IT'S ALL ABOUT TIMING & ASSESSMENTS

INITIAL ASSESSMENT VISIT, COMPREHENSIVE ASSESSMENT, TIME POINTS, DEPRESSION AND FALL RISK ASSESSMENTS

Teleconference

September 16, 2011

Wyoming Department of Health, Aging Division, Healthcare Licensing and Surveys

PRESENTED BY:
Debbie Chisholm,
RN BSN CPHQ COS-C

OASISanswers

TOPICS

- **Timing**
  - Initial assessment visit
  - Comprehensive assessments
  - Who can do them and when
  - How do I handle unusual situations?
- **Assessments**
  - M1730 – Depression Screening
  - M1910 – Fall Risk Assessment
  - Who must do them, when and what does CMS require?
  - Key guidance, time-saving and accuracy-promoting tips
- **Q&A Session**
  - Q&A to further clarify your questions

INITIAL AND COMPREHENSIVE ASSESSMENT

What's the difference? What are the requirements?

COMPREHENSIVE ASSESSMENT OF PATIENTS

CONDITION OF PARTICIPATION (SECTION 484.55)

Cover today

a) Initial Assessment Visit
b) Completion of the Comprehensive Assessment
c) Drug Regimen Review
d) Update of the Comprehensive Assessment
e) Incorporation of the OASIS Data Set

(www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html)

INITIAL VS COMP. ASSESSMENT

Assmt.	Timing	Tasks	Data elements	Who?
Initial Assessment Visit *A Visit with specified tasks*	Within 48 hrs (2 calendar days) of referral or pt's return home or on physician ordered start of care date	Determine immediate care and support needs Determine benefit eligibility & homebound status (for MC)	Agency determines what data elements must be assessed to accomplish the required tasks	First person that walks through the door. Must be RN if orders exist for nursing. (Therapy may NOT go in 1st) If therapy only, appropriate therapist performs initial assessment per payer benefit criteria (For MC PPS, never OT).
Compre-hensive Assessment *A Task that may occur over multiple visits*	Within 5 calendar days after the SOC date (SOC = Day 0) Within 2 calendar days at ROC, Other FU, DC Within the last 5 days at Recert Must be in a timely manner, consistent with patient's needs	Assess nursing, medical, social, rehabilitative, & DC planning needs Collect OASIS if required	-OASIS data items if required -Agency determined core comprehensive assessment items -Discipline specific assessment items (if agency has discipline specific assmts)	One clinician only. Must be RN if orders exist for nursing. Therapy only, appropriate therapists may perform (Never OT at SOC for MC PPS)
NOTES	SOC Comp. assessment may not be started before the SOC date SOC date = date 1st billable service provided. If done accidentally before SOC, it must be redone.	Initial and comp. assmts can and usually are done at the same time Can be performed separately	Must be arranged in a clinically meaningful way in the agency's forms	After SOC, any qualified clinician (RN, PT, OT, or SLP) may perform subsequent assessments. Discharge performed by last qualified clinician in home

INITIAL VS COMP. ASSESSMENT

Assmt.	Timing	Tasks	Data elements	Who?
Initial Assessment Visit *A Visit with specified tasks*	Within 48 hrs (2 calendar days) of referral or pt's return home or on physician ordered start of care date	Determine immediate care and support needs Determine benefit eligibility & homebound status (for MC)	Agency determines what data elements must be assessed to accomplish the required tasks	First person that walks through the door. Must be RN if orders exist for nursing. (Therapy may NOT go in 1st) If therapy only, appropriate therapist performs initial assessment per payer benefit criteria (For MC PPS, never OT).
Compre-hensive Assessment *A Task that may occur over multiple visits*	Within 5 calendar days after the SOC date (SOC = Day 0) Within 2 calendar days at ROC, Other FU, DC Within the last 5 days at Recert Must be in a timely manner, consistent with patient's needs	Assess nursing, medical, social, rehabilitative, & DC planning needs Collect OASIS if required	-OASIS data items if required -Agency determined core comprehensive assessment items -Discipline specific assessment items (if agency has discipline specific assmts)	One clinician only. Must be RN if orders exist for nursing. Therapy only, appropriate therapists may perform (Never OT at SOC for MC PPS)
NOTES	SOC Comp. assessment may not be started before the SOC date SOC date = date 1st billable service provided. If done accidentally before SOC, it must be redone.	Initial and comp. assmts can and usually are done at the same time Can be performed separately	Must be arranged in a clinically meaningful way in the agency's forms	After SOC, any qualified clinician (RN, PT, OT, or SLP) may perform subsequent assessments. Discharge performed by last qualified clinician in home

COMPLETING THE OASIS ASSESSMENT

MUST BE COMPLETED BY ONE CLINICIAN - RN, PT, OT, or SLP

- For a few selected items, collaboration is allowed
  - Exceptions noted in Item Specific Guidance
    - Examples Medication items M2000-M2004
      - Still only one clinician completes assessment

(Ch. 3, M2000, M2002, M2004)

TEST TIME - 1

Referral received on 9/1; S/P right total knee replacement; Hospital DC 9/2: Referral orders for PT to evaluate and treat and RN for one visit to remove staples in 4 days. RN visited 9/3, performed initial assessment and completed the SOC comprehensive assessment. Assessment revealed no need for nursing other than staple removal as the wound was closed, no s&s of infection. Pt. was knowledgeable regarding their postoperative care needs & meds. PT eval was performed 9/3 following the RN visit.

- Who must visit first?
- When must the initial visit occur?
- Who must complete the SOC comprehensive assessment?
- When must it be completed?
- Who established SOC in this case?
- Does the PT have to visit same day as RN?
- What's the SOC date (M0030)?

TEST TIME - 2

Referral received on 9/1: PT only, RN opened for PT on 9/2, no nursing need at all. PT visit/evaluation on 9/2

- Who must visit first?
- When must the initial visit occur?
- Who must complete the SOC comprehensive assessment?
- What's the SOC date (M0030)?

TEST TIME - 3

Referral received on 9/1: Nursing and SLP ordered. RN plans first visit for Tuesday at 1 pm. SLP has a patient in that neighborhood at 9 am and a patient 70 miles away at 2 pm.

- Who must visit first?
- Can the SLP visit after her 9am appointment?
- When must the visit occur?
- Who must complete the SOC comprehensive assessment?

TEST TIME - 4

Referral: Orders for PT only. RN opened case for PT at 9 am Monday (Initial and SOC comprehensive assessment done). No nursing needed found. PT scheduled to visit at 2 pm Monday but doesn't visit until 2 pm Tuesday

- Who must visit first?
- What is the SOC date (M030)?
- Do we have a problem?
- If a problem, how do we compliantly fix it?

TIME POINTS

Understanding critical guidance related to the OASIS Data Collection Time Points

OASIS TIME POINTS - M0100

M0100 – REASON FOR ASSESSMENT (RFA)
1 – Start of Care
3 – Resumption of Care
4 – Recertification (Follow-up)
5 – Other Follow-up
6 – Transfer to Inpatient Facility – Not Discharged
7 – Transfer to Inpatient Facility – Discharged
8 – Death at Home
9 – Discharge from Agency

-(OASIS Assessment Reference Sheet)

HANDLING UNUSUAL SITUATIONS

BEST REFERENCE: *OASIS Considerations for Medicare PPS Patients – Revised November 2010*

Examples of unusual situations:

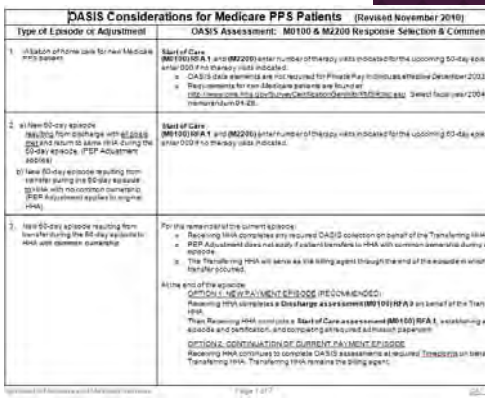
~Qualifying inpatient stay and returned during last 5 days

~Recertified during last 5 days, Transferred and ROC

~On day 60 or 61

~After day 61

~Recertified and then Transferred in the new episode before first visit


OASIS Considerations for Medicare PPS Patients (Revised November 2010)

Type of Episode or Adjustment | OASIS Assessment: M0100 & M2200 Response Selection & Commen

RFA 1 START OF CARE - M0100
FURTHER VISITS PLANNED

START OF CARE (SOC) COMPREHENSIVE ASSESSMENT

Must be completed within 5 days after SOC date

Home visit is required

-(OASIS Assessment Reference Sheet)

RFA 3 RESUMPTION OF CARE - M0100 (AFTER INPATIENT STAY)

RESUMPTION OF CARE (ROC)

- Following an inpatient stay of 24 hours or longer
- For reasons other than diagnostic tests
- Home visit is required
- Must be completed within 2 calendar days of patient's return home (or knowledge of the patient's return home)

- (OASIS Assessment Reference Sheet, CMS Q&As Cat 2, Q2)

RFA 3 RESUMPTION OF CARE - M0100 (AFTER INPATIENT STAY)

RETURN HOME FROM INPATIENT STAY DURING THE LAST 5 DAYS OF AN EPISODE

S	M	T	W	T	F	S
48	49	50	51	52	53	54
55	**56**	**57**	**58**	**59**	**60**	61

WHAT IF MY PATIENT RETURNS HOME FROM THE INPATIENT FACILITY BETWEEN DAYS 56 & 60

- If patient returns home during the last 5 days of the current episode, **complete the RFA 3, ROC only**
- Recertification assessment not required
- ROC determines case mix assignment for subsequent 60-day episode
  - Answer M0110, M1308, & M2200 accordingly

(OASIS Considerations for Medicare PPS Patients; CMS OCCB Q&As, 7/10, Q4)

RFA 4 RECERTIFICATION - M0100
(FOLLOW-UP) REASSESSMENT

COMPREHENSIVE ASSESSMENT (REASSESSMENT) DURING THE LAST FIVE DAYS OF THE 60-DAY CERTIFICATION PERIOD

May be completed over multiple days (56-60) – by one clinician

Home visit is required

IF AGENCY MISSES RECERT WINDOW, BUT STILL PROVIDES CARE:

- Do not discharge & readmit
- Make a visit and complete Recertification assessment as soon as oversight identified
- M0090 = the date the assessment completed
- A warning message will result
- Explain circumstances in clinical documentation

(CMS Q&As Cat 3 Q11; CMS OCCB Q&As 4/10 Q3; OASIS Assessment Reference Sheet)

RFA 5 OTHER FOLLOW-UP – M0100
(FOLLOW-UP) REASSESSMENT

COMPREHENSIVE ASSESSMENT (REASSESSMENT) DUE TO MAJOR DECLINE OR IMPROVEMENT IN PATIENT CONDITION NOT ENVISIONED IN THE ORIGINAL PLAN OF CARE

- Completed at time other than when another assessment is due
- May indicate need to update the patient's plan of care
- Home visit is required
- Policies regarding criteria for RFA 5 must be determined by individual agencies

Must be completed within 2 calendar days of identifying a major improvement or decline in patient's health status

SCIC Payment adjustment removed from 2008 PPS Model

-Must still complete the Other Follow-Up comprehensive assessment when patient experiences a major change in their health status

(CMS Q&As Cat 3 Q12 & 17; OASIS Assessment Reference Sheet CMS Q&As Cat 3, Q18)

RFA 6 TRANSFER TO AN INPT FACILITY
M0100 PATIENT NOT DISCHARGED FROM AGENCY

TRANSFERRED TO INPATIENT FACILITY

- Transferred and **admitted** to inpatient bed of inpatient facility
- **Stay of 24 hours** or longer
- For **reasons other than diagnostic tests**
- Does not require a home visit
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria
- If patient does not return to agency after inpatient admission, no OASIS discharge is required, do internal agency DC
- Includes "Planned admissions"

COMPLETE RFA 6 if you believe **the MC PPS** patient WILL return to your service ~ Other payers may have different requirements

M0906 TRANSFER DATE = Date patient is admitted to inpatient bed; not the ER

(OASIS Considerations for MC PPS Patients; CMS Q&As Cat 2 Q41; Cat 4b Q23.10; OASIS Assessment Reference Sheet; CMS OCCB 7/11 Q3; CMS Q&As Cat 4b Q21.1)

RFA 6 TRANSFER TO AN INPT FACILITY
M0100 PATIENT NOT DISCHARGED FROM AGENCY

YOU MAKE A ROUTINE VISIT AND DISCOVER THE PATIENT HAD A QUALIFYING STAY IN AN INPATIENT FACILITY AND YOU HAD NOT BEEN INFORMED

- Within 2 calendar days of knowledge of transfer
  - Complete the RFA 6 – Transfer to Inpatient Facility
  - Then, complete the RFA 3 – Resumption of Care

- (CMS Q&As Cat 4b Q23.3)

RFA 7 TRANSFER TO AN INPT. FACILITY
M0100 PATIENT DISCHARGED FROM AGENCY

TRANSFERRED TO INPATIENT FACILITY

- Transferred and admitted to inpatient bed of inpatient facility
- Stay of 24 hours or longer
- For reasons other than diagnostic tests
- Does not require a home visit
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria

COMPLETE RFA 7 when you believe the patient will NOT return to your service. Examples: Patient needs higher level of care, no longer appropriate for home care, moving out of service area

Also complete for patients who die in ER, outpatient surgery/outpatient recovery room, while under outpatient observation status or who die within 24 hours of being admitted to an inpatient facility

- Usual requirements for Transfer waived

(OASIS Considerations for MC PPS Patients; OASIS Assessment Reference Sheet; CMS Q&As Cat 2 Q22; Cat 4b Q21.1 & Q183.1; CMS OCCB Q&As, 01/11, Q1)

RFA 8 DEATH AT HOME - M0100

RFA 8 DEATH AT HOME

DEATH ANYWHERE EXCEPT IN AN INPATIENT FACILITY OR IN THE EMERGENCY DEPARTMENT

- Examples: Patient dies at home, at church, in an ambulance, is pronounced DOA in ER

Home visit not required

MUST BE COMPLETED WITHIN 2 CALENDAR DAYS OF DEATH DATE (M0906)

(CMS Q&As Cat 2 Q22 ; OASIS Assessment Reference Sheet)

RFA 9 DISCHARGE FROM AGENCY - M0100

DISCHARGE - Not due to an inpatient facility admission

Not due to death

Home visit required

Must be completed within 2 calendar days of discharge date (M0906) or knowledge of need to discharge

(OASIS Assessment Reference Sheet; Ch. 3)

UNPLANNED OR UNEXPECTED DC

IF DC IS UNPLANNED – The requirements must still be met

DISCHARGE ASSESSMENT MUST REPORT PATIENT STATUS AT AN ACTUAL VISIT – *Not information gathered on a telephone call*

Assessment data should be based on the last visit conducted by a qualified assessing clinician – RN, PT, OT, OR SLP

- Explain this in the clinical documentation

Don't include any events - good or bad - that occurred after the last visit by a qualified clinician, e.g., ER Visit, foley DC'd, change in medical treatment

There may be times when you choose not to complete a discharge assessment if no one person has all the information necessary to complete it and you don't want to copy the SOC assessment

(CMS Q&As Cat 2 Q37 ; CMS Q&As Cat 4b Q181.3 ; CMS Q&As Cat 2, Q37.1, 37.3, 37.3)

UNPLANNED OR UNEXPECTED DISCHARGES

DATES:

M0090 DATE ASSESSMENT COMPLETED

- Actual date agency completed assessment

M0903 DATE OF THE LAST (MOST RECENT) HOME VISIT

- Date of the last visit by agency staff
- Visit by any agency staff included on the plan of care

M0906 DISCHARGE DATE

- Determined by agency policy
- Can't be before the last visit

(Ch. 3)

PROCESS MEASURE ASSESSMENTS

Understanding critical guidance related to M1730 Depression Screening & M1910 Fall Risk Assessment

PROCESS MEASURE ASSESSMENTS COMMON DENOMINATORS

M1240 Pain Assessment, M1300 Pressure Ulcer Risk
M1730 Depression Screening, M1910 Fall Risk

- CMS OASIS-C standardized tool criteria
  - Scientifically tested & validated as effective in identifying a specified condition or risk in a population with characteristics similar to the patient being evaluated
  - Must have a standard response scale
  - Must be appropriately administered based on established instructions
  - Must be appropriate for the patient
  - Must be conducted by the clinician responsible for completing the assessment during the CMS specified assessment timeframe
    - SOC – within 5 days; ROC – within 48 hours following inpatient discharge or knowledge of DC

(Ch. 3; CMS Q&As Cat 4b Q159.3 & Q159.4)

DEPRESSION PROCESS MEASURE

At SOC/ROC Assessment & Identification

M1730 Depression Screening: Has the patient been screened for depression, using a standardized depression tool?

0 – No

1 - Yes, patient was screened using the PHQ-2©* scale

2 - Yes, with a different standardized assessment and the patient meets criteria for further evaluation for depression.

3 – Yes, patient was screened with a different standardized assessment and the patient does not meet criteria for further evaluation for depression

At SOC/ROC Plan

M2250 Plan of Care Synopsis: (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment

0 – No

1 - Yes

NA - Patient has no diagnosis or symptoms of depression

At Transfer & DC Implementation

M2400 Intervention Synopsis: (Check only **one** box in each row.) Since the previous OASIS assessment, were the following intervention(s) BOTH included in the physician-ordered plan of care AND implemented?

c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment

0 – No

1 – Yes

NA – Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment

SOC ROC

M1730 Depression Screening asks if the patient been screened for depression, using a standardized depression tool? Four possible responses:

0 - No
1 - Yes, patient was screened using the PHQ-2©* scale
2 - Yes, with a different standardized assessment – and the patient meets criteria for further evaluation for depression.
3 - Yes, patient was screened with a different standardized assessment – and the patient does not meet criteria for further evaluation for depression

Select "1 - Yes, patient was screened using the PHQ-2©* scale"

First, assess to determine if the PHQ-2 is an appropriate tool, If so:
Ask the patient this question: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2© *	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	0	1	2	3	na
b) Feeling down, depressed, or hopeless?	0	1	2	3	na

29

PHQ-2

- The **patient is the source**
  - Not to be administered by asking caregiver the questions or based on clinical observation
  - If assessment revealed PHQ-2 appropriate for patient, but then clinician cannot elicit responses, select Response 1 with NA as answer
    - Example: Cognitively intact patient, who cannot verbalize/quantify how often she has been bothered by the problems
- If PHQ-2 is not appropriate for patient due to their cognitive status or communication deficits, may choose a different tool
  - Select Response 2 or 3
- If agency provides no appropriate tool, Select Response 0-No
- PHQ-2 total score = 3 or higher indicates need for further evaluation

(Ch. 3; CMS Q&As Cat 4b Q124.5)

30

FALL RISK PROCESS MEASURE

At SOC/ROC Assessment & Identification	At SOC/ROC Plan	At Transfer & DC Implementation
(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?: 0 – No multi-factor falls risk assessment conducted. 1 – Yes, and it does not indicate a risk for falls. 2 – Yes, and it indicates a risk for falls.	**(M2250) Plan of Care Synopsis:** (Check only **one** box in each row.) Does the physician-ordered plan of care include the following: **c.** Falls prevention interventions 0 - No 1 - Yes NA - Patient is not assessed to be at risk for falls	**(M2400) Intervention Synopsis:** (Check only **one** box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? b. Falls prevention interventions 0 - No 1 - Yes NA - Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment

31

MULTI-FACTOR FALL RISK ASSESSMENT TOOL

SOC ROC

- **May be a single standardized assessment tool** that **addresses 2 or more factors**
  - At this time there is no single tool that meets all CMS criteria, but tools are in the validation process
- M**ay be a standardized screen** (like the Timed Up and Go or Functional Reach), **coupled with evaluation of at least one more fall risk factor**, such as:
  - fall history (M1032), polypharmacy (M1032), impaired vision (M1200), incontinence (M1610)
- M**ay be a standardized screen** (like the Timed Up and Go or Functional Reach), **coupled with another multi-factor fall risk tool,** e.g. MAHC (Missouri Alliance for Home Care Tool)

-(Ch.3; CMS Q&As Cat. 4b Q159.2 -159.6)

32

MULTI-FACTOR FALL RISK ASSESSMENT TOOL

- **Select "0-No multi-factor falls risk assessment conducted"**, if:
  - **NO** multi-factor falls risk **screening** conducted by assessing clinician
  - A multi-factor falls risk **screening WAS** conducted but **NOT during the required time frame**
    - SOC – within 5 days after SOC date
    - ROC – within 2 calendar days after inpatient DC date
  - The **patient was unable to participate** in tasks required by tool
    - Note there are tools for assessing risk in the non-ambulatory
    - A single tool may not meet the fall risk assessment needs of all the agency patients

-(Ch.3; CMS Q&As Cat. 4b Q159.6)

33

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?:
0 – No multi-factor falls risk assessment conducted.
1 – Yes, and it does not indicate a risk for falls.
2 – Yes, and it indicates a risk for falls.

- **Select** "1"if the **assessing clinician,** not someone else**, performed** a multi-factor **fall risk assessment during the specified time frame AND** there is **NO identified risk** for falls
  - Standardized response scale rates patient as at no-risk, low risk, or minimal risk

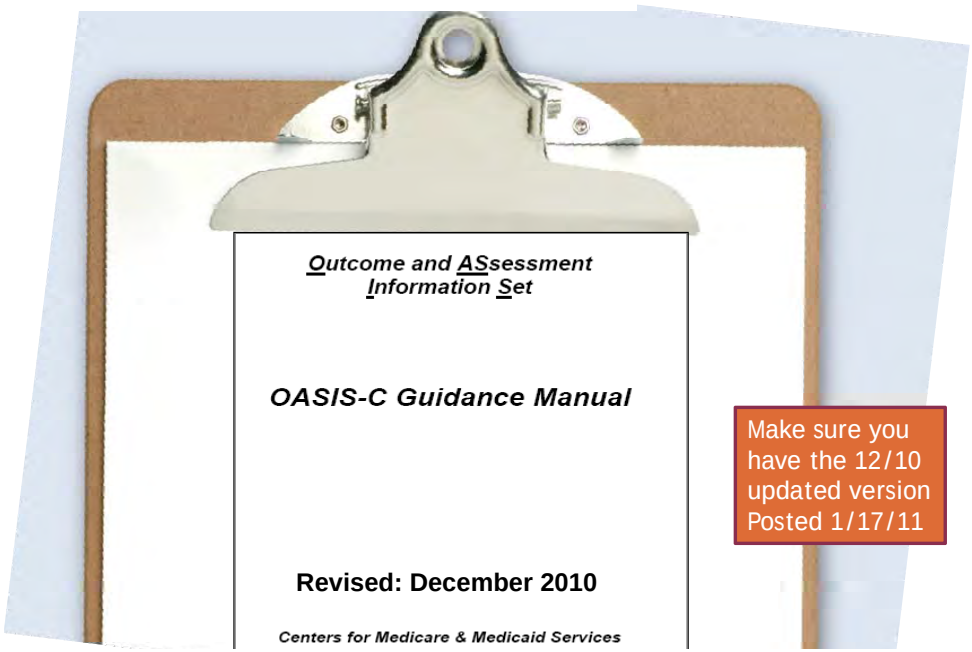
-(Ch.3; CMS Q&As Cat 4b Q159.5)

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?:
0 – No multi-factor falls risk assessment conducted.
1 – Yes, and it does not indicate a risk for falls.
2 – Yes, and it indicates a risk for falls.

- **Select** "2" if the **assessing clinician**, not someone else, **performed** a multi-factor **fall risk assessment during the specified time frame AND** there **IS** an identified risk for falls
  - Standardized response scale rates patient at anything above low/minimal risk
- If you combine a validated tool with a non-validated tool to make your assessment multi-factorial
  - Use the results of the validated tool

-(Ch.3; CMS Q&As Cat 4b Q159.5)

OASIS-C GUIDANCE MANUAL



Make sure you have the 12/10 updated version Posted 1/17/11

www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp

REFERENCES

HOME HEALTH AGENCY CENTER
www.cms.gov/center/hha.asp

CMS OASIS QUESTION MAILBOX
cmsoasisquestions@oasisanswers.com

CMS OCCB Q&As
www.oasiscertificate.org

CMS OASIS Q&AS
www.qtso.com/hhadownload.html

COMPREHENSIVE ASSESSMENT OF PATIENTS ~ PATIENT CLASSIFICATION TABLE
www.cms.gov/oasis/downloads/patientclassificationtable.pdf

OASIS ASSESSMENT REFERENCE SHEET
www.cms.gov/OASIS/Downloads/OASISRefSheet.pdf

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS
www.hhs.gov/OASIS/Downloads/OASISConsiderationsforPPS.pdf

QUESTIONS?