If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.

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Technical issues with the Recording?

- Clear browser cache using these instructions
- Switch to another browser
- Use a hardwired Internet connection
- Restart your computer/device

Still having issues?

- Call 866-782-6258 (M-F, 8 AM-8 PM ET)
- Email customerservice@PhysicalTherapy.com
At the completion of this educational activity, the learner will be able to:

Learning Outcomes

- Identify the OASIS items that are scheduled to be removed from the OASIS D data collection tool
- Formulate strategies to manage data collection for the modified items in OASIS D
- Create a plan to address training needs for OASIS items that will be new in 2019
OASIS D Guidance


OASIS D Modifications

- 28 Items Removed
- 14 Items Changed
  - Skip Patterns related to removed items
  - Text of Item
- 41 Items with Guidance Changes
  - Intent
  - Response Specific Instructions
  - Time Points
  - Sources
OASIS D – Removed Items

Let the grieving process begin....

Removed Items

- M1011 – Inpatient Diagnosis
- M1017 – Medical or Treatment Regimen Change
- M1018 – Conditions Prior
- M1025 – Optional Diagnoses
- M1034 – Overall Status
- M1036 – Risk Factors
- M1210 – Ability to Hear
- M1220 – Understanding of Verbal Content
- M1230 – Speech and Oral Expression
- M1240 – Pain Assessment
### Removed Items Continued

- M1300 – Pressure Ulcer Assessment
- M1302 – Risk of Developing Pressure Ulcers
- M1313 – Worsening in Pressure Ulcer Status
- M1320 – Status of Most Problematic Pressure Ulcer
- M1350 – Skin Lesion
- M1410 – Respiratory Treatments
- M1501 – Symptoms in Heart Failure Patients
- M1511 – Heart Failure Follow Up
- M1615 – When Does Incontinence Occur
- M1750 – Psychiatric Nursing Services

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### Removed Items Continued

- M1880 – Light Meal Preparation
- M1890 – Telephone Use
- M1900 – Prior Functioning ADLs/IADLs
- M2040 – Prior Medication Management
- M2110 – ADL or IADL Assistance
- M2250 – Plan of Care Synopsis
- M2430 – Reason for Hospitalization
- M0903 – Date of Last Home Visit
OASIS D – Changed Items

Now we get nervous....

Changed Items: Skip Patterns

- M1000 – Inpatient Facilities
- M1051 – Pneumococcal Vaccine
- M1311 – Current Number of Unhealed Pressure Ulcers
- M1340 – Surgical Wound
- M1610 – Urinary Incontinence or Urinary Catheter
- M2001 – Drug Regimen Review
- M2410 – Inpatient Facility Admission
- M2420 – Discharge Disposition
Changed Items: Response / Text

- M1028 – Active Diagnoses
  - None of Above Added (yay!!)

- M1306 – Unhealed Pressure Ulcer Stage 2 or Higher
- M1311 – Current Number Unhealed Pressure Ulcers
- M1322 – Current Number Stage 1
- M1324 – Stage of Most Problematic Pressure Ulcer

“injuries”, “ulcers/injuries”

- M2310 – Reason for Emergent Care
  - Only #1 (medication), #10 (Hypo/hyperglycemia), #19 (Other) and UK (unknown)

- M2102 – Types and Sources of Assistance
  - SOC/ROC:
    - ONLY row f – Supervision and Safety
    - Focus on cognitive behavioral component
  - DC:
    - Row a – ADL Assistance
    - Row c – Medication Administration
    - Row d – Medical Procedures/Treatments
    - Row f – Supervision and Safety
### Ability and Willingness

| Response 0 | No assistance needed – patient is independent or does not have needs in this area |
| Response 1 | Non-agency caregiver(s) currently provide assistance |
| Response 2 | Non-agency caregiver(s) need training/supportive services to provide assistance |
| Response 3 | Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance |
| Response 4 | Assistance needed, but no non-agency caregiver(s) available |

*Indicates that the caregiver(s) has indicated an unwillingness to provide assistance OR That the caregiver(s) is/are physically and/or cognitively unable to provide needed care.*

*Indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance.*

### Changed Items: Guidance

- M0080 – Person Completing Assessment
- M0090 – Date Assessment Completed
- M0102 – Physician Ordered SOC Date
- M1046 – Influenza Vaccine Received
- M1056 – Reason Pneumococcal Vaccine not Received
- M1610 – Urinary Incontinence or Urinary Catheter
- M2301 – Emergent Care
- M2401 – Intervention Synopsis
  - References to OASIS items as risk tools removed since M1300 and M1240 no longer exist.

*Will you still use tools??*
“Ulcer/Injury” and remove “suspected” from DTI

- M1306 – Pressure Ulcer Stage 2 or Higher
- M1307 – Oldest Stage 2 Present at Discharge
- M1322 – Current Number Stage 1 Pressure Ulcers
- M1324 – Stage of Most Problematic Pressure Ulcer

M1332 Dropped from DC / WOCN Resource Reference removed
- M1332 – Current Number Stasis Ulcers
- M1334 – Status of Most Problematic Stasis Ulcer

M1340 Dropped reference to M1350 / WOCN Resource Reference
- M1340 – Surgical Wound
- M1342 – Status of Most Problematic Surgical Wound

“When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact.”

- M1800 – Grooming
- M1810 – Upper Body Dressing
- M1820 – Lower Body Dressing
- M1830 – Bathing
- M1840 – Toilet Transferring
- M1845 – Toileting Hygiene
- M1850 – Transferring
- M1860 – Ambulation
- M1870 – Feeding or Eating
Changed Items:
Guidance (not substantive)
- M2003 – Medication Follow Up
- M2005 – Medication Intervention
- M2010 – High Risk Drug Education
- M2016 – Drug Education Intervention

How much time do you need to spend on these changes?

Priorities:
- M1028
- M2102
- Injury/Ulcer Risk Tools Collaboration

Changed Items:
Guidance (substantive)
- M1021 – Primary Diagnosis
- M1023 – Secondary Diagnosis
- M1028 – Active Diagnosis
  - Instructions for “None of the Above”
- M1060 – Height and Weight
  - With “unsuccessful attempts”, agency collected data from a visit within last 30 days can be used. NOT go to method.
- M1311 – Current Number Pressure Ulcers
  - Instructions tweaked….again
- M1730 – Depression Screening
  - Someone else can administer test for assessing clinician to analyze results

References to Columns 3 and 4 removed
**Changed Items: Guidance** (substantive)

- M1910 – Fall Risk
  - Someone else can administer test for assessing clinician to analyze results
- M2001 – Drug Regimen Review
  - “Issues” list changed

“Day of” and documentation of others can be considered

- M2020 – Oral Medication Management
- M2030 – Injectable Medication Management

Updated due to removed response options

- M2102 – Types and Sources of Assistance
- M2310 – Reason for Emergent Care

**Strategies for Changed Items**

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

These get people’s attention….

OASIS D Additions

- GG0100 - Prior Functioning
- GG0110 - Prior Device Use
- GG0130 - Self Care
- GG0170 - Mobility
- J1800 - Any Falls
- J1900 - Number of Falls
GG0100. Prior Functioning: Everyday Activities: Indicate the patient’s usual ability with everyday activities prior to the current illness, exacerbation, or injury.

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Independent</td>
<td>A. <strong>Self Care:</strong> Code the patient’s need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>2. Needed Some Help</td>
<td>B. <strong>Indoor Mobility (Ambulation):</strong> Code the patient’s need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>1. Dependent</td>
<td>C. <strong>Stairs:</strong> Code the patient’s need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.</td>
</tr>
<tr>
<td>8. Unknown</td>
<td>D. <strong>Functional Cognition:</strong> Code the patient’s need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>9. Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Manual wheelchair</td>
</tr>
<tr>
<td>B. Motorized wheelchair and/or scooter</td>
</tr>
<tr>
<td>C. Mechanical lift</td>
</tr>
<tr>
<td>D. Walker</td>
</tr>
<tr>
<td>E. Orthotics/Prosthetics</td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>
Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient, clinicians, care staff and/or family.

When possible, CMS invites a multidisciplinary approach to patient assessment.

Patients should be allowed to perform activities as independently as possible, as long as they are safe.
  - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
  - Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely.

RSI - Performance Assessment: Timing

Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

The discharge time frame period under consideration includes the last 5 days of care. This includes the date of the discharge visits plus the four preceding calendar days. Code the patient's functional status based on a functional assessment that occurs at or close to the time of discharge.
A patient’s functional ability can be impacted by the environment or situations encountered in the home. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient’s functional status.

If the patient’s ability varies during the assessment timeframe, record their usual ability to perform each activity. Do not record the patient’s best performance and do not record the patient’s worst performance, but rather the patient’s usual performance; what is true greater than 50% of the assessment timeframe.

For the Home Health (HH) Quality Reporting Program (QRP) a minimum of one self-care or mobility goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal. Code the patient’s discharge goal(s) using the 6-point scale. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded.
RSI – Goals

- Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance or lower than SOC/ROC performance.

- If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88) a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

- Licensed clinicians can establish a patient’s discharge goal(s) at the time of the SOC/ROC based on the patient’s prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession’s practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient’s care plan.

Not Attempted Codes

- Code 07, Patient Refused
- Code 09, Not Applicable
- Code 10, Not Attempted due to Environmental Limitations
- Code 88, Not Attempted due to Medical Condition or Safety Concern
- Two or more helpers = Code 01 Dependent
- DASH = NO INFORMATION (Use should be “rare”)
Not Attempted Clarifications

If a patient does not attempt the activity and a helper does not complete the activity, and the patient’s usual status cannot be determined based on patient or caregiver report, code the reason the activity was not attempted:

- Code 07 = refused
- Code 10 = environmental limitations
- Code 09 if the patient could not perform an activity at the time of the assessment, and also could not perform the activity prior to the current illness, exacerbation or injury
- Code 88 if the patient could not perform an activity at the time of the assessment, and but could perform the activity prior to the current illness, exacerbation or injury
  - Physician restrictions require documentation to support
<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Enter Codes in Boxes</td>
<td>A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.</td>
</tr>
<tr>
<td>[ ]</td>
<td>B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from the mouth, and manage equipment for soaking and rinsing them.</td>
</tr>
<tr>
<td>[ ]</td>
<td>C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.</td>
</tr>
<tr>
<td>[ ]</td>
<td>D. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.</td>
</tr>
<tr>
<td>[ ]</td>
<td>E. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable.</td>
</tr>
<tr>
<td>[ ]</td>
<td>F. Lower body dressing: The ability to dress and undress below the waist, including fasteners, does not include footwear.</td>
</tr>
<tr>
<td>[ ]</td>
<td>G. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.</td>
</tr>
</tbody>
</table>

GG0170. Mobility

Code the patient’s usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient’s discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

Safety and Quality of Performance – If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up assistance – Helper sets up or cleans up, patient completes activity. Helper assists only prior to or following the activity.
04. Supervision or touching assistance – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. Patient refused
09. Not applicable – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
88. Not attempted due to medical conditions or safety concerns
<table>
<thead>
<tr>
<th>1. SOC/ROC Performance</th>
<th>2. Discharge Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Roll left and right:</strong> The ability to roll from lying on back to left and right side, and return to lying on back on the bed.</td>
<td></td>
</tr>
<tr>
<td><strong>B. Sit to lying:</strong> The ability to move from sitting on side of bed to lying flat on the bed.</td>
<td></td>
</tr>
<tr>
<td><strong>C. Lying to sitting on side of bed:</strong> The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.</td>
<td></td>
</tr>
<tr>
<td><strong>D. Sit to stand:</strong> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</td>
<td></td>
</tr>
<tr>
<td><strong>E. Chair/bed-to-chair transfer:</strong> The ability to transfer to and from a bed to a chair (or wheelchair).</td>
<td></td>
</tr>
<tr>
<td><strong>F. Toilet transfer:</strong> The ability to get on and off a toilet or commode.</td>
<td></td>
</tr>
<tr>
<td><strong>G. Car Transfer:</strong> The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.</td>
<td></td>
</tr>
<tr>
<td><strong>H. Walk 10 feet:</strong> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.</td>
<td></td>
</tr>
<tr>
<td><strong>I. Walk 50 feet with two turns:</strong> Once standing, the ability to walk 50 feet and make two turns.</td>
<td></td>
</tr>
<tr>
<td><strong>J. Walk 150 feet:</strong> Once standing, the ability to walk at least 150 feet in a corridor or similar space.</td>
<td></td>
</tr>
<tr>
<td><strong>K. Walking 10 feet on uneven surfaces:</strong> The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.</td>
<td></td>
</tr>
<tr>
<td><strong>L. 1 step (curb):</strong> The ability to go up and down a curb and/or up and down one step.</td>
<td></td>
</tr>
<tr>
<td><strong>M. 4 steps:</strong> The ability to go up and down four steps with or without a rail.</td>
<td></td>
</tr>
<tr>
<td><strong>N. 12 steps:</strong> The ability to go up and down 12 steps with or without a rail.</td>
<td></td>
</tr>
<tr>
<td><strong>O. Picking up object:</strong> The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.</td>
<td></td>
</tr>
<tr>
<td><strong>Q. Does patient use wheelchair and/or scooter?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>R. Wheel 50 feet with two turns:</strong> Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</td>
<td></td>
</tr>
<tr>
<td>RR1. Indicate the type of wheelchair or scooter used.</td>
<td></td>
</tr>
<tr>
<td><strong>S. Wheel 150 feet:</strong> Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.</td>
<td></td>
</tr>
<tr>
<td>SS1. Indicate the type of wheelchair or scooter used.</td>
<td></td>
</tr>
</tbody>
</table>
Unpacking the Ambulation Assessment

- Assistive device(s) and adaptive equipment “should not affect coding” (but do impact with respect to retrieval and Code 05 Setup or Clean Up Assistance)

- Assessment starts from standing position
  - 10 Feet
  - 50 Feet with Two Turns
    - 90 degree turns in same or different directions
  - 150 Feet (“or more”)
    - Based on environment can include “turns”
  - 10 Feet Uneven/1 Step (curb)/4 Steps/12 Steps
    - “Not Attempted” options need documentation

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### J1800. Any Falls Since SOC/ROC, whichever is more recent

Has the patient **had any falls since SOC/ROC**, whichever is more recent?

- **0. No** → Skip J1900
- **1. Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

### J1900. Number of Falls Since SOC/ROC, whichever is more recent

<table>
<thead>
<tr>
<th>CODING:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. None</td>
<td></td>
</tr>
<tr>
<td>1. One</td>
<td></td>
</tr>
<tr>
<td>2. Two or more</td>
<td></td>
</tr>
</tbody>
</table>

- **A. No injury**: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient’s behavior is noted after the fall

- **B. Injury (except major)**: Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain

- **C. Major injury**: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
Fall Definitions

Fall:
• Unintentional change is position coming to rest on the ground, floor or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushed a patient).

Intercepted Fall:
• Occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

Strategies for New Items

- Focus on GG170c in OASIS C
- Emphasize foundation of instructions consistent for entire GG Section
  - Assessment
  - Time Frames
  - Goal Setting
- Practice these specific activities NOW
  - Staff Meetings
  - Skills Labs
  - Patient Assessments (consider co-visits)
- Drill in definitions of Falls

COLLABORATION IS CRITICAL
Thank you!

Are you confident in the accuracy of your OASIS data collection? We can help!

Kornetti & Krafft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions to address OASIS and coding needs.

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