OASIS-C
Integumentary Status Domain
Items 1300-1350

Tips for OASIS-C

- Approach these items as if it is the first time you have seen an OASIS assessment
- Read each question thoroughly on all assessments types every time
- Changes in the sequencing of items
- Many new wound items

Tips for OASIS-C

- Major changes to the previous wound items
- Some items are Process Data Items
- Think, Think, Think- this assessment will require you to utilize your nursing skills and judgment
- Remember this is a NEW OASIS tool

Integumentary Status Domain Resources

- OASIS-C Manual- especially Chapter 3, Chapter 5 and Attachment C
- NPUAP definitions, in the OASIS-C Manual and http://www.npuap.org/
- NDNQI Web training on Pressure Ulcer Staging and Other Wounds- https://www.nursingquality.org/

Integumentary Status Domain Resources

- Wound Documentation and Assessment
  - ADPH secure web site
    - On Demand video
- Pressure Ulcer Staging
  - Standardized Procedure class when available in our Area

OASIS-C

- OASIS-C Manual Appendix C Table
  - Item #
  - Time points
  - Item uses
    - Medicare payment
    - Quality measures
    - Risk adjustment

Integumentary Status Domain Items 1300-1307

- 1300- SOC, ROC : QM & RA
- 1302- SOC, ROC : QM & RA
- 1306- SOC, ROC, FU, DC: QM & RA
- 1307- DC only: RA

Integumentary Status Domain Items 1308-1320

- 1308- SOC, ROC, FU, DC: $, QM, RA
- 1310- SOC, ROC, DC: QM, RA
- 1312- SOC, ROC, DC: RA
- 1314- SOC, ROC, DC: RA

Integumentary Status Domain Items 1308-1320

- 1320- SOC, ROC, DC: RA
- 1322- SOC, ROC, FU, DC: $, RA
- 1324- SOC, ROC, FU, DC: $, QM, RA
- 1330- SOC, ROC, FU, DC: $, RA

Integumentary Status Domain Items 1308-1320

- 1332- SOC, ROC, FU, DC: $ & RA
- 1334- SOC, ROC, FU, DC: $ & RA
- 1340- SOC, ROC, FU, DC: QM & RA
- 1342- SOC, ROC, FU, DC: $, QM, RA
- 1350- SOC, ROC, FU,DC: RA only

Integumentary Status Domain Pressure Ulcers

- Many changes to pressure ulcer items
  - (M1300) Pressure Ulcer Risk Assessment - *NEW*
  - (M1302) Pressure Ulcer Risk - *NEW*
  - (M1307) Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge - *NEW*

Integumentary Status Domain Pressure Ulcers

- (M1308) Current Number of Pressure Ulcers Table – *Revised*
- (M1310 M1310/M1312/M1314) Pressure Ulcer Length, Width & Depth - *NEW*

Integumentary Status Domain Pressure Ulcer Risk Assessment

- (M1300) Pressure Ulcer Assessment
  - Was this patient assessed for Risk of Developing Pressure Ulcers?
    - 0 - No assessment conducted [*Go to M1306*]

Integumentary Status Domain Pressure Ulcer Risk Assessment

- 1-Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- 2 - Yes, using a standardized tool e.g., Braden, Norton, other

Integumentary Status Domain Pressure Ulcer Risk Assessment

- (M1302) Does this patient have a Risk of Developing Pressure Ulcers?
  - 0 - No
  - 1 - Yes

Integumentary Status Domain Pressure Ulcer Risk Assessment

- If using standardized tool, use tool's scoring parameters to identify risk
- If using clinical factors, clinician or agency must define what constitutes risk

Integumentary Status Domain Pressure Ulcers Stage II or Higher

- (M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?
  - 0 - No [Go to M1322]
  - 1 - Yes

Integumentary Status Domain Pressure Ulcers Stage II or Higher

- At SOC/ROC, allows the clinician to skip the next 5 questions if the patient does not have a Stage II or higher pressure ulcer
- Clinicians will need to study and refer to Chapter 3 in the guidance manual to know how to respond to M1306 and M1308

Integumentary Status Domain Pressure Ulcers Stage II or Higher

- Guidance about counting fully epithelialized Stage II, III and IV ulcers has not changed
  - Closed Stage II are still NOT counted in this item
  - Closed Stage III and IV ulcers are still counted

Integumentary Status Domain Unhealed Pressure Ulcers

- (M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge
  - 1 - Was present at the most recent SOC/ROC assessment

Integumentary Status Domain Unhealed Pressure Ulcers

- 2 - Developed since the most recent SOC/ROC assessment: record date pressure ulcer first identified:

  __ __ /__ __ /__ __ __ __

  month / day / year
- NA - No non-epithelialized Stage II pressure ulcers are present at discharge
  - *Collected at Discharge ONLY*

Integumentary Status Domain Unhealed Pressure Ulcers

- Respond 1 or 2 only if discharging with an unhealed Stage II pressure ulcer
- If more than one unhealed Stage II pressure ulcer, determine which one is the oldest

Integumentary Status Domain Unhealed Pressure Ulcers

- If the oldest Stage II Pressure Ulcer was present at the last SOC/ROC select response 1
- If the oldest Stage II Pressure Ulcer present at discharge developed since the last SOC/ROC
  - Select response 2
  - Record the date the ulcer was first identified

Integumentary Status Domain Pressure Ulcer Count

- (M1308) Current number of Unhealed (non epithelialized Pressure Ulcers at each stage
  - Enter “0” if none
    - Excludes Stage I pressure ulcer

Integumentary Status Domain Pressure Ulcer Count

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a. **Stage II:** Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the	___	___

Integumentary Status Domain Pressure Ulcer Count

- What's new in M1308
  - Stage I pressure ulcers are not counted
  - Number of ulcers at each stage is documented
  - Unstageable ulcers are broken out into reason for unstageable

Integumentary Status Domain Pressure Ulcer Count

- 2nd column at FU and DC identifies ulcers that were present on admission
  - Tracks whether an ulcer developed during a quality episode

Integumentary Status Domain Pressure Ulcer Count

- (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
  - Enter "0" if none
    - Excludes Stage I pressure ulcers

For Column 1, report the number of unhealed Stage II or higher pressure ulcers on the current day of assessment.

This column must be completed at Start of Care, Resumption of Care, Follow-up and Discharge.

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
tion – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
Partial thickness loss of dermis ng as a shallow open ulcer with red nd bed, without slough. May also as an intact or open/ruptured serum-filled blister.	___	___
b. **Stage III:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the tissue loss. May include undermining eling.	___	___
Full thickness tissue loss with one, tendon, or muscle. Slough or ay be present on some parts of the ed. Often includes undermining and	___	___
ble: Known or likely but unstageable n-removable dressing or device	___	___
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	___	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___	___

Integumentary Status Domain Pressure Ulcer Count

- (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
  - Enter "0" if none
    - Excludes Stage I pressure ulcers

For Column 2, report the number of unhealed Stage II or higher pressure ulcers that were identified in column 1 and were present on the most recent SOC/ROC.

Column 2 is completed only at Follow-up and Discharge.

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
- unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
al thickness loss of dermis a shallow open ulcer with red ed, without slough. May also intact or open/ruptured serum-	___	___
thickness tissue loss. s fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___	___
c. **Stage IV:** Full thickness tissue loss with tendon, or muscle. Slough or e present on some parts of the ften includes undermining and	___	___
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	___	___
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	___	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___	___

Integumentary Status Domain Pressure Ulcer Count

- **Example #1**
  - **No pressure ulcers**
    - **Patient assessed on SOC and has no unhealed pressure ulcers Stage II or higher but a Stage II develops during the episode and is still present at FU**

Example #1- No Pressure Ulcers

For Column 1, at SOC you would put "0" because there are no unhealed Stage II or higher

	COLUMN 1 **Complete at** SOC/ROC/FU & D/C	COLUMN 2 **Complete at** FU & D/C
Stage description- unhealed pressure ulcers	Number Currently Present	**Number of those listed in Column 1 that were present on admission (most recent SOC / ROC**
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	0	______
b. b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	0	______

Integumentary Status Domain Pressure Ulcer Count

- **Example #1**
  - **At FU, the patient has developed a Stage II…**

Example 1, at FU

For Column 1 at FU put "1" because there is one Stage II on the current day of assessment .

"0" goes in column 2

	COLUMN 1 **Complete at** SOC/ROC/FU & D/C	COLUMN 2 **Complete at** FU & D/C
Stage description- unhealed pressure ulcers	Number Currently Present	**Number of those listed in Column 1 that were present on admission (most recent SOC / ROC**
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	1	0
b. b. Stage III:Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	0	0

Integumentary Status Domain Pressure Ulcer Count

- **Example #2**
  - **Patient has one Stage III pressure ulcer at SOC**
    - **However at FU the ulcer has progressed to Stage IV**

Example #2

For Column 1, at SOC you would put “1” because there is one Stage III

	COLUMN 1 **Complete at** SOC/ROC/FU & D/C	COLUMN 2 **Complete at** FU & D/C
Stage description- unhealed pressure ulcers	Number Currently Present	**Number of those listed in Column 1 that were present on admission (most recent SOC / ROC**
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	0	______
b. b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	1	______

Integumentary Status Domain Pressure Ulcer Count

- Example #2 –Stage III becomes Stage IV
  - At FU, the Stage III pressure ulcer has progressed to a Stage IV

Example #2 FU

For Column 1, at FU in section b (Stage III) put “0” in both column 1 and 2 as there is no Stage III at that assessment

But in section c (Stage IV) put 1 in both columns 1 and 2

	COLUMN 1 Complete at SOC/ROC/FU & D/C	COLUMN 2 Complete at FU & D/C
	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC
[illegible]	______	______
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	0	0
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling	1	1

Integumentary Status Domain Pressure Ulcer Dimensions

- M1310 , M1312, and M1314 – Pressure Ulcer Length, Width and Depth
- Reports dimensions of pressure ulcer with the largest surface area that is

Integumentary Status Domain Pressure Ulcer Dimensions

  - Stage III or IV not covered with epithelial tissue
  - Unstageable due to eschar or slough
- Skip if no stage III, IV or unstageable
  - If multiple open stage III, IV or unstageable ulcers, measure to see which has largest surface area

Integumentary Status Domain Pressure Ulcer Dimensions

- M1310 , M1312, and M1314 – Pressure Ulcer Length, Width and Depth
- Record dimensions of pressure ulcer with the largest surface area in centimeters

Integumentary Status Domain Pressure Ulcer Dimensions

- Length = longest head to toe
- Width = greatest width perpendicular to length
- Depth = from visible surface to deepest area

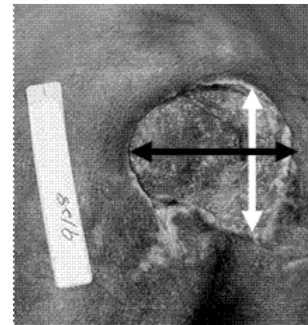
Integumentary Status Domain Pressure Ulcer Dimensions

- Chapter 3 of OASIS-C Guidance Manual has further instructions and pictures
  - Clinicians must become familiar with the manual instructions to respond accurately

M 1310, 1312, 1314

- White line - Length
  - Head to toe
- Black line - Width
  - Perpendicular to the length
- Surface area
  - Length x width

M 1310, 1312, 1314



Integumentary Status Domain Pressure Ulcer Healing Status

- M1320 Status of Most Problematic (Observable) Pressure Ulcer
  - 0 - Newly epithelialized
  - 1 - Fully granulating
  - 2 - Early/partial granulation
  - 3 - Not healing
  - NA - No observable pressure ulcer

Integumentary Status Domain Pressure Ulcer Healing Status

- M1320 Status of Most Problematic (Observable) Pressure Ulcer
  - Response 0 – Newly Epithelialized
    - Epithelial tissue has completely covered wound surface regardless of how long the pressure ulcer has been re-epithelialized

Integumentary Status Domain Pressure Ulcer Healing Status

- Response 1 – Fully Granulating
  - Epithelial tissue has not completely covered the wound surface
- Response 2 – Early/Partial Granulation
  - Necrotic or avascular tissue covers <25% of the wound bed

Integumentary Status Domain Pressure Ulcer Healing Status

- Response 3 - Not Healing
  - For a Stage III or IV pressure ulcer if the wound has ≥25% necrotic or avascular tissue
- Refer to the OASIS-C Guidance Manual and the WOCN OASIS Guidance Document

Integumentary Status Domain Stage 1 Pressure Ulcers

- (M1322) Current Number of Stage I Pressure Ulcers
- Identifies the presence of Stage I pressure ulcers at SOC/ROC, FU and DC
- NPUAP definition of Stage I ulcer

Integumentary Status Domain Stage 1 Pressure Ulcers

- Intact skin with non-blanchable redness of a localized area usually over a bony prominence
- Darkly pigmented skin may not have visible blanching
  - Its color may differ from the surrounding area

Integumentary Status Domain Most Problematic Pressure Ulcer

- (M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer
  - Final item in pressure ulcer section
  - Identifies the stage of the most problematic observable Stage 1 or higher pressure ulcer

Integumentary Status Domain Most Problematic Pressure Ulcer

- Skip if no observable pressure ulcers
- Most problematic may be the largest, most advanced stage, most difficult to access for treatment, most difficult to relieve pressure, etc.
- Used for payment and quality measures

Integumentary Status Domain Stasis Ulcers

- Three items on stasis ulcers
  - (M1330) Does this patient have a StasisUlcer?
  - (M1332) Current Number of (Observable) Stasis Ulcer(s)

Integumentary Status Domain Stasis Ulcers

- (M1334) Status of Most Problematic (Observable) Stasis Ulcer
- Review the manual to see changes to skip patterns, response options

Integumentary Status Domain Surgical Wounds

- Two items on surgical wounds
  - (M1340) Does this patient have a Surgical Wound?
  - (M1342) Status of Most Problematic (Observable) Surgical Wound

Integumentary Status Domain Surgical Wounds

- Both collected at SOC, ROC, FU and DC
- Used for payment and quality measurement
- Item counting number of surgical wounds was dropped

Integumentary Status Domain Surgical Wounds

- (M1340) Does this patient have a Surgical Wound?
  - 0 - No [*Go to M1350*]
  - 1 - Yes, patient has at least one (observable) surgical wound

Integumentary Status Domain Surgical Wounds

- 2 - Surgical wound known but not observable due to non-removable dressing [*Go to M1350*]
- Non-observable = covered by a dressing (or cast) which cannot be removed per physician order

Integumentary Status Domain Surgical Wounds

- (M1342) Status of Most Problematic (Observable) Surgical Wound
  - 0 - Newly epithelialized
  - 1 - Fully granulating
  - 2 - Early/partial granulation
  - 3 - Not healing

Integumentary Status Domain Surgical Wounds

  - NA – Not observable
- A surgical site can be considered “newly epithelialized” for approximately 30 days after epithelial tissue covers the surface of the wound
- After 30 days, it is considered a scar and no longer reported

Integumentary Status Domain Other Wounds

- (M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

Integumentary Status Domain Other Wounds

  - 0 - No
  - 1 - Yes
- Skin lesions or open wounds that are not receiving clinical intervention from the home health agency should not be considered when responding to this question

M1400 M1630/M2100,M2110,M2300, M2310

M1400

- Old MO490
- When is the patient dyspneic or noticeably short of breath?
  - The wording in this question has not changed
  - Option #1 the word “Never” has been removed
  - Used for Payment item, Quality Item, and Risk Adjustment

M1410

- Old MO500
- Respiratory Treatments utilized in the home? (Mark all that apply)
- The wording in this question has not changed
  - Change to Option #3 now reflects both CPAP and BiPAP
- Used in risk adjustment

M1500 New Category!!!

- Process measure
- Question
  - Symptoms in Heart Failure Patients
    - If the patient diagnosed with heart failure, did patient exhibit symptoms by clinical heart failure guidelines at any point since previous OASIS assessment?

M1500 New Category!!!

- Item intent
  - Identifies whether the patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment

M1510 New Category!!!

- Process Measure
- Question
  - Heart Failure Follow-up
    - If patient diagnosed with heart failure and has symptoms indicative of heart failure since previous OASIS assessment, what action(s) has/have been taken to respond? (Mark all that apply.)

M1510 New Category!!!

- Item intent
  - Identifies action the home health care provider took in response to symptoms of heart failure that occurred at the time of the most recent OASIS assessment

M1600 and M1610

- M1600/Old MO510 and M1610/OldMO520
- The only change in these questions were the numbers
- Both Quality Measures
- Used in Risk Adjustment

M1615

- Old MO530
- The wording in the question has not changed
  - However, the options have changed
    - Option #1- occasional stress incontinence

M1615

- Option #3- during the day only
- New options are a ***GOOD*** change as they will allow for more accurate answer
- Home Health Compare

M1620 and M1630

- M1620/Old MO540 and M1630/Old MO550
- The only change in these questions were the numbers
- Both Quality Measures
- Used in Risk Adjustment

Neuro/Emotional/Behavioral/ Status Domain

- Cognitive functioning
- M1700 replaces MO560
- The only change to this item is that the current level of functioning is based on the observations on "day of assessment" which is interpreted as the time of the assessment and in the preceding 24 hours

Neuro/Emotional/Behavioral/ Status Domain

- Confusion/anxiety
- M1710 (When Confused) replaces MO570
- M1720 (When Anxious) replaces MO580
  - Only change in both items is to specify the observations for the last 14 days
  - Used for quality measures

Neuro/Emotional/Behavioral/ Status Domain

- Depression Screening
- M1730 is a new item
- ADPH will be using the PHQ-2 assessment provided on the OASIS C for all patients
  - Therefore, select #2 after completing assessment using the PHQ-2 scale

Neuro/Emotional/Behavioral/ Status Domain

- Questions on the PHQ-2 include
  - Over the last two weeks, how often have you been bothered by any of the following problems?
    - Little interest or pleasure in doing things

Neuro/Emotional/Behavioral/ Status Domain

    - Feeling down, depressed, or hopeless
  - A score of three or more will require further assessment with the PHQ-9

Neuro/Emotional/Behavioral/ Status Domain

- A satellite is scheduled for December 9th regarding how to complete the PHQ-9, educate patients regarding depression, and incorporate depression in the plan of care

Neuro/Emotional/Behavioral/ Status Domain

- Cognitive, Behavioral, and Psychiatric Symptoms
  - M1740 replaced MO610
  - No other changes
- Frequency of Disruptive Behavior Symptoms

Neuro/Emotional/Behavioral/ Status Domain

  - M1745 replaces MO620
  - In description now states, "Any physical, verbal, or other disruptive/dangerous symptoms <u>that are injurious to self or others or jeopardizes safety</u>"

Neuro/Emotional/Behavioral/ Status Domain

- Psychiatric Nursing Services
  - M1750 replaces MO630
  - No other changes to the item

Assessing the ADL Domain

Assessing the ADL/IADL Domain

- Relatively few changes which are
  - Straight forward and
  - POSITIVE!
- More latitude to show improved outcomes

Assessing the ADL/IADL Domain

- Items are scored by OBSERVATION
- Intended to identify the patient's ABILITY, not necessarily actual performance
- Intended to identify patient's ability to SAFELY perform the functional items

Assessing the ADL/IADL Domain

- For multi-task items, if the patient's ability varies between the different tasks, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed

ADL/IADL Data Elements Major Changes

- All old items have new numbers but no changes to when the items are to be collected
- Deletions
  - Transportation, shopping, housekeeping, laundry

ADL/IADL Data Elements Major Changes

  - Prior status 14 days before the SOC/ROC
- Additions
  - Prior status grid
  - Toileting hygiene and fall risk assessment

ADL/IADL Data Elements Major Changes

- Revisions
  - Wording changes (safely has been added to all the items)
  - New response scales (bathing, ambulation)
  - Bathing now includes ability to perform the tub/shower transfer

ADL/IADL Data Elements Major Changes

- Toileting now includes transferring on and off the toilet
- Medication items are now in their own domain

M 1800 Grooming

- Current ability to tend safely to personal hygiene needs
  - Washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care
- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods

M 1800 Grooming

- 1 - Grooming utensils must be placed within reach before able to complete grooming activities
- 2 - Someone must assist the patient to groom self
- 3 - Patient depends entirely upon someone else for grooming needs

M 1800 Grooming

- Item intent
  - Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene
- Identify the patient's ABILITY, not necessarily actual performance

M 1800 Grooming

- "Willingness" and "compliance" are not the focus of these items
- These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment

M 1800 Grooming

- The patient must be viewed from a holistic perspective in assessing ability to perform ADLs
  - Ability can be temporarily or permanently limited by physical impairments
    - Limited range of motion, impaired balance

M 1800 Grooming

- Emotional/cognitive/behavioral impairments
  - Memory deficits, impaired judgment, fear
- Sensory impairments
  - Impaired vision or pain

M 1800 Grooming

- Environmental barriers
  - Accessing grooming aids, mirror and sink

M 1800 Grooming

- Question 1
  - Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?

M 1800 Grooming

- Answer
  - No, assessment of patient's coordination, manual dexterity, upper extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow clinician to evaluate patient's ability to perform grooming activities

M 1800 Grooming

- Question 2
  - Is hair washing/shampooing considered a grooming task, a bathing task or neither?

M 1800 Grooming

- Answer
  - The task of shampooing is not considered a grooming task
  - Hair care includes combing, brushing and/or styling the hair
  - Shampoo is also excluded from bathing, M1830, therefore the specific task of shampooing hair is not included in the scoring of either of these ADL items

M1810 and M1820 Ability to Dress Upper and Lower Body

- Assesses current ability to perform the items safely
- Assessment methodology
  - Observe opening and removing upper body garments during physical assessment of heart and lung to assess manual dexterity needed for dressing

M1810 and M1820 Ability to Dress Upper and Lower Body

- Ask the patient to demonstrate the motions required for dressing
- Assess ability to put on whatever clothing is routinely worn based on your observation

M 1830 Bathing

- Quality Measure
- Medicare Payment
- Risk Adjusted
- Old MO670
- Item 4 is new
- Item 5 is changed
  - New verbiage added

M 1830 Bathing

- Item intent
  - Identifies the patient's ability to bathe entire body and the assistance that may be required to <u>safely bathe, including transferring in/out of the tub/shower</u>

M 1830 Bathing

- <u>The intent of item is to identify patient's ABILITY, not necessarily actual performance</u>
- <u>"Willingness" and "compliance"</u> are not the focus of these items
- These items address patient's ability to safely bathe, given the current physical and mental, emotional, cognitive status, activities permitted, and environment

M 1830 Bathing

- The patient must be viewed from a holistic perspective in assessing ability to perform ADLs
- Ability can be temporarily or permanently limited by
  - Physical impairments
    - Limited range of motion, impaired balance

M 1830 Bathing

- Emotional/cognitive/behavioral impairments
  - Memory deficits, impaired judgment, fear
- Sensory impairments
  - Impaired vision or pain

M 1830 Bathing

- Environmental barriers
  - Stairs, narrow doorways, location of bathroom or laundry

M 1830 Bathing

- Current ability to wash entire body safely
  - <u>Excludes grooming (washing face and hands and shampooing hair only)</u>

M 1830 Bathing

- 0 - Able to bathe self in <u>shower or tub independently, including getting in and out of tub/shower</u>
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower

M 1830 Bathing

- 2 - Able to bathe in shower or tub with the intermittent assistance of another person
  - For intermittent supervision or encouragement or reminders, <u>OR</u>
  - To get in and out of the shower or tub, <u>OR</u>
  - For washing difficult to reach areas

M 1830 Bathing

- **3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision**

M 1830 Bathing

- **4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode**

M 1830 Bathing

- **5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath**
- **6 - Unable to participate effectively in bathing and is bathed totally by another person**

M 1830 Bathing

- **Question 1**
  - **How would I answer this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge independently at the sink?**

M 1830 Bathing

- **Answer**
  - **Item addresses the patient's ability, not actual performance**
  - **Willingness and compliance are not the focus**
  - **If assistance to bathe in shower or tub is needed, level of assistance must be noted, and response 1,2, or 3 should be selected**

M 1830 Bathing

- **Question 2**
  - **If the patient uses the tub/shower for storage, is this an environmental barrier?**

M 1830 Bathing

- Answer
  - If the patient's personal preference is to bathe at the sink, the patient should be scored based on his/her ability to bathe in the tub/shower when it is empty

M 1830 Bathing

- If tub/shower is used for storage because patient has a physical or cognitive/emotional barrier that prevents them from bathing in tub/shower and now uses the area for storage, the score would be 4, 5 or 6 depending on patient's ability at the time of the assessment

M 1830 Bathing

- Question 3
  - If a patient can bathe everything except wash their back and feet and requires a long handle brush/sponge, would they be marked a "1"

M 1830 Bathing

- Answer
  - Because the patient does not have a device and requires assistance to reach hard to wash areas, you should score the ability of the patient without the device

M 1830 Bathing

- If by the end of the episode the needed equipment is obtained and the patient can use it safely, you would show the improvement on bathing

M1840 Toilet Transferring

- Assesses current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode
- Some new text
  - Now includes *safely* and *transfer on and off toilet/commode*

M1840 Toilet Transferring

- Assessment methodology
  - Observe/assist the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc.
  - Determine how much assistance is needed for the patient to safely use the toilet or commode

M1840 Toilet Transferring

- Tasks related to personal hygiene and management of clothing are NOT considered when scoring this item
  - Such tasks are now captured in M1845

M1840 Toilet Transferring

- New OASIS “M” item!
- Quality Measure
- Risk Adjusted

M1845 Toileting Hygiene

- Item intent
  - Identifies patient’s ability to manage personal hygiene and clothing when toileting
  - Identify the patient’s ABILITY, not necessarily actual performance
- "Willingness" and "compliance" are not the focus of these items

M1845 Toileting Hygiene

- These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment

M1845 Toileting Hygiene

- The patient must be viewed from a holistic perspective in assessing ability to perform ADLs
- Ability can be temporarily or permanently limited by
  - Physical impairments
    - Limited range of motion, impaired balance

M1845 Toileting Hygiene

- Emotional/cognitive/behavioral impairments
  - Memory deficits, impaired judgment, fear
- Sensory impairments
  - Impaired vision or pain

M1845 Toileting Hygiene

- Environmental barriers
  - Stairs, narrow doorways, location of bathroom or laundry

M1845 Toileting Hygiene

- Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal
  - If managing ostomy, includes cleaning area around stoma, but not managing equipment

M1845 Toileting Hygiene

- 0 - Able to manage toileting hygiene and clothing management without assistance
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient

M1845 Toileting Hygiene

- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing
- 3 - Patient depends entirely upon another person to maintain toileting hygiene

M1845 Toileting Hygiene

- Response specific
  - Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area

M1845 Toileting Hygiene

- The patient’s ability may change as the patient’s condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified

M1845 Toileting Hygiene

- The clinician must consider what the patient is able *to do* on the day of the assessment
- If ability varies over time, choose the response describing the patient’s ability more than 50% of the time period under consideration

M1845 Toileting Hygiene

- The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent
- Read each response carefully to determine which one best describes what the patient is able to do

M1845 Toileting Hygiene

- This item refers to the patient’s ability to manage personal hygiene and clothing with or without assistive devices
- The word “assistance” in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance

M1845 Toileting Hygiene

- Select Response 0 if the patient is independent in managing toileting hygiene and managing clothing
- Select Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for patient

M1845 Toileting Hygiene

- If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2
  - Response 2 includes standby assistance or verbal cueing

M1850 Transferring

- Assesses current ability to move safely from bed to chair or ability to turn and position self in bed if patient is bedfast
- Revised text
  - *Dropped on and off toilet or commode, into and out of tub or shower (this is now assessed in M1830 and M1840)*

M1850 Transferring

- Assessment methodology
  - Observe the patient during transfers and determine the amount of assistance required for safe transfer from bed to chair

M1860 Ambulation/Locomotion

- Current ability to walk safely, once in a standing position, or use a w/c, once in a seated position, on a variety of surfaces
- New text
  - Now able to score use of a one-handed device (Response 1)

M1860 Ambulation/Locomotion

  - Or two-handed device (Response 2) separately
    - Provides opportunity to show improved outcomes
- Assessment methodology
  - Observe/assist the patient in ambulating (or propelling w/c – manual or power) to bathroom

M1860 Ambulation/Locomotion

  - Note if the patient uses furniture or walls for support and assess if an assistive device should be used for safe ambulation

M1870 Feeding Eating

- Change in number from MO710
- Quality Measure
- Risk Adjusted
- Only content change is eliminating the prior status

M1880 Ability to Prepare Light Meals

- Change in number from MO720
- Quality Measure
- Risk Adjusted
- Only content change is the elimination of the prior status

M1880 Ability to Prepare Light Meals

- Question
  - Should a therapeutic diet be considered when assessing the patient's ability to plan and prepare light meals?

M1880 Ability to Prepare Light Meals

- Question
  - For example, if a patient is able to heat a frozen dinner in the microwave or make a sandwich, but is not able to plan and prepare a simple meal within the currently prescribed diet, would the patient be considered able or unable to plan and prepare light meals?

M1880 Ability to Prepare Light Meals

- Answer
  - M1880 identifies patient's cognitive and physical ability to plan and prepare light meals or reheat delivered meals

M1880 Ability to Prepare Light Meals

- The patient who can complete the mobility and cognitive tasks required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively unable to plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a "1"

M1880 Ability to Prepare Light Meals

  - "1" <u>Unable</u> to prepare light meals on a regular basis due to physical, cognitive or mental limitations
- This "M" item could change after you have completed your diet teaching

M1890 Ability to use Telephone

- Number change from the old 770
- Quality Measure
- Risk Adjusted
- Only content change is the elimination of the prior status

M1900
Prior Functioning ADL/IADL

- New item
- Reflects patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury

M1900
Prior Functioning ADL/IADL

- Separates the functional areas into self-care (grooming, dressing, bathing), ambulation, transfer, and household tasks (light meal preparation, laundry, shopping)

M1900
Prior Functioning ADL/IADL

- Identifies changes that have occurred in the patient's ability to perform ADL/IADL
- This item is used for risk adjustment and can be helpful for setting realistic goals for the patient

M1910
Fall Risk Assessment

- New item
- Identifies whether the HHA has assessed the patient and home environment for characteristics that place the patient at risk for falls

M1910
Fall Risk Assessment

- 3 responses
  - No fall risk assessment completed
  - Yes, and does not indicate risk for falls
  - Yes, and indicates a risk for falls

M1910
Fall Risk Assessment

- **Assessment completed by observation, pt/CG interview, physical assessment, environmental assessment, review of past health history, referral info, etc.**
- **Used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment**

Assessment of ADL Data Elements

- **All ADL and IADL items are to be scored based on the patient's current ability and level of assistance needed to perform the activity safely**
- **Assessed by** OBSERVATION
- **Helpful to organize activities that must be observed in order to be as efficient as possible and to score the ADL items as accurately as possible**

SHOW ME

			NEW
S	Shirt & Shoes • Observe patient don/doff shirt and a shoe/sock	M0650 M0660	M1810 M1820
H	Hike to bathroom • Observe transfer on/off beside commode/toilet • Observe transfer in/out tub/shower • Ask patient to reach head, lower back, & toes • Observe ability to adjust clothing before/after using toilet	M0670 M0680 M0690	M1830 M1840 M1850 M1845
O	Organization and use of grooming utensils • Shaving equipment • Comb/brush • Toothbrush	M0640	M1800
W	Walk through home to all areas needed for ADLs/IADLs • Bedroom, kitchen, laundry, access to transportation • Include all surfaces-even & uneven surfaces, stairs & steps • Note cleanliness of clothes/home & ask who does laundry/housekeeping	M0700 M0740 M0750	M1860 Dropped Dropped M1850
M	Medications • Observe where meds kept & device/techniques used to take meds as ordered • Observe ability to select right med, right dose, right time	M0780 M0790 M0800	M2020 Dropped M2030
E	Eating and making meals • Access to/use of refrigerator and microwave or stove • Carry meal to table • Chew and swallow adequately	M0710 M0720	M1870 M1880

Definitions:

- "Supervision" - watching performance
- "Verbal cueing" - watching and talking through
- "Assistance" - Physical contact
  - Minimal: 25% - 50% (touching)
  - Moderate: 50% - 75% (holding)
  - Maximal: 75% - 100% (carrying)

Ability to perform during an entire 24-hour period, in patient's own environment, as influenced by:

- Physical factors (endurance, strength, pain, fatigue, dyspnea, vision/sensory, etc.)
- Cognitive factors (memory, orientation, etc.)
- Physchological factors (fear, depression, psychosis, etc.)
- Environmental factors (arrangement of home, stairs, clutter, facilities available)
- Medical contraindications (restrictions on driving, stair climbing, etc.)
- **SAFELY!!!!!** (If performing the activity, but not safely, increase functional deficit)

If Functional Deficits, Plan Care! Achieve better outcomes for our patients with referrals!!!

- Deficits in ambulation or transferring → PT
- Deficits in ADLs or IADLs → OT
- Deficits in IADLs, no caregiver → MSW
- Deficits in eating, related to swallowing → SLP
- Defictis in medication management → RN
- Difficulty with grooming, dressing, bathing → HHA/OT