POLICIES AND PROCEDURES FOR USING OASIS

POLICY:

Agency will conduct comprehensive, patient-specific assessments that contain Outcomes and Assessment Information Set (OASIS) criteria that accurately reflect the patient’s current health status and include information that may be used to demonstrate the patient’s progress toward achievement of desired outcomes. The assessment will be performed on appropriate patients, IE: patients age 18 and older that are non-maternity patients receiving skilled services under Medicare or Medicaid. Skilled services are defined as those services requiring the skills and knowledge of, and can only be provided by, a nurse as defined in the HIM-11 by Medicare. The Agency will use the current OASIS information supplied by the U.S. Centers for Medicare and Medicaid Services (CMS). Please refer to policy on admissions and assessments, Section V of the Agency policy manual.

Each patient who meets the admission policies of the Agency will receive a patient-specific comprehensive assessment that will identify the patient’s continuing need for home care, will support eligibility for payor source criteria including a description of homebound status, if applicable, and facilitate care planning and care delivery to meet the patient’s medical, nursing, rehabilitative, social and discharge planning needs.

Home Care Plus and each staff member will assure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data. The Agency will not release patient identifiable OASIS information to the public. Access to all OASIS data (hard copy as well as electronic data) is secured and controlled by the Agency. Patient-identifiable OASIS data are not released for any reason other than for intended purpose: IE, to transmit to the state survey agency for the development of outcome reports.

PROCEDURES:

I. Initial Assessment Visit

A. A registered nurse will conduct an initial assessment visit to determine the immediate care and support needs of the patient. The nurse will determine the patient’s homebound status and whether or not the patient is eligible for the Medicare home health benefit. The nurse will follow the Agency’s policies and procedures for admitting or referring patients for other services. (Please see Administrative Clinical Section of the policy manual).

B. The initial assessment visit will be conducted either within 48 hours of referral, within 48 hours of the patient’s return home, or on the physician’s ordered start of care date. (Please refer to policies in the Admission Open Process section of the Agency’s policy manual).
C. The comprehensive assessment will be completed in a timely manner, consistent with the patient’s immediate needs, but no later than five (5) calendar days after the start of care.

D. The patient will be given a copy of Federal letters labeled Attachments A, B, and C that explain patient’s privacy rights, confidentiality, and patient’s rights regarding clinical records. Medicare and Medicaid patients receive the “Statement of Patient Privacy Rights” and the “Privacy Act Statement (Health Care Records).” NonMedicare and nonMedicaid or personal care only patients receive the “Notice about Privacy for Patients who do not have Medicare or Medicaid Coverage.”

E. During the initial assessment visit, the admitting professional explains to the patient and/or his/her representative, before the initiation of care: the Patient Rights and Responsibilities; the home health hotline, release of record policy, Advance Directives and applicable policies and procedures, OASIS data collection and related procedures.

F. The patient will be informed, orally and in writing, of these rights regarding OASIS collection:

   a. How data will be collected and the purpose of that collection
   b. The Agency will keep that information confidential and secure
   c. Be informed that OASIS information will not be disclosed except for legitimate purposes.
   d. The patient may refuse to answer any questions. If the patient refuses to answer any OASIS questions, the Agency may still deliver care to the patient as long as it completes and submits OASIS to the best of its ability. Staff will report the most appropriate response, based on professional judgment.
   e. See, review and request changes to the OASIS assessment.
   f. Know that the Agency collects data on the patient’s financial status but does not submit that data to the state agency.
   g. The agency monitors collection of OASIS data and the patient’s privacy issues to promote these patient rights.

II. Update of the Comprehensive Assessment

A. The comprehensive assessment will be updated and revised, including the administration of the OASIS, as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status according to the following guidelines:

   a. At least within the last five days of every 60 day period/episode beginning with the start of care date for patients receiving skilled nursing care. For
b. patients receiving personal care only, the visit may be moved outside this five day window to meet patient needs or to promote patient satisfaction.
c. Within 48 hours of the patient’s return home from a hospital admission of 24 hours or more for any reason other than diagnostic testing, or within the Agency’s knowledge of the patient’s return home.
d. At time of discharge from the Agency.
e. With a significant change in patient status. A significant change for prospective payment is one that was not envisioned in the plan of care, involves a change in the HHRG code and is accompanied by physician ordered changes to the plan of care. A significant change for clinical reasons may be defined as one requiring an increase in visits of a discipline, the addition of a new medical diagnosis and/or treatment affecting the delivery of care, a change in caregiver or environment that affects the patient’s ADL/IADL abilities, or an unforeseen deterioration or improvement in the patient’s status.
f. Within 48 hours of learning of a transfer to an inpatient facility for other than diagnostic testing or a stay less than 24 hours. (Transfer OASIS).

B. Each comprehensive assessment will verify the patient’s continued need for home care. For Medicare patients, there must be verification of the continued eligibility for the Medicare home health benefit, including homebound status.

C. If the patient simply changes physician or payor source within a two month period without the requirement for a new start of care date on the plan of care, these changes will be made when the next OASIS is due.

D. The updated assessment may be performed by a registered nurse, or by a physical, speech or occupational therapist if a therapy service is the only professional service ordered by the physician. All staff will receive the necessary education, training and supervision in comprehensive assessment techniques and documentation requirements.

E. If a patient refuses to answer OASIS items, staff will:
   a. Encourage but not force patients to respond.
   b. Explain that data will help to plan their care. Reaffirm confidentiality.
   c. Complete the OASIS based on professional judgment.
   d. Report to the supervisor if the patient refuses to answer any questions.
   e. Document the patient’s refusal on the OASIS assessment and the reason stated by the patient.

III. **Drug Regimen Review**

A. Each comprehensive assessment will include a review of all medications the patient is currently using.
B. The review is done to identify any potential adverse effects and drug interactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy.

C. The nurse will notify the patient’s physician and/or pharmacist of any potential adverse effects and drug interactions or ineffective drug therapy.

D. High risk drug education will be provided based on the BEERS list.

IV. Reporting OASIS Information

A. Agency will encode (as of 7/19/99) and transmit (after 8/24/99) all OASIS data collected on patients receiving skilled care under Medicare and/or Medicaid to the Telligen (formerly the Iowa Foundation of Medical Care or CMS, formerly HCFA), in accordance with all applicable regulations and laws, including the Conditions of Participation.

B. Agency will encode and lock OASIS data prior to submission of the initial RAP for Medicare patients or within 30 days of completing the patient’s OASIS data set. The encoded OASIS data will accurately reflect the patient’s status at the time of assessment.

C. OASIS data will be submitted to IFMC at least monthly after the initial transmission of data on/after 8/24/99 by regulation. The Agency uses electronic communications software that meets the established requirements to ensure secure transmission.

D. Patients will sign a release of information for transmission of OASIS to Telligen (formerly IFMC/HCFA) prior to transmission of said data. Please refer to Agency Consent for Treatment form.

E. Data entry will be performed by qualified individuals only, which include the Office Assistant, Accounts Coordinator, Quality Improvement nurse, or the Director. Data transmission will be done by the Quality Improvement nurse, or designee, as necessary. Access to the OASIS software is secured by password. Access to data entry, transmission, and editing is each secured by password. Unlocking data may only be done by the Quality Improvement nurse or the Director.

F. All staff are required to log off the data entry system when leaving the system unattended.

V. Quality Improvement

A. Accuracy of staff encoding and locking of OASIS data will be maintained by performing random edits of each type of OASIS assessment at least quarterly.
Random audits will be done for OASIS onsite with the clinician to monitor the accuracy of OASIS assessment (IE: evaluate assessment methodology and assessment skills of the professional staff), or via a paper audit for chart content and consistency.

B. Chart audits done randomly by the Director or designee will be done to assure accuracy and reliability of OASIS assessment. The comprehensive assessment containing OASIS will be reviewed in addition to the patient’s outcome goals.

C. Individual or group meetings will be held with the Director to identify performance improvement areas, and to implement appropriate action using FOCUS PDCA.

D. A file will be maintained of Final Validation Reports according to Agency policy on record retention.

E. Correction of data entry errors can be made by, and only with the direct knowledge of, the Director and Quality Improvement nurse once records are locked and ready for export.

F. Bulletins will be monitored online at least monthly.

G. Clinical record audit will be performed at least monthly to verify accuracy of OASIS patient status items compared to other related patient documentation in the clinical record for that patient.

H. A data entry audit will be performed at least monthly to verify the accuracy of OASIS data.

VI. Patient Review of the Record

A. A patient has the right to review OASIS assessment data and/or to request a response be changed.

B. If a patient requests that a response be changed, Agency staff will:

   a. Inform the patient about the time parameters and methods for review of data.
   b. Review responses with the patient, discuss rationale and how the answer affects care planning and delivery.
   c. Ask the patient about the reason for the change in response and which response the patient believes is appropriate. The patient’s request and response will be added as a late entry to the record according to policy.

C. If there is a dispute regarding the need to change the OASIS information collected, the Agency will pursue one of the following two choices:
a. The Agency can agree with the patient’s request and change the applicable OASIS data elements, and then resubmit the information to the State agency, following the established procedure for submitting corrected OASIS data

OR

b. The Agency can disagree with the change. The nurse or therapist will discuss the situation with the supervisor. The Agency will provide written documentation to the patient, detailing the reasons that it will not change the information.

For patient choosing to pursue their requests for change at the Federal level, the Agency will provide the toll-free number (1-800-638-6833) for the CMS. During that call, CMS will provide additional information to the patient on how to proceed with the dispute. CMS may also request additional notarized information for verification, including the patient’s name, health insurance claim number, social security number, address, date of birth, and sex.

*See also “Patient Access to Record” in Administrative Clinical Policy

VII. Contracts

The Agency will establish a written contract with the agent acting on the Agency’s behalf for OASIS data outcome reporting. The contract will require confidentiality of all patient-identifiable information in the clinical record, including OASIS data. Agents acting on behalf of the Agency are bound by confidentiality requirements established by the Agency and state and federal regulations, and are aware of the requirements and security policies of the Agency and Privacy Act.

Any breach in security by the agent will be grounds for termination of the contract.

VIII. Making Corrections to the OASIS

The Outcome and Assessment Information Set (OASIS) is part of a comprehensive assessment, and because it requires the clinical judgement and evaluation skills of a professional, it can only be performed by a professional nurse or therapist.

Corrections to the medical record are to be completed, whenever possible, by the author of the document. Changes by the author are to be implemented by making a single line through the entry which is in error. The clinician will initial and date the correction.

Changes in the order of ICD-9 codes will be made by the clinician who authored the document.
In some instances, it may not be possible for the originating clinician to make all corrections timely, or due to scheduling or staff turnover. If, upon discovering an error, the original clinician is unable to make the needed correction timely, documentation will be made in the clinical record that describes the reason for the change in the assessment and the communication that took place among the involved staff. Changes will be made on a separate correction form. The correction form will be a permanent part of the medical record. The changes will only be made by the Director or Quality Improvement nurse. The originated clinician will be contacted prior to the change being made to verify accuracy of the data and to give approval for the change. The consultation will be documented in the record, along with the title of the Director or Quality Improvement nurse as the person making the change. The date of the entry change will be recorded, along with an explanation of the reason for the change. When feasible, the originating clinician will sign off on the change.

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Documenting Changes to the OASIS Assessment

1. Professional who completed the OASIS: Name______________________Title________

2. Date the professional contacted about the change________________________________________

3. The change was validated for accuracy of the assessment with the clinician  YES  NO
   If NO, a detailed reason must be listed________________________________________________________________________
   __________________________________________________________________________

4. Person making the change in the record: Name______________________Title________

5. Date change was made by the Director or the QI Nurse__________________________________

6. Change made on an addendum to the record: YES, see attached

7. Explain in detail why the change is warranted:________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

8. List the change(s) made: