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Crunch Time OASIS-E Guide

Refresh training on BIMS, mood items to include final changes

With just a short time until clinicians begin using OASIS-E in the field, agencies have received new guidance from CMS on Section D and the Brief Interview for Mental Status (BIMS), as well as revised guidance for the patient mood interview.

CMS released the final version of the OASIS-E instrument on Dec. 6, along with a document that outlines changes to the draft OASIS-E Guidance Manual that has been the focus of training since May.

While some of the changes were simply to fix typographical errors or add a missing word, experts say that a handful of the changes were significant — particularly in Section D: Mood regarding the use of a dash as a response.

CMS' October quarterly OASIS Q&As had been in direct conflict with what was listed in the OASIS-E draft guidance manual regarding this, notes Sherri Parson, RN, HCS-D, HCS-O, HCS-H, COS-C, chief compliance officer/director of operations with Infusion Health in Ypsilanti, Mich.

CMS corrected this in the new guidance by stating that a dash is no longer allowed as a valid response in column 2 (symptom frequency) for D0150 (Patient Mood Interview) and clarified scoring calculations.

Under D0150, when describing when to use "9 — No response," CMS removed the phrase "and/or the agency was unable to complete the assessment."

"We have instructions on when to use each code available in column one and then instructions on what code to enter — or when to skip — in column two," explains Claudia Baker, RN, MHA, HCS-D, HCS-O, senior manager with SimiTree Healthcare Consulting.

"If the assessor is unable to get a response from the patient, we are told how to code it; therefore, there is no need for the instruction about when an agency can't complete the assessment."

More clarity was provided under D0160 (Total Severity Score) as well with the guidance regarding the use of a dash being updated from the previous manual, "Dash indicates no information. CMS expects dash use to be a rare occurrence," to "Dash is not a valid response for this item."

"I was also happy to see more guidance located at the item responses for when to use a '0' for no or never, 9-no response or blank," Parson adds.

Other changes to the manual

- **K0520A (Nutritional Approaches).** Substantial changes were also made under the coding tips for K0520A. The tip was updated to now state: "IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration." The "and/or" wording replaced the word "and," which implied that the fluid intake was necessary for both nutrition and hydration instead of one or the other, Baker explains.
- **J0520 (Pain Interference with Therapy Activities).** For this item, clinicians ask patients how often they have limited participation in rehab therapy due to pain. Changes were made to add more specificity in the guidance

for J0520. CMS clarified the definition for rehabilitation therapy by adding the words "and/ or maintain." So rehabilitation therapy "Includes but is not limited to special health care service or programs that help a person regain and/or maintain physical, mental and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment."
"Changes under J0520 also clarified that the focus of the therapy is not the emphasis but rather whether there is prescribed therapy being carried out by anyone," Parson adds.

- **N0415 (High risk Medication: Use and Indication)** and **O0110 (Special Treatments, Procedures and Programs)**. Clarifications for items N0415 and O0110 were needed around the time period and recognizing those items that are part of the current plan of care on the day of assessment that may not take place at the specific OASIS timepoint but need to be considered for accurate item completion, Parson adds. The item under consideration also cannot be anticipated to occur, but not currently part of the patient's current treatment plan as of the day of assessment. For example, plans to initiate outpatient chemo or radiation post discharge from home health, which are not currently part of the patient's plan of treatment on the day of assessment would not be considered for O0110. — *Megan Herr*

TO VIEW ALL OF THE CHANGES SINCE THE DRAFT GUIDANCE MANUAL, VISIT https://bit.ly/3Yludfd. THE FINAL VERSION OF THE OASIS-E CAN BE VIEWED AT https://go.cms.gov/3hjdzMO.

Master OASIS-E pain items for smooth implementation

Education for clinicians and reviewers on the new OASIS-E items for pain and their intent — as well as the included time frames and the recommended method of obtaining an accurate response — is vital ahead of implementation on Jan. 1.

The frequency of pain interfering with activity (M1242) has been retired and items assessing pain in three areas have been added.

These items are:

- J0510 (Pain effect on sleep)
- J0520 (Pain interference with therapy activities)
- J0530 (Pain interference with day-to-day activities)

It is extremely important to accurately assess and code the answers to the pain questions under OASIS-E, notes Nanette Minton, senior clinical coding manager with MAC Legacy in Denton, Texas.

Failure to appropriately assess pain and respond to the new OASIS-E pain items can result in lack of adequate care planning when it comes to pain management. For example, identifying and planning for appropriate measures needed due to inadequate sleep resulting from pain, which may result in confusion, falls or medication noncompliance issues.

OASIS-E guidance defines pain as "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 and should be documented as whatever the experiencing person says it is," Minton says.

Understand the new items

One of the bigger adjustments in these items — as well as other new OASIS-E items — will be adjusting to different time frames and making sure this item is answered as a patient self-report item.

Note: The new pain items (J0510, J0520, and J0530) all include only a five-day lookback period. This is the period of time that the clinician should reference when asking the patient about their pain. For example, "In the past five days, what impact has pain had on these activities."

"By making these new pain items patient self-report items in OASIS-E — as well as expanding the items into more specific times/effects of pain on activity — a more accurate evaluation can be made of the type of pain the patient has, when it occurs and what may relieve the pain," says Ohio-based independent home health and hospice consultant Brandi Whitemyer.

For example, she says the patient may have pain only when performing therapy activities, only when in bed so sleep is affected or only when up in the wheelchair that the patient is dependent to sit in throughout the day.

This detail can help when evaluating whether the current pain management is appropriate as well as developing a better home health plan of care to support pain management, Whitemyer adds.

And the response should be based upon the patient's interpretation of the frequency response options, not the clinician's interpretation.

"The clinician can assist to narrow down responses with follow-up questions about the frequency of pain when a patient's response does not lead to a clear answer, but the response to the item should not be coded based solely upon a clinician's assessment of the patient's pain levels alone," Whitemyer notes.

Pain effect on sleep

For J0510 (pain effect on sleep), the answer will consider the patient's experience over the past five days.

When answering how often pain has made it hard to sleep, the patient will choose one of the following: does not apply, rarely or not at all, occasionally, frequently or almost constantly.

Choose "unable to answer" when the patient truly is unable to answer the question, does not respond or gives a nonsensical response, Minton explains. "Without adequate rest, we know our patients are not likely to feel well enough to participate in therapy or other activities."

Pain interference with activities

For J0520, specifically, clinicians need to verify if the patient has been offered therapy services in the five-day period included in this item, Whitemyer notes.

This item will assist in giving a clearer picture of potential untreated or undertreated pain, Minton adds.

If there were no ordered therapy services to be considered, then the best response here would be 0, indicating there's no therapy, she adds.

"However, if therapy services were ordered and the patient was unable to be evaluated and had to reschedule one or more times due to pain or because they could not fully complete sessions, this would warrant a response of 2, 3 or 4 — depending upon the circumstances of the particular case," Whitemyer explains.

J0530, however, will assess how the patient's pain is interfering with normal activities — excluding rehabilitation therapy.

The guidance does not provide any pre-determined definitions to offer the patient while administering this question, Minton notes.

Prepare for these items

The pain assessment will be completed at start of care, resumption of care and discharge from agency time points.

The draft OASIS-E Guidance Manual provides clear response-specific instructions that should be followed to ensure the most accurate answers, Minton says.

"The assessing clinician should be educated to directly ask the patient each item in J0510 through J0530 in the order provided and to use other terms for pain or follow-up discussion if the patient seems unsure or hesitant," she adds.

For example, some patients may avoid use of the term "pain" but may report that they "hurt," Minton explains. — *Megan Herr*

Stress importance of A1110 (Language) ahead of OASIS-E

Agencies should educate staff now on the significance of the addition of A1110 (Language) to the OASIS-E assessment come Jan. 1, as details could improve care plan compliance and lead to better outcomes.

"All care provided can be impacted when a language barrier exists," notes Claudia Baker, RN, MHA, HCS-D, HCS-O, senior manager with SimiTree Healthcare Consulting. "When providing care to limited English proficient patients, the agency needs to make sure staff knows how to access alternate language documents."

"Remind staff that agencies are required by the Conditions of Participation (CoPs) to provide notices that are understandable to patients in writing and/or verbally in the patient's primary or preferred language," Baker says. "And if an interpreter is needed, they must be provided at no cost to the patient."

Some of the most common types of notices include consents, reporting of OASIS data, patient rights and privacy notices.

But overall care and best practice go beyond just notices, Baker adds.

Ideally, agencies would provide all educational material — disease-specific, medication and safety information, for example — in the patient's preferred language (written and/or spoken), Baker says.

Staff should be educated on where the agency keeps these materials, both electronically or written, and how to contact language service providers (phone, email or online).

Effects of language barriers

"The formal recognition of a patient's [preferred]language is more important than ever," Baker notes.

According to the Center for Immigration Studies, over 67 million people in the U.S. speak a foreign language at home, she adds.

"Home health staff members need to be able to effectively communicate with their patients," Baker says. "The operative word there being effectively."

Otherwise, a language barrier is created which can lead to health disparities for the patient and is not something to be ignored.

When a language barrier is identified, it gives the agency the opportunity to address the need, Baker says.

"It must be included in the patient's care plan, so the entire care team is aware and knows to use alternative communication methods," she adds. "The solution may be to provide written materials in their language and include an approved family/friend as a translator."

Additionally, the agency may have bilingual staff or need to utilize an agency-provided translator.

"The key is recognition that a language barrier exists so it can be addressed," Baker says.

"If a language barrier is not handled properly, the patient may not get the education and treatment they need, which in turn, could result in poor or decreased outcomes," says Karen Carter, RN, HCS-D, HCS-O, chief operating officer/chief compliance officer with Trinity Home and Health Care in North Richland Hills, Texas.

"The patient's inability to understand health information can also lead to unequal treatment and reduced access to care, including patient satisfaction, Baker says.

Patients with a language barrier tend to have higher hospital readmission rates, says Sherri Parson, RN, HCS-D, HCS-O, HCS-H, COS-C, chief compliance officer/director of operations with Infusion Health in Ypsilanti Mich.

Identify health literacy crossover

There is some crossover with A1110 and another new OASIS-E item, B1300 (Health literacy) which is the ability of the patient to obtain, process basic health information and make health decisions, Parson notes.

The items work together to ensure that the necessary educational information is relayed during the plan of care period and that the info is provided in a way that patients understand.

"[For instance] B1300 only asks about the patient's ability to read health-related materials such as drug information pamphlets which surely would be impacted if those materials were not in the language that the patient is most proficient in," she adds.

However, while both of these items are considerations in how the social determinants of health (SDoH) affect the patient's overall health status and seem like they could go hand-in-hand, it's important to remember that language is just a piece of health literacy.

Other things, such as cognition and vision also play roles in health literacy, Baker notes. For instance, in addition to language barriers, the patient's reading level may not match the level of the written material. When this happens, patient education is not effective.

Their level of cognition may impair their ability to comprehend or remember information, Baker adds.

Follow language/health literacy tips

Have illustration-based materials. Make sure much of your patient materials are illustration-based as well as available in multiple languages, Parson says. The CDC has many free illustrations for use on various topics at www.vizhealth.org as well as zone tools from www.hsag.com/zone-tools. "These are some of my favorite free tools," Parson says.

Teach staff how to reach and use interpreters. Make sure your staff are comfortable utilizing an interpreter, Baker says. "It's the staff's responsibility to make sure the interpreter doesn't sway the interview in any way," she adds. "Asking the question to the patient exactly as the clinician indicates is important."

And it's important to make sure staff are comfortable working with a translator, Baker says. "Try role-playing in the office setting," she suggests. "Clinicians should be confident in their instructions to the interpreter and allow time for communication to happen."

- **Talk through the interpreter, not to.** Train your staff to use the interpreter to have a conversation with the patient that still feels personal and don't just talk to the interpreter like they aren't even there, Carter says.
- **Know your resources.** Ensure that your staff knows and understand the resources that are available such as interpreters and materials, Parson says. And help staff become knowledgeable and comfortable with any translation help as it promotes a more accurate assessment, Baker adds. — *Megan Herr*

Update process around oxygen therapy, SDOH assessments

CMS clarified how to answer new OASIS-E item O0110 (Special Treatments, Procedures, and Programs; Oxygen therapy) in its fourth quarter OASIS Q&As, released Oct. 18.

One question asks if the clinician should consider how oxygen is worn or ordered when determining whether the oxygen is continuous or intermittent.

CMS states that O0110 should be completed based on a comprehensive assessment that occurs at start of care (SOC), resumption of care (ROC) or discharge.

"Regardless of how the oxygen is ordered (i.e., continuously or intermittently), apply the OASIS-specific definitions in determining whether oxygen is coded as continuous (delivered for ^{3} 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day)," the response notes.

A similar question asked whether you should mark for BiPAP and CPAP if patients only use them during the assessment window.

An example would be if the treatment is ordered and available, but the patient refuses to wear it.

To this, CMS advises, "if the BiPAP or CPAP is part of the patient's current care/treatment plan, then mark O0110G1 — Non-Invasive Mechanical Ventilator and O0110G2 — BiPAP or O0110G3 — CPAP."

"These are important clarifications since the one clarifies we will mark oxygen not on how it is ordered, but how it is worn. But the other seems to do a complete reverse and states we will mark the BiPAP/CPAP use based on how it's ordered, not how it's used," notes Sherri Parson, RN, HCS-D, HCS-O, HCS-H, COS-C, chief compliance officer/director of operations with Infusion Health in Ypsilanti Mich.

This is a good example of how you can have response-specific instructions that differ within the same item — in this case O0110, Parson adds.

Don't use prior info for SDoH items

CMS also provided guidance that patient information collected prior to SOC or ROC should not be used to complete the new OASIS-E items such as A1005 (Ethnicity), A1010 (Race), A1110 (Language), A1250 (Transportation), B1300 (Health Literacy) and D0700 (Social Isolation).

"If information used to complete the OASIS is gathered prior to the patient's admission, this information should be verified and coded following applicable coding guidance during an assessment that occurs during the SOC/ROC time period," CMS explains.

An agency's software may not answer or "generate" the OASIS response for the assessing clinician, CMS states.

This answer further reminds clinicians of the importance of following specific item guidance, as not all the guidance is the same for these items, Parson says.

Agencies should also keep in mind that the medical record should not be used as the data source for coding ethnicity, race, language and transportation unless the patient and proxy are unable to respond during each specific assessment period during the SOC/ROC or discharge assessment time periods, CMS adds.
— Megan Herr

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The OASIS-E Trainer provides your agency with a rundown of the drastic changes coming to the home health assessment document to minimize the impact to productivity. You'll get official CMS guidance, assessment strategies and care planning tips that go a long way to improve quality outcomes. Get details at: https://store.decisionhealth.com/oasis-e-trainer.