Oklahoma State Department of Health

OASIS News You Can Use

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278

Special points of interest:

Fond Farewell
Points to Ponder
Pain and Falls

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Fond Farewell

By Nancy Atkinson, Chief QIES

It was August 18, 1994 when I first walked into the Oklahoma State Department of Health to begin my career with the Protective Health Services area. I had worked at the Department of Human Services in the long term care area for many years, so I had background on the payment process, medical eligibility, and PASRR (known as PASARR at that time). I knew nothing about the survey process or Medicare certification, and had only seen a copy of the MDS one time (OASIS did not exist). After a couple of years of concentrated training, I was assigned the new federal program titled SAQIP (State Agency Quality Improvement Program) and because there was no other staff to do it, I received the designation as the MDS Automation Coordinator. At the time I had no idea how much those two assignments would affect my life. Long story short—the experience I obtained working on the SAQIP program and my involvement with the electronic side of MDS, eventually brought me to the position of Director of Quality Improvement and Evaluation Service. It is here that my career with the Oklahoma State Department of Health will end with my retirement on May 31, 2016. Many changes have occurred in the MDS-OASIS programs over the last 16 years and I'm certain that will continue. I trust that in the past you have found the MDS-OASIS staff willing and able to assist you. That will not change with my retirement. The same dedicated group of individuals will be here to assist you with any problems or questions you encounter.

It has been my privilege to work with you throughout the past years. You have taught me many things and helped to shape my life both professionally and personally. I am deeply grateful for our experiences together and for the collaborative spirit with which we have all worked to assist residents and clients to reach their highest practicable level of functioning.

Points to Ponder

One of the Governor's Healthy Aging initiatives is to reduce depression in Oklahoma's elderly population. When an individual is in pain, they may feel depressed and clinicians can help by incorporating effective pain management strategies.

The goal of pain management is to address the levels of pain and provide maximum pain relief with minimal side effects.

One of the primary roles of nursing is serving as a patient advocate. As an advocate, you will identify all possible ways to help relieve the patient's pain and suffering. Being a patient advocate in a nursing home is critical to help ensure the resident's pain is properly managed. Many times you will be the resident's voice and report to the interdisciplinary team the different characteristics of the resident's pain. Such as, type, location, frequency, impact on ADLs, etc.

The standard of care for pain management is ongoing pain assessment and pain management. This includes: 1) acknowledging and accepting the resident's pain; 2) identifying the source of the pain; 3) assessing the resident's level of pain using a pain assessment tool at regular intervals; 4) implement pain management strategies and evaluate their effectiveness; 5) document the resident's response and outcome of the intervention and 6) advocate for the resident.[1]

. Pain Management Nursing Role/Core Competency A Guide for Nurses; Maryland Board of Nursing

Inside this Issue

Falls and Pain

Falls and pain are both events that are concerning to individuals, families, and caregivers. Falls can be debilitating and in some cases life threatening. Frequently we think of pain occurring when a person falls. due to an injury.

In truth people who have chronic pain may be falling as a result of chronic pain.

Can you remember an individual that you have known, who usually stayed in bed all day because they had such high levels of pain. They were very weak, tired, didn't sleep well, pain medications were ineffective, sometimes developed orthostatic hypotension as a result of being in a recumbent position so much of the time. These individual's were at a very high risk to fall due to general debility secondary to their pain.

When an individual has chronic pain they frequently decrease their activities. This can result in a decrease in muscle mass, strength, and stamina/endurance. Which also can lead to shortness of breath and increased pain with activity. Chronic pain is a vicious cycle, which is very difficult to control.

As medical caregivers education on the subject of pain can be beneficial not only to us but also to the individual's we serve and their families. It is standard practice today to routinely evaluate an individual's pain level. It is important to report relevant information concerning pain to the physician and team. This should include the level of pain experienced, any precipitating factors, interventions to decrease pain (visualization, meditation, medication, topical applications, etc.), acceptable levels of pain, and the effectiveness of interventions.

If interventions need to be implemented or adjusted this information that should be communicated with the physician and team. At times some physicians may not be prompt at responding to this information and the team may have to have a meeting regarding this issue.

At this time there are numerous non pharmacological interventions that can be attempted. Therapy sometimes can decrease pain, may build strength and endurance. Which can also decrease the risk of falls. Relaxation techniques, visualization, massage, and exercise are some other things that may help decrease pain.

Many times the actual pharmacological interventions themselves may need to be reevaluated. Of course, we all know to follow up with an individual to determine the effectiveness of the intervention.

If you have been in the medical field for very long you have probably come in to contact with an individual who has continuous chronic high levels of pain. In the past it has been very frustrating to try different high potency medications that do not seem to phase the pain an individual is experiencing.

Today Pharmocogenics can determine the effectiveness of a number of medications for individuals, including pain medication.

It is necessary to holistically view the individual. If pain can be managed successfully, an individual can become more active. This can have numerous benefits. Here are a few benefits:

1. Decrease pain
2. Decrease Falls
3. Increase mobility
4. Build Stamina
5. Decrease depression
6. Increase appetite
7. Decrease in Constipation

This list could go on and on with the benefits.

The most important items to remember is that pain is caused by many issues some are treatable and may be eliminated such as a toothache. Other pain may be chronic such as arthritis, headaches, sciatica, etc. In the case of chronic pain we need to use all assessment and interventions at our disposal to manage the pain. The improvement that adequate pain control can have in an individual's life can be transforming.

Years ago I had a patient who had Rheumatoid Arthritis. This individual consistently rated their pain level at a 10 out of 10 with the use of pain medication. This individual had falls frequently while ambulating with the use of their walker. I talked to the individual numerous times about PT. Eventually the individual agreed to PT. This made a tremendous difference in the individual's life. The pain level decreased to a more tolerable 5 out of 10. This person was able to socialize with friends and family, they had increased strength, falls dramatically decreased, the individual's mood improved, the individual was happier and experienced better quality of life.

OAISIS Q &A

Question: If I complete my comprehensive assessment late (my M0090 date is 6 days post SOC) and I do a standardized pain assessment on that 6th day, would I report the pain assessment when completing M2250 (and when completing M2400 at Transfer/ Discharge) because I did conduct the pain assessment?

Answer: M2250 and M2400 don't directly report if the pain assessment was conducted. M2250 reports if the physician-ordered plan of care includes specific interventions (in this case, to monitor and mitigate pain) and should be marked "No" or "Yes", depending on the presence of the orders, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all. M2400 reports if specific interventions (in this case, to monitor and mitigate pain) were BOTH included in the physician-ordered plan of care AND implemented. M2400 should also be marked "No" or "Yes" based on the presence of the orders and documentation of their implementation, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all. "NA - Formal assessment did not indicate pain since the last OASIS assessment" may not be selected in this case, since item guidance states that the formal assessment referred to for column d is M1240, Pain Assessment, and that since the pain assessment was conducted after completion of the comprehensive assessment (and outside the assessment time frame), M1240 should be reported as "0 – No standardized assessment conducted", and therefore "NA" could not be reported for row d on M2400.

Question : For the Process Measure items related to patient assessments, I am not clear when a standardized tool is required and when the assessment can be completed based on clinical factors of the clinician's choosing.

Answer : Standardized assessments are required to meet the intentions of the M1240 Pain Assessment, the M1730 Depression Assessment, and the M1910 Multi-factor Fall Risk Assessment. Clinical factors may be used to conduct the M1300 Pressure Ulcer Assessment, or the agency may use a standardized Pressure Ulcer Risk Assessment tool.

Question : For the process measure items requiring use of a standardized assessment, can an agency develop their own "standardized tool" based on agency policy or do they need to use a tool developed by a nationally recognized authority? Define "standardized".

Answer : A standardized tool is one that has been scientifically tested and validated an effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. To meet the need of the pain assessment, the depression screen or the multifactor fall risk assessment referenced in the OASIS, an agency may use a standardized tool from any organization able to effectively develop, test, and validate the tool for use on a population similar to that of the patient(s) being assessed. An agency may not create an assessment by combining clinical assessment factors, unless the OASIS item indicates that the assessment can be based on clinical judgment, such as M1300, Pressure Ulcer Risk.

CMS OCCB Q&As – October 2009 (www.oasiscertificate.org)

M item	Standardized Assessment Required?
M1240 Pain	Yes
M1300 Pressure Ulcer	No; optional
M1730 Depression	Yes
M1910 Falls	Yes

OASIS Automation Tips

Recent Q&A's

Question: The Guidance Manual states that the patient's name for M0040 should match the Medicare or insurance card, but what should I do if the patient's last name has more letters than M0040 allows?

Answer: For M0040 Patient Name, the OASIS Guidance Manual states the name should appear exactly as it does on the Medicare card or other insurance card. The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name. The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted to the CMS ASAP system. In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters for the purposes of M0040. This approach should be used for all time points throughout the patient's episode of care.
Note that this M0040 limitation should not be applied to other documentation (clinical records, claims, etc.) where the patient's full name should be used.

Additional Q&A's and Thoughts

A New grouper goes into effect 10-1-2016 for OASIS-C2. This is related to ICD-10 updates and upgrades.
Is your software vendor ready to go on the billing issues?

All Submissions, to include OASIS-C1/OASIS-ICD-10 and C2 will go through the Assessment Submission and Processing (ASAP). Your Software should accommodate this for you. "Verify with your vendor" how you will complete and submit both OASIS-C1/ICD-10 & C2.

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Question: When will the final version of the OASIS-C2 data set be available? I see the OASIS-C2 form is available on the CMS website, but am not certain if this is a final version.
Answer: On December 22, 2015, the OASIS-C2 All Items Data Set was posted on the CMS Home Health Quality Initiatives webpage . The OASIS-C2 version of the data set is scheduled to go into effect for all assessments with a M0090 Date Assessment Completed on or after January 1, 2017. Once this new version of the data set is approved by the Office of Management and Budget, an OMB approval number will be added to the data set and it will be re-posted as **Final**.

Contact Us

Oklahoma State Department of Health

QIES Help Desk

1000 N. E. 10th Street
Oklahoma City, OK
73117-1299

Phone: (405) 271-5278
Fax: (405) 271-1402

Automation Tip:
Remember to occasionally pull CASPER reports in order to compare to software reports. CASPER reports are housed with CMS and are utilized with the survey process. What appears on the CASPER reports is a result of OASIS submitted and accepted assessments in the Federal Database and could be different than what appears on your software generated reports.

MARK YOUR CALENDAR!

Upcoming OASIS Training

RESCHEDULED
August 18, 2016
OASIS Automation
Shawnee

OASIS-C2 and Updates

OASIS Clinical
November 17, 2016

OASIS Automation
November 18, 2016
Shawnee

QIES Team:
Diane Henry RN
Wanda Roberts RN
Stephanie Sandlin RN
Bob Bischoff

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