CareForum 2022

The WellSky® Conference

Achieving OASIS excellence in preparation for OASIS-E

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Senior Advisor, Clinical Integration; Subject Matter Expert – OASIS

WellSky

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Today's speaker

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Agenda

- Why does OASIS change?
- Helicopter view of OASIS-D1 to OASIS-E transition
- A glimpse at the guidance for new OASIS-E data elements
- Re-writing the OASIS narrative at your agency
- Building a foundation of OASIS excellence

OASIS — why does it keep changing?

IMPACT!

Improving **M**edicare **P**ost-**A**cute **C**are **T**ransformation Act of 2014

- Goal is to improve Medicare beneficiary outcomes through:
  - Shared decision-making
  - Care coordination
  - Enhanced discharge planning

- Work to meet intent of CMS initiative "Meaningful Measures":
  - Identifying high priorities for quality measurement and improvement

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures

IMPACT Act

- Requires **standardized patient assessment data** elements (SPADES)

- Requires the submission of standardized data by:
  - Long-term care hospitals- (CARE)
  - Skilled nursing facilities- (MDS)
  - Home health agencies- (OASIS)
  - Inpatient rehabilitation facilities- (IRF-PAI)

- Data standardization and gathering allows:
  - Domains pertaining to resource use
  - Interoperability

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures

MedPAC Unified PAC PPS

- **MedPAC research and development of a Unified Post-Acute Prospective Payment System (Unified PAC PPS) is active**

- Goals of Unified PAC PPS:
  - MedPAC to develop prototype spanning payment over four PAC settings (LTCH, SNF, IRF, HHA)
  - Align patient assessment data elements, refining over time
    - Integrating elements reflective of Social Determinants of Health (SDoH), as they directly impact resource use and quality outcomes

- July 2022- Draft Prototype Unified PAC PPS- scrutinized for "numerous fundamental flaws"
  - Report to Congress: Unified Payment for Medicare-Covered Post-Acute Care (cms.gov)

Why should you care about OASIS positioning?

- Assessment impact today:
  - Clinical decisions and care planning
  - Your revenue and revenue cycle
  - Your publicly reported outcomes and star ratings
  - First performance year — 2023, impacting 2025 as the first payment year
    - Baseline year? 2022
- Each assessment you submit contributes to the future payment and positioning within a Unified PAC PPS

- Build a foundation of key skills to transition efficiently into HHVBP and OASIS-E
  - Core assessment **competence**
  - Foundational OASIS element **competence**
  - Risk-based clinical decision support **– built on foundation of assessment competence**

OASIS-D1 to OASIS-E
Helicopter view of changes

Change overview

- Reorganization of elements into sections
- New data elements (addressed later)
- Revision of items required at assessment time points, removal of items, revision of items, updated skip patterns (not here, not today)

A - Administrative Section	H - Bladder and Bowel
B - Hearing, Speech, and Vision	I - Active Diagnoses
C - Cognitive Patterns	J - Health Conditions
D - Mood	K - Swallowing/nutritional status
E - Behavior	M - Skin Conditions
F - Preferences for Customary Routine Activities	N - Medications
G - Functional Status	O - Special treatment, Procedures, Programs
GG - Functional Abilities	Q - Participation in Assessment and Goal Setting

Change overview — rearrangement

- A — Administrative
- B — Hearing, Speech, and Vision
- C — Cognitive Patterns
- D — Mood
- E — Behavior
- F — Preferences for Customary Routine Activities
- G — Functional Status
- GG — Functional Abilities
- H — Bladder and Bowel
- I — Active Diagnoses
- J — Health Conditions
- K — Swallowing/Nutritional Status
- M — Skin Conditions
- N — Medications
- O — Special Treatments, Procedures and Programs
- Q — Participation in Assessment and Goal Setting

Simple D1 to E crosswalk

1- Green- high impact on outcomes and payment
2- Orange- risk adjustment, payment impact, GG future impact
3- Blue- transitioning needing review, outcomes- less "difficult"
4- Black- new items

Section	A - Administrative	B - Hearing, Speech, Vision	C - Cognitive Patterns	D - Mood	E - Behavior	F - Preferences for Customary Routine Activities	G - Functional Status	GG - Functional Abilities & Goals	H - Bowel & Bladder	I - Active Diagnoses	J - Health Conditions	K - Swallowing & Nutritional Status	M - Skin Conditions	N - Medications	O - Special Treatment, Procedures, & Programs	Q - Participation in Assessment & Goal Setting
Transitioning Elements	Admin M0030 M0032 M0090 M0102/ M0104 M0100 M0110 M0906 M1000 M1005 M2301 M2310 M2410 M2420		M1700 M1710 M1720		M1740 M1745	M1100 M2102	M1800 M1810 M1820 M1830 M1840 M1845 M1850 M1860	GG0100 GG0110 GG0130 GG0170	M1600 M1610 M1620 M1630	M1021 M1023 M1028	M1033 J1800 J1900 M1400	M1060 a,b M1870	M1306 M1311 M1322 M1324 M1330 M1332 M1334 M1340 M1342	M2001 M2003 M2005 M2010 M2020 M2030	M1041 M1046 M2200	M2401
New Elements	A1005 A1010 A1110 A1250 A2120 A2121 A2122 A2123 A2124	B0200 B1000 B1300	C0100 C0200- C0500 C1310	D0150 DO160 D0700							J0510 J0520 J0530	K0520		N0415	O0110	

Resource: This version of OASIS is based on the Draft OASIS-E Item Set posted by CMS on May 16, 2022

Transitional items — high impact baseline!

Data Element	PDGM	HHVBP	Star Rating	PRA
M1033 — Risk for Hospitalization	x			x
M1700 - M1720 — Cognitive Functioning, When Confused, When Anxious		x	x	x
M1800 — Grooming	x	x		x
M1810 — Current ability to Dress Upper Body	x	x		x
M1820 — Current ability to Dress Lower Body	x	x		x
M1830 — Bathing	x	x	x	x
M1840 — Toilet Transferring	x	x		x
M1845 — Toileting Hygiene		x		x
M1850 — Transferring	x	x	x	x
M1860 — Ambulation/Locomotion	x	x	x	x
M1870 — Feeding/Eating		x		x
M0102/M0104 — Date of Physician-Ordered Start of Care (Resumption of Care); Date of Referral			x	
M1400 — Shortness of Breath		x	x	x
M2020 — Management of Oral Medications		x	x	x
M2420 — Discharge Disposition		x		
GG items — HHQRP	?	?	?	x

OASIS-E

A glimpse of the new elements

Section A — new elements – A1005. Ethnicity; A1010. Race

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ **Check all that apply**	
☐	A. **No, not of Hispanic, Latino/a, or Spanish origin**
☐	B. **Yes, Mexican, Mexican American, Chicano/a**
☐	C. **Yes, Puerto Rican**
☐	D. **Yes, Cuban**
☐	E. **Yes, another Hispanic, Latino, or Spanish origin**
☐	X. **Patient unable to respond**
☐	Y. **Patient declines to respond**

A1010. Race What is your race?	
↓ **Check all that apply**	
☐	A. **White**
☐	B. **Black or African American**
☐	C. **American Indian or Alaska Native**
☐	D. **Asian Indian**
☐	E. **Chinese**
☐	F. **Filipino**
☐	G. **Japanese**
☐	H. **Korean**
☐	I. **Vietnamese**
☐	J. **Other Asian**
☐	K. **Native Hawaiian**
☐	L. **Guamanian or Chamorro**
☐	M. **Samoan**
☐	N. **Other Pacific Islander**
☐	X. **Patient unable to respond**
☐	Y. **Patient declines to respond**
☐	Z. **None of the above**

Expands D1 M0140 (Race/ Ethnicity)

- Better data for SDOH

Self-reported

- All that apply

Pt unable to respond — may use proxy/medical record

Pt declines to respond

- If declines to respond, do not use other data source

Section A — new elements – A1110. Language; A1250 Transportation

A1110. Language

Enter Code	
☐	A. **What is your preferred language?**
	B. **Do you need or want an interpreter to communicate with a doctor or health care staff?** 0. **No** 1. **Yes** 9. **Unable to determine**

A1250. Transportation ***(NACHC ©)***

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ Check all that apply	
☐	A. **Yes, it has kept me from medical appointments or from getting my medications**
☐	B. **Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need**
☐	C. **No**
☐	X. **Patient unable to respond**
☐	Y. **Patient declines to respond**

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Self-reported preferred language

- May use proxy or medical record secondary

Interpreter need

- Do you need or want an interpreter to communicate with a doctor or health care staff?
- Agency policy is important- Condition of Participation

Identify language barriers

- Improve assessment accuracy
- Identify risk

Identify needs to address barriers

- Essential access necessary for effective care

Facilitate connections

- All that apply

Section A — new elements – A2121.- A2124. TOH

Communication of accurate medication information at transfer/d/c is critical to ensure safe and effective transitions

M2420 updates segue to TOH measures

2. Formal assistive services= skilled services from Medicare certified HHA

3. Non-institutional hospice

M2420. Discharge Disposition
Where is the patient after discharge from your agency? (Choose only one answer.)

Enter Code ☐

1. **Patient remained in the community (without formal assistive services)** ➔ *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*
2. **Patient remained in the community (with formal assistive services)** ➔ Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
3. **Patient transferred to a non-institutional hospice** ➔ Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
4. **Unknown because patient moved to a geographic location not served by this agency** ➔ *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*

UK **Other unknown** ➔ *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*

D/C responses 1,4,UK= any other d/c disposition

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐

0. **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to B1300, Health Literacy*
1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

After completing A2122, Skip to B1300, Health Literacy at Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code ☐

0. **No– Current reconciled medication list not provided to the patient, family, and/or caregiver** ➔ *Skip to B1300, Health Literacy*
1. **Yes – Current reconciled medication list provided to the patient, family, and/or caregiver** ➔ Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

Transfer

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer
At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?

Enter Code ☐

0. **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to J1800, Any Falls Since SOC/ROC*
1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider
2. **NA** – The agency was not made aware of this transfer timely ➔ *Skip to J1800, Any Falls Since SOC/ROC*

Medication reconciliation involves a **three-step** process: verification (collecting an accurate **medication** history); clarification (ensuring that the medications and doses are appropriate); and **reconciliation** (documenting every single change and making sure it "squares" with all the other **medication** information).

This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care.

Section B – new elements – B0200. Hearing; B1000. Vision

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy) 2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 3. **Highly impaired** – absence of useful hearing

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** – sees fine detail, such as regular print in newspapers/books 1. **Impaired** – sees large print, but not regular print in newspapers/books 2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** – object identification in question, but eyes appear to follow objects 4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Identify hearing ability

- Risk of isolation/depression etc...
- Accuracy with cognitive assessment

Assess with usual appliances

- Can be glasses, magnifying glass etc.

Identify ability to see

- Identify risk isolation/depression/safety etc...

Section B — new elements – B1300. Health Literacy

B1300. Health Literacy ***(From Creative Commons ©)***

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code	
☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 7. **Patient declines to respond** 8. **Patient unable to respond**

Obtain, process, and understand

- Basic health information
- Make informed and understood health decisions

Self-reported ONLY

Identify risk

- Lower Health Literacy linked to worse outcomes, higher cost

Section C — new elements – C0100 - C0500. BIMS

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all patients.

Enter Code	
☐	0. **No** (patient is rarely/never understood) ➔ *Skip to C1310, Signs and Symptoms of Delirium (from CAM ©)* 1. **Yes** ➔ Continue to C0200, Repetition of Three Words

Structured Cognitive Interview

- More accurate than observation

MOST can participate

- Can be given verbally or in writing

Determine objectively

- Attention span
- Orientation
- Register and recall information

C0200. Repetition of Three Words

☐	*words are:* ***sock, blue, and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the patient's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)

Enter Code	
☐	Ask patient: *"Please tell me what year it is right now."* A. **Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
☐	Ask patient: *"What month are we in right now?"* B. **Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
☐	Ask patient: *"What day of the week is today?"* C. **Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

C0400. Recall

Enter Code	
☐	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. **Able to recall "sock"** 0. **No** – could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
☐	B. **Able to recall "blue"** 0. **No** – could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
☐	C. **Able to recall "bed"** 0. **No** – could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score	
☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the patient was unable to complete the interview**

13-15: Cognitively Intact
8-12: Moderately Impaired
0-7: Severely Impaired

What kind of outcomes/ goals? Translate to Plan of Care

Section C — new elements – C1310. Signs and Symptoms of Delirium (CAM®)

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status and reviewing medical record.

A. **Acute Onset of Mental Status Change**

Enter Code	Is there evidence of an acute change in **mental status** from the patient's baseline?
☐	0. **No** 1. **Yes**

No skip pattern… even if you say "no" to A -still answer B,C,D

Coding:	↓ Enter Codes in Boxes	
0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	☐	B. **Inattention –** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	C. **Disorganized thinking –** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	☐	D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** – startled easily to any sound or touch ▪ **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** – very difficult to arouse and keep aroused for the interview ▪ **comatose** – could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Observation Acute Mental Status Changes

- Delirium — new or worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations
  - May be reversible if caught and treated timely

Risk

- Increased mortality, functional decline, worsening incontinence, behavior problems, withdrawal, rehospitalizations

Clinical judgement

- Compare baseline status (not time defined) to status on day of assessment

Section D — new elements – D0150. PHQ2 to 9

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	↓ Enter Scores in ↓ Boxes	
A. ***Little interest or pleasure in doing things***		☐	☐
B. ***Feeling down, depressed, or hopeless***		☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. ***Trouble falling or staying asleep, or sleeping too much***		☐	☐
D. ***Feeling tired or having little energy***		☐	☐
E. ***Poor appetite or overeating***		☐	☐
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		☐	☐

D0160. Total Severity Score

Enter Score	
☐☐	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

A validated interview that screens for mood distress/ depression

- Not diagnostic of depression/mood disorder

Risk

- Psychological and physical distress, decreased participation, decreased functional status, poorer outcomes
- Typically underdiagnosed in home health

Patient interpretation

- 9 — if not appropriate for test = no response

Section D — new elements – D0700. Social Isolation

D0700. Social Isolation How often do you feel lonely or isolated from those around you?	
Enter Code ☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Patient declines to respond 8. Patient unable to respond

Self-report ONLY

- Perceived lack of contact with people

Risk

- Physical and mental illness
- Predictor of mortality

Section J — new elements – J0510-J0530- Pain

J0510. Pain Effect on Sleep

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night***"

0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800, Any Falls Since SOC/ROC at DC*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

0 - no pain = skip pattern
1 - pain not affecting sleep

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?***"

0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?***"

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

DEFINITION

PAIN

- Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.

Patient report —interpretation of responses

- Frequency of **interference** sleep, therapy, daily activities
- No definitions for responses
- Pain is whatever the patient says it is
- Lookback period is 5 days

Choose the "more frequent" response

- A patient cannot decide between 2
- Repeat and narrow response to clarify

Not associated with specific approach to management

- Plan of Care options — address pain

Section K — new elements – K0520. Nutritional Approaches

SOC/ROC	
K0520. Nutritional Approaches	
1. On Admission Check all of the nutritional approaches that apply on admission	**1. On Admission** Check all that apply ↓
A. **Parenteral/IV feeding**	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐
Z. **None of the above**	☐

DEFINITION

PARENTERAL/IV FEEDING
Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

FEEDING TUBE
Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.

MECHANICALLY ALTERED DIET
A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET
A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical condition to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet.[1]

Discharge		
K0520. Nutritional Approaches		
4. **Last 7 days** Check all of the nutritional approaches that were received in the last 7 days 5. **At discharge** Check all of the nutritional approaches that were being received at discharge	**4. Last 7 days** ↓	**5. At discharge** ↓
	Check all that apply	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

Nutritional approaches **USED** by the patient

- On admission — applicable and/or as a result of the SOC/ROC visit
- D/C- 4. last 7 days ; 5. at D/C

Parenteral/IV feeding

- Nutrition and hydration- documented need based on inadequacy

Feeding tubes

- Only code if used to deliver nutrition/hydration during time period

Mechanically altered

- NOT enteral feeding formulas
- NOT automatically considered therapeutic

Therapeutic diet

- Manage problematic health conditions
  - Nutritional supplements
  - Food elimination diets

Section N — new elements

SOC/ROC and Discharge		
N0415. High-Risk Drug Classes: Use and Indication		
1. **Is taking** Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. **Indication noted** If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is Taking ↓ Check all that apply	2. Indication Noted ↓
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the Above**	☐	

DEFINITION

ADVERSE DRUG REACTION

Adverse drug reaction (ADR) is a form of an adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR: however, side effects are but one of five ADR categories. The others being; hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse reaction.

Pt meds in specified drug classes are indicated

- Not based on use case

Risk

- Side effects with **adverse effect** on health, safety, quality of life
- ADRs hypersensitivity, idiosyncratic response, toxic reactions, adverse medication interactions

Inclusive of medications

- By any route
- Even it not taken on day of assessment — part of drug regimen
- Given in any setting
- 1 drug can = multiple categories (select them all) - combination

Coding Tips

- Do NOT code Antiplatelet (such as ASA) in Anticoagulant (N0415 E)
- Include Long-Lasting Medications (including transdermals)
- Herbals and alternative medicine products are NOT included here (dietary supplements per FDA)

Section O — new elements – O0110. Special Treatments, Procedures and Programs

SOC/ROC	
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

Same at D/C

c. At Discharge Check all that apply ↓

Effect/risk

- Health status, self-image, dignity, quality of life

Any treatment, procedure, or program

- Part of the patient's current care/ treatment plan (not just HH)
- Performed by anyone or independently
- Any setting

Monitoring on home health care plan?

Section O — new elements – O0110. Cont.

SOC/ROC	
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
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A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

Same at D/C

c. At Discharge Check all that apply ↓

Cancer Treatments and Respiratory Therapies Tips

- IV — DO not include pre/post operative provided solely for surgical or diagnostic procedures- Dialysis/Chemotherapy
- Chemotherapy (oral) includes enterally
- Radiation — continuous or intermittent or via implant
- Oxygen Therapy — continuous ≥14 hrs/day or intermittent <14 hours/day
  - Include BiPAP/CPAP use with O2 delivery
  - High Concentration= >4L/min
- Suctioning — do not include ORAL suctioning
  - Tracheal/nasopharyngeal by anyone (or independently)

IV Medication Specific Tips

- Include through IV push, epidural pump, or drip through central/peripheral port
- Include epidural, intrathecal, and baclofen pumps
- DO NOT INCLUDE
  - Subcutaneous pumps
  - IV medications from chemotherapy, dialysis

Transfusions

- Do not include transfusions administered during dialysis or chemotherapy

IV Access — variety of reasons

- Peripheral — peripheral vein
- Midline — antecubital (upper arm) do not reach to central vein
- Central (PICC, tunneled, port)

Section O — new elements – O0110. Cont.

SOC/ROC	
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	**a. On Admission** **Check all that apply** ↓
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D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
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None of the Above	
Z1. None of the Above	☐

Same at D/C

c. At Discharge Check all that apply ↓

Effect/ Risk

- Health status, self-image, dignity, quality of life

Any treatment, procedure, or program

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Monitoring on home health care plan?

Other notable changes

Organization of items — transitional items moved into appropriate sections

M1021/M1023 — Removed from Recertification

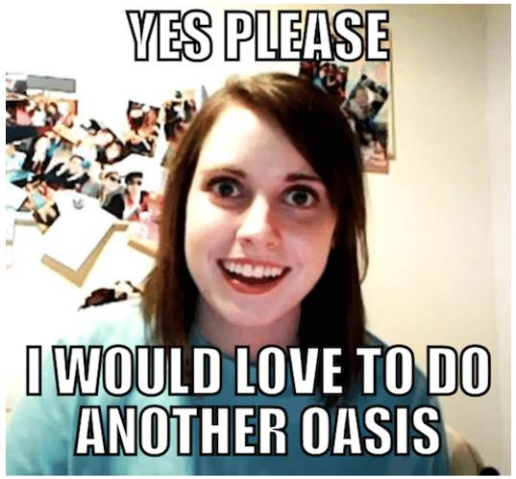
- Payments based on diagnoses on claim (not OASIS dependent, review every 30-day billing cycle)

M2401 — Intervention Synopsis

- Diabetic footcare removed (should still be doing it)

OASIS excellence:
Change the OASIS narrative in your agency

OASIS dread — why does it exist?



Lack of competence and confidence

- Poor orientation on and positioning of OASIS
- Inconsistent, finite, and overly complicated "education"
  - Inconsistent "feedback" from reviewers
  - Lack of consistent association and simulation to the comprehensive assessment and patient care
  - Lack of strategy and individualized spaced repetitive learning — data fueled decision making
- Lack of accountability, ownership, and understanding of importance of the data collection:

  "I just want to take care of patients!"
- Siloed "care plans" and "visits" versus specific and individualized to the patient
- Ritualized behaviors not addressed
- **Agency culture** and ultimately **employee retention** and **patient care and experiences suffer**

Disrupt the bad habits…what are yours?

- Rushed and inadequate orientation and mentoring programs
- Staffing challenge solution — work harder— do more visits
- Competency “check-offs” are formalities
  - Are your competencies inclusive enough?
    - Train and measure OASIS/assessment competence where the work is done
- The QA cycle — “just change it”
- Assessment by interview as primary source
- Delayed documentation

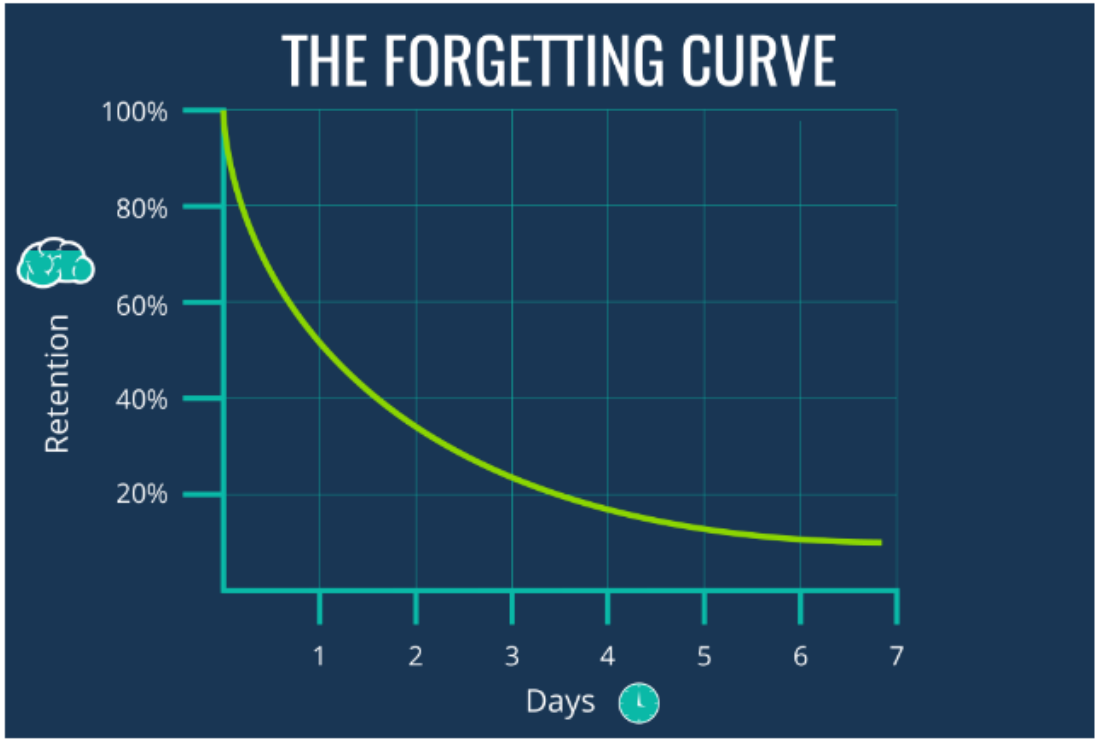
Building the OASIS excellence foundation

- How much of my earlier OASIS presentation do you think you can recall?

Based on the Ebbinghaus' Forgetting Curve, learners will have forgotten an average of 90% percent of what they have learned within the first month.

  - And then… think about how to layer in all that "guidance" to a real patient assessment!
  - And don't forget **everything else** (Conditions of Participation, EHR, Policies and Procedures)

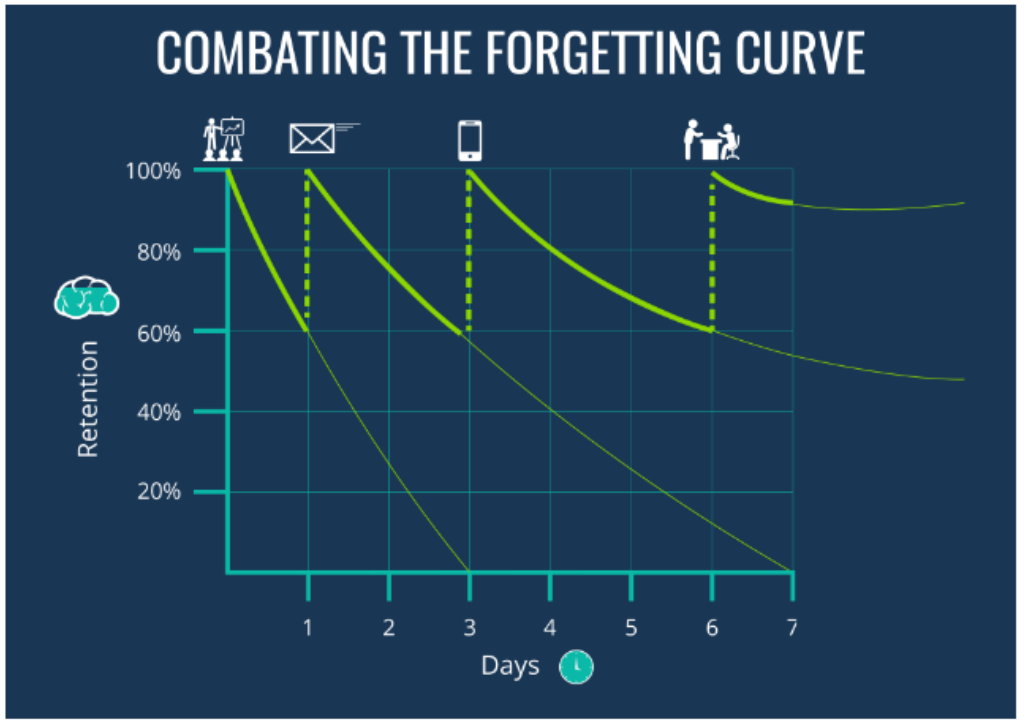
Credited to Hermann Ebbinghaus – born in 1850



Source: https://elearningindustry.com/forgetting-curve-combat

Building the OASIS excellence foundation

- Relevance creates stronger memories — **link** to passion for patient care — **care plans**
- **Repeat** — remembering information that is reinforced often solidifies active recall
- **Clarify** — **simplify** as much as possible (80/20 rule)
- Interactive learning/situational learning



Source: https://elearningindustry.com/forgetting-curve-combat

Stop the data dump – OASIS dread cycle

Building the OASIS excellence foundation

- Repetitive, layered, spaced micro-learning is supported in the research to promote retention of information
- Create a “story” and promote **active** learning: link OASIS guidance to patient assessment strategies — Best Practice OASIS Walk ®
- Use quick visual resources as reminders of complex information
- Layer education ….practice….give feedback….layer….
- Strategically, systematically **use data** to approach improvement (individual, team, agency-wide)
- Partnerships and outsourcing

Stack skills to build competency and confidence

Resting on foundation of **OASIS Excellence**

- **OASIS Excellence** Strengthens **Clinical Excellence**

Set performance expectations

- Build comprehensive and realistic orientation and education **retention** plans
- Set expectations of performance and provide the tools to meet expectations
- Review performance and celebrate accountability!
- Mentorship programs and career ladders

Data-enhanced layered education

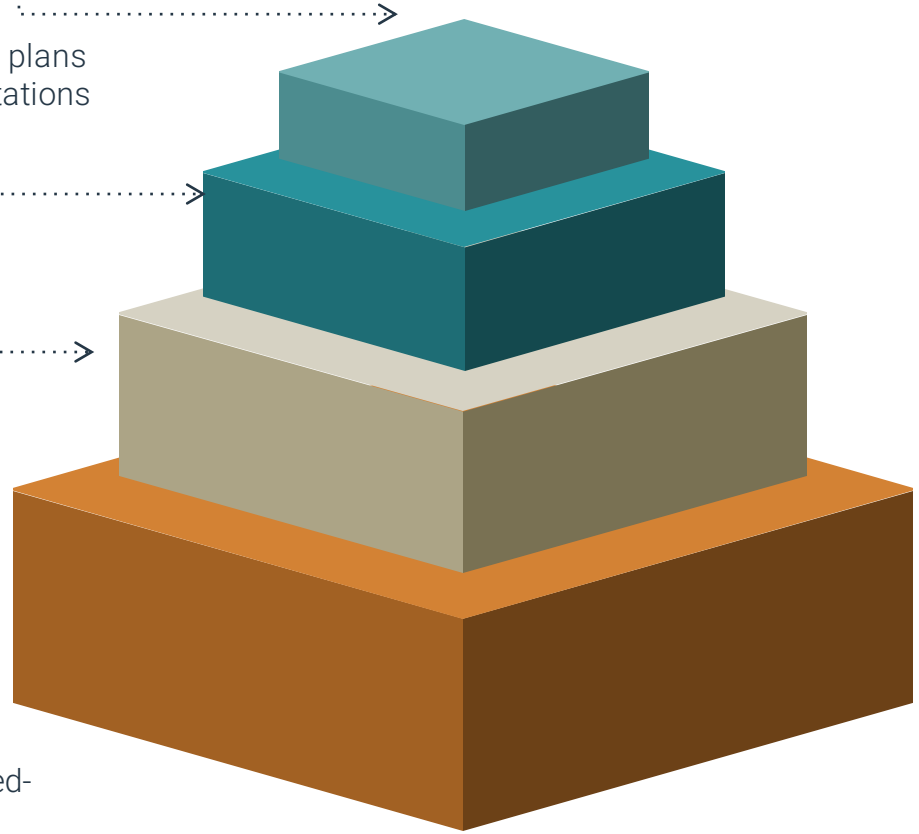
- Predictive analytic data integrated into team discussion - stacking skills of clinicians and their impact and engagement — link OASIS to patient care
- Share ongoing performance data and insights/actions/celebration as quality grows

High value assessment/POC capture

- The perfect example of integration of people, process, and technology – all which build clinical decision support
- High performing teams: individual competence and confidence

Normalize the use of predictive analytics

- Tie everything back to patient care
- Better understand and serve the patient, identifying real-time risk/need-providing efficient appropriate care



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Questions?

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