CHAPTER 7

DOCUMENTATION REVIEW AND REVISION

A. INTRODUCTION

In this chapter, we assume that two decisions have been made by the appropriate agency staff members: (1) the policies or procedures to be followed when a patient is admitted to an inpatient facility (i.e., whether or not patients are routinely discharged in this situation), and (2) which documentation approach the agency will be using (i.e., revision of its own paper and pen documentation forms, use of forms downloaded from the CMS web site, purchase of commercially available paper and pen forms, or use of point of service electronic documentation). Some content of this chapter pertains to all documentation approaches, while other content applies primarily to paper and pen approaches.

Implementing the OASIS data set as part of an agency's comprehensive assessment requires that the OASIS items be integrated into an agency's standard home care record. This approach to uniform data collection increases the accuracy of assessment as well as decreasing the abstraction and encoding (i.e., data entry) burden and minimizing the documentation and paperwork burden for agency clinical staff.

Integration means that items on an agency's current assessment that are substantive duplicates of OASIS items are eliminated. It also means that OASIS items are not simply added on to the beginning or end of an existing assessment form, but that OASIS and other items are interspersed in a manner that creates a logical and clinically appropriate flow to the assessment as well as facilitating efficient data entry.

Regardless of the documentation approach chosen by the agency, decisions are required about the number of unique form versions to be developed and utilized. In addition, careful review of the new assessment forms is necessary to monitor accuracy. Review and revision of forms are precise, time-consuming activities. For these reasons, it is suggested that a team or task force be utilized for the activities associated with documentation review and revision.

B. THE OASIS DOCUMENTATION REVIEW AND REVISION TEAM

In most agencies, a team approach to documentation review and revision has proven most effective. In those instances when teams have not been used, subsequent activities emphasize the value of group involvement in this task. Ideally, the team should include clinicians of various disciplines, a clinical manager, medical records staff member, and information systems (or clerical

staff) representative. All these staff groups are affected by documentation changes and thus have investments in the final product(s).

Another approach to choosing the team is to select the appropriate mix of personality attributes to complete the task successfully. Descriptors of such attributes include:

- the "prima donna," who considers herself/himself the best assessor of patient health status in the agency;
- the "informal leader," whose opinions are respected by others and who will keep the group on track;
- the "nit-picker," who is sufficiently detail-oriented that errors in wording or skip logic will not be overlooked;
- a "whine-er," who has never encountered anything anywhere that satisfies her/him, and who is likely to introduce anticipated barriers which can be addressed early in the process for a more satisfactory product later on; and
- a "cheerleader," whose energy and enthusiasm will keep the group moving toward task completion now and will increase full staff acceptance of the changes later.

While leading such a group can be challenging, the effort is likely to be fully worth the investment when the final product is accepted by such a diverse group. If the personality attributes and the various staff categories can be combined in team selection, the likelihood of success is maximized.

C. INTEGRATING OASIS ITEMS INTO CLINICAL DOCUMENTATION

1. General Principles for Integration

OASIS items must be integrated into clinical documentation—not presented as a separate form or an attached form. Whether paper and pen documentation or a point of service electronic approach[1] is utilized, several general principles for integration of OASIS items must be followed. These include:

a. *Items in the revised clinical documentation must be exact (verbatim) duplicates of the OASIS items.* Emphasis added to items by underlining, boldface, and capitalization must be retained. (In point of service record-

[1] See the Software Guidelines included in Appendix F for additional information to be followed in using point of service clinical documentation approaches.

keeping systems, such emphasis can be made through use of highlighting approaches other than boldface, but it should be included.) Uniformity of data collection cannot be assured if modifications are made to the items. Five possible exceptions to this principle are:

- Diagnoses are included as five-digit ICD codes, although only three-digit ICD codes are required. **For Medicare patients:** Because diagnosis codes are used to determine payment for Medicare PPS patients, the use of four- and five-digit codes is encouraged, and the codes should match the codes on the 485.

- Where the response option of "Other (specify)_____" appears, the "(specify)" portion may be excluded if an agency chooses. Any information written into the response option will not be data entered or transmitted, but it might be determined useful for agency clinicians.

- The end points of any items with "skip" logic should be renumbered to direct the clinician to the next appropriate item. Skip logic allows a clinician to proceed more quickly through the assessment form, but items should not be skipped inappropriately.

- Response options for M0100-Reason assessment is being completed that are not appropriate for the time point (e.g., Responses 4 through 10 do not apply to SOC documentation) can be omitted on that form only.

- The name requirement for M0040 can be reordered to match the data entry software (i.e., Last, First, MI, Suffix).

b. *All OASIS items (appropriate for the time point) must be included in the assessment documentation, though their sequencing may be altered.* The sequence in which the OASIS items appear follows a systematic assessment approach. However, agencies may choose to alter this sequence. If they do so, it is strongly recommended that skip patterns not be altered because data entry errors and edit checks will result from improper sequencing of some items. It is suggested that agencies retain the sequencing of items within OASIS subcategories.

c. *Unique OASIS identification markers should be retained.* These identifiers consist of five characters (one letter and four numbers, Mxxxx). While the identifiers do not contribute to patient assessment or care planning, they facilitate locating the item within the clinical record for data entry purposes. In addition, the identifier clearly designates an OASIS item and serves to eliminate potential "tinkering" with the item.

d. *"Skip patterns" must be carefully observed.* For example, the OASIS contains a series of questions on wounds. If the patient has no wound, the first question in the series directs the clinician to "skip" the subsequent wound items. Such skip logic assists the clinician to proceed quickly past nonrelevant items. However, this logic can be easily overlooked during the form revision process, resulting in critical data errors. Special attention regarding skip patterns should be directed to the forms for transfer to inpatient facilities and discharge.

e. *Item wording variations between specific time points must be observed.* Some OASIS items include an "unknown" response option at start of care, but this option is not present at later time points. Some items ask about "prior status" at start of care, but not later. Other such changes are made to select OASIS items. The wording variations must be followed exactly in reviewing and revising documentation. The wording variations between the various time points are identified in Appendix B of this manual.

f. *Documentation for all disciplines who are able to complete the comprehensive assessment must follow OASIS integration guidelines.* For example, an occupational therapist (OT) may be the only discipline seeing a Medicare patient at agency discharge. The OT documentation for discharge assessment must have OASIS items incorporated according to the guidelines presented here.

2. How Many Versions of Forms are Needed?

A minimum of three unique form types are needed (i.e., a "universal" or discipline-neutral form for start of care/resumption of care, and a second "universal," discipline-neutral form for use at follow-up and a third universal form for use at discharge/transfer to inpatient facility). The same form would be used by all clinical disciplines of the agency. Three unique forms are necessary because of the wording changes to items between start (or resumption) of care and the other time points. Three forms are a "barely manageable" number, and most agencies also will have separate forms for transfers and for discharges.

Many agencies will prefer to use discipline-specific or time point-specific forms. For example, a therapist will prefer different assessment items than a nurse at start (or resumption) of care. Alternatively, the brevity of the transfer to inpatient facility data set is likely to cause many agencies to develop this as a separate form, reducing printing costs when compared to a full assessment form of which only a few pages are used. The exact number and type of forms is thus determined by the agency. (See Chapter 4 for a discussion of an approach to developing a discipline-specific comprehensive assessment form.)

3. Carefully Review and Proofread the New Documentation

Regardless which documentation approach is utilized (i.e., revision of current forms, purchase of commercial forms, point of service electronic forms, etc.), the new documentation should be reviewed carefully to determine the accuracy of the integration efforts. Thorough proofreading and checking of the documents are necessary to avoid major data entry problems later. Checklists for review of new clinical records for each time point are found in Appendix D of this manual. These checklists allow several individuals (or a single individual at multiple times) to carefully review the documentation, check off items that have been examined for specific characteristics, and determine the existence of any problems. Uniformity and accuracy of the OASIS data can be negatively impacted by failure to carefully review the new clinical documents once they are completed.

Also review the forms from an overall editing perspective. Is the print size sufficiently large to read? Are too many items crowded on a page? Can the clinician proceed appropriately through the document without missing items? Do items change from vertical column to horizontal row placement suddenly in rather indiscriminate fashion?

D. REVISING AGENCY-SPECIFIC DOCUMENTATION: APPROACH THE TASK SYSTEMATICALLY

1. Evaluate Current Documentation

An agency choosing to revise its own clinical documentation should approach this task systematically, beginning with a thorough evaluation of its current clinical records, comparing current documentation to the OASIS items. Mark on the OASIS data set those current assessment items that are exact duplicates, those that are similar but not exact, and those that are currently not present. In some cases, minimal or no change to the current data item is needed (e.g., start of care date, gender, date of birth, Medicare number, etc.). In other situations, the precision of the OASIS item will require the agency to substitute the OASIS item for its current documentation (e.g., scale for shortness of breath, bathing scale, etc.). Completing this review will provide information as to the anticipated size of the task ahead.

This review should be done for the documentation of all comprehensive assessment time points (i.e., start of care, follow-up every 60 days, discharge, transfer to inpatient facility, etc.) and for all disciplines eligible to do the comprehensive assessment (i.e., RN, PT, OT, ST). In all likelihood, the start of care assessment for any one discipline is likely to be the most complete, as few agencies have required comprehensive assessments at discharge or other follow-up time points,

regardless of discipline. These disciplines and time points are likely to require new documentation, rather than being able to modify existing records.

2. Decide Whether to Adapt or to Begin Anew

Evaluating current documentation in comparison to the OASIS data set helps the team decide whether to modify their own records, possibly to modify the sample OASIS assessment forms (found in Appendix C and on the OASIS web site), or to develop an entirely new set of forms. If the latter approach is chosen, some agencies begin this process with the OASIS items and add to these the additional items they find necessary and appropriate for comprehensive assessment. Whichever approach is chosen, the team should follow the principles listed above for integrating OASIS items, determining how many form versions are needed, and carefully reviewing the completed documentation.

3. Other Tips for Reviewing/Revising Documentation

Attempt to maintain a format similar to existing agency documentation as much as possible. The transition necessary for clinical staff will be smoother if they can recognize consistencies or similarities with current forms.

Review current forms for consolidation or elimination possibilities. Many agencies have discovered that integrating OASIS items into current documentation makes other (long-desired) record changes possible. Some have been able to decrease the number of different forms in their admission packets. Some have made concerted efforts to simplify their current paperwork when integrating OASIS. Others have used rules such as deleting one (old) page for every two new pages they added to the overall documentation. Such efforts have increased staff receptivity to the new forms.

E. PILOT TESTING, REVISIONS, AND REFINEMENT

All documentation forms and associated processes should be pilot tested prior to agency-wide implementation. The team members responsible for documentation review and revision are the primary candidates to participate in this pilot test. If the team does not include members of each discipline responsible for conducting comprehensive assessments, the pilot test group should be expanded to incorporate these disciplines.

For the pilot test, each team member should utilize the new forms on three to five patients. Some of these patients can receive the start of care assessment, some the follow-up assessment, and some the discharge assessment. The patients for whom the documentation is pilot tested need not be at that particular time point in

their home care episode, as the pilot testing is for the clinician's assessment of the form's ease of use rather than the evaluation of patient health status. After the forms are pilot tested, the team should meet to discuss possible revisions or refinements. If major documentation revisions are needed after the first pilot test, additional pilot testing should be conducted until any needed revisions are only minor in scope.

When the date for training of all clinical staff is set, the team should also plan the process to "search and destroy" all prior agency documentation for these specific time points. Outdated agency documentation has a tendency to reappear from car trunks, home desk drawers, or temporary files long after it has been abandoned as an official form. The need for this activity cannot be overemphasized, as non-OASIS forms will not meet a variety of regulations under the Conditions of Participation and software specifications which are periodically updated.

The documentation review/revision team should participate in training the agency staff on the new forms. Additional details on agency training are found in Chapter 11 of this manual.

F. REVISING AGENCY FORMS TO COMPLY WITH NEW OASIS VERSIONS

When new OASIS versions are anticipated (e.g., being discussed in industry periodicals, pending/proposed regulation changes affecting OASIS data), agencies have an opportunity to consider what changes, if any, they would like to make to their forms. Since impending changes are often forecast months ahead, this process can be implemented well in advance of any "deadlines."

Whether or not a team approach was used initially to develop OASIS comprehensive assessment forms, agencies have found that they benefit by obtaining input from various departments. It is wise to involve a variety of clinical disciplines and specialties (staff who must complete assessments regularly), as well as medical records staff, data entry and/or information services staff, and other agency departments that frequently use or handle clinical records in the regular performance of their duties. As stated before, the agency benefits by getting much better "buy-in" from staff, which greatly expedites the implementation of new forms.

1. Areas to Evaluate at Times of Change

Before beginning the revisions, consider the benefits of evaluating the forms from various perspectives, (e.g., gaining current clinicians' input about possible changes needed). The team will need to determine the time frame for

completion, tasks to be addressed, necessary changes versus "nice to do" changes and agency resources available. Some agencies will decide not to make any changes except those required, but the decision should have the consensus of clinicians on the team.

- *Adequacy of clinical information (not OASIS) required by the forms*. Does the information documented by clinicians provide adequate detail for direct patient care, use by several care providers, coordination and communication among internal team members, quality improvement, and billing activities as well as physicians and other outside providers?

- *Intuitive flow of assessment information throughout the form.* Does the flow of assessment data to be collected seem appropriate to the majority of clinicians who perform the assessments? Are OASIS items located in proximity to non-OASIS items assessing similar aspects of the patient's condition or situation (e.g., OASIS M0340 - M0380 items located in the same area as names and phone numbers of contact people)? Is there adequate room to record appropriate information about wounds and lesions (e.g., the wounds and lesions not covered by OASIS items, wound description, and wound care being provided)? Have agency items that simulate or duplicate OASIS items been completely removed to avoid potential conflicting information residing in the record?

- *Appropriateness of forms for use by various disciplines.* Has the agency developed appropriate discipline-specific forms (e.g., comprehensive assessment forms with OASIS items integrated for therapists)? Do therapists agree that the discipline specific forms are appropriate to their practice? Does the staff want to consider developing discipline-neutral forms?

- *Ease of use of forms.* Are assessment forms "user friendly" (e.g., easy to read, easy to mark, easily read by data entry/medical records/billing staff)? How could they be improved? Does the order of OASIS items on the forms match the order of OASIS items in the data entry software being used?

- *Forms comply with OASIS integration guidelines.* Refer to Sections C and D on pages 7.2 - 7.6 to refresh your memory. These guidelines can be helpful in revising your forms.

As staff members discuss the adequacy of the current forms, topics such as challenges to efficiently completing comprehensive assessments may arise. Be attentive for comments that indicate a faulty understanding of assessing specific OASIS items (sometimes indicated by varying interpretations by different

disciplines) or difficulties completing comprehensive assessments in general. These can be noted as educational issues needing to be addressed separately.

2. Incorporating OASIS Changes Into Forms

Updated versions of the OASIS forms are posted on the OASIS Data Sets section page of CMS' OASIS web site (www.cms.hhs.gov/oasis/oasisdat.asp) when final, and can be downloaded from that site directly. Additional guides are provided, such as a "Comparison Document," which outlines the changes from the most recent (current) version to the new version for each time point.

Making these changes will require that team members go through your existing forms for each time point, to make certain that all required changes are addressed. Be especially careful that wording changes are included verbatim. If the agency purchases prepared forms from a vendor, remember that it is the agency's responsibility to ensure that the forms comply with all of the guidelines for integrating OASIS items.

If the most recent version of the forms was saved in a word processing file (preferably on a diskette), the changes can be done most efficiently on the computer. Using the computer to accomplish this task makes it easier to identify formatting and space problems. Ascertain that changes inserted in the forms do not cause parts of one OASIS item to be printed on two different pages or columns. Do not neglect careful proofreading by more than one reviewer. If the agency makes significant changes to the assessment forms, it is best to do some pilot testing of the forms (review Section E on pages 7.6-7.7), preferably by care providers not involved in developing the revisions.

FREQUENTLY ASKED QUESTIONS

1. Where do I get CMS' comprehensive assessment form? Which vendors have CMS-approved forms?

There is no official CMS comprehensive assessment form. The comprehensive assessment regulation specifies that OASIS must be part of the comprehensive assessment, but leaves the choice of assessment form up to each home health agency. The sample clinical record forms included in the OASIS User's Manual (Appendix C) may be used by agencies, but they have no official status. Form sets incorporating OASIS are available from vendors, but CMS does not review, test, or approve any forms or vendors. If you use forms from a vendor, review the products carefully to ascertain that OASIS items have been incorporated appropriately.

2. Are the forms in the User's Manual scannable?

The sample clinical forms included in Appendix C were not designed for optical scanning. You should consult with a scanning software vendor to determine if the forms can be adapted for use with optical scanning software. A number of vendors offer scannable form sets incorporating OASIS along with scanning software. If you are considering this option, you should review the products carefully to ascertain if OASIS items have been incorporated appropriately.

3. What about date of onset/exacerbation for home care diagnoses, as required on the CMS 485?

These dates are not part of the OASIS, but they may be included in your assessment form to avoid duplication of paperwork. In general, anything that can be done to consolidate your assessment form is acceptable, as long as no wording changes are made to OASIS items.

FREQUENTLY ASKED QUESTIONS

4. Will agencies be allowed to modify skip patterns through alternative sequencing of OASIS questions?

While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the current OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. We do not recommend this because of the skip patterns built into the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items EXACTLY as they are written into their own assessment instrument. Agencies may wish to incorporate the assessment categories (e.g., ADLs/IADLs, Medications, etc.) into their own assessment instrument in a different order than presented on the OASIS data set. We caution the agency to consider any skip instructions contained within the questions in the assessment categories and provide the proper instructions.

When agencies encode the OASIS data they have collected, that is, enter them into a computer for electronic transmission to the State agency, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence them and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data as long as the data are ultimately presented to the State agency in a file format specified by CMS, that is, a file that contains the OASIS data items in the same order as contained on the most recent OASIS data set.

FREQUENTLY ASKED QUESTIONS

5. Is there a separate OASIS admission form that can be used for rehab-only cases where skilled nursing is not involved?

The sample assessment forms (incorporating OASIS items) found in the OASIS User's Manual most closely resemble nursing assessments. CMS does not have sample rehab assessment examples, though we are aware that such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for incorporating OASIS items into an agency's clinical documentation are outlined in this chapter. Also see Chapter 4 for discussion of the components of a discipline-specific assessment form.

6. Are the OASIS data sets (all time points) to become part of the patient's record? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the resumption of care, transfer, discharge, do we make this part of the record?

The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessment for each time point. Because this documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the Condition of Participation on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation.

FREQUENTLY ASKED QUESTIONS

7. If the OASIS data elements are being filled out for the start of care, follow-up and discharge, is there an additional nursing note required as a Federal regulation? Or is an additional nursing note (as a summary of data gathered) not required, assuming the OASIS elements include all necessary patient information?

As noted in CFR §484.55 (the comprehensive assessment regulation), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Additional nursing notes (or rehab notes) are to be completed as required by the home care agency.