Assessing 24 Hour Time Period
1/20/09

Did you know when assessing pain, dyspnea, current ADL status and Medication management that you need to consider the day of your visit and the 24 hours preceding the visit?

These Oasis items should be assessed and scored based on what is true for the patient greater than 50% of the time over the 24 hour time period.

MO420 Pain
1/27/09

Pain MO420 asks how often pain interferes with activity or movement.
Consider that pain interferes with activity when the pain results in:

- Activity being performed less often than otherwise desired
- Requires the patient to need help in performing activities
- Causes the activity to take longer to complete

The patient may not report pain during your visit, but remember to assess the 24 time period leading up to your visit.

Pain may not be the main focus of care for every patient, but if they have pain it needs to be part of your care plan. Think about how you can improve the patient's overall condition by discharge.

If your patient still has pain at discharge, but is now independent or no longer going to be homebound, does the pain still interfere with activity?

M0490 Dyspnea - When is the patient Dyspneic or Noticeably Short of Breath?

2/3/09

During your visit there are many ways to assess for SOB while assessing other Oasis items. It is not enough to only ask your patient if they become SOB

- Have the patient walk to the bathroom. How far can they ambulate before becoming SOB? (also assesses ambulation, transfers, toileting and BR setup)
- Ask pt to remove or put on upper/lower body clothing. Do they become winded? (also assesses dressing and skin integrity, such as foot assessment)
- Have the patient lye flat in bed. Can they breathe easily? Do they need extra pillows? (also assesses bed transfers)

Avoid using min and mod exertion to describe SOB. Rather, DOCUMENT THE ACTIVITY that causes the patient to become SOB. Include # of feet w/ambulation.

MO490 Dyspnea
Clarification of Response #4
Dyspnea at rest
6/18/09

To further clarify dyspnea at rest, here is a Q&A directly from CMS…..

Q- Patient currently sleeps in the recliner or currently sleeps w/2pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. How would you mark MO490?

A- MO490 reports what is true at the time of your assessment (the 24 hours immediately preceding the visit and what is observed during your assessment) If the patient has not demonstrated or reported SOB during that timeframe, the correct response would be "0-Never" even though the environment or patients activities were modified in order to avoid the SOB.

So in the case of a patient who reports SOB when lying flat who is currently not doing anything to modify the problem, you would indicate "sob at rest-#4" and institute interventions to modify the problem.

MO430 Intractable Pain
2/10/09

To be considered intractable pain (per Oasis guidelines) the pain must meet ALL 3 criteria.

- Not easily relieved
- Occurs at least daily
- Affects the pt's quality of life (i.e.- may affect sleep, appetite, physical/emotional energy, concentration, personal relationships or ability/desire to perform activity)

This type of pain likely interferes with the patient's activities and needs to be considered when developing the plan of care

MO520/530 Urinary Incontinence Part 1
2/17/09

MO520- Is the patient incontinent? Any dribbling and leaking at any time is considered incontinence.

MO530- When does the incontinence occur? It doesn't have to occur all the time. Consider the day of your assessment and the relevant past (i.e.-patient with stress incontinence that only dribbles urine when they cough or laugh) use your clinical judgment when considering the relevant past.

Even if the incontinence only occurs during the day, to answer M0530 your only option is to check occurs day and night. Document your assessment in your clinical note.
Stay tuned for tips on timed voiding next week!

MO530 Urinary Incontinence Part 2
Timed Voiding
2/24/09

If a patient is on a timed void program you need to document the program in your note AND indicate if it is successful? Ask the patient if the program works all the time. "Timed-voiding defers incontinence" should only be marked if the plan successfully prevents leaking 24hrs per day, otherwise mark when the incontinence occurs.

If the patient is having accidents/leaking despite the program then consider what changes could be made to make it work for the patient by identifying patterns in their voiding and leaking and tweaking their program. Be sure to monitor and document the patient's progress.

*Avoid using the word Incontinence. Ask the patient if they ever leak, wear pads or not make it to the bathroom in time. You may make the patient more willing to answer truthfully by saying…. Hey do you ever find when you cough or sneeze you dribble a little bit? Don't you hate when that happens?

MO690 Transfers Part 1
3/3/09

Did you know that there are 3 activities involved in assessing transfers?

- Ability to move from bed to chair
- Ability to get on and off toilet or commode
- Ability to get in and out of shower or tub

For bedfast patients, assess the ability to turn and position self in bed.
If the patient's ability varies between transfer activities then document the level of ability applicable to the majority of the activities and remember "ABILITY IMPLIES SAFETY"

MO690 Transfers Part 2
3/10/09

Remembering that there are 3 tasks involved in assessing transfers (bed to chair, on/off toilet/commode and in & out of shower/tub) also remember that armrests of a chair DO NOT count as an assistive device.

- If a patient needs only assistive devices to transfer safely, score a (1).
- If a patient needs only minimal human assist or cues/supervision to be safe, score a (1).
- If a patient needs both devices and the human assist to be safe, score a (2). This means the patient is able to bear weight to transfer but is unable to do it safely by himself (the device and assist to safely transfer).

MO670 Bathing Part 1
3/18/09

MO670 BATHING - Ability to wash entire body and assistance required to be safe (excludes hands/face only)

Assess the patient's ABILITY not preference. Pt's who prefer to sponge bathe must still be assessed on the level of assist needed to SAFELY bathe in shower or tub.

There may be a barrier that prevents them from showering (i.e.-medical restrictions, access to shower, nonfxing shower, fear of falling d/t past hx of fall) document the barrier in your note!

At SOC, the patient may not have what they need to be safe (i.e.-equipment)
Score the Oasis according to what is SAFEST for the patient to do even if it conflicts with what the patient is actually doing and again document in your note.
Include interventions in your plan of care to improve patient safety/ability such as safety teaching, therapy evals.

* Extra tip - the tub or shower transfer should not be considered when assessing bathing ability even though it is mentioned in response option 1.

MO670 Bathing Part 2
Focus on Sponge Bathing
3/25/09

MO670 BATHING PART 2/ Sponge bathing, Response option 4
Unable to use shower or tub and is bathed in bed or bedside chair is response option #4 on the Oasis.

This answer implies that there is an actual BARRIER that prevents the patient from showering. You would then need to document in your note the barrier that prevents the pt. from showering.

Some Examples of barriers include:

- medical conditions or restrictions
- no access to shower maybe due to inability to climb stairs to BR
- nonfunctioning or unsafe showering facilities
- realistic fear of falling due to history of fall

MO670 Bathing Part 3
Unable to participate in bathing
4/1/09

MO670 BATHING PART 3/ Unable to participate in bathing, Response option 5
Unable to effectively participate in bathing and is TOTALLY bathed by another person. This may include quadriplegics or patients with cognitive deficits who cannot follow through with tasks.

So a patient who is truly unable to participate in any part of the bathing process even if they are put into the shower, select response 5
Support your response in your note.

MO650/660 Upper and Lower Body dressing
4/8/09

DRESSING: MO650 (upper body)
MO660 (lower body)

Dressing (per Oasis guidelines) is the ability to SAFELY dress with or without dressing aides. It includes obtaining, putting on and removing clothing.

Assess the patient's ability based on clothing usually worn. Don't make assumptions about what the patient "routinely wears".

Devices such as prosthesis, orthotics, AFO, splint, corset, brace, knee immobilizer, TED support hose are all part of body apparel.

If a patient requires stand-by assistance, verbal cues or reminders to dress safely then response 2 applies (someone must help the patient dress)

Direct questions AND observation are necessary to determine the patients dressing ability. Have the patient perform or simulate dressing activities to determine their ability to complete the task safely.

MO680 TOILETING
4/15/09

MO680 TOILETING (per Oasis guidelines) is defined as the "ABILITY TO SAFELY GET TO/FROM" the toilet or use a bedside commode or bedpan/urinal.
EXCLUDE from your assessment:

- personal hygiene
- clothing management
- transfer on and off the toilet or commode
- emptying bedpan or urinal

*For patients who must use a bedpan then you would only be assessing their ability to get on/off the bedpan.

*Patients with urinary catheters and/or ostomies can still be assessed on their ability to get to and from the toilet or a commode even if they do not use the toilet for elimination.

*Remember to assess ABILITY and not preference… Pt's who choose to use a commode for conveniences still need to be assessed as to their ability to get to the toilet.

*Lastly, remember that the ability to transfer on and off the toilet/commode will be assessed during the transfer question MO690.

MO700 AMBULATION
4/23/09

MO700 AMBULATION> Defined as the ABILITY to SAFELY walk once in a standing position or use a wheelchair once seated.

Think about the usual surfaces a patient would routinely encounter in their environment, even and uneven. Are they safe on ALL of those surfaces? If not, what level of assist is needed for them to be safe at all times?

Things to consider:

- A patient must be able to take more than a few steps to be considered ambulatory.
- Weight bearing/activity restrictions- what the patient can do and what they are allowed to do may differ. Consider what level of assist is needed to ambulate safely AND maintain the restriction.

A patient who is unsteady or unsafe ambulating should be scored a (2) on the Oasis (able to walk with assist or supervision at all times) regardless of whether they live alone or not Your care plan should then include interventions such as safety teaching and therapy evals

A patient with cognitive deficits who is steady when ambulating may still require verbal cues or constant supervision for safety due to risk of wandering and would not be (0) independent in ambulation.

Bedfast is the inability to ambulate or be in a chair. Pt's who get out of bed at all are not bedfast.

MO780 ORAL MED MANAGEMENT Part 1
4/29/09

MO780 ORAL MED MANAGEMENT- is the patient's ability to prepare and take ALL oral meds RELIABLY AND SAFELY!

- Includes prescription and over the counter meds
- Assess all, report most: This means consider all the meds the patient takes and then score the Oasis based on how the pt manages the majority of the meds
-

SCORE 0- INDEPENDENT= If the pt can correctly prefill their own med box using a written list that they develop, they would be considered independent with oral meds.

SCORE 1-NEEDS ASSIST= In order for a patient to be scored a (1) they would need only to require one of the following:

- individual doses prepared by another person OR
- given daily reminders OR
- someone (other than the pt) develops a drug diary or chart to follow

SCORE 2-UNABLE TO MANAGE= If someone prepares meds for the pt (i.e.-med box or written list) AND the pt also requires reminders in order to SAFELY take their meds, the Oasis score would be a (2) Unable to take meds unless administered by someone else.

***Stay tuned next week for CMS clarification and more tips for assessing oral meds

MO780 ORAL MED MANAGEMENT Part 2
5/7/09

- Avoid just asking questions and have the patient demonstrate their ability to manage meds
- Score the Oasis based on the pt's ability and not their willingness or compliance
- Many ALF's require staff to administer meds, but you should assess the pt's ability as if he/she lived on their own.
- Tasks related to filling/reordering meds are part of IADL's and should be noted in MO760 shopping
- At SOC the pt may correctly verbalize or demo any med teaching you provide, but follow-up visits are necessary to ensure the teaching was effective. In this case don't give the pt credit at the initial eval for teaching provided. Score the Oasis based on where they where at before you taught them.
- Determine how the patient takes the MAJORITY of their medications:
  Example 1) If a patient takes 5 meds daily, 4 of which they take independently every morning, but one at night that they need reminders to take, the pt would still be considered independent because they can manage 4 out 5. The majority rules!

Example 2) A pt. who has 2 meds, one of which is taken daily and the other taken 4xday (i.e. Parkinson's med) if the pt is independent with taking both meds first time in the morning, but needs reminders to take the remaining 3 doses of the second med , they would score 1 on the Oasis, needs cues or reminders.

Please contact your QA specialist for any concerns or confusion regarding oral med management.

OASIS AND OUTCOMES
5/14/09

Oasis Outcomes are a measurement of changes in a patient's health status between 2 time points. Outcomes are determined by Oasis data from a SOC or ROC to a DC.

The following Oasis Items are reported as Outcomes:

- MO420 PAIN
- MO490 DYSPNEA
- MO488 SURGICAL WOUND STATUS
- MO530 URINARY INCONTINENCE
- MO780 ORAL MED MGMNT
- MO670 BATHING
- MO690 TRANSFERS
- MO700 AMBULATION

The reason for homecare services may not be related to the Oasis items listed above, but if any are identified as a problem or are scored 1 or lower on the Oasis, then you should include interventions in your care plan to address the issues.

The goal is to see improvement in outcomes at discharge!

MO200/210 Change in Medical Treatment or Regime
5/21/09

MO200 - Has the patient experienced a change in medical or treatment regime in the last 14days prior to your SOC, ROC or DC visit?

This may include medication changes or service change due to a new or exacerbated diagnosis, new diet, new exercise program, new or changed wound care.

Questions to consider and Assessment tips;

- Is there a new DX or exacerbation of an old DX that necessitates a change in treatment?
- Has there been a medication change?
- Are therapy services newly ordered or has a regime changed occurred in response to a change in the pt's health status?
- Check med bottles against MD orders, do they match?
- Ask patients when the last time they had med changes or saw MD
- Think of 14days in terms of week day. It's easier to think in terms of what day of the week it is. So if you admit on a Monday, look back at the Monday 2wks ago as day #1

The exacerbation of a disease itself would NOT be considered a "change in medical condition" unless it required a medication change, treatment plan change or service change such as addition of added disciplines.

If you answer "YES" to MO200 then you must answer MO210

MO210 Lists the patient's entire Medical Diagnoses, only check off those that required a change in medication, treatment plan or services.

MO850/870 Inpatient Facility Admission and Discharge Position

5/29/09

Case scenario: You are discharging a patient from VNA services to start Hospice care at home. How would you answer MO855 and MO870? (Scroll to the bottom for answer)

MO855- To which INPATIENT FACILITY has the patient been admitted?

1-hospital
2-rehab facility
3-nursing home
4-hospice
NA- no inpatient facility admission at time of discharge from agency

MO870- Discharge disposition: Where is the patient after discharge from the agency?

1-patient remained in the community (NOT in a hospital, nsg home or rehab facility)
2-Pt transferred to a NONINSTITUTIONAL HOSPICE
3-Unknown because the patient moved to a geographic location not served by this agency.
4-UK- unknown

When a patient is discharged from VNA to start Hospice care at home, you would answer NA to MO855 and #2 for MO870, pt transferred to noninstitutional hospice. Noninstitutional Hospice is defined as the patient receiving hospice care at home or a caregiver's home, NOT in an inpatient hospice facility.

MO220 and Risk Adjustment
6/10/09

It is important to score ALL of the Oasis questions as accurately as possible even if it is not an Outcome or reimbursement question.

MO220 is one of many Oasis questions that do not directly affect payment or outcomes, but do play into Risk Adjustment.

Risk-adjustment is a method used by CMS to adjust Outcome results in order to level the playing field among all Home Health agencies. This means, CMS recognizes it is more difficult for agencies with "sicker" or "more disabled" patients to achieve improved outcomes as opposed to agencies with healthier or more functional patients.

MO220- Conditions prior to Medical or Treatment Regime Change or Inpatient stay within the last 14days: If the patient experienced an inpatient facility discharge or change in medical treatment in the last 14 days, indicate any conditions which existed PRIOR TO the inpatient stay.

1-urinary incontinence
2-indwelling/suprapubic catheter
3-intractable pain
4-impaired decision-making
5-disruptive or socially inappropriate behavior
6-memory loss to the extent that supervision is required
7-none of the above
NA- no inpatient facility discharge AND no change in medical/treatment regime in the past 14 days
UK- unknown

Stay tuned for future tips on risk adjusted Oasis questions…….

MO250 Therapies at Home
6/30/09

MO250 Therapies the patient receives at home (Mark all that apply)

1. Intravenous or infusion therapy (excludes TPN)
2. Parental nutrition (TPN or lipids)
3. Enteral nutrition
4. None of the above

The key is that the patient is receiving infusion services AT HOME regardless of who is administering them. This includes therapies they are receiving at the time of your visit or therapies they will receive as a result of your assessment (i.e.- if the MD orders IV therapy or tube feedings as a result of your assessment, response 1 or 3 would apply)
IV or infusion therapy (response #1) includes: central lines, subcutaneous devices, implanted pain pumps, insulin pumps, epidural or intrathecal infusions and home peritoneal dialysis.

For enteral nutrition (response #3) the patient must be receiving nutrients through the tube (H20 flushes and meds only via the tube DO NOT COUNT) in this case you would check #4-None of the above

MO390 VISION
7/9/09

MO390 VISION WITH CORRECTIVE LENSES IF THE PATIENT USUALLY WEARS THEM:
0-Normal vision- see adequately in most situations: can see med labels, newsprint
1-Partially impaired-cannot see medication labels or newsprint, but can see obstacles in path; and surrounding layout; can count fingers at arm's length.
2-Severely impaired- cannot locate objects w/o hearing or touching them or pt is nonresponsive.

It is important to have the patient demonstrate and not just ask about their vision! You are assessing the ability to see, not read, so an illiterate person can still have adequate vision.

Prescription and nonprescription eyeglasses (i.e.-corrective magnifying lenses bought at drug store) are considered corrective lenses.

A magnifying glass itself is NOT considered a corrective lens. If a patient requires a magnifier glass to read, then response #1 would apply.

Disoriented or cognitively impaired pts can still have their vision assessed by assessing their response to familiar objects or place a tiny object such as a penny in front of them and see if they can pick it up...

Document your findings in your clinical note. Avoid writing visual deficit, instead use the objective measures found in the answer choices themselves. (i.e. - pt cannot see med labels or newsprint or pt. uses a magnifier to read med labels, etc…)

Remember, if the patient doesn't normally wear glasses, then assess without them. This may be the case if the patient's glasses are broken.

Oasis and Pressure Ulcers
7/16/09

Oasis and Pressure Ulcers

- Never reverse stage a pressure ulcer
- A pressure ulcer that is debrided remains a pressure ulcer and does NOT become a surgical wound
- A pressure ulcer covered with slough/eschar is considered nonobservable. It cannot be staged unless the deepest viable tissue layer is visible.
- If the pressure ulcer is "nonobservable" due to the presence of eschar then your response to MO464 (status of healing) would be #3- not healing
- A pressure ulcer treated with a MUSCLE FLAP becomes a surgical wound
- A pressure ulcer treated with a SKIN FLAP remains a pressure ulcer
- A healed stage 3 or 4 pressure ulcer that reopens is staged at it's worst stage prior to healing
- Per Oasis guidelines, healed stage 3 and 4 pressure ulcers are to be reported on the Oasis and the status of healing (MO464) would be #1- fully granulating
- A healed stage 1 or 2 would no longer be indicated on the Oasis as a pressure ulcer, it may however leave a scar in which case you would answer yes to MO440 and no to MO445
- Stage 1 definition – Area of intact skin that is red and nonblanchable
- MO464-status of pressure ulcer- Stage 1 ulcers, infected ulcers, pressure ulcers with equal to or greater than 25% avascular tissue are considered Not Healing per Oasis guidelines.

MO440-MO488 Oasis and Skin Lesions/Open Wounds
7/22/09

By now most clinicians know that any alteration in skin integrity whether closed or open would be considered a “YES” response to M0440 (Does this patient have a skin lesion or open wound?)

This includes but is not limited to: sores, skin tears, venous/arterial/pressure ulcers, surgical wounds, crusts, scars, rashes, burns, cysts, moles, edema, nodules, ecchymosis and petechiae

Once you have answered “yes” to MO440, you then have the option to report 3 types of wounds

- MO445 (Pressure Ulcers)
- MO468 (Venous Stasis Ulcers)
- MO482 (Surgical wounds)

If the patients wound type does not fit into the above options you would still answer “yes” to MO440 then “No” to Pressure ulcer, Stasis ulcer and surgical wound. (See example below).

Support the wound type and your assessment in the wound tab section of the clinical note

Patient admitted with a diabetic ulcer on their toe.

- MO440- skin lesion or open wound, response “yes”
- MO445 pressure ulcer response “no”
- MO468 venous stasis ulcer response “no”
- MO482 surgical wound response “no”

MO468 Stasis Ulcers
July 2009

MO468 Does this patient have a Stasis Ulcer?

This Oasis question is asking ONLY about Venous Stasis Ulcers and EXCLUDES Arterial Ulcers.

If the pt has a venous stasis ulcer then answer “yes” to MO468
Document the wound type (Venous stasis ulcer) and description in the wound tab section of your note.
*** Remember, the Oasis and your clinical note must match!

For arterial ulcers, answer “YES” to MO440 (skin lesion/open wound) and “NO” to pressure ulcer, stasis ulcer and surgical wound. The wound type (Arterial ulcer) and description would then be supported in the wound section of your note.

- Refer to the WOCN (Wound Ostomy and Continence Nurses Society) and
- NPUAP (National Pressure Ulcer Advisory Panel) for guidance on determining the healing status of pressure, venous stasis and surgical wounds. The healing status (fully granulating, early partial healing, not healing, non-observable) will vary depending on the type of wound.

MO482-MO488 Surgical Wounds Part 1
8/27/09

MO482 Does this patient have a surgical wound?

This can be a tricky question because surgical wounds are more than just surgical incisions yet don't include all surgical incisions.

Some examples of what is considered a Surgical Wound per CMS clarification:

- most surgical incision
- orthopedic pin sites
- wounds with drains (excludes ostomies)
- central line sites (even if not presently in use and/or when initial insertion site is healed)
- implanted infusion devices (i.e.-portacaths) same as central line sites
- peritoneal dialysis catheter (exit site), AV fistula
- muscle flap (placed over a pressure area)
- shave, punch or excisional biopsy sites
- thoracentesis/arthrocentesis if surgical procedure performed via scope
- wound created when and ostomy is reversed
- trauma that resulted in surgery to repair ruptured organs, torn tendons, ligaments, muscle, fractures (beyond simple sutured traumatic laceration)

MO488 (Healing) Status of the most problematic, observable surgical wound.
Refer to the WOCN guidelines for guidance on the healing status< Remember this question not only affects reimbursement, but also Outcomes and Non routine supply reimbursement.

Stay tuned next week for guidance on what IS NOT considered a surgical wound for purpose of OASIS.

If you do not have a surgical wound tip sheet to help guide you as to what wounds are surgical and which ones aren't, please see your QA specialist for a copy.

MO482-MO488 Surgical Wounds Part 2
9/2/09

THE PRESENCE OF SUTURES DOES NOT AUTOMATICALLY EQUAL A SURGICAL WOUND

Last week I highlighted examples of surgical wounds that require a "yes" response to MO482- Does this patient have a surgical wound?

The examples below are NOT considered surgical wounds per CMS clarification:
In this case you would answer "NO" to M0482

- ALL Ostomies
- Chest tube sites with or without a drain
- An ostomy closing on its own (without surgical reversal)
- The surgical line around a fresh ostomy stoma
- Debridement or suturing of a burn, pressure ulcer, stasis ulcer or traumatic laceration DOES NOT make it a surgical wound, even if done by a plastic surgeon
- Simple Incision and drainage
- Cardiac catheterization done by needle puncture
- PICC lines
- Implanted pacemakers or defibrillators after original incision has healed
- Arthrocentesis/Thoracentesis sites-if a needle is inserted for fluid aspiration only
- Peripheral IV sites sutured in place
- Pressure ulcers sutured shut
- Traumatic lacerations
- Cataract surgery
- Gynecological surgery by vaginal approach
- Skin graft recipient site

Some of the above examples may require a "yes" response to MO440 (Does this pt have a skin lesion or open wound) but would never be a "yes" response to MO482

Consult with your QA specialist if you have questions and remember to ask for a copy of the Oasis Surgical Wounds Quick Reference guide.

MO510- Has this patient been treated for a Urinary tract infection in the past 14days?

9/16/09

The key is has the patient been treated in the last 14 DAYS…….

If the pt had symptoms of a UTI or a positive culture for which the MD DID NOT prescribe treatment, or the treatment ended MORE THAN 14 DAYS AGO, response "0-No" would apply

Answer "Yes" when the patient had a UTI for which they received treatment in the last 14days

If the patient is on prophylactic treatment to prevent UTI's the appropriate response is "NA-pt on prophylactic treatment"

If the patient is on prophylactic treatment AND develops a UTI, mark response 1 "yes"

When completing a Discharge Oasis a "yes" response to MO510 will trigger an Adverse Event.

Before discharging a patient from services you need to consider if the patient is still being treated for a UTI. If yes, then further skilled assessment and follow-up (i.e. - repeat urine culture) may be necessary to ensure the infection and/or symptoms are resolved.

MO610/620
9/24/09

Identifying and documenting cognitive/behavior problems impacts Outcomes, affects risk adjustment and helps to support the patients acuity in other areas of the Oasis. Behaviors identified in MO610/620 potentially affect the patient's ability to learn, takes meds properly, follow direction or improve their well-being, etc…

MO610 Behaviors Demonstrated at LEAST ONCE A WEEK (Reported or Observed)

1. Memory deficit
2. Impaired decision making
3. Verbal disruption
4. Physical aggression
5. Disruptive, infantile or socially inappropriate behavior
6. Delusions, hallucinations or paranoid behavior
7. None of the Above

Please be sure to read the descriptors for each possible response and mark all that apply.

MO620 Frequency of Behavior Problems (Reported or Observed)
THIS INCLUDES, BUT IS NOT LIMITED TO the responses in MO610 and examples in 620.

There are behaviors other than those in MO610 and the examples in 620 that can be indications of alterations in the patient's cognitive, neuro/emotional status.

Any behavior or concern for the patient's safety or social environment can be regarded as problem behavior and should be documented in your note.

MO290 High Risk Factors (Mark all that apply)
10/7/09

1- Heavy smoking
2- Obesity
3- Alcohol dependency
4- Drug dependency
5- None of the above
UK- Unknown

This question identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.

It is important to assess patients for high risk factors and document in your clinical note. Patients with one or more high risk factors are more likely to be hospitalized or need emergent care.

High Risk factors will impact Risk adjustment, Outcomes and the patient's plan of care.

Oasis- C and Process Measures
10/21/09

The introduction of Oasis-C is under way. The implementation date is January 1st 2010. You will be hearing and learning more about the new Oasis-C process questions at your team meetings.

Why is CMS adding process questions to the Oasis?

- to prevent exacerbations of serious conditions
- to improve care for each individual patient
- to provide guidance for Home health agencies on how to improve care and avoid adverse events.

A few of the tools that will help you answer the process questions and identify at risk patients include the Braden scale, PHQ2 depression screen and the falls risk assessment. Once completed, there will be specific guidelines to help you develop an individualized patient plan of care.

Oasis C - M1730 Depression screening
11/13/09

To reinforce recent education from your team meetings about new the Oasis C, here is a synopsis of the new Depression question M1730

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

The PHQ-2 is the screening tool that we will be using; it consists of 2 questions and will be incorporated into the Oasis.

All patients will need to be screened for depression at SOC and ROC; therefore you should always answer yes to this question.

If the patient scores a 2 or more on either question then further depression screening is indicated.

Offer and initiate a consult for a PSN eval. If the patient refuses, document in your note.

The physician ordered plan of care must include orders for treating depression if it is being monitored. Such interventions may include monitoring med effectiveness, teaching re: meds or referrals to other agency resources (i.e.- PSN, MSW)

Implementation and eval of interventions will be crucial for answering plan of care synopsis questions at SOC, ROC, TIF and DC.

M1300 & M1302 Pressure Ulcer Risk Screening

New Oasis C questions starting January 1, 2010

M1300 Pressure Ulcer Assessment: Was this patient assessed for Risk of developing Pressure ulcers?

The Braden scale is the standardized tool we will be using to assess ALL patients for Pressure ulcer risk. The Braden scale is currently an addable form in your tablet. M1300 should always be a "yes response" option #2

M1302 Does this patient have a Risk of Developing Pressure Ulcers?
The Braden will calculate a risk number; refer to the "Braden Scale intervention guide" to determine the level of risk and interventions.

So you determine the patient is at risk: What next?

1. choose interventions per Braden scale recommendations
2. confirm & communicate with the physician and add interventions to the POC
3. implement the POC interventions and document in your clinical notes
4. monitor the interventions and communicate with the MD as needed to change the plan.