row d1 are considered not “Observable” (M1320, Response NA)
  • Rows d2 (slough/eschar) and d3 (suspected DTI) are considered “observable” for this item
## M1320 – Tips for Accuracy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Stage Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Newly epithelialized</td>
<td>(Stage III or IV only)</td>
</tr>
<tr>
<td>1</td>
<td>Fully granulating</td>
<td>(Stage III or IV only)</td>
</tr>
<tr>
<td>2</td>
<td>Early/partial granulation</td>
<td>(Stage III or IV only)</td>
</tr>
<tr>
<td>3</td>
<td>Not healing</td>
<td>(Stage II and higher; suspected DTI)</td>
</tr>
<tr>
<td>NA</td>
<td>No observable pressure ulcer</td>
<td></td>
</tr>
</tbody>
</table>

- Newly epithelialized: Stage III or IV only
- Fully granulating: Stage III or IV only
- Early/partial granulation: Stage III or IV only
- Not healing: Stage II and higher; suspected DTI
- No observable pressure ulcer: Dressing/device only

(<25% necrotic) (≥25% necrotic) (dressing/device only)
OASIS-C1: “Stage” of “Stageable”

- (M1324) Stage of Most Problematic Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury)
- Item Stem Change:
  - OASIS-C: “Stage of Most Problematic (Observable) Pressure Ulcer”
- Ulcers identified in M1308, rows d1, d2, and d3 are all considered NOT “Stageable”
- OASIS-C1 changes provide clarity of differences between pressure ulcers included in M1320 and M1324
**Observable versus Stageable**

☐ Scenario: Mrs. Vermillion has 2 pressure ulcers. A fully granulating and partially epithelialized Stage III ulcer on her sacral area which is progressing well and a pressure ulcer on her right ear that is 100% covered by eschar. Treatment of the ear ulcer is problematic due to the patient’s tendency to lie on that side and her habit of pulling the dressing off to pick at the site.

☐ Which ulcer is the most problematic and what is the appropriate responses to (M1320) and (M1324)?

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### (M1320) Status of Most Problematic Pressure Ulcer that is Observable:
- Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

### (M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable:
- Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - Patient has no pressure ulcers or no stageable pressure ulcers
OASIS-C1: Bathing

• (M1830) Bathing
  • Response 5:
    • OASIS-C: “Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bed side chair, or on commode, with the assistance or supervision of another person throughout the bath”
    • OASIS-C1: removed phrase “throughout the bath” to include patients who require either intermittent or continuous assistance
### M1830 – Tip for Accuracy

#### Bathing: Current ability to wash entire body safely. **Excludes** grooming (washing face, washing hands, and shampooing hair).

- **Tub/Shower (0-3)**
  - **0** - Able to bathe self in *shower or tub* independently, including getting in and out of tub/shower.
  - **1** - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.

- **Other Site (4-5)**
  - **4** - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
  - **5** - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.

- **Pt not active (6)**
  - **6** - Unable to participate effectively in bathing and is bathed totally by another person.

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**“Independently”** in responses 1, 2, & 4 means the patient requires no human assistance for any portion of the activity.

- Patient who can safely bathe self in chair, but requires someone to set up the basin of water is Response 5
OASIS-C1: Plan of Care Synopsis

- (M2250) Plan of Care Synopsis
  - Added new aspect to Depression interventions (row d)
  - OASIS-C: “Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment”
  - OASIS-C1: “Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression”

- Revised “NA – Not Applicable” responses for rows b-g to add detail & improve clarity
  - Row b:
    - OASIS-C: “Patient is not diabetic or is bilateral amputee”
    - OASIS-C1: “Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)”
  - Row c:
    - OASIS-C: “Patient is not assessed to be at risk for falls”
    - OASIS-C1: “Falls risk assessment indicates patient has no risk for falls”

- Row d:
  - OASIS-C: “Patient has no diagnosis or symptoms of depression”
  - OASIS-C1: “Patient has no diagnosis of depression AND depression screening indicates 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”

- Row e:
  - OASIS-C: “No pain identified”
  - OASIS-C1: “Pain assessment indicates patient has no pain”

- Row f:
  - OASIS-C: “Patient is not assessed to be at risk for pressure ulcers”
  - OASIS-C1: “Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers”
OASIS-C1: Plan of Care Synopsis

- (M2250) Plan of Care Synopsis, continued
  - Row g:
    - OASIS-C: “Patient has no pressure ulcers with need for moist wound healing”
    - OASIS-C1: “Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated”

OASIS-C1: Intervention Synopsis

- (M2400) Intervention Synopsis, continued
  - Item Stem: phrase “…since the previous OASIS assessment…” replaced with “at the time or at any time since the previous OASIS assessment…”
  - Response Option:
    - Revised “Not Applicable” responses for all rows to add detail & improve clarity
  - Row a:
    - OASIS-C: “Patient is not diabetic or is bilateral amputee”
    - OASIS-C1: “Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)”

OASIS-C1: Intervention Synopsis

- (M2400) Intervention Synopsis, continued
  - Row b:
    - OASIS-C: “Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment”
    - OASIS-C1: “Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls”

OASIS-C1: Intervention Synopsis

- (M2400) Intervention Synopsis, continued
  - Row c:
    - OASIS-C: “Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment”
    - OASIS-C1: “Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS 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”
OASIS-C1: Intervention Synopsis

• (M2400) Intervention Synopsis, continued
  • Row d:
    • OASIS-C: “Formal assessment did not indicate pain since the last OASIS assessment”
    • OASIS-C1: “Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain”

OASIS-C1: Intervention Synopsis

• (M2400) Intervention Synopsis, continued
  • Row e:
    • OASIS-C: “Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment”
    • OASIS-C1: “Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers”

OASIS-C1: Intervention Synopsis

• (M2400) Intervention Synopsis, continued
  • Row f:
    • OASIS-C: “Dressings that support the principles of moist wound healing not indicated for this patient’s pressure ulcers OR patient has no pressure ulcers with need for moist wound healing”
    • OASIS-C1: “Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated”
### Care Planning with OASIS

- All OASIS items have purpose
  - Patient demographics
  - Quality measurement (outcome & process measures)
  - Risk adjustment of outcomes
  - Case mix calculation (PPS)
  - Comprehensive Assessment (subsequently used to develop the Plan of Care in coordination with the physician)
- The quality measure and case mix items naturally “speak” to a clinician (vision, pain, dyspnea, ADLs, UTI, wound/ulcers, elimination, medications, diagnoses, etc.)
- Typically, these items are a primary focus for clinician education and internal audits

- However, no item should be “thrown away” or regarded as unimportant – OASIS accuracy is vital to agency, clinician, and patient success
- Consider the role of these aspects when care planning:
  - Prior Status – important for goal-setting
  - Risk & Safety – identify disciplines & interventions
  - Supportive Assistance – availability & adequacy

### Prior Status

- **(M1018)** Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days
- **(M1900)** Prior Functioning ADL/IADL
- **(M2040)** Prior Medication Management

- **(M1018)** Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days
  - 1-Urinary incontinence
  - 2-Indwelling/suprapubic catheter
  - 3-Intractable pain
  - 4-Impaired decision-making
  - 5-Disruptive or socially inappropriate behavior
  - 6-Memory loss to the extent that supervision required
  - NA-No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
  - UK-Unknown
### Prior Status

**• (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days, continued**

- NA response (“and” - both criteria must be met)
- Logic/consistency with (M1000) Inpatient Facilities and (M1017) Diagnoses Requiring Medical or Treatment Regimen Change within Past 14 Days
- This response is occasionally seen with readmit situations
- Consider whether and how diagnoses documented here will impact the home care Plan of Care

**Potential relationship between this item and other OASIS items**

- (M1610) Urinary Incontinence & Urinary Catheter presence
- (M1240) Pain Assessment
- (M1242) Frequency of pain Interfering

**• (M1018) Responses 1 & 2: (M1740) Cognitive, behavioral, and psychiatric symptoms**

### Prior Status

**• (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days, continued**

- The presence or absence of these conditions PRIOR to this episode
- Should be considered when evaluating patient’s potential for improvement
  - For example, if the patient did not have incontinence prior (M1018) but does have incontinence currently (M1610) – what disciplines & interventions might be appropriate to address this “new” incontinence?

**Intractable pain: (OASIS Q&A43.2)**

- Occurs at least daily, is not easily relieved, and affects the patient’s sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability to perform physical activity
- Note definition does NOT state “pain is ever present”
- Not relieved by ordinary medical, surgical, and nursing measures
- Often chronic and persistent and can be psychogenic in nature

**• (M1018) Responses 4, 5 & 6: (M1740) Cognitive, behavioral, and psychiatric symptoms**
Prior Status

- (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days, continued
  - More on Intractable pain:
    - (M1240) Pain Assessment: select response 1 or 2 based on the pain reported at the time the standardized, validated tool was administered, per the tool’s instructions
    - Document presence or absence of logic/consistency of responses to (M1018) and (M1240)
    - It is possible to have “intractable pain” in M1018 & not have “severe pain” in M1240

Prior Status

- (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days, continued
  - More on Intractable pain:
    - (M1242) Frequency of Pain Interfering with patient’s activity or movement
      - Pain interferes with activity when the pain results in the activity being performed less often than desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete.
      - Include all activities (e.g., sleeping, recreational activities, watching television), not just ADLs
      - By definition, intractable pain occurs at least daily and affects the patient’s energy, sleep, activity, etc.
      - Logically, the consistent M1242 response would be 3 (daily, but not constantly) or 4 (all of the time)

Prior Status

- (M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within Past 14 Days, continued
  - The presence or absence of these conditions PRIOR to this episode, continued
  - (M1740) Cognitive, behavioral, and psychiatric symptoms
    - M1740 responses 1, 2, and 5 correlate with M1018
    - Consider patient’s potential to participate in the POC and safety concerns
      - For example, when a patient has significant memory loss so that supervision is required, teaching & training may be appropriate for caregiver (but not patient)
      - Does the impaired decision-making manifest itself in a manner that can be addressed with home care interventions?

Prior Status

- (M1900) Prior Functioning ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury
  - a. Self-care (specifically: grooming, dressing, bathing, and toileting hygiene)
  - b. Ambulation
  - c. Transfer
  - d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)
Prior Status

• (M1900) Prior Functioning ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to this current illness, exacerbation, or injury, continued
  • “Independent” means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper
  • “Needed Some Help” means that the patient contributed effort but required help from another person to accomplish the task/activity safely
  • “Dependent” means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort

Prior Status

• (M2040) Prior Medication Management: Indicate the patient’s usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation, or injury
  • Oral Medications
  • Injectable Medications
  • Includes all prescribed and OTC oral medications and all prescribed injectable medications that the patient is currently taking and are included on the plan of care

Prior Status

• Identify the patient’s prior ABILITY, not necessarily actual performance
• Ambulation refers to walking (with or without assistive device). Wheelchair mobility is not directly addressed. A patient who is unable to ambulate safely (even with devices and/or assistance), but is able to use a wheelchair (with or without assistance) would be reported as “Dependent” in Ambulation for M1900
• Transfer refers to tub/shower, toilet/commode, and bed/Chair transfers

Prior Status

• If the patient was previously independent in some self-care tasks (or some transfer, or some household tasks), but needed help or was completely dependent in others, pick the response that best describes the patient’s level of ability to perform the majority of included tasks
  • This guidance differs from that for similar item M2040
Prior Status

(M2040) Prior Medication Management, continued

• “Independent” means that the patient completed the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper or reminders from another person (reminders provided by a device that the patient can independently manage are not considered “assistance” or “reminders”)

• “Needed Some Help” means that the patient required some help from another person to accomplish the task/activity

• “Dependent” means that the patient was incapable of performing any of the task/activity. For oral medications, this means that the patient was capable only of swallowing medications that were given to her/him. For injectable medications, this means that someone else must have prepared and administered the medication.

Risk & Safety

(M1033) Risk for Hospitalization

(M1240) Pain Assessment

(M1300) Pressure Ulcer Assessment

(M1730) Depression Screening

(M1910) Falls Risk Assessment

[NOTE: Safety assessment is integral to other OASIS items not discussed in this presentation; including ADL/IADL, Medication Management, Neuro/Emotional/Behavioral, etc.]

Risk & Safety

(M1033) Risk for Hospitalization

- 1-History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- 2-Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3-Multiple hospitalizations (2 or more) in the past 6 months
- 4-Multiple emergency department visits (2 or more) in the past 6 months
- 5-Decline in mental, emotional, or behavioral status in the past 3 months
- 6-Reported or observed history of difficulty complying with any medical instruction (for example, medications, diet, exercise) in the past 3 months

[continued]
Risk & Safety

(M1033) Risk for Hospitalization, continued
- 7-Currently taking 5 or more medications
- 8-Currently reports exhaustion
- 9-Other risk(s) not listed in 1-8
- 10-None of the above

Include specific care planning to prevent hospitalization during the home care episode (targeting those risks identified in responses 1-9)

(M1240) Has this patient had a formal Pain Assessment using a standardized, validated pain assessment tool (appropriate to the patient’s ability to communicate the severity of pain)
- 0-No standardized, validated assessment conducted
- 1-Yes, and it does not indicate severe pain
- 2-Yes, and it does indicate severe pain

Risk & Safety

(M1240) Pain Assessment, continued
- Intent: identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used
- Variety of standardized, validated tools
  - Appropriate to patient’s ability to communicate the severity of pain
  - Visual analog, Wong-Baker FACES, numerical scales, Memorial Pain Assessment Card, PAIN-AD

Risk & Safety

(M1240) Pain Assessment, continued
- Chapter 3: Select Response 1 or 2 based on the pain reported at the time the standardized tool was administered
  - OASIS Q70.3. Is the intention of M1240 to identify whether a clinically significant pain is present at the time the pain assessment is conducted regardless of the activity level at the time (i.e., using a numeric pain scale, ask the patient to rate his pain this moment) or the presence of clinically significant pain on the day of assessment (i.e., using a numeric pain scale, ask the patient to rate his pain on the average for the day of assessment)?

[REMEMBER: “day of assessment” is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home]
Risk & Safety (M1240) Pain Assessment, continued

• A70.3. Pain Assessment reports if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized pain assessment tool... The response options then report either “No” that the standardized assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not, at the time of the standardized assessment, per the assessment's scale... The response is not necessarily a reflection of the average or summary of the pain experienced on the day of assessment... The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the plan of care....

Risk & Safety (M1240) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

- 0-No assessment conducted
- 1-Yes, based on an evaluation of clinical factors (for example: mobility, incontinence, nutrition) without use of standardized tool
- 2-Yes, using a standardized, validated tool (for example: Braden Scale, Norton Scale)

Risk & Safety (M1300) Pressure Ulcer Assessment [Example: Braden]

• Sensory Perception: ability to respond meaningfully to pressure-related discomfort
• Moisture: degree to which skin is exposed to moisture
• Activity: degree of physical activity
• Mobility: ability to change and control body position
• Nutrition: usual food intake pattern
• Friction & Shear

Risk & Safety (M1300) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

- 0-No
- 1-Yes, patient was screened using the PHQ-2 scale
- 2-Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression
- 3-Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression
Risk & Safety
• (M1730) Depression Screening, continued
  • Chapter 3 Guidance:
    • Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others
    • If a standardized depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation
    • OASIS Q&A 124.5. The PHQ-2 tool is a standardized, validated screening tool in which the patient is the source of report
    • If the PHQ-2 is not used, choose a tool with instructions that allow for information to be gathered by observation and/or caregiver interview as well as self-report
  • The Cornell Screen for Depression in Dementia (CSDD) is a validated tool that could be used in this patient population

Risk & Safety
• (M1910) Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?
  □ 0-No
  □ 1-Yes, and it does not indicate a risk for falls
  □ 2-Yes, and it does indicate a risk for falls
• Intent: The multi-factor falls risk assessment must include at least one standardized tool
• Use the scoring parameters specified in the tool to identify if a patient is at risk for falls

Risk & Safety
• (M1910) Falls Risk Assessment, continued
  • OASIS January 2013 Q&A 13: If more than one falls risk tool is used (for example, the MAHC-10 and the TUG) and the findings differ:
    1. Determine whether either tool meets the best standard practice criteria (validated, standardized, & multifactor).
    2. If more than one validated/standardized/multifactor tool was used and findings differ, report findings from the tool that indicate patient is “at risk” for falls.
    3. In this example, two validated tools were used
      • TUG – a single factor assessment tool
      • MAHC-10 – a multi-factor assessment tool (M1910 response should be based on these findings)
    4. If agency uses a single factor, validated tool (e.g., TUG) with another factor or non-validated tool to meet multi-factor requirement, score based on the validated tool.

Risk & Safety
• (M1910) Falls Risk Assessment, continued
  • Consider logic/consistency between the Falls Risk tool and OASIS items (such as the ADL/IADLs)
    • For example, when TUG is >14 seconds (high risk), this is a safety concern that should be considered while determining accurate response to (M1860) Ambulation/Locomotion (and other activities in which an ambulatory person is getting to/from the toilet, obtaining clothing items, etc.)
    • MAHC-10 tool includes incontinence, vision, functional mobility, pain affecting function, and cognitive impairment
Supportive Assistance

- M1100) Patient Living Situation
- M2102) Types and Sources of Assistance
- M2110) How Often ADL or IADL assistance

Supportive Assistance

- M1100) Patient Living Situation: Which of the following best describes the patient’s residential circumstance and availability of assistance?
  - Living Arrangement (rows)
    a. Patient lives alone
    b. Patient lives with other person(s) in the home
    c. Patient lives in congregate situation (for example: assisted living, residential care home)
  - Availability of Assistance (columns)
    a. Around the clock
    b. Regular daytime
    c. Regular nighttime
    d. Occasional/short-term assistance
    e. No assistance available

Supportive Assistance

- M1100) Patient Living Situation, continued
  - Living Arrangement (rows): report the patient’s usual status prior to the illness, injury, or exacerbation for which the patient is receiving care
  - Availability of Assistance (columns): refers to the expected availability and willingness of (non-agency) caregivers to provide in-person assistance in upcoming care episode
  - Common error: selecting response box 1 when patient “lives alone around the clock”
  - Response box 1 does NOT indicate “patient lives alone around the clock”
  - Response box 1 indicates “patient lives alone” and with “around the clock availability of in-person assistance”

Supportive Assistance

- M1100) Patient Living Situation, continued
  - This item documents the time caregivers are in the home and available
  - Without regard to the amount or types of assistance the patient requires
  - Whether or not the caregivers are able to meet all or only some of the patient’s needs
  - Adequacy of caregiver assistance for different types of needs is captured in another item (Types & Sources of Assistance)
Supportive Assistance

- (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.
  - Categories of Assistance (rows)
    a. ADL assistance
    b. IADL assistance
    c. Medication administration
    d. Medical procedures/treatments
    e. Management of equipment
    f. Supervision and safety
    g. Advocacy or facilitation of patient’s participation in appropriate medical care

- Sources of Assistance (columns)
  - No assistance needed – patient is independent or does not have needs in this area
  - Non-agency caregiver(s) currently provide assistance
  - Non-agency caregiver(s) need training supportive services to provide assistance
  - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
  - Assistance needed, but no non-agency caregiver(s) available

At SOC/ROC, report what is known on the day of assessment regarding the availability and ability of caregivers to provide help in the various categories of assistance (rows) for the upcoming episode.

At Discharge, report what is known on the day of assessment regarding the availability and ability to provide assistance to the patient at the time of discharge.

If patient needs assistance with any aspect of a category of assistance (such as needs assistance with some IADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregivers to meet that need.

Supportive Assistance

- (M2110) How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?
  - At least daily
  - Three or more times per week
  - One to two times per week
  - Received, but less often than weekly
  - No assistance received
  - Unknown

UK-Unknown
Supportive Assistance

- (M2110) How Often ADL or IADL, continued
  - Identifies frequency of assist with ADLs (for example, bathing, dressing, toileting, transferring, ambulating, feeding) or IADLs (for example, medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers
  - This item is concerned broadly with ADLs and IADLs, not just those specified in other OASIS items
  - Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet
  - IADLs are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone
  - Select the response that reports how often the patient receives assistance with any ADL or IADL

Supportive Assistance

Compare & Contrast:
- (M1100) Patient Living Situation (one response)
  - Patient’s residential environment and the availability of non-agency caregivers to provide any in-person assistance
- (M2102) Types and Sources of Assistance (one response in each category of assistance)
  - Identifies specific broad categories of assistance and the availability & ability of non-agency caregivers to provide assistance in each category
- (M2110) How Often ADL or IADL assistance
  - Frequency that the patient receives assistance with any ADL/IADL from non-agency caregivers
  - No assumed logic exists between these 3 items
Supportive Assistance

- SCENARIO: Elderly patient with history of falls lives with her adult, handicapped son who does not routinely leave the home due to severe mental and physical limitations. He is able to prepare coffee, pb&j sandwiches, & ramen noodles for the two of them and would be able to use the telephone to call 911 in an emergency. He does not have the mental capacity to assist otherwise. Patient’s medications are delivered monthly by the pharmacy and are pre-sorted into a medication dispensing system – allowing the patient to safely manage her medications. A friend lives out of town, but visits monthly to stock the pantry, do laundry, and help with bill payment. This friend also takes responsibility for helping the patient get to her physician as needed. Home care is needed for Physical Therapy because patient exhibits unsafe performance in all ADL/IADLs. A walker has been ordered and is scheduled for delivery tomorrow.
(M1100) **Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>□ 01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>□ 06</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example, assisted living, residential care home)</td>
<td>□ 11</td>
</tr>
</tbody>
</table>

(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. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed – patient is independent or does not have needs in this area</th>
<th>Non-agency caregiver(s) currently provide assistance</th>
<th>Non-agency caregiver(s) need training/supportive services to provide assistance</th>
<th>Non-agency caregiver(s) are not likely to provide assistance or it is unclear if they will provide assistance</th>
<th>Assistance needed, but non-agency caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>b. IADL assistance (for example, meals, housekeeping, laundry, telephone, shopping, finances)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>c. Medication administration (for example, oral, inhaled or injectable)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>d. Medical procedures/treatments (for example, changing wound dressing, home exercise program)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>e. Management of Equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>f. Supervision and safety (for example, due to cognitive impairment)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>g. Advocacy or facilitation of patient's participation in appropriate medical care (for example, transportation to or from appointments)</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
</tbody>
</table>

(M2110) **How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?**

- □ 1 - At least daily
- □ 2 - Three or more times per week
- □ 3 - One to two times per week
- □ 4 - Received, but less often than weekly
- □ 5 - No assistance received
- □ UK - Unknown
Supportive Assistance

• (M1100) Patient Living Situation:
  • Response box 6 (patient lives with other person in
    the home; son provides around the clock
    availability for in-person assistance)

• (M2102) Types and Sources of Assistance
  a. ADL assistance: 4 – Assistance needed, but no
     non-agency caregiver available (son is
     unwilling/unable to assist with these activities)
  b. IADL assistance: 1 – Non-agency caregivers
     currently provide assistance (son is able to
     prepare light meals, other IADLs such as finances,
     shopping, laundry, and housekeeping are
     performed monthly by friend)
  c. Medication administration: 0 – No assistance
     needed – patient is independent or does not have
     needs in this area (per M2020 guidance in Q167.2,
     special packaging performed by the pharmacist
     does not necessarily make the patient
     dependent; once medications are in the home,
     patient requires no assistance to safely manage
     medications)
  d. Medical procedures: 0 (No needs in this area)
  e. Management of Equipment: 4 – assistance
     needed, but no non-agency caregivers available
     (son will most likely not be able to provide
     assistance with walker)

  f. Supervision and safety: 3 – Non-agency
     caregiver(s) not likely to provide assistance OR
     it is unclear if they will provide assistance (due
     to son’s physical and cognitive limitations,
     although he does know how to respond to the
     smoke detector & other emergencies and
     verbalized/demonstrated willingness and ability
     to dial 911, there are questions raised per
     clinician’s judgment)
  g. Advocacy or facilitation: 1 – Non-agency
     caregiver(s) currently provide assistance (out-of-
     town friend)

• (M2110) How Often ADL or IADL assistance
  • Response 1 – At least daily (son prepares coffee and
    light meals)

• Logic and adequacy of documentation to support POC
  • Additional documentation is needed to thoroughly
    describe this patient’s supportive assistance
  • She has “around the clock” assistance (M1100), but
  • (M2102) indicates “Assistance needed, but no caregiver
    available” in ADL assistance, yet
  • Patient receives daily ADL or IADL assistance in (M2110).
  • Without additional documentation describing exactly WHO
    does WHAT and WHEN, these item responses are insufficient
    to adequately describe this patient’s situation
Final Thought: OASIS & ICD-10

Transitional version: OASIS-C1/ICD-9

- The “transitional” OASIS-C1/ICD-9 version
- Effective January 1, 2015
- Slated to be replaced by the “original” OASIS-C1 version
- No earlier than October 1, 2015 – to coincide with transition to the ICD-10-CM diagnosis code set
- Accommodate the 7-digit format of ICD-10 codes
- OASIS changes associated with transition to ICD-10]
- PPS Grouper
- OASIS Guidance Manual
- OASIS Q&As
- Expect change – except from vending machines!

Resources

- OASIS-C1/ICD-9 Guidance Manual
- OASIS Q&As (June 2014 set)
  - https://www.qtsco.com/hhatrain.html
QUESTIONS?

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