OASIS-C2

OASIS Accuracy: Sharpening Your Skills
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OASIS-C2
SHARPEN YOUR SKILLS

DISCLOSURES

• In order to successfully complete this educational activity, you must:
  ✓ Participate the entire activity
  ✓ Complete the evaluation

Disclosures

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OBJECTIVES OF THIS SESSION

• Recognize the significance of OASIS accuracy in relation to outcomes, HHRG scores, Star ratings, and Value Based Purchasing.

• Demonstrate best practice measures for patient assessment and OASIS data collection.

• Identify common errors in selecting OASIS Item responses.

• Document assessment findings correctly following CMS guidance for OASIS Items impacting outcomes, Star ratings, and reimbursement.

OASIS QUALITY OUTCOMES AND STAR RATINGS

Home Health Compare Star Ratings
Six OASIS Quality Outcome Measures:
✓ M1242 – Improvement in pain.
✓ M1400 – Improvement in dyspnea.
✓ M1830 – Improvement in bathing.
✓ M1850 – Improvement in transferring.
✓ M1860 – Improvement in ambulation.
✓ M2410 – Acute care hospitalization rate.

The first five are frequently answered incorrectly!

OASIS QUALITY OUTCOMES AND STAR RATINGS

Home Health Compare Star Ratings
Three OASIS Process Measures:
✓ Timely initiation of care (M0102/M0104)
✓ Drug education provision on all medications (M2015)
✓ Influenza vaccination for the current flu season (M1046)
VALUE BASED PURCHASING

- Reimbursement impacted by outcomes:
  - Began January 1st, 2016 in nine states.
  - Five-year demonstration with payments impacted in 2018.
  - Likely to be expanded in some form to other states as the IMPACT act requires payment to be tied to quality at an increasing percentage rate over the next 2 years.

- Commonly missed OASIS Items used in calculations that aren’t impacted by OASIS-C2 changes:
  - Improvement in Pain (M1242)
  - Improvement in Dyspnea (M1400)
  - Improvement in Bathing (M1830)
  - Improvement in Transferring (M1850)
  - Improvement in Ambulation (M1860)
  - Improvement in Oral Med Management (M2020)

M0102-PHYSICIAN ORDERED SOC/ROC DATE & M0104-DATE OF REFERRAL

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): if the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐ Go to M0110, if date entered
☐ NA - No specific SOC date ordered by physician

(M0104) Date of Referral: indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

☐ UK - Unknown

M0102-PHYSICIAN ORDERED SOC/ROC DATE & M0104-DATE OF REFERRAL

- What counts as a valid referral?
  - COPs require patient to be “under the care of a physician”.
  - Referral must be made by a physician who is willing to follow the patient and has provided adequate information to contact the patient.
  - When a hospitalist or other facility physician orders home care but will not follow home care, the date the PCP or other attending physician gives an order for home health services becomes the M0104 date (unless this physician gives a specific M0102 date).

- What if there is a delay in inpatient discharge?
  - Verify the updated referral date is entered into the EMR if this will default into M0102 or M0104.
  - Referral date is the last day updated discharge orders are received, including discharge medication orders.
M0102 - PHYSICIAN ORDERED SOC/ROC
DATE & M0104 - DATE OF REFERRAL

• What if there is a delay in SOC?
  ✓ Verify the updated referral date is entered into the EMR if this will
default into M0102 or M0104.
  ✓ Physician should be contacted before the end of the 48 hour window
  following inpatient discharge or referral. Determine if a delay in SOC
  is medically acceptable for the patient and obtain an order for a new
  SOC date (M0102). This new order must be received within the time
  frame to impact M0102/M0104.

• How is ROC different?
  ✓ Patient must be seen within 48 hours of inpatient discharge.
  ✓ M0102 date cannot be outside of the 48 hour window.
  ✓ If the physician ordered SOC date is outside of the 48 hour window,
    contact the physician to determine if an order to see patient within the
    48 hour window can be obtained.

• What if insurance changes or new SOC is needed due to a late Face to
  Face visit?
  ✓ Mark M0102 “N/A” and complete M0104 with the date one day prior to
    the new SOC date.

Test Your Understanding…

• Mr. Anderson was admitted to the hospital on 9/1/16 after tripping on a
  curb and sustaining a mild concussion with an open wound on his knee.
• He was transferred to a SNF on 9/3/16 for wound care and physical
  therapy due to difficulty walking following his fall.
• A faxed referral from the SNF physician was received by the home health
  agency on 9/12/16 indicating Mr. Anderson would likely be discharged on
  9/16.
• On 9/15 the patient’s discharge order and homegoing medication list
  were faxed to the office.
• The intake nurse reached Mr. Anderson’s physician on 9/17 and received
  an order to begin home care on 9/19.

How should M0102/M0104 be answered?

M0102 - PHYSICIAN ORDERED SOC/ROC
DATE & M0104 - DATE OF REFERRAL

(M0102) Date of Physician-ordered Start of Care (Resumption of Care):
If the physician indicated a specific start of care (resumption of
care) date when the patient was referred for home health services,
record the date specified.

☐ / / [Go to M0110, if date entered]
☐ NA - No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for
initiation or resumption of care was received by the HHA.

Answer:
M0102 = 09/19/2016
M0104 = Will be skipped [Go to M, if date entered]
Mr. Anderson was admitted to the hospital on 9/1/16 after tripping on a curb and sustaining a mild concussion with an open wound on his knee. He was transferred to a SNF on 9/3/16 for wound care and physical therapy due to difficulty walking following his fall. A faxed referral from the SNF physician was received by the home health agency on 9/12/16 indicating Mr. Anderson would likely be discharged on 9/16. On 9/15 the patient’s discharge order and homegoing medication list were faxed to the office. The intake nurse reached Mr. Anderson’s physician on 9/17 and received an order to begin home care on 9/19.

OASIS C1:
(M1242) Frequency of Pain Interfering with patient’s activity or movement:
- 0 - Patient has no pain.
- 1 - Patient has pain that does not interfere with activity or movement.
- 2 - Less often than daily
- 3 - Daily but not constantly.
- 4 - All of the time

OASIS C2:
(M1242) Frequency of Pain Interfering with patient’s activity or movement:

What does CMS define “interfering” and “activity”?
- Interfering means the activity is not done, done less often, done differently, takes longer to do, or assistance is needed for the activity.
- Activity includes sleeping, eating, hobbies, leisure activities.

What changes are in the 2017 Home Health Prospective Payment System?
- One additional clinical point in 1st or 2nd episodes with 0-13 therapy visits.

What should be assessed?
- Pain present on the day of assessment and recent pertinent past.
- All pain, not just pain related to reason for hospitalization or homecare. Acute pain may be controlled while chronic pain still remains or may cause more interference with activity.
**M1242 – PAIN INTERFERING WITH ACTIVITY**

- What impacts how pain is captured?
  - When a patient restricts activities to limit pain, report how often the patient must do this.
  - Respond to M1242 taking into account any treatment prescribed, as the effectiveness of the treatment may impact the response.
  - When a patient takes medication to limit pain, report how often the patient’s activities are still affected or limited by pain.
  - When a patient uses a device to decrease interference of pain, report how often pain is still limiting activity.

- How should I assess pain?
  - Be sure to assess pain while the patient moves through their environment, not just while at rest.
  - Use a standardized assessment tool whenever possible.
  - Base response upon patient report of pain, but also non-verbal s/s, clinician observation, and caregiver input.

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**Test Your Understanding…**

- Mrs. Davies is a 94 year old woman who fell and injured her left hip while climbing the four stairs from her garage to kitchen entry. She went to the ED where x-rays were negative. Although able to walk with a walker borrowed from her sister, a home health physical therapy evaluation has been ordered.

- At the SOC visit she informs the physical therapist she doesn’t have any pain and states, “I can get around just fine.” While sitting at the table reviewing her medications she does not appear to be in pain and reports she slept most of the night.

- During the OASIS Walk® the PT notes the patient to be favoring her right leg and grimacing with ambulation and transfers. A heating pad is noted on the left side of the seat of her favorite rocking recliner chair.

- She agrees to two weeks of home therapy and indicates, “I’ll do it because I’m not going to have some social worker coming out here to send me to a nursing home.”

**How should M1242 be answered?**

**Key Information…**

- M1242 = 3-Daily but not constantly

- While sitting at the table reviewing her medications she does not appear to be in pain and reports she slept most of the night.

- During the OASIS Walk® the PT notes the patient to be favoring her right leg and grimacing with ambulation and transfers. A heating pad is noted on the left side of the seat of her favorite rocking recliner chair.

- She agrees to two weeks of home therapy and indicates, “I’ll do it because I’m not going to have some social worker coming out here to send me to a nursing home.”
M1400 – DYSPNEA

OASIS C1:

(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 (for example, while dressing, using commode or bedpan, walking distances less than 20 feet).
□ 3  - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation.
□ 4  - At rest (during day or night).

OASIS C2:

(M1400) When is the patient dyspneic or noticeably Short of Breath?

Enter Code

0  Patient is not short of breath.
1  When walking more than 20 feet, climbing stairs.
2  With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet).
3  With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation.
4  At rest (during day or night).

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M1400 – DYSPNEA

• What changes are in the 2017 Home Health Prospective Payment System?
  ✔ No more clinical points for dyspnea, but still important for star ratings, publically reported outcomes, and Value Based Purchasing.

• What factors contribute to dyspnea?
  ✔ Disease states and temporary conditions such as a fracture that make mobility difficult.
  ✔ Anxiety, fear, and morbid obesity.

• How should I assess dyspnea/shortness of breath?
  ✔ Observe the patient moving through their environment and when dressing/undressing for the physical examination.
  ✔ Include dyspnea present at the time of assessment and during the preceding 24 hours.
  ✔ Interview the patient and caregiver.

• What about chairbound and bedbound patients?
  ✔ Also assessed while performing ADLs or at rest.
  ✔ Chairbound: Mark “1” when dyspnea is only present with physically demanding transfer activities.
  ✔ Bedbound: Mark “1” when dyspnea is only present with demanding bed mobility activities.

• What about patient’s who wear oxygen?
  ✔ Determine if the patient wore their oxygen continuously, intermittently, or not at all in the 24 hours preceding the visit, regardless as to whether the physician ordered oxygen to be used intermittently or continuously.
  ✔ Worn Continuously: Report what level of activity caused dyspnea when wearing oxygen.
  ✔ Worn Intermittently or Not At All: Report what level of activity caused dyspnea without use of oxygen.
M1400 - DYSPNEA

- What if they have dyspnea during some but not all ADLs?
  - ADLs requiring minimal effort are reflected in response 3.
  - ADLs requiring moderate exertion are reflected in response 2.
- What if they have changed their environment or activity level?
  - Response will reflect how often dyspnea is still present after modifying the environment.
  - When patient regularly stops and rests before dyspnea begins, then dyspnea isn’t present at those times.
  - When dyspnea is relieved by propping with pillows or sleeping in a recliner, capture any other instances of dyspnea still present.
  - Mark “4-All of the time” when dyspnea can’t be relieved by propping with pillows or sleeping in a recliner, even if dyspnea isn’t present at all other times.

Test Your Understanding...

Mr. Jackson has been referred for home health nursing care following exacerbation of his COPD with superimposed pneumonia. He reports to the SOC nurse that he took his last antibiotic just prior to his arrival.

- The referral indicates new aerosols have been ordered and there is an order for 2L of Oxygen via nasal cannula continuously. Mr. Jackson states he only wears his oxygen when he is sitting or lying down as he’s afraid of tripping over the tubing.
- Mr. Jackson is short of breath when walking from the bathroom to the bedroom, a distance of approximately 15 feet. After resting on the edge of the bed he begins unbuttoning the front of his shirt and sleeves and becomes dyspneic again, but takes regular breaks as he undresses and is able to undress himself independently.

How should M1400 be answered?
Assess with or without oxygen in place?

- Assess With or Without Oxygen = Without, as patient is using intermittently
- M1400 = 3-With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation

Key Information...

- The referral indicates new aerosols have been ordered and there is an order for 2L of Oxygen via nasal cannula continuously. Mr. Jackson states he only wears his oxygen when he is sitting or lying down as he’s afraid of tripping over the tubing.
- Mr. Jackson is short of breath when walking from the bathroom to the bedroom, a distance of approximately 15 feet. After resting on the edge of the bed he begins unbuttoning the front of his shirt and sleeves and becomes dyspneic again, but takes regular breaks as he undresses and is able to undress himself independently.
WHAT CAN THE PATIENT DO SAFELY?

- What is CMS trying to learn about the patient?
  - What can the patient SAFELY do?
  - Are they physically and mentally able to care for themselves in their home environment and do they have any assistance?
  - NOT “but they’re doing it now” or “they’re not willing to do that” or “but that’s what they said they can do.”

M1810 AND M1820 – DRESSING

OASIS C1:
(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
- □ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- □ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- □ 2 - Someone must help the patient put on upper body clothing.
- □ 3 - Patient depends entirely upon another person to dress the upper body.

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
- □ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- □ 1 - Able to dress lower body without assistance if clothing is laid out or handed to the patient.
- □ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons and shoes.
- □ 3 - Patient depends entirely upon another person to dress the lower body.

M1810 & M1820 – DRESSING

OASIS C2:

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

| 0 | Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. |
| 1 | Able to dress upper body without assistance if clothing is laid out or handed to the patient. |
| 2 | Someone must help the patient put on upper body clothing. |
| 3 | Patient depends entirely upon another person to dress the upper body. |

(M1820) Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

| 0 | Able to obtain, put on, and remove clothing and shoes without assistance. |
| 1 | Able to dress lower body without assistance if clothing is laid out or handed to the patient. |
| 2 | Someone must help the patient put on undergarments, slacks, socks or nylons and shoes. |
| 3 | Patient depends entirely upon another person to dress the lower body. |
M1810 & M1820 – DRESSING

• What changes are in the 2017 Home Health Prospective Payment System?
  ✓ Decreases from two to one functional point in 1st or 2nd episode with 0-13 therapy visits.
  ✓ All points for the combination of M1810 ≥ 1 with a Neurological diagnosis will be removed.

• What impacts ability to dress?
  ✓ Pain may impair ability to dress independently, but dyspnea delaying the process cannot be factored into the response.
  ✓ Ability to SAFELY access clothing and SAFELY put it on and take it off.

M1810 & M1820 – DRESSING

• How should I assess independence in dressing?
  ✓ Determine if they’ve changed into new clothing since returning home.
  ✓ Determine if they’ve had to modify their usual clothing worn and if this will be a permanent change.
  ✓ Determine ability to select all needed clothing items appropriate to the season.

• What should the response reflect?
  ✓ Report level of independence with putting on and taking off the majority of clothing items worn.
  ✓ Consider splints, braces, orthotics, and wraps applied for compression.
  ✓ Don’t reflect wraps used as a part of a dressing.

Test Your Understanding...

Mrs. Simpson has returned to home care following readmission to the hospital following a CVA with right hemiplegia. She spent five weeks in an inpatient rehabilitation facility working with therapists to regain function.

At the SOC visit Mrs. Simpson is dressed in her pajamas but asks the therapist to bring her regular clothing over to the bed after her skin check.

She proudly demonstrates to the physical therapist how she “learned all the tricks” and can use her dressing aids to put on both upper and lower body clothing.

She explains she’s going to wear elastic waist jeans and dress pants from now on along with Velcro-closure shoes to take care of herself.

How should M1810 and M1820 be answered?
M1810 & M1820 – DRESSING

Key Information...

- At the SOC visit Mrs. Simpson is dressed in her pajamas but asks the therapist to bring her regular clothing over to the bed after her skin check.
- She proudly demonstrates to the physical therapist how she “learned all the tricks” and can use her dressing aids to put on both upper and lower body clothing.
- She explains she’s going to wear elastic waist jeans and dress pants from now on along with Velcro-closure shoes to take care of herself.

M1830 – BATHING

OASIS C1:

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.
2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders; OR (b) to get in and out of the shower or tub; OR (c) for washing difficult to reach areas.
3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
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.
6 - Unable to participate effectively in bathing and is bathed totally by another person.
M1830 – BATHING

OASIS C2:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Able to bathe self in shower or tub independently, including getting in and out of the shower/tub.</td>
</tr>
<tr>
<td>4</td>
<td>Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminder.</td>
</tr>
<tr>
<td>5</td>
<td>Able to bathe in shower or tub with the intermittent assistance of another person: (b) to get in and out of the shower/tub.</td>
</tr>
<tr>
<td>6</td>
<td>Able to bathe in shower or tub with the intermittent assistance of another person: (c) for assistance in personal care.</td>
</tr>
<tr>
<td>7</td>
<td>Unable to use the shower or tub, but able to bathe with independent assistance or without the use of devices at the sink, in chair, or on commode.</td>
</tr>
<tr>
<td>8</td>
<td>Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in chair, or on commode, with the assistance or supervision of another person.</td>
</tr>
<tr>
<td>9</td>
<td>Unable to participate effectively in bathing and is bathed entirely by another person.</td>
</tr>
</tbody>
</table>

M1830 – BATHING

• What changes are in the 2017 Home Health Prospective Payment System?
  ✓ M1830 ≥ 2: Episodes with ≥ 14 therapy visits: Increases from two to six functional point in 1st or 2nd episode, and from zero to two points in 3rd or later episodes.
  ✓ M1830 ≥ 2: Points when combined with a diagnosis of MS will be removed except in 1st or 2nd episodes with ≥ 14 therapy visits — and then it decreases from ten to eight clinical points.

M1830 – BATHING

• What impacts the ability to bathe independently?
  ✓ Inability to access the tub/shower or non-functional tub/shower.
  ✓ Need for assistance to get to the tub/shower.
  ✓ Physician has ordered “No showers or baths.”
  ✓ Mental, cognitive, and emotional barriers.
  ✓ Fear that is a realistic barrier to transferring into/out of or using the tub/shower.
  ✓ Sensory impairments such as vision or pain.
  ✓ Need for assistance to cover a dressing/wound/cast.

• How should I assess ability to bathe independently?
  ✓ Have the patient demonstrate transferring in/out of the tub/shower if this is safe to attempt, even if patient is sponge bathing as a personal choice.
  ✓ Assess ability based upon the assistive devices the patient already has available. Don’t assume they could safely bathe if they were to have a new assistive device.
M1830 – BATHING

Test Your Understanding…

• Mr. Abraham has been referred for home health nursing, physical therapy, and occupational therapy services. Five weeks prior to SOC he inadvertently filled his medication planner with both the generic and trade-name versions of his anti-hypertensive pills, became dizzy, and fell getting into the shower. He sustained a severe sprain of his right knee and went to a SNF for two weeks to rehabilitate.

• At SOC Mr. Abraham explains to the nurse that the day of discharge he was able to sponge bathe himself with the exception of his right lower leg due to leg pain and stiffness. The day prior to admission his daughter came over to help him shower using his new shower chair. He reports feeling very anxious and states he nearly fell twice when transferring because he was so scared.

• The nurse finds the bathroom to be well equipped with grab bars and an appropriately adjusted shower chair, along with a long-handled shower head.

• During the OASIS Walk® Mr. Abraham shows good safety awareness, walks safely with his cane, and performs his bed transfer with minimal assistance from supine to sit. Additionally, he’s able to retrieve his clothing and dress himself independently using his assistive equipment.

How should M1830 be answered?

M1830 = 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.

M1830 – BATHING

Key Information…

• Mr. Abraham has been referred for home health nursing, physical therapy, and occupational therapy services. Five weeks prior to SOC he inadvertently filled his medication planner with both the generic and trade-name versions of his anti-hypertensive pills, became dizzy, and fell getting into the shower. He sustained a severe sprain of his right knee and went to a SNF for two weeks to rehabilitate.

• At SOC Mr. Abraham explains to the nurse that the day of discharge he was able to sponge bathe himself with the exception of his right lower leg due to leg pain and stiffness. The day prior to admission his daughter came over to help him shower using his new shower chair. He reports feeling very anxious and states he nearly fell twice when transferring because he was so scared.

• The nurse finds the bathroom to be well equipped with grab bars and an appropriately adjusted shower chair, along with a long-handled shower head.

• During the OASIS Walk® Mr. Abraham shows good safety awareness, walks safely with his cane, and performs his bed transfer with minimal assistance from supine to sit. Additionally, he’s able to retrieve his clothing and dress himself independently using his assistive equipment.
M1840 – TOILET TRANSFERRING

OASIS C1:
(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
- 0  - Able to get to and from the toilet and transfer independently with or without a device.
- 1  - When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer.
- 2  - Unable to get to and from the toilet but able to use a bedside commode (with or without assistance).
- 3  - Unable to get to and from the toilet or bedside commode but able to use a bedpan/urinal independently.
- 4  - Is totally dependent in toileting.

OASIS C2:

M1840 – TOILET TRANSFERRING
• What changes are in the 2017 Home Health Prospective Payment System?
  - M1840 ≥ 2: Episodes with ≥ 14 therapy visits: Decreases from four to three functional points in 1st or 2nd episode.
  - M1840 ≥ 2: Points when combined with a diagnosis of MS will be removed except in 1st or 2nd episodes with ≥ 14 therapy visits – and then it decreases from ten to eight clinical points.

• What impacts independence in toilet transferring?
  - Need for assistance to get to/from the toilet.
  - When a patient cannot ambulate safely to/from the toilet without cueing, supervision, SBA, CGA, or direct assistance they are NOT independent - unless they can perform the entire to/from on/off process safely and independently with a wheelchair.
  - Need for assistance to transfer on/off the toilet.

M1840 – TOILET TRANSFERRING
• What should I assess in toilet transferring?
  - Observe the patient walking/wheeling to/from the toilet and transferring on/off.
  - Ability to perform all parts of the transfer process even if patient has both a bladder and bowel diversion.
  - Ability to perform all parts of the transfer process with a caregiver’s assistance, even if the patient doesn’t have a caregiver.
  - Ability of a chairbound patient to ‘meaningfully’ participate in all parts of the transfer process.
  - Ability of a bedbound patient to independently use both the urinal and bedpan.
Miss Kingsley has been referred to home health care for IV antibiotics following cellulitis associated with a cat bite. She reports to her SOC nurse that she accidentally stepped on her cat when she lost her balance momentarily walking to the bedroom. Her MS has been “acting up” and Miss Kingsley states, “I know I should probably start using this cane all of the time.” At the SOC assessment the nurse accompanies the patient to her bathroom and asks her to demonstrate transferring on and off of the toilet. An over the toilet commode is in place and Miss Kingsley safely transfers on and off the toilet using the support bars. While walking from the bathroom to bedroom she demonstrates a loss of balance when turning through doorways and the nurse provides standby assistance.

How should M1840 be answered?

M1840 = 1—When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer

Key Information...

- Miss Kingsley has been referred to home health care for IV antibiotics following cellulitis associated with a cat bite.
- She reports to her SOC nurse that she accidentally stepped on her cat when she lost her balance momentarily walking to the bedroom. Her MS has been “acting up” and Miss Kingsley states, “I know I should probably start using this cane all of the time.”
- At the SOC assessment the nurse accompanies the patient to her bathroom and asks her to demonstrate transferring on and off of the toilet. An over the toilet commode is in place and Miss Kingsley safely transfers on and off the toilet using the support bars.
- While walking from the bathroom to bedroom she demonstrates a loss of balance when turning through doorways and the nurse provides standby assistance.
M1850 – BED TO CHAIR TRANSFER

OASIS C1:
(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

□ 0 - Able to independently transfer.
□ 1 - Able to transfer with minimal human assistance or with use of an assistive device.
□ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
□ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
□ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
□ 5 - Bedfast, unable to transfer and is unable to turn and position self.

OASIS C2:

M1850 – BED TO CHAIR TRANSFER

• What changes are in the 2017 Home Health Prospective Payment System?
  ✓ M1850 ≥ 2: Decreases from two to zero functional point in 1st or 2nd episode with ≥ 14 therapy visits.
  ✓ M1850 ≥ 2: Increases from one to two functional point in 3rd or later episodes with ≤ 14 therapy visits.
  ✓ M1850 ≥ 2: Points when combined with a diagnosis of MS will be removed except in 1st or 2nd episodes with ≥ 14 therapy visits – and then it decreases from ten to eight clinical points.

M1850 – BED TO CHAIR TRANSFER

• What definitions should I be aware of?
  • “Minimal Assistance” in Response 1: Caregiver contributes <25% of the required effort (cueing, supervision, SBA, CGA, direct assist).
  • “Or” in Response 1: Move down to response 2 when the following apply:
    ✓ The patient needs more than minimal assistance, and/or...
    ✓ The patient needs minimal assistance and an assistive device.
  • “And” in Response 2: Move down to response 3 when the patient either can’t bear weight OR can’t pivot. They must be able to do both safely to select response 2.
  • “Bedfast” in Responses 4 & 5: The patient must be either medically restricted to bed by the physician or they must be totally unable to tolerate being up in a chair.
M1850 – BED TO CHAIR TRANSFER

• What should I assess with bed transfers?
  ✓ Several components to this item:
  ✓ Sit on the side of the bed or other usual sleeping surface;
  ✓ Move from sitting to supine;
  ✓ Move from supine to sitting;
  ✓ Stand, pivot, and transfer into a chair that’s already by the bed; or
  ✓ Stand and ambulate to the next sitting surface.
✓ Ability to perform the transfer process from their current sleeping space – access to their usual bed is not a factor under consideration.
✓ Ability to maintain weight-bearing restrictions, hip precautions, or other prescribed limitations.

Test Your Understanding...

• Mr. Franklin has been referred to home health care for psychiatric nursing services, physical therapy, and occupational therapy. The physician’s Face to Face visit note accompanying the referral indicates he has Alzheimer’s Dementia and has recently been moved from his home out of state to live with his daughter who can provide 24/7 supervision.
• Mr. Franklin’s daughter reports her father had been living alone with a neighbor checking in, however it came to light he was not taking his medications, ate sporadically, and had fallen several times without significant injury.
• Mr. Franklin is cooperative during the nurse’s SOC assessment and is able to follow one-step commands. He requires frequent reminders to take his walker with him when ambulating and forgets where he is going.
• During his physical examination, the patient is able to sit down on his bed, lie back, return to sitting, and stand up again. The nurse reminds him to use his walker when he heads to his chair to put his shoes back on. He is steady ambulating the 5 foot distance to the chair.

How should M1850 be answered?

M1850 = 2-Able to bear weight and pivot during the transfer process but unable to transfer self
M1850 – BED TO CHAIR TRANSFER

Key Information:

- Mr. Franklin has been referred to home health care for psychiatric nursing services, physical therapy, and occupational therapy. The physician’s Face to Face visit note accompanying the referral indicates he has Alzheimer’s Dementia and has recently been moved from his home out of state to live with his daughter who can provide 24/7 supervision.
- Mr. Franklin’s daughter reports her father had been living alone with a neighbor checking in, however it came to light he was not taking his medications, ate sporadically, and had fallen several times without significant injury.
- Mr. Franklin is cooperative during the nurse’s SOC assessment and is able to follow one-step commands. He requires frequent reminders to take his walker with him when ambulating and forgets where he is going.
- During his physical examination, the patient is able to sit down on his bed, lie back, return to sitting, and stand up again. The nurse reminds him to use his walker when he heads to his chair to put his shoes back on. He is steady ambulating the 5 foot distance to the chair.

M1860 – AMBULATION/LOCOMOTION

OASIS C1:

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically, needs no human assist or assistive device).
- 1 - With the use of a one-handed device (for example, cane, single crutch, hemi walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

OASIS C2:

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
M1860 – AMBULATION/LOCOMOTION

• What changes are in the 2017 Home Health Prospective Payment System?
  ✓ M1860 ≥ 4: Increase of one functional point in 1st and 2nd episodes with any amount of therapy, or in 3rd or subsequent episodes ≤ 14 therapy visits.
  ✓ M1860 ≥ 4: Points when combined with a diagnosis of MS will be removed except in 1st or 2nd episodes with ≥ 14 therapy visits – and then it decreases from ten to eight functional points.
  ✓ M1860 ≥ 1: New award of 3 clinical points in combination with a pulmonary diagnosis in 1st or 2nd episodes with ≥ 14 therapy visits.

• How should I assess ability to ambulate and locomotion?
  ✓ Review history of recent falls or near falls.
  ✓ Observe ambulating throughout the home and on a variety of surfaces in the areas patient accesses.
  ✓ Assess ability only with the assistive devices on hand – do not assume patient could function safely with a device that hasn’t yet been obtained.
  ✓ Ability to maintain weight-bearing restrictions, hip precautions, or other prescribed limitations
  ✓ Assess for environmental barriers such as narrow doorways, clutter, unsafe floor coverings, stairs, etc.

• How should I assess ability to ambulate and locomotion? (cont…)
  ✓ Observe for physical, cognitive, emotional, or mental deficits that are barriers to safe ambulation:
    ✓ Lack of safety awareness.
    ✓ Impulsivity.
    ✓ Incorrect use of devices.
    ✓ Forgetting to use an assistive device.
    ✓ Sensory issues such as vision loss, pain, neuropathy, etc.
    ✓ Effect of medications.
  ✓ Observe ability to safely maneuver a wheelchair or other similar device throughout the home on a variety of surfaces in the areas patient accesses.
Ms. Montgomery is a 32 year old nurse who fell ascending a broken staircase while on her way to perform an OASIS assessment. She was hospitalized for five days and underwent an ORIF to repair three fractures to her right ankle. She is to maintain non-weight bearing status on her right ankle and may use her rollator, crutches, or wheelchair.

Physical therapy has been ordered in the home following hospital discharge. At the SOC visit the therapist meets with the patient who is seated on her rolling kitchen chair.

The patient remembers to brace her rolling chair against the wall before attempting to stand. She is able to raise out of her chair using the crutches for support and places a minimal amount of weight on her surgical ankle. She performs a hopping motion to move down the two steps to get to the bathroom level of the home. She requires a rest break after this and balances with only toe-touch weight bearing at this point. When reminded by the therapist she remembers to lift her right foot off of the floor.

How should M1860 be answered?

M1860 = 3-Able to walk only with the supervision or assistance of another person at all times
M2020 – MANAGEMENT OF ORAL MEDS

OASIS C1:

(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/interval. 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.

OASIS C2:

(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/interval. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

What impacts the ability to safely take oral medications?

- Patients cannot demonstrate an ability to take a medication if it’s not in the home.
- Patients must be able to safely retrieve their medications and a beverage if not always stored next to them – otherwise, response 3 applies.
- Patients must be able to safely swallow their oral medications.
- Vision impairment, impaired cognition, pain, and dexterity may limit ability to be independent with oral medications.
- Finances may be a barrier if a patient cannot obtain a medication due to the cost.
- Choosing not to take a medication or fill a prescription does not impact the assessment of a patient’s ability to take medications.
M2020 – MANAGEMENT OF ORAL MEDS

• What should I assess with oral medication management?
  ✓ Determine if any medication requires any level of assistance and report the most amount of assistance required, even if only needed for one medication or dose.
  ✓ Determine if meds were taken correctly in the 24 hours prior to the assessment visit. If this is unclear, was there a history of medication errors or compliance concerns?

• What should the response reflect?
  ✓ Only oral medications that are placed in the mouth and swallowed.
  ✓ Ability to take all medications including prescribed, over the counter, minerals, vitamins, and herbal.
  ✓ Assistance provided by another person with pill boxes, diaries, charts, alarms, etc.
  ✓ Ability to take medications after dispensed by the pharmacist – whether in a bottle or a blister pack.

Test Your Understanding...

• Mr. Lewis has been referred for skilled nursing in the home following hospitalization for a CVA with cognitive deficits and mild ataxia. He has returned to his home where he lives with his wife who has Parkinson's disease, and tells the nurse his daughter will be providing him with more help in caring for his wife.

• Mr. Lewis' daughter Susan arrives at the beginning of the SOC assessment visit, and together the nurse works with the patient and daughter to review the medication profile. His daughter has correctly filled a medication planner for the patient, and the doses due since returning home have all been taken.

• Susan explains the night her father was discharged from the hospital he forgot to take his medications. Since then she calls him at the times meds are due as a reminder and Mr. Lewis has since taken all his medications as prescribed.

• The nurse observes Susan being careful to stand near her father when he takes the medications back into the kitchen as his balance is impaired following the CVA. He has begun using a wheeled walker and needs reminders slow his pace for safety.

How should M2020 be answered?

M2020 = 3-Unable to take medication unless administered by another person.
M2020 – MANAGEMENT OF ORAL MEDS

Key Information…

• Mr. Lewis has been referred for skilled nursing in the home following hospitalization for a CVA with cognitive deficits and mild ataxia. He has returned to his home where he lives with his wife who has Parkinson’s disease, and tells the nurse his daughter will be providing him with more help in caring for his wife.
• Mr. Lewis’ daughter Susan arrives at the beginning of the SOC assessment visit, and together the nurse works with the patient and daughter to review the medication profile. His daughter has correctly filled a medication planner for the patient, and the doses due since returning home have all been taken.
• Susan explains the night her father was discharged from the hospital he forgot to take his medications. Since then she calls him at the times meds are due as a reminder and Mr. Lewis has since taken all his medications as prescribed.
• The nurse observes Susan being careful to stand near her father when he takes the medications back into the kitchen as his balance is impaired following the CVA. He has begun using a wheeled walker and needs reminders slow his pace for safety.

WHAT’S NEXT IN THE OASIS-C2 READINESS PROGRAM

• OASIS-C2 format changes
• Revisions to the OASIS to meet IMPACT act requirements including three new OASIS questions
  ✓ M1028 – Active Diagnosis of Peripheral Vascular Disease, Peripheral Arterial Disease, or Diabetes
  ✓ M1060 – Height and Weight
  ✓ GG0170C – Mobility: Lying to Sitting on the Side of the Bed
• Revision to guidance on multiple OASIS items

CONTACT HOURS

How to Get Contact Hours:

• This continuing nursing education activity was approved for 1.0 Contact Hours
• The expiration date for awarding contact hours is 9/30/2019.
• Each participant must complete an electronic evaluation in order to receive contact hours: https://www.research.net/r/P963LSQ
• If you have questions about the program content or other concerns contact us via email: training@fazzi.com

Fazzi Associates, Inc. is an approved provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.